May 2012
Vol. 4

Medication Safety Bulletin

This bulletin serves as an educational publication to share medication safety-related issues

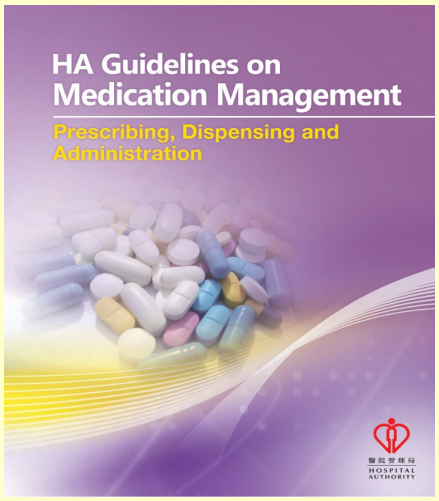
- Please refer to the HA Risk Alert (HARA) for sharing of medication incident cases reported in HA

Inside this issue:

NEW

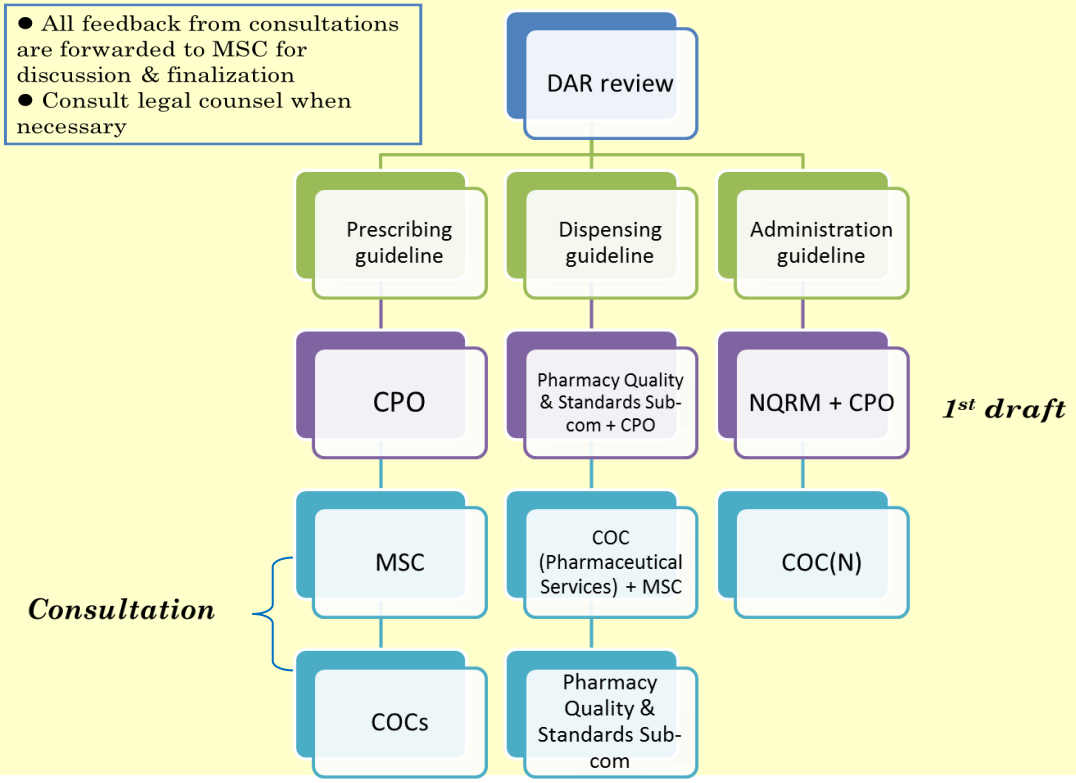
HA Guidelines on Medication Management
Prescribing, Dispensing & Administration

According to the medication management process, based on the "Report on Drug Administration Procedures & Practices (DAR) 2005, the sections pertaining to prescribing, dispensing and administration were updated and reformatted into HA guidelines, to provide guidance on the aspect of safe medication management with the aim of preventing medication errors through uniformed practices that can provide greater assurance in patient safety.



Process of the Review

The Medication Safety Committee (MSC) made reference to the DAR 2005 Report, compiled a draft of the guidelines and circulated to the relevant COCs for consultation before being endorsed by the HAHO MSC and reported to both the Drug Utilisation Review Committee (DURC) and the Central Committee on Quality and Safety (CCQ&S).



Mechanism for updating future guidelines

Feedback any proposed updates on the guidelines to MSC for consideration

Proposed updates forwarded to respective committee for discussion according to the types of guidelines involved
- Prescribing: respective COCs
- Dispensing: COC (Pharmaceutical Services)
- Administration: COC(Nursing)

Bring back to MSC for discussion and finalisation. The change would be decided by MSC

Forward to DURC and CCQRM for endorsement & electronic version would be updated

Future updates of the Guidelines as well as the MSC guidelines will need to be printed and filed in the distributed ring folders.

Highlights of Major Changes in the new Guidelines

Newly added statement - to review patient's complete drug profile before initiating any drug orders

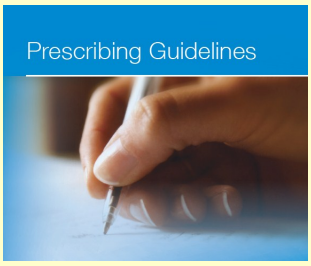
- Check the name & ID of patient & drug allergy history (e.g. on gum label, computer record, laboratory results) as well as the complete drug profile (including the medication history & the current drug profile in all specialties) before initiating any drug order.

Verbal order of dangerous drugs

- Dangerous drugs should not be ordered through verbal orders unless in cases of predefined emergency situation and with hospital DTC's endorsement.
- All verbal instructions must be supported by a written order within the next 24 hours.

Update on the List of HA-wide Approved/Standard Abbreviations in Prescribing

- 1D1S
- 2D1S
- D5
- D10
- NS



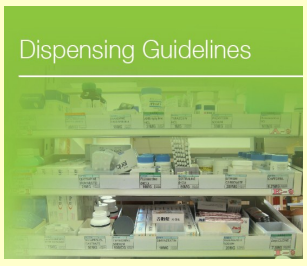
More coverage on the Assessment & checking of prescription validity by pharmacy staff, e.g

- Ensure the presence of Dr's name/code and signature
- Check patient's personal details & drug allergy information
- Check for completeness & clarity of drug orders
- Abbreviations used in handwritten prescriptions

Checking requirements when issue medicines to patients

- Check the details of drug label against prescription
- Check the dispensed drugs against prescription
- Check the patient's identity (at least 2 core patient identifiers)

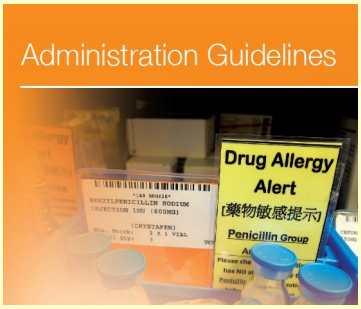
New guidelines appended for reference



- Drug prepacking for dispensing
- Extemporaneous Compounding
- Reuse of Returned Medicines

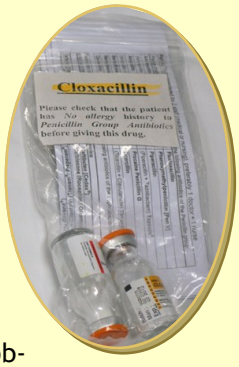
- Nurse should record the details of verbal instruction and administration of the dangerous drugs in writing
- Change the principle of "3 checks and 5 rights" to "5 rights"

The right drug in right dose is given to the right patient by the right route at the right time



Sharing of Effective measures used in Two cluster in tackling Drug Allergy incidents

Prescribing medications that are known to cause drug allergy has been identified as one of the key focus action points for HA patients care related risks

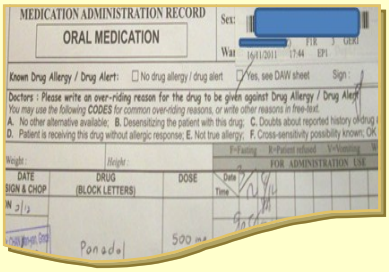


New Territories East Cluster

Two staff to complete the drug allergy check list to exclude known drug allergy/ cross sensitivity at the point of dispensing i.e. before obtaining the first dose of penicillin group antibiotics from ward stock

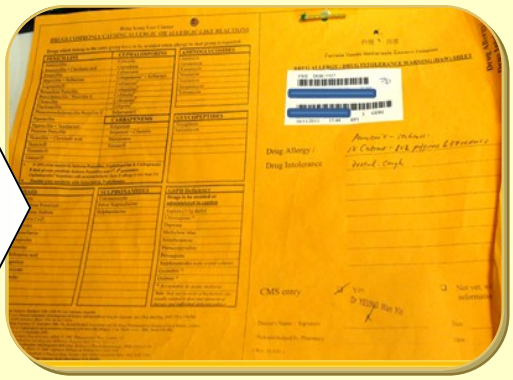
Hong Kong East Cluster

☑ Dr to tick & sign the drug alert boxes on MAR



☑ Dr to complete the Drug Allergy/drug intolerance warning sheet (DAW)

Drug allergy reference table shown on the left handside of the DAW



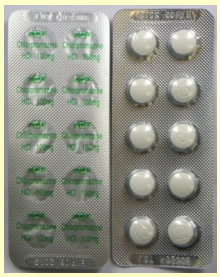
Risk with Mixup of Blister packs/Ready to dispense medicines

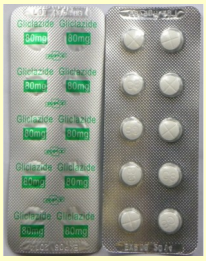
In order to minimise pre-packing of medicines in HA pharmacies, there is a preference to purchase medicines in blister or ready-to-dispense packaging. Essential information that are required to be printed at the back of individual blister without interference from the foil are:

- Generic name
- Strength
- Batch number
- Expiry date

Targeted drug groups for blister packs:

- Oral hypoglycaemics
- Cardiovascular drugs
- Anti-epileptics
- Antipsychotics





However, blister packs might pose other threats in dispensing safety due to similarity, and staff are reminded of the importance of reading the prints on the packs particularly during the checking step. Blister packs are ONLY safe when the prints are read. Thus, READ THE LABEL is essential. The risk could be further increased when blister packs from the same manufacturer are stored in close proximity to each other.

Sharing of potential risk in HA hospitals

—Tiotropium capsule prescribed /administered orally vs. via inhalation

Medication incidents have been reported in the US arising from the inadvertent oral administration of tiotropium capsules for inhalation, a long-acting anticholinergic agent for treating asthma and chronic obstructive pulmonary disease. Such incidents could be attributed by the resemblance of these capsules with those of the usual oral capsules and that the labelling are not marked with "For inhalation use only" or "Not for oral use". Reports of ingestions indicate that few patients experienced side effects from the swallowed capsules. Nevertheless, swallowing the capsules for inhalation, rather than using the capsule via the intended inhalation device may lead to delayed onset of action, reduced efficacy and inadequate drug delivery.

Since 2006 to present, within the Hospital Authority, there have been cases of tiotropium wrongly prescribed and wrongly administered to patients via the oral route instead of for inhalation reported in the Advanced Incident Reporting System (AIRS), most of which were successfully intervened and the remaining without leading to adverse event.

Recommendations:

1. Counsel the patients on its proper use, including only to be administered via the HandiHaler device and must not swallow the capsules
2. Educate and alert both patients and healthcare professionals about the potential for confusion with oral products
3. Advise patients to store the capsules for inhalation together with the inhaler in a location separate from the other oral medicines to minimise confusion

References

http://www.fda.gov/downloads/Drugs/DrugSafety/MedicationErrors/ucm080689.pdf
http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm080885.htm
Spriva® and HandiHaler® Package inserts. Boehringer Ingelheim International GmbH.

Sharing of globally reported medication errors

-Alert on confusion between Plavix vs Pradax

There have been incidents of medication errors in Canada arising from the confusion of drug name between Plavix® (clopidogrel hydrogen sulphate) and Pradax® (dabigatran etexilate, an oral anticoagulant indicated for the prevention of venous thromboembolic events in adult patients following total hip or knee replacement surgery and for prevention of stroke and systemic embolism in patients with atrial fibrillation, in whom anticoagulation is appropriate). Although in HK, the brand name of dabigatran is slightly different (Pradaxa®), healthcare professionals are alerted to this issue so that similar errors can be avoided locally.

Reference

http://www.hsa.gov.sg/publish/hsaportal/en/health_products_regulation/safety_information/product_safety_alerts/Safety_Alerts_2012/medication_errors.html