

High risk medicines – feeling the PINCH!

High Risk Medicines (HRM) Working Party (WP), Quality Use of Medicines (QUM) Program Department of Health, Victoria

Introduction

HRMs have a heightened risk of causing serious or catastrophic harm when used in error.

The HRM WP was established in July 2006 to develop initiatives to increase awareness and assist Victorian healthcare professionals in reducing patient harm from 'PINCH' HRMs and systems.

Aims

Alerts, audit tools and an on-line survey were developed to:

- increase awareness of medicines that are 'high risk'
- decrease the potential risk of harm to patients prescribed high risk medicines
- evaluate the impact of the alerts on HRM systems and processes

Methodology

Through a 'competitive tender' process a project officer (pharmacist) was appointed. The project officer and HRM WP developed the alerts, audit tools and an on-line survey through:

- literature review
- consultation with healthcare experts
- formatting by communication expert
- endorsement by the Victorian Medicines Advisory Committee
- dissemination to chief executive officers, quality managers, doctors, nurses and pharmacists
- development of a website for the alerts, audit tools, support material and on-line survey

Results

- three alerts (illustrated), plus the on-line survey link, were sent to 89 health services and via the Victorian Quality Use of Medicines Network (250 members)
- 90 responses to the survey were received (Table 1)

Conclusions

The on-line survey indicated that, the HRM alerts increased awareness, were considered to be relevant and were used to improve systems for managing HRMs, thus reducing the potential for patient harm.

Future work

The HRM WP is using the feedback around barriers and desired focus to develop future HRM initiatives.

The Victorian QUM program is collaborating with the Australian Commission for Safety and Quality in Healthcare (ACSQHC) on the development of a national approach to the development and dissemination of alerts.

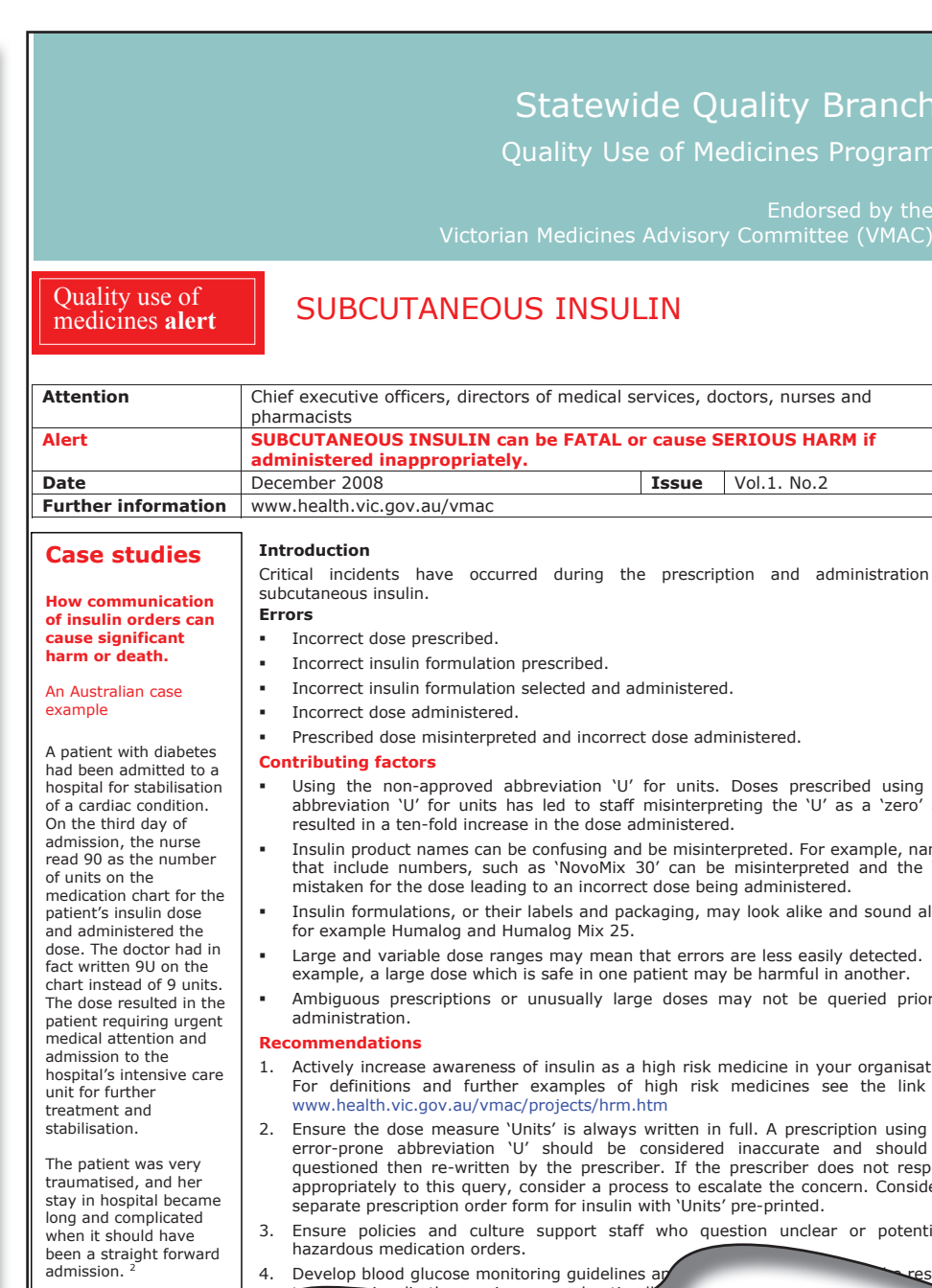
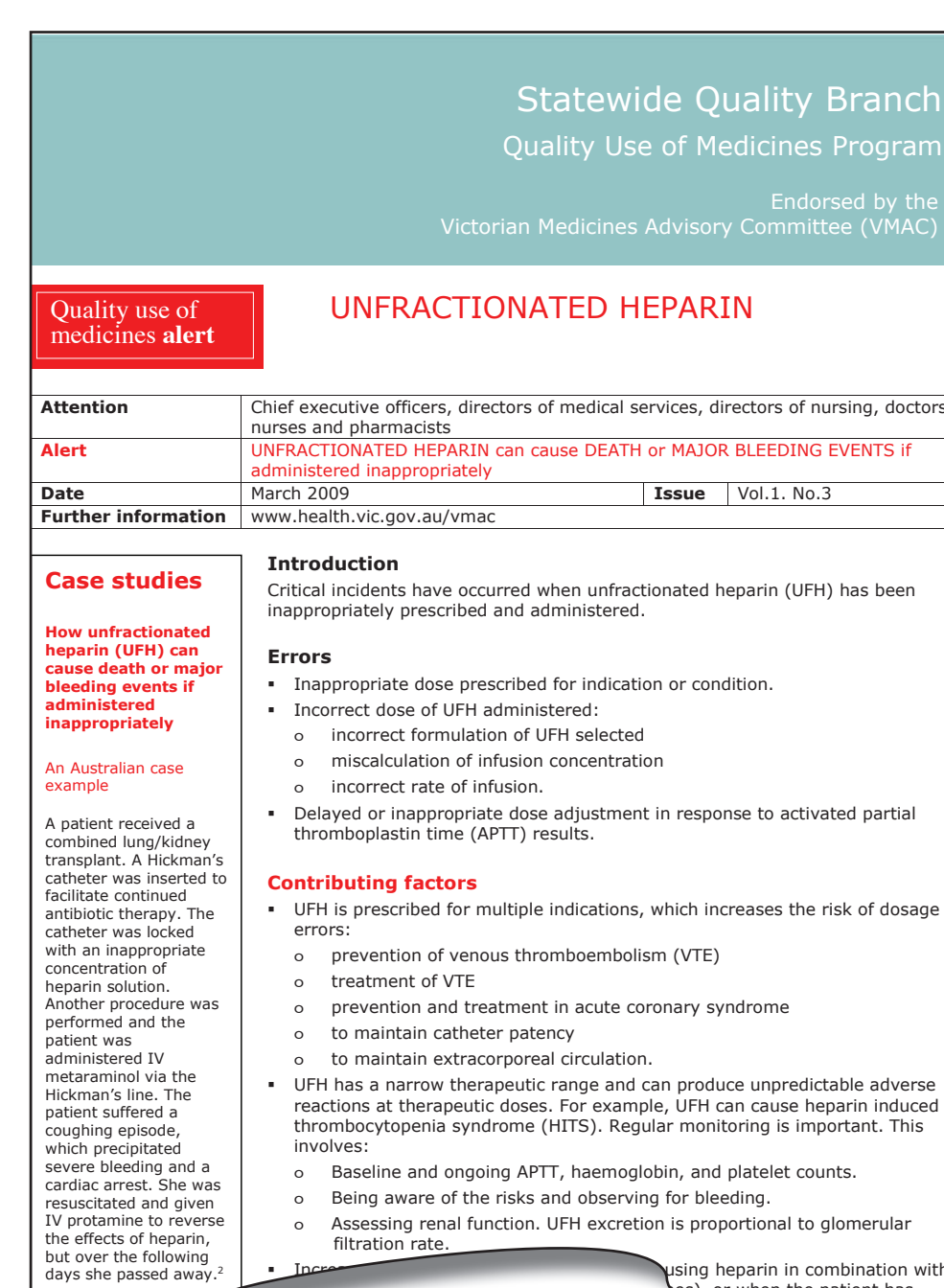
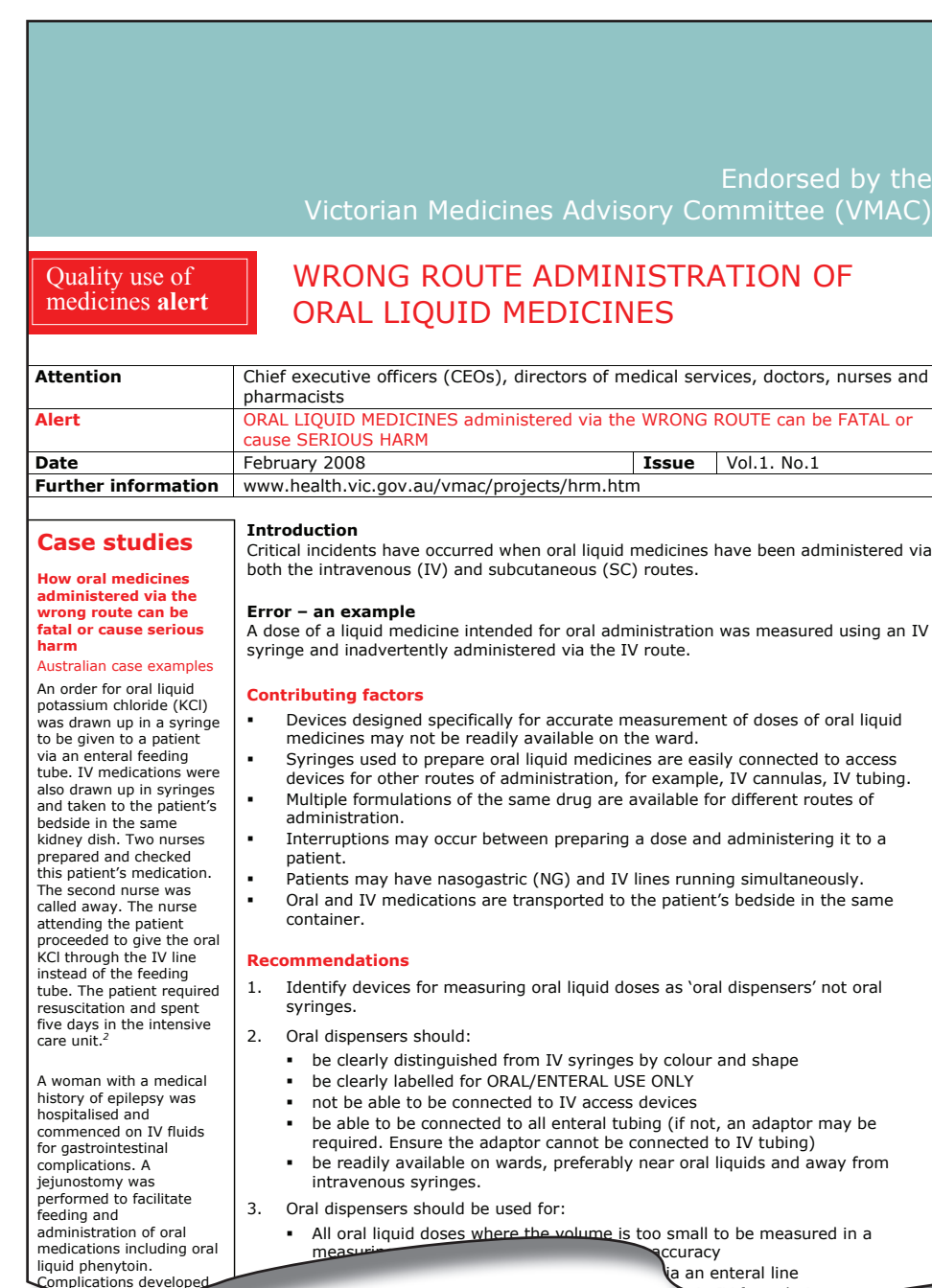
Acknowledgements

Nick Jones, Alison McMillan, John T Walker and Meredith Wiseman.

P: Potassium
I: Insulin
N: Narcotics
C: Chemotherapy
H: Heparin
S: Systems

Table 1: On-line survey results

<ul style="list-style-type: none">• 90 responses• Responses predominantly from nurses (31%) and pharmacists (53%)• Responses were evenly distributed across the three alerts<ul style="list-style-type: none">- wrong route (35%)- insulin (29%)- heparin (30%)
<ul style="list-style-type: none">• The alerts were considered to be<ul style="list-style-type: none">- useful for making changes to practice (86%)- increasing awareness of HRM issues (87%)- relevant to an area of concern (71%)
<ul style="list-style-type: none">• Changes made in response to the alerts:<ul style="list-style-type: none">- charts revised- stocks revised- policies and procedures amended- orientation and education revised
<ul style="list-style-type: none">• Perceived systemic barriers<ul style="list-style-type: none">- resources- processes for changing policies and procedures- availability of materials- no governing body to influence change in gp practices- drug in focus rarely used
<ul style="list-style-type: none">• Proposed areas for future safety information:<ul style="list-style-type: none">- insulin infusions- cytotoxics- opioids- pumps- allergy recording- clinical handover- labelling and packaging- omission of medicines
<ul style="list-style-type: none">• Will the alert improve patient safety in my organisation? - Yes (90%)
<ul style="list-style-type: none">• The alert could be improved by making the following changes<ul style="list-style-type: none">- increasing awareness- recognition that they don't apply to all hospitals- acknowledging that specific competencies are unworkable- timing in relation to chart development (insulin)- extending the dissemination network- focusing on neonatal ng feeds- providing a draft hypoglycaemic management policy- enabling on-line completion of the audit tool
<ul style="list-style-type: none">• The audit tool was useful for identifying areas for improvement in our organisation - Yes (86%)
<ul style="list-style-type: none">• The audit tool could be improved by making the following changes:<ul style="list-style-type: none">- recognition that small units may use HRM infrequently- making less labour intensive- timing to synchronise with other tools such as insulin charts- providing an on-line audit tool- conducting a staff survey
<ul style="list-style-type: none">• It would be useful for us to submit data on-line - Yes (79%)
<ul style="list-style-type: none">• Further comments<ul style="list-style-type: none">- tailor to suit large and small health services- audit tool valuable- useful and timely- nurses adopt changes more readily than drs- several alerts - took up med safety wp time



The High Risk Medicines Working Party are: Helen Leach, Melita VanDeVreede, John Buckley, Trisha Dunning, John Jackson, Anne Leversha, Roger Nation, Mary O'Reilly, Catherine Rokahr, Allison Williams and Sue Kirska (chair).

www.health.vic.gov.au/qum/initiatives/hrm.htm

Department of Health

