

encapsulate

Welcome to 'encapsulate'

The new publication from Slade Pharmacy & Galen Health will provide current and relevant pharmacy information on topics including:

- Medication Safety
- Clinical Services
- Legislative Issues
- Pharmacy Procedures

encapsulate will be published bimonthly in print, via e-mail and on our website – www.slade.net.au. If you have any comments, or wish to suggest a topic for our next issue, please e-mail us - marketing@slade.net.au.

Medication Safety Alert No. 5

A Medication Safety Alert for Intravenous Amphotericin was published in October 2007 in response to two recent sentinel events in the United Kingdom. The sentinel events involved mis-selection and administration of non-lipid amphotericin (Fungizone) where liposomal amphotericin (AmBisome) had been prescribed. Numerous near misses have also been reported internationally.

Four types of errors have been reported:

1. mis-selection of amphotericin formulation
2. dose mis-calculation
3. dose preparation error
4. administration error.

Intravenous amphotericin is available in non-lipid, lipid complex and liposomal forms. The dose recommended for these preparations range from 0.25-5mg/kg daily. Administration of the incorrect intravenous amphotericin can lead to excessive or sub-therapeutic dosing and patients experiencing potentially lethal side effects.

The alert was distributed to all pharmacy, dispensary, nursing and medical staff to communicate the potential risks and recommendations to prevent future medication incidents with intravenous amphotericin.

Medication Safety Alert No. 6

A Medication Safety Alert for Schedule 8 Medicine Selection Errors was published in January 2008 in response to a report released by the Victorian Quality Use of Medicines Network. The recent report has identified an increased prevalence of medication errors involving selection and administration of Schedule 8 medications, Australia wide. The medications most frequently involved are oral dose forms of morphine and oxycodone.

The alert was distributed to all pharmacy, dispensary, nursing and medical staff. Recommendations to reduce the future risk of selection errors in the dispensing, supply and administration of Schedule 8 medications are detailed in the alert.

A Schedule 8 medicine identification chart accompanied the alert. The chart outlines the clear differences for oral dose forms of oxycodone and morphine products. Please ensure that the coloured chart is displayed prominently near all Drug of Addiction Safes in the pharmacy/dispensary and throughout the hospital.

List of Similar Medication Names

Similar names contribute to medication errors when they are confused due to poor handwriting, look-a-like medication names or sound similar when verbal instructions are given.

Slade Pharmacy and Galen Health have compiled a list of medication where such errors may occur. The list is based on reports and incidents received by Slade Pharmacy, the Pharmacy Board of Victoria, Pharmacy Board of Tasmania, Pharmaceutical Council of Western Australia and Pharmaceutical Defence Limited together with the RGH, Daw Park, SA, Pharmacy Bulletin

The list was distributed to all hospitals in late January 2008.

encapsulate

Patient Self Administration of Medications in the Acute Care Setting

Patient participation in planning and implementing health care is encouraged as a means of improving patient outcomes. We see a number of instances when patient self administration is considered a more viable option in the acute care setting:

- Patient self administration can help health professionals identify areas where patients need assistance, education and intervention to optimise their health outcomes post-discharge.
- Nurses are not permitted to administer medications packaged in Webster® packs or Dosettes® that patients may have brought with them from home. In instances when therapy is not likely to be altered, patient self administration may be considered.

Best practice dictates the following:

- Self administration of medications by competent patients should only be permitted on the specific written order of the doctor. This means that all self administered medication should be clearly charted by the clinician;
- Medications for self-administration should be stored in the patient's locked bedside drawer (or alternate lockable facility);
- Nursing supervision of patient self-administration is required. Nurses should confirm that the medications have been taken with the patient. Self administration must be indicated with an 'S' on the patient's drug chart.

As a result, a thorough patient medication history is available for the entire health care team which ensures optimal patient safety and reduces the risk of medication related incidents.

Medication Chart Documentation

Compliance to medication chart documentation is critical to ensure patient safety. During a recent medication chart audit, a number of common areas of non-compliance were noticed. It is essential that the following points are considered by prescribers and nurses to encourage greater compliance and adherence to legislation, policy and best practice:

- Doctors should ensure that each medication order is signed and dated to comply with legislation.
- Doctors should ensure the patient's name is handwritten in addition to the patient label. In the past, errors have been identified whereby the incorrect patient label has been attached to a drug chart resulting in a drug being dispensed to the incorrect patient.
- Doctors must ensure the patients' identification label/full particulars are on each drug therapy chart (including duplicates) and the number of charts per patient is annotated.
- Doctors should ensure that all orders are written clearly and include all medication details.
- Ceased medication needs to be signed off on the drug chart by the doctor and noted in all sections of the patient record.
- For hospitals who utilise the medication chart for PBS prescription purposes, doctors must printed their name and prescriber number for each medication order to comply with legislation. (It is good practice for doctors to print their name in any case.)
- Nursing staff and the ward pharmacist should ensure that the drug sensitivities and allergies box is completed to help prevent repeat adverse drug reactions. Even when there are no previous adverse drug reactions, the chart needs to be notated to indicate that the matter has been considered.

This publication is intended to provide a general outline and is not intended to be and is not a complete or definitive statement of the information on the subject matter. Further professional advice should be sought before any action is taken in relation to the matters described in this publication. To obtain further copies of all documents referred to in this publication please see your pharmacist.