Issue 11,
Jul/Aug 16

Ballarat Health Services

Medication Safety Newsletter

The Worry with Workarounds: an oral liquid given intravenously

A Riskman incident described how a patient was administered liquid oxycodone (*Oxynorm*—formulated for oral administration only) intravenously. The dose was drawn up in an intravenous syringe, and administered to the patient via their IV port.

The area involved only had a superseded brand of oral dispensers available. This brand did not allow for easy removal of the liquid from the bottle. An intravenous syringe was used instead.

Staff are reminded that;

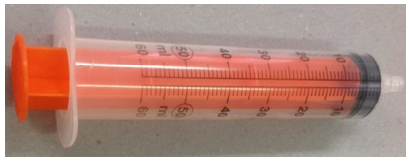
- The *Vygon (Nutrisafe*) brand is the only oral dispenser brand to be used at BHS, unless an alternative is approved by the BHS Product Evaluation and Standardisation Committee (PESCOM).
- The *Vygon (Nutrisafe*) brand has a range of oral dispenser sizes and accessories, including "drawing up straws". Drawing up straws help with removing liquid from a bottle and can be cut to size to fit.
- All oral dispensers and accessories are available to order through the Supply Department.

One important lesson highlighted from this incident was the risks involved in using "workarounds". Workarounds are a symptom of a process problem that **requires resolution**.

If you are using a workaround, or see another staff member using a workaround, speak up.
Be the person who begins the process of eliminating the workaround.

In this case, a phone call to another ward area or to pharmacy could have highlighted a solution (i.e. the current range of oral dispensers and accessories).

Vygon Oral Dispenser



Are you Choosing Wisely? 5 Statements for Medicine Prescribing

"Choosing Wisely" is a campaign intended to initiate **important conversations** about eliminating the use of unnecessary and sometimes harmful tests, treatments, and procedures.

The NPS MedicineWise campaign in conjunction with the Society of Hospital Pharmacists of Australia (SHPA) has released a set of 5 "Choosing Wisely" Statements for medicine prescribing. These are;

1. Don't initiate and continue medicines for primary prevention in individuals who have a limited life expectancy.
2. Don't initiate an antibiotic without an identified indication and a predetermined length of treatment or review date.
3. Don't initiate and continue antipsychotic medicines for behavioural and psychological symptoms of dementia for more than 3 months.
4. Don't recommend the regular use of oral non-steroidal anti-inflammatory medicines (NSAIDs) in older people.
5. Don't recommend the use of medicines with sub-therapeutic doses of codeine (less than 30mg for adults).

The full discussion of these recommendations can be viewed at www.choosingwisely.org.au

Take a moment to **reflect** on whether you can **adopt these statements into your practice**.

Always continue the same brand of warfarin

Coumadin and *Marevan*—the two brands of warfarin available in Australia- are not equivalent. Always confirm what brand the patient takes at home, and continue this brand. Circle this brand on the pre-printed warfarin order (acute stay chart) or write the brand (long stay chart) to communicate this to nursing and pharmacy staff. All patients are initiated on *Coumadin* at BHS.
For more information on warfarin prescribing, please see *Warfarin (DRG0039).*

Product NEWS—Fentanyl Sublingual (*Abstral*) & Strontium (*Protos*)

Fentanyl sublingual (*Abstral*) - a new formulation

Fentanyl is now available in a new sublingual formulation (*Abstral).*
It is approved at BHS for use in patients with cancer related pain who are being treated palliatively and are unable to use other short acting opioids. This approval aligns with the listed PBS indication.
The sublingual tablets provide an alternative to fentanyl lozenges (*Actiq)* that have been available for some years.
Abstral (fentanyl) tablets are available in 100 microgram, 200microgram and 400microgram strengths. The sublingual tablets are administered by placing the tablet under the tongue and allowing it to dissolve completely (without chewing or sucking). Moistening the mouth with water before use may aid the dissolution of the tablet.
Safe prescribing with *Abstral* includes always writing the order with;

- Generic AND brand name.
- The route as sublingual or sub/ling.
- The strength as microg or micrograms.

Strontium ranelate (*Protos*) - removed from the PBS

Strontium ranelate (*Protos*) has been removed from the PBS and is only available on a private prescription. This follows the addition of a black box warning in 2014 that restricted its use to patients who were intolerant of other therapies. This was based on an increased risk of cardiovascular events and venous thromboembolism.

Prescribing with generic AND brand name

BHS has a small list of medicines that must be prescribed with the generic AND brand name (listed below). This list was created to try and minimise the risk of error.

Generic Name	Brand Names
Warfarin	*Coumadin, Marevan*
Hydromorphone	*Jurnista, Dilaudid*
Oxycodone	*Endone, Oxycontin, Oxynorm*
Levodopa containing Parkinson's medicines	*Sinemet, Kinson, Madopar, Stalevo*
Fentanyl sublingual	*Abstral*

Prescribers are reminded to endorse generic and brand names for these medicines.

Immediate Release and Slow Release Products

There have been a number of Riskman incidents where, despite double checking, the wrong formulation of the medication was selected. For example, the immediate release product was selected when the slow release product was prescribed. The incidents primarily relate to;

- Tramadol
- Oxycodone

Some suggested strategies to prevent these errors are;

- Ensure that any double check performed is "independent".
- Think about why you are giving the medication. "As required" pain relief is more likely to be an immediate release product.
- Organise the safe so that immediate release and slow release products are on different shelves and therefore separated.

High Risk Drug—Methotrexate

A Safety Advice that outlines the key requirements of **Methotrexate (oral) - Guidelines For Use** - *CPG0069* was distributed in July 2016. A copy can be located on the Pharmacy Intranet page.
As a high risk medication, all staff are requested to review the memo and/or policy and adapt their practice accordingly.