Issue 12,
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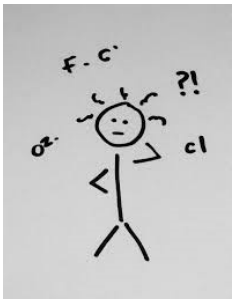
Ballarat Health Services

Medication Safety Newsletter

Safe Prescribing is a Team Effort

A death at a Tasmanian hospital was investigated by their State Coroner. It involved a patient who required palliative pain management. The patient was switched from a fentanyl patch to a morphine subcutaneous infusion (via syringe driver).
The doctor initiating the syringe driver had little experience with morphine subcutaneous infusions, and incorrectly calculated the daily infusion as 1080mg. The error occurred when a suitable dose (45mg over 24 hours) was mistaken to be an hourly dose by the prescriber, and therefore multiplied by 24. The patient received 496mg over 12 hours before the infusion was ceased.

The Coroner indicated that the overdose "likely accelerated" her death by a relatively short (but indeterminable) duration.



Key contributors identified included;
- Multiple mid career medical staff not detecting the gross error in calculations.
- Lack of familiarity with opioid dose conversion tables.
- Lack of appropriate escalation by nursing and pharmacy staff.

Key messages from this incident include;
- The importance of timely escalation of concerns about medication dosing. BHS has a Clinical Escalation Policy (CPP0231) that can guide staff.
- Ensuring that any dose conversion tools that are consulted contain clear and unambiguous information.

The Medication Management Committee, in conjunction with the Department of Anaesthesia and Pharmacy, are planning to evaluate available dose conversion tools for use at BHS.

The full report can be located at;
www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0007/353527/Teressa_Besswick_web_publication.pdf

New Drug Guideline: Vancomycin (DRG0051)

A vancomycin drug guideline for adult patients has been developed to help ensure patients are receiving consistent dosing and therapeutic drug monitoring for this important antibiotic throughout BHS.

Key points in this guideline include:
- All patients should receive a loading dose of 25-30mg/kg, based on their actual weight to rapidly achieve a therapeutic level.
- The subsequent maintenance dose and frequency should be based on the patient's actual weight and renal function.
- Vancomycin blood levels should be taken immediately before the 4th dose (or sooner in patients with impaired renal function).
- Do not withhold doses while awaiting levels unless specifically requested by Medical or Pharmacy staff.

In addition to the drug guideline, a flow chart has been placed around the acute wards, to assist medical and nursing staff with appropriate dosing and monitoring of vancomycin.

For further information, contact the AMS pharmacist (David Brownridge) on pager 5780, or speak to a clinical pharmacist. The Guideline is now available from the Governance Document portal on the BHS intranet.

Antimicrobial Awareness Week—14-20 November

ANTIBIOTIC AWARENESS WEEK
14-20 NOVEMBER 2016
Preserve the Miracle

BHS will mark Antimicrobial Awareness Week with a number of activities including;
- A Grand Round presentation on 16 November by the BHS AMS team.
- Completion of the National Antimicrobial Prescribing Service (NAPS) audit.
- Visual displays of key messages in ward areas.

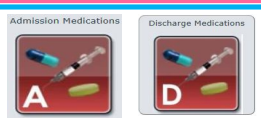
Prescribing Penicillin: Vigilance Required

There continues to be Riskman reports relating to incidents where a patient with a documented penicillin allergy is prescribed a penicillin.
For example, a patient had a documented allergy to flucloxacillin (rash) and was prescribed and administered flucloxacillin. There was no reason documented for prescribing this drug.

Remember the following safe medication tips;

- **Prescribers:** Check patient allergies before prescribing. Say the allergy out loud to reinforce it.
- **Nurses:** Check the patient allergies before administering the medication and verbalise this check.
- **Pharmacists:** Check the patient's allergies before authorising medication supply.

Improving Medication Safety in BOSSnet: Admission and Discharge Module



A project is currently underway to introduce a new medication management module within BOSSnet that will create two key functions;

- Recording of the patient's Best Possible Medication History (BPMH) electronically and the generation of a printable BPMH.
- Electronically prepared discharge prescriptions, that can then populate the Discharge Summary.

There is great potential for this functionality to improve medication safety by;

- Improving legibility of BPMH and discharge prescriptions.
- Minimising unsafe abbreviations and some prescribing errors by pre-populating certain data fields (e.g. with acceptable abbreviations).
- Reducing prescriber stress at discharge, as the prescription can be prepared in advance, ready for final authorisation.
- Reducing the time required to prepare the medication section of the Discharge Summary. The discharge prescription can be uploaded directly to the Discharge Summary.
- Reducing transcription errors and workload as admission medication entered into BOSSnet can be transferred to the discharge script. Discharge medications can then be imported into the patient's next admission to begin a BPMH.

The BOSSnet team is looking forward to rolling the new module out in the coming months. For further information contact Magdalena Kvasnicka (Project Officer) on Magdalena.Kvasnicka@bhs.org.au

Unsafe abbreviations update

The pivotal Australian Commission on Safety and Quality in Healthcare (ACSQHC) document "Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines" outlines a number of acceptable abbreviations and those that are prone to risk. Two examples are highlighted below.

PRESCRIBING	USE	AVOID
Hourly frequencies	4 hourly, 6 hourly 4hrly, 6 hrly	Fractions and latin abbreviations e.g. 4/24, q6h
Daily	Daily	OD, OM, ON

Please speak up and help educate our prescribers about their use of unsafe abbreviations.

Safety Terminology: Workaround

Thank you for the feedback from the Jul/Aug 16 edition of the Medication Safety Newsletter regarding the term "workaround". In response, a definition of "workaround" is provided:
"A workaround is a method of accomplishing an activity when the usual system/process is not working well".
The key message is that if the existing system is not working, highlight this immediately and collaborate with your colleagues to develop a safe working solution. More avid readers, please see http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2005/dec2(4)/documents/25.pdf