

4th Annual Medication Safety Symposium

High-risk, high-returns: Investing in medication safety

Program

26 June 2008

University Club
University of Western Australia, Crawley

Welcome

Welcome to the fourth symposium run by the Western Australian Medication Safety Group, and my first as Chairman. We hope that you enjoy the day and gain useful knowledge to take back to your hospital or organisation. The main purpose of the day is to stimulate interest in medication safety and provide you and your colleagues with ideas and practical advice about how to tackle this important topic.

This year the theme of the meeting is identifying high-risk drugs, high-risk situations and high-risk patient groups and strategies to mitigate the risk. We hope that this symposium will provide opportunities for you to share your ideas and that some of these will lead to practical improvements in patient safety.

Once again, may I wish you an enjoyable and stimulating day.

With best wishes,



Clinical Professor Alasdair Millar
Chairman
West Australian Medication Safety Group
26 June 2008

Program

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| 8:00 | Registration / Coffee / Tea |
| 8:30 | <p>WELCOME</p> <p><i>Clinical Professor Alasdair Millar, Chairman WAMSG</i></p> |
| 8:45 | <p>HIGH RISK, HIGH RETURNS: INVESTING IN MEDICATION SAFETY - SETTING THE SCENE</p> <p><i>Penny Thornton, Pharmacy Services Manager, Children's Hospital Westmead.</i></p> |
| 9:30 | <p>CURRENT SAFETY MANAGEMENT IN HEALTHCARE SYSTEMS: KEY NATIONAL AND INTERNATIONAL TRENDS</p> <p><i>Dr Dorothy Jones, Director, Office of Safety and Quality in Health Care</i></p> |
| 10:00 | <p>WHAT CAN YOU DO TO GET A BETTER RISK PROFILE?</p> <p><i>David McKnight, Deputy Chief Pharmacist, St John of God Hospital, Subiaco</i></p> |
| 10:30 | Morning tea |
| 10:50 | <p>CLEANING UP NARCOTIC USE WITH SOAP</p> <p><i>Dr Stephen Lim, Chief Pharmacist, Armadale Health Service</i></p> |
| 11:10 | <p>IV HEPARIN - GETTING THE BALANCE RIGHT</p> <p><i>Karen Flounders, Thrombosis Nurse Consultant, Royal Perth Hospital</i></p> |
| 11:30 | <p>INTEGRATED MEDICATION MANAGEMENT TO PREVENT ERRORS</p> <p><i>Barry Jenkins, Chief Pharmacist, Royal Perth Hospital</i></p> |
| 11:50 | <p>ENOXAPARIN USE IN THE TREATMENT OF VENOUS THROMBOEMBOLISM AND ACUTE CORONARY SYNDROMES AT WA TERTIARY HOSPITALS</p> <p><i>Yueng Yueng Chai, School of Pharmacy, UWA</i></p> |
| 12:05 | <p>PARACETAMOL USE IN OVERWEIGHT AND OBESE CHILDREN</p> <p><i>Helen Knappe, School of Pharmacy, UWA</i></p> |
| 12:20 | <p>IMPLEMENTING CLINICAL AUDIT TEACHING IN A MEDICAL SCHOOL: AN OPPORTUNITY TO IMPROVE MEDICATION SAFETY</p> <p><i>Dr Sally Murray, School of Medicine, University of Notre Dame, Fremantle</i></p> |
| 12:35 | Lunch |
| 13:15 | <p>COMPLIANCE WITH MEDICATION CHECKING & ADMINISTRATION POLICY</p> <p><i>Jeanette Robertson and Pania Falconer, Princess Margaret Hospital for Children</i></p> |
| 13:30 | <p>NIMC CHART TURNOVER COMPARED WITH THREE DISPLACED PERTH HOSPITAL CHARTS</p> <p><i>Robyn C Silla, Drug Usage And Assessment Group, Royal Perth Hospital</i></p> |
| 13:45 | <p>ADVERSE DRUG REACTION ANNOTATION ON MEDICATION CHARTS. DISAPPOINTING RESULTS FROM A PAEDIATRIC DISCHARGE SURVEY</p> <p><i>Chantelle M van Bronswijk, Department of Pharmacy, Princess Margaret Hospital</i></p> |
| 14:00 | CONCURRENT SESSION: WORKSHOPS 1, 2 AND 3 |
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| 15:30 | Afternoon Tea |
| 16:00 | <p>WORKSHOP WRAP-UP</p> <p>FUTURE PLANS</p> |
| 16:45 | Close |

Western Australian Medication Safety Group

Alasdair Millar (Chairman)
Physician & Clinical Pharmacologist
Royal Perth Hospital

Rhonda Clifford
Senior Lecturer
UWA School of Pharmacy Practice

Christopher Beer
Senior Lecturer, Geriatric Medicine
UWA/Royal Perth Hospital

Catherine Hynch
Risk Manager
Princess Margaret Hospital

Katherine Birkett
Clinical Nurse Manager
Royal Perth Hospital

Helen Lovitt
Senior Pharmacist, Dispensing Services
Fremantle Hospital and Health Service

Beress Brooks
Director, Safety, Quality and Performance
North Metro Area Health Service

David McKnight
Deputy Chief Pharmacist
St John of God Hospital, Subiaco

Rowan Davidson
Chief Psychiatrist
WA Dept of Health

Mark Newman
Clinical Director
Safety and Quality Unit, SCGH

Tanya Gawthorne
Manager Office of Safety & Quality
WA Dept of Health

Nancy Pierce
Health Consumer

David Lyon
Executive Officer
Western Australian Therapeutics Advisory Group

Margherita Veroni
Project Coordinator
Western Australian Medication Safety Group

Invited Speakers

Penny Thornton

Penny is currently Pharmacy Services Manager at The Children's Hospital Westmead, NSW.

She has previously been Vice-president and Federal Councillor, the Society of Hospital Pharmacists of Australia (SHPA) and member of their Committee of Specialty Practice in Medication Safety

Penny is representative of the Directors of Hospital Pharmacy on the NSW Statewide Medication Safety Committee. She is Australian representative for the Institute for Safe Medication Practices, USA and in this role, editor of the Medication Safety Series in the Journal of Pharmacy Practice & Research.

Penny was the Australian representative at the inaugural meeting of the International Network of Safe Medication Practice Centres, 2006, producing the Salamanca Declaration.

Penny is a member of the National Medication Scoping Study Steering Committee of the Australian Commission on Safety & Quality in Health Care. She was previously a member of the Medication Safety Taskforce of the Australian Council of Safety & Quality in Healthcare 2002-4.

Dorothy Jones

Dorothy is Principal Medical Officer & Director of the Office of Safety & Quality in Healthcare at the Department of Health as well as Adjunct Professor Health Sciences (Curtin).

Dorothy originally trained in medicine and over the last ten years has made the transition into strategic health policy, planning and executive management within the Western Australian state government health department.

She works as a senior clinical executive within the Department and has specific carriage, as foundation Director (2001), of the statewide patient safety, quality and clinical governance reform program. Dorothy recently undertook a mid-career sabbatical to the US and spent some time at the Harvard Kennedy School studying governance and executive leadership and visiting key international centres in patient safety and health care improvement.

Dorothy is especially interested in how best to apply improvement science and leadership behaviours and skills to influence modern healthcare systems, which healthcare improvement activities (and associated reforms) makes a real difference to consumers and patients who need it, and how to accelerate health improvement and patient outcomes in Western Australia.

David McKnight

David is Deputy Director of Pharmacy at St John of God, Subiaco. He was a member of the WAMSG Anticoagulant Working Group and the WAMSG Medication History working group. He is currently a member of the WAMSG.

Stephen Lim

Stephen is Chief Pharmacist, Armadale Health Service. He was a member of the WAMSG Anticoagulant Working Group.

Karen Flounders

Karen is Thrombosis Nurse Consultant at Royal Perth Hospital. She was a member of the WAMSG anticoagulant working group.

Barry Jenkins

Barry is Chief Pharmacist, Armadale Health Service. He is a past member of the WAMSG.

11:10 IV HEPARIN - GETTING THE BALANCE RIGHT

Karen Flounders, Thrombosis Nurse Consultant, Royal Perth Hospital

Background

Intravenous heparin is a difficult drug to administer, necessitating the use of an intravenous pump, frequent laboratory testing, and frequent dose adjustments. It is a complicated process that entails a series of steps involving multiple clinicians. IV Heparin is associated with a high rate of drug-related problems due to its complex pharmacological profile, and high potential for medication errors. One review of patients receiving IV Heparin, (Cynthia, 2004), found that approximately 70 steps were required to reach completion of the first dosage adjustment and most of the steps, provided no prompt for the next step.

During a recent audit of a newly introduced anticoagulation chart at Royal Perth Hospital it was found that despite IV UFH being highlighted as 7th in medicines most frequently involved in incidents reported through AIMS in WA there were no processes in place to reduce these errors.

A total of 274 anticoagulant charts were audited at RPH. Of the 274 charts 35 charts contained orders for the administration of IV Heparin. Results are as follows.

- Nine aPPT samples took longer than 3 hours to get to the labs.
- Seven aPPT samples took longer than 5 hours to be actioned.
- 6 aPPT samples were taken 3 hours too early.
- Lack of confidence in converting heparin units to mls (60% nurses not confident with mathematical conversions)
- Heparin infusions disconnected for showers xrays, etc
- Variation in who accessed aPTT results
- Variation in whom was responsible for new heparin rate and bolus doses
- Variation in how many nurses checked the infusion rate change.
- Telephone Orders/Transcribing Errors

Lessons for Best Practice -KISS is Best (Keep It Simple Stupid)

- Education for all staff involved in prescribing and administration of IV Heparin
- Clearly define WHO is responsible for what action all of the time ie Dr accesses results, Nurse rings Dr ect
- Two nurses to check heparin infusion rate changes
- Timely aPPT results (1-2 hours)
- Simple heparin nomograms (less nomograms the better)
- Readily convertible heparin bolus doses
- Provide units to mls conversion charts
- Consider whether you should use IV heparin in all areas of practice?
- Consider LMWH as an alternative or
- Switch to LMWH as soon as possible

There has been a recent development of a Nursing Practice Standard (NPS) at Royal Perth Hospital. The Director of Nursing (DON) and other Heads of Department have endorsed the NPS. The NPS clearly defines who is responsible for what actions and when in the prescribing and administration of IV Heparin. The NPS is currently with the Nursing Practice Committee.

The aim of the NPS is to give nursing staff some clear guidelines in the administration of IV Heparin. Hopefully, with clearer processes in place and best practice guidelines as a guide, the administration of IV Heparin will be safer to manage.

12:20 IMPLEMENTING CLINICAL AUDIT TEACHING IN A MEDICAL SCHOOL: AN OPPORTUNITY TO IMPROVE MEDICATION SAFETY

DB Mak and Sally B Murray School of Medicine, University of Notre Dame, Fremantle

Background

Clinical audits are increasingly used as a tool for monitoring practice and improving health outcomes. Professional colleges are also increasingly requiring doctors to perform quality improvement activities, such as clinical audit, as part of their ongoing registration. There are few examples of hands-on clinical audit teaching in undergraduate medicine.

Objective

To describe Notre Dame medical school's clinical audit curriculum.

Method

Information was collected through course documents and interviews with key staff members.

Results

From 2008 onwards, all final year students are required to undertake a clinical audit involving 20-30 patients in either a hospital or private practice setting. The audit comprises 10% of their marks for final year assessment. Learning is supported with a handbook, lectures and individual meetings with the clinicians whose patients they audit. The handbook contains audit topics identified by hospital Clinical Quality and Safety Committees as priorities for investigation. Students are required to submit an audit proposal for formative assessment by the University before implementation; this provides opportunity for individual feedback and suggestions for improvement. Audits must be approved by the relevant Clinical Quality and Safety Committee before data collection can begin. Topics chosen by students this year include medical practitioners' adherence to thromboembolism prevention guidelines, adherence to antibiotic guidelines for treatment of community acquired pneumonia and use of pre-operative prophylactic antibiotics.

Conclusions

Encouraging medical students to undertake clinical audits in partnership with pharmacists and clinical pharmacologists has the potential to improve prescribing practices.

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| 14:00 | Concurrent session Workshops 1, 2 and 3 |
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| | <p>WORKSHOP 1: LOOK-A-LIKE/SOUND-A-LIKE DRUGS - DOES YOUR HOSPITAL HAVE A STRATEGY?</p> <p><i>Facilitator: Penny Thornton, Pharmacy Services Manager, Children's Hospital Westmead</i></p> |
| | <p>WORKSHOP 2: IMPROVING SAFETY OF INTRAVENOUS DRUG ADMINISTRATION - PEOPLE VS TECHNOLOGY?</p> <p><i>Facilitator: Helen Lovitt, Deputy Chairman, WAMSG</i></p> |
| | <p>WORKSHOP 3: MEDICATION SAFETY IN THE PAEDIATRIC SETTING - HOW IS IT DIFFERENT?</p> <p>Facilitator: Violet Ford, A/Pharmacist in Charge of Clinical Services, Princess Margaret Hospital</p> |
| 15:30 - 16:00 | Afternoon tea |
| Session 4 | |
| Chairman: Margherita Veroni | |
| 16:00 | <p>WORKSHOP WRAP-UP</p> <p>FUTURE PLANS</p> |
| 16:45 | END |