

The Safer Medicines Group: A Medication Safety Initiative

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About NSW TAG

- Independent, not-for profit association funded by NSW Health
- Members:
 - Clinical pharmacologists, pharmacists, other clinicians from NSW teaching hospitals & affiliated academic units
- Goal:
 - To promote quality use of medicines by sharing unbiased, evidence-based information about drug therapy
- Objectives:
 - To investigate and evaluate new initiatives in therapeutics
 - To support drug and therapeutics committees
 - To promote rational, high quality, cost-effective use of medicines in public hospitals and the wider community

Linking in with NSW TAG

NSW TAG Management Committee



NSW TAG Committee

- To investigate and evaluate new initiatives in therapeutics
- To support drug and therapeutics committees
- To promote rational, high quality, cost-effective use of medicines

High Cost Drugs Working Party

DUE Support Group



NSW TAG Safer Group

Standardise
Advice
Facilitate
Education
Research

Secretariat: 1.4 Clinical
0.6 Administrative

Background

- NSW TAG has a number of subcommittees eg the Adverse Drug Reactions Committee
- In 2002 this Committee was reconstituted with a stronger focus on medication safety
- In May 2003 a Forum for future directions was held - 40 people
- Forum outcomes included decisions to:
 - Use available evidence
 - Respond to specific requests
 - Be proactive
 - Evaluate on a continual basis
 - Sustain activity (consider resources)
 - Focus on high value
 - Remember consumer perspective

The Safer Medicines Group is born

- SAFER Committee set up 2003
- Multidisciplinary – Medical, Nursing, Pharmacy, Academic, **Managerial and Frontline**, Consumers
- Since then new state & national groups/activities established
 - Established links with NSW Health Quality Branch
 - Clinical Excellence Commission (2004)
 - IIMS (2005)
 - Australian Commission for Safety and Quality in Healthcare (2006)
 - NIMC (2006)

Original Terms of Reference

- Promote Medication Safety NSW Hospitals
- Facilitate Communication
- Support DTC & CGU and patient safety committees
- Work in partnership with state & national governments & organisations
- Ensure activities take into account consumer issues & perspectives

The Acronym: SAFER

- **S**tandardise
- **A**dvice
- **F**acilitate
- **E**ducation
- **R**esearch

Standardise

Eg Terminology document:

- Principles for consistent terminology
- Acceptable terms & abbreviations
- Abbreviations, symbols & dose designations to avoid

TABLE 1: Principles for consistent prescribing terminology

- Use plain English - avoid jargon**
- Write in full - avoid using abbreviations wherever possible, including Latin abbreviations**
- Print all text - especially drug names**
- Use generic drug names**
 Exception may be made for combination products, but only if the trade name adequately identifies the medication being prescribed. For example, if trade names are used, combination products containing a penicillin (eg Augmentin®, Timentin®) may not be identified as penicillins.
 Exception may also be made where significant bioavailability issues exist, for example cyclosporin, simvastatin
- Write drug names in full, NEVER abbreviate any drug name**
 Some examples of unacceptable drug name abbreviations are: G-CSF (use filgrastim or lenograstim or pegfilgrastim), AZT (use zidovudine), 5-FU (use 5-fluorouracil), DTIC (use dacarbazine), EPO (use epoetin), (use intravenous)
 Exception may be made for modified release products
 For slow release, controlled release, continuous release or other modified release products, the description used in the trade name to denote the release characteristics should be included with the generic drug name, example: tramadol SR, carbamazepine CR
 For multi-drug protocols, prescribe each drug in full and do not use acronyms, for example do not prescribe chemotherapy as 'CHOP'. Prescribe each drug separately
- Do not use chemical names/symbols, for example HCl (hydrochloric acid or hydrochloride) may be misread for KO (potassium chloride)**
 Do not include the salt of the chemical unless there are multiple salts available
 Where the salt is part of the name, it should follow the drug name and not precede it, for example, mycophenolate sodium or mycophenolate mofetil
- Dose**
 - Use words or Hindi-Arabic numerals, ie 1, 2, 3 etc
 - Do not use Roman numerals, ie do not use II for two, III for three, IV for five etc
 - Use metric units, such as gram or mL
 - Do not use apothecary units, such as minims or drams
 - Use a leading zero in front of a decimal point for a dose less than 1, for example use 0.5 not .5
 - Do not use trailing zeros, for example use 5 not 5.0
 - For oral liquid preparations, express dose in weight as well as volume, for example in the case of morphine oral solution (Simgin[®]) prescribe the dose in mg and confirm the volume in brackets, eg 10mg (2mL)
 - Express dosage frequency unambiguously, for example use 'three times a week' not 'three times weekly' as the latter could be confused as 'every three weeks'
- Avoid fractions, for example**
 - 1/2 could be interpreted as 'for one day', 'once daily', 'for one week' or 'once weekly'
 - 1/2 could be interpreted as 'half' or 'one to two'
- Do not use symbols**
- Avoid acronyms or abbreviations for medical terms and procedure names on orders or prescriptions, for example avoid EBM meaning 'expressed breast milk'**

Intended meaning	Acceptable Terms or Abbreviations
Dose Frequency or Timing	
(in the) morning	morning, mane
(at) midday	midday
(at) night	night, nocte
twice a day	bd
three times a day	tds
four times a day	qid
every 4 hours	every 4 hrs, 4 hourly, 4 hly
every 6 hours	every 6 hrs, 6 hourly, 6 hly
every 8 hours	every 8 hrs, 8 hourly, 8 hly
once a week	once a week and specify the day in full, eg, once Tuesdays
three times a week	three times a week and specify the exact days if times a week on Mondays, Wednesdays and Saturdays
when required	prn
immediately	stat
before food	before food
after food	after food
with food	with food
Route of administration	
epidural	epidural
inhalation	inhale, inhalation
intracardiac	intracardiac
intramuscular	IM
intraosseous	intraosseous
intrathecal	intrathecal
intranasal	intranasal
intravenous	IV
irrigation	irrigation
left	left
rectified	NEB
per rectum	NG
percutaneous enteral gastrostomy	PEG
per vagina	PV
per rectum	PR
peripherally inserted central catheter	PICC
right	right
subcutaneous	subcut
sublingual	subling

TABLE 3: Error-prone abbreviations, symbols and dose designations to be avoided
(Adapted from the Institute of Safe Medication Practices (ISMP) list of the same name, with permission from ISMP)

Error-prone Abbreviation	Intended Meaning	Why?	What should be used
mg, mcg or ug	microgram	Mistaken as 'mg'	microgram
BD or bid	twice daily	Mistaken as 'bd' (three times daily)	bd
BT or bi	bedtime	Mistaken as 'BD' (twice daily)	bedtime
cc	cubic centimetres	Mistaken as 'L' (units)	mL
DC	discharge or discontinue	Premature discontinuation of medications if discharge intended	'discharge' or 'discontinue' whichever is intended
e or E	ear or eye	Mistaken for 'ear' when 'eye' intended or for 'eye' when 'ear' intended	'eye' or 'ear' and specify whether 'left', 'right' or 'both'
gtt or gulle	drops	Latin abbreviation meaning 'drops', not universally understood	'drops' or 'eye drops' whichever is intended
HS	half-strength	Mistaken as bedtime	'half-strength' or 'bedtime' whichever is intended
h	at bedtime, hours of sleep	Mistaken as half-strength	
IU	injection	Mistaken as 'IV' or 'intravenous'	injection
IN	intranasal	Mistaken as 'IM' or 'IV'	intranasal
IT	intrathecal	Mistaken as intravenous	intrathecal
IU	international units	Mistaken as 'IV' (intravenous) or '10' (ten)	international units
M	morning	Mistaken for 'r' (right)	morning
N	night	Mistaken for 'r' (right)	night
DO or ODO	eye ointment	Mistaken for eye drops	eye ointment
m	mixture	Latin abbreviation, not universally understood	mixture
o.s. or OD	once daily	Mistaken as 'right eye' (OD=oculus dexter), leading to oral liquid medications administered in the eye. Can also be mistaken for OD (twice daily)	'daily', preferably specifying the time of the day, eg 'morning', 'mid-day', 'at night'
OJ	orange juice	Mistaken as 'OD' or 'OZ' (right or left eye); drug meant to be diluted in orange juice may be given in the eye	orange juice
OW	once a week	Not universally understood	once a week
pf	per fortnight	Not universally understood	every two weeks, per fortnight
qd or QD	every day	Mistaken as 'Qid', especially if the period after the 'q' or the tail of the 'q' is misunderstood as an 'l'	daily
pu	powder	Latin abbreviation, not universally understood	powder
qhs	nightly at bedtime	Mistaken as 'q' or 'every four'	'nightly' or 'daily at bedtime'
qh	every hour	Not universally understood	'hourly', 'every hour'
qod or QOD	every other day	Mistaken as 'qd' (daily) or 'qid' (four times daily)	'every second day', 'on alternate days'
QPM etc	every evening at 6 pm	Mistaken as every six hours	'6pm daily', 'every night at 6pm', 'every day at 6 pm'

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Advise & Liaise

- NSW Health (eg safety alerts)
- Representation on Statewide Medication Safety Committee (Now Statewide Medication Expert Advisory Committee)
- ACHS (Adverse drug reactions indicators)
- ACSQHC (NIMC)
- Responses to requests from other groups
- ADRAC
- Safer Systems Saving Lives
- Conferences

Facilitate

- Communication & feedback about IIMS, eMM
- Warfarin Booklets + field testing
- Other states- joint survey on premixed Potassium solutions (NSW & Vic)

Education

- Medication Incidents (IIMS) guides to help hospitals
- Analgesic patch advice

Research

- Seek additional funding for projects using research methodologies
 - Medication Safety Self Assessment MSSA / QUM indicators- funded and managed by CEC
 - Standardised recommendations for labelling injectable medicines fluids and lines

Planning Issues 2009

- What are the priorities now?
- How do we balance workload?
- What about innovations?
- How do we communicate and report
- How to meet member and stakeholder needs
- How to measure & monitor: Using data wisely

Multidisciplinary planning

July 22, 2009



- 30 clinicians and stakeholders including representation from:
 - Medical, nursing, pharmacy professions
 - Consumers
 - Clinical governance
 - Other stakeholders eg NSW Health, CEC, NPS, ACSQHC
- Teleconference held a week later with a further 9 rural colleagues

Revised Terms of Reference

- Goal: To undertake activities directed at improving safe medication practices in NSW hospitals and the wider community
- Objectives:
 - Promote safe medication practices in the acute care setting and at points of transitions of care with particular attention to:
 - High risk medicines
 - High risk settings
 - High risk practices
 - High risk patients
 - Facilitate communication regarding medication safety between key stakeholders eg consumers; healthcare professionals: state and national agencies
 - Support Drug and Therapeutics Committees and other hospital groups
 - Work in partnership with government and other relevant national and state-based groups to improve medication safety in hospitals

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- Goal: Promote Medication Safety NSW Hospitals
- Promote Medication Safety
- Facilitate Communication
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- Ensure activities take into account consumer issues & perspectives

The first new activity

- Development multidisciplinary Medication Safety Support Group
 - Open to clinicians from all specialties interested in or concerned about improving medication safety
 - Facilitate discussion and information sharing
 - Over 50 doctors/nurses/pharmacists enrolled representing every area health service

Strategies for Success

- Multidisciplinary
- Highly committed secretariat & group members
- Use voluntary expertise
- Access to wider TAG membership including interstate groups
- Set up working parties
- Worked up initial proposals & sought external funding & project officers

Thank you

Measurement Tools for QUM

[Indicators for QUM in Australian Hospitals](#)

[Medication safety self assessment for Australian hospitals](#)

[Medication safety self assessment for antithrombotic therapy in Australian hospitals](#)

NSW TAG Groups and Working Parties

[Safer Medicines Group](#)

[Drug Usage Evaluation Group](#)

[High Cost Drugs Working Group](#)

[Editorial Committee](#)

NSW TAG Projects

[DMACS](#)

[APOP](#)

[CAPTION](#)

[PIMS](#)

TAG Mail

Contact Us

SAFER Medicines Group

Welcome to the NSW TAG SAFER Medicines Group Web page. Our goal is to improve patient safety by enhancing medication safety in NSW hospitals and the wider community.

Terms of Reference

Please [click here](#) to access the Safer Medicines Group Terms of Reference

Membership

The Safer Medicines Group is a multidisciplinary team of health professionals and consumers: [2010 Membership List](#).

Resources

Guidance About Use of Abbreviations

The NSW TAG Safer Medicines Group has prepared a guidance document which provides recommendations for terminology, abbreviations and symbols used in prescribing and administration of medicines. Please [click here](#) to download the document.

Frequently Asked Questions

Please [click here](#) to read answers to questions received by NSW TAG related to the abbreviations guidance document.

Analgesic Skin Patches

A **Safety Alert** has been prepared on the use of analgesic skin patches, based on a number of safety warnings issued following reports of deaths and serious side effects in patients using fentanyl skin patches.

Intravenous Potassium Chloride

Please [click here](#) to access the current list of potassium chloride policies that have been submitted to NSW TAG (user name and pass word required).

High Risk Medications (NSW Health)

Managed by the NSW Health Quality and Safety Branch, the high risk medicines page provides a list of known high risk medications along with links to safety alerts from various sites and programs, to provide guidance on how harm with high risk medications can be avoided.

Lessons Learned in Quality and Safety (NSW Health)

NSW Health has created a forum for the health community of NSW to share experiences of **incidents** and **proven solutions** to quality and safety issues that arise in the health system. [Click here](#) to go to the Lessons Learned webpage.

Medication Incidents and IIMS

NSW TAG's Safer Medicines Group has prepared some advice on reports of medication incidents and IIMS, based on member requests, and therefore not exhaustive. Click the following link to access [Medication Incident Reports and IIMS](#).

JPPR Medication Safety Series: On-line

The Medication Safety series published in the Journal of Pharmacy Practice and Research (journal of the Society of Hospital Pharmacists of Australia) is [now available](#) to all comers.

NSW TAG Links

[Abbreviations](#)

[Abbreviations - FAQs](#)

[Complementary medicines in public hospitals](#)

[Guidelines for GPs: Back pain, migraine, chronic pain](#)

[Life Saving Drugs Register](#)

[Pethidine DUE Resource Kit](#)

Resources for Evaluating New Drugs

[Decision algorithm](#)

[Example forms](#)

[Off-label use of medicines](#)

[Other guidance](#)

External Links

[ADRAC](#)

[Australian Health Care Agreements](#)

[NPS](#)

[NPS: Common colds campaign](#)

[NSW Health](#)

[PBS Online](#)

[SA TAG](#)

[VicTAG](#)

[VMAC](#)

[WA TAG](#)

Analysis & Monitoring



- Gentamicin iims analysis
- Tiotropium iims analysis
- Abbreviation audit

Expert Group- Consultation and Advice

- NIMC
- ACHS Medication Safety Standards
- Safety Alerts NSW Health & policies eg paracetamol, allopurinol azathioprine
Safety Alert
- Advice re eMM
- Potassium, vincristine safety alerts

Priorities



How have they been set?

- Members Raising Issues
- At the request of the management executive board
- At request of NSW Health

TAG Member Survey



- Indicators & MSSA
- Initiatives Implemented
- Abbreviations
- Members perceptions of activities
- Priority Areas-nursing, administration, promotion, activities, High Risk Medications, IT

TAG Member Survey Safer

