promoting excellence in medicines management

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RE: Draft national guidelines for the on-screen display of clinical medicines information

The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for over 3,000 pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia's health system. SHPA is the only professional pharmacy organisation with a core base of members practising in public and private hospitals and other health service facilities.

SHPA is committed to facilitating the safe and effective use of medicines, which is the core business of pharmacists, especially in hospitals.

SHPA welcomes the Australian Commission on Safety and Quality in Health Care's (ACSQHC) initiative to establish national guidelines for the on-screen display of clinical medicines information. These guidelines are much needed as the contemporary delivery of healthcare continues to capitalise on the potential which health informatics and e-Health initiatives can deliver to clinicians, patients and the healthcare system overall.

We note that several sections of the document are incomplete, these need to be complete to enable an adequate assessment of the guidelines as a whole. SHPA has the following specific comments about the draft guidelines.

3. Scope

SHPA believes these guidelines should not relate to just prescriptions but all instances where clinicians select and share information regarding medicines electronically. That is: medicines information, medicine charts, medicine selection lists, as well as discharge summaries; software is used in all these examples. To ensure consistency and minimise the potential for error for clinicians the guidelines should be applied in these contexts, therefore the scope of these guidelines should be broader than to just *'convey the intent of the prescriber of that medicine'*.

The terms 'pack-based' and 'dose-based' are used and defined in the glossary, however SHPA believes this section should display examples to give clinicians clarity and context, as most clinicians will typically operate in only one type of environment and not both. We also believe that pack-based examples and dose-based examples should be displayed in all sections of the document.

Mobile devices have been excluded from these guidelines. However to meet the aims and objectives of the guidelines, SHPA believes that they should specifically consider and recognise the use of mobile devices in clinical settings and the specific potential for errors caused by non-uniform presentation of clinical information on devices they use across their working day.

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Portable clinical Information systems are increasingly being exploited in the clinical environment with the use of mobile devices such as tablets and smartphones (e.g. clinicians providing hospital in the home services). In addition many patients are using mobile devices to record personal information about their medicines and the use of mobile devices as part of clinical trials is becoming more common. It is important that clinicians who use a clinical information system on both mobile devices and desktop computers are presented with a consistent display of medicines information.

SHPA believes that if the guidelines do not address this issue, they will quickly become redundant.

6.1.1. Display full medicine names

This section contains the following statements:
The full medicine name should be displayed in the prescription, medication order, medicines list or selection list.
This recommendation does not preclude the use of shortened forms for unambiguous rapid data entry.

This exception will allow a clinical information system to display ambiguous contractions of medication names, leading to erroneous medication selection. It is not clear as to how ambiguity from the use of shortened medicine names can be prevented.

This exception is also contrary to the statement in 6.4 - General information display:
Serious problems may emerge when prescription details or medicine names are truncated.

This section should give guidance on the order in which active ingredients should appear for combination products to ensure consistency.

SHPA would also welcome comment on the approach to be used when the manufacturer does not adhere to the principles in this document and therefore the product's labelling is different to the information shown on the screen which may lead to confusion when selecting or checking the selection of a medicine (e.g. units or international units used with bleomycin, or where screen display is 1 g and medicine is labelled as 1000 mg).

6.1.3 Display active ingredient name adjacent to brand name using recommended consistent font styles for each

We are unclear how local brand substitution policies can be supported if there is no clear link between different brands of generic or biosimilar medicines. It is also unclear how variations of the same medicine in the same dose form should be identified for example where there is a slow release and normal release product or multiple slow release products.

SHPA notes that the guidance on active ingredient names and brand names differs to the United Kingdom's National Health Service recommendations in their version of similar guidelines, *Design for patient safety: guidelines for the safe on-screen display of medication information.* The UK document lowercase letters in bold are used for active ingredients, and uppercase non-bolded for brand names. We query the evidence for this determination; SHPA would like to ensure that appropriate evaluation is conducted to inform evidence and future policy.

6.1.4. Use National Tall Man Lettering for medicine names known to cause confusion

A list of all the medicines that fall under the National Tall Man Lettering system should be included as an appendix.

A pack-based example in this section would be welcome.

6.2.2. Display prescription details in full

There appears to be a referencing error within the following sentence:
The '+' separator should be reserved solely for this purpose as supported by heuristic analysis (See Appendix 9.5). Appendix 9.5 (page 67) is Acknowledgements and does not contain support to the above statement.

We are concerned that there is an insufficient level of detail to adequately reflect the selection of medicines required in combination over multiple days e.g. chemotherapy cycles.

6.3.1. Use a consistent display format and order

This section contains the following recommendation:
Dose (or dose equivalent, e.g. volume or rate) is a key element and its prominence and readability is increased by
*- preceding it by a **label***

In this case, label is being used to describe a word indicating the nature of the information immediately following. For example **DOSE** (Label) **1 drop** (Dose).

As the document refers to labelling of dispensed items, unit dose dispensing, bags containing dispensed products, labels for dispensed medicines and user-applied labels of injectable medicines, the use of the word *label* in the former context is potentially confusing. This could be clarified by defining the word's use in this context in the glossary, or using an alternative word.

With respect to the pack-based and dose-based examples on page 32-33 we query why information such as strength, form, route, site, frequency, administration duration, and duration of course are **optional** and would like to seek clarification and justification on this matter.

The fluconazole example on page 37 appears to contradict the statement '*do not use the 'en' dash to precede a number for the following reasons … the active ingredient name and strength are inextricably linked'*. Also this fluconazole lists the dose as a volume of the solution rather than the actual dose to be infused.

On the same page, with reference to morphine oral solution, the strength is displayed as '5mg/1 mL', SHPA queries if this is deliberate or if it should be '5mg/mL'.

The guidelines should also consider the inclusion of chemotherapy cycles information into both pack-based and dose-based settings, as this can often be an area of confusion and misinformation between clinicians and patients.

6.3.2 Use standard approved units of measure consistently formatted

Insulin is used in the examples, the medicine is presented without a strength (e.g. 100 u/mL); these examples should be reconsidered given the imminent introduction of 300 u/mL insulin products.

6.4.1. Unambiguously position related elements and labels when text wrapping

The guidelines should consider that systems and software may have restrictions around the number of characters that can be displayed, and fonts and font sizes can have implications on whether appropriate display of clinical medicines information is achieved or not according to the guidelines. An example is the use of conventional amphotericin and liposomal amphotericin http://www.ismp.org/Newsletters/acutecare/showarticle.aspx?id=59. Comment on the screen territory may be appropriate.

In the paracetamol example, the strength is displayed as '120 mg in 5 mL', which is different to the fluconazole example in 6.3.1. where the strength is displayed as 200mg/100mL. If the intent is that there is a difference in how strengths are displayed for different formulations (e.g. solutions for injections compared to oral solutions) the guidelines should deliberate on this matter and give reasoning and examples.

6.4.3 Ensure the full details of multiple prescriptions in a selection list are accessible

A pack-based example would be useful in this section.

6.4.4. Use human factors design principles to distinguish prescription elements

This section is incomplete and does not contain the justification or reasoning for the recommendation. SHPA believes this section needs to be complete to enable an adequate assessment of the guidelines as a whole.

9.4 Human factors assessment

This section is blank. SHPA believes this section needs to be complete to enable an adequate assessment of the guidelines as a whole.

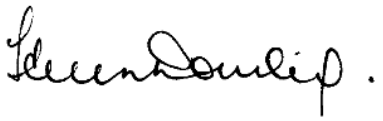
Glossary

We believe the glossary should include biosimilar medicines, the range of medication ordered referred to in the document and the range of electronic devices referred to in the document

Finally we note that some of the terminology within the document could be more consistent; for example ‘pack-based’ and ‘pack based’, ‘dose-based’ and ‘dose based’ and that there is some inconsistency between how spaces are used e.g. 200mg/2mL should be 200 mg/2 mL or 200mg/1mL should be 200 mg/mL.

If you would like to discuss the issues raised in this submission or require further information, please contact Jerry Yik (JYik@shpa.org.au or 03 9486 0177)

Yours sincerely



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