

PHARMAC Labelling Preferences

PHARMAC

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Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 46,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces Te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse.*

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on PHARMAC's proposal to develop pharmaceutical labelling preferences.
2. NZNO has consulted widely with staff and members, in particular the Aotearoa College of Diabetes Nurses, the NZNO Respiratory Nurses Section, the NZNO Gerontology Section, the NZNO Peri-operative Nurses College, NZNO's professional nurse advisers, and a range of other nurses in practice.
3. As the leading professional nursing organisation and union for nurses in Aotearoa New Zealand, NZNO strongly supports the intent of the proposal and wish to commend PHARMAC for undertaking this initiative.
4. Nurses are the health professionals administering medicines most frequently in health settings and NZNO believe developing pharmaceutical labelling preferences will contribute to improved medication safety in the workplace and at home.
5. NZNO recommends:
 - a) greater consultation with consumers;
 - b) greater thought be given to ensuring a balance between plain language for consumers/public and clinical language for clinicians;

- c) larger font size on lettering;
 - d) greater differentiation between products with similar names including tall lettering in the case of similar drug names;
 - e) a review of the effective use of expiry dates including ensuring they are present on all packaging and are readable – particularly where indented and on plastic vials;
 - f) improved labelling on inhalers;
 - g) the inclusion of ingredient information on packaging eg. the presence of lactose;
 - h) the inclusion of information sheets on all medicines included in a multi-blister pack; and
 - i) inclusion of information on the types of conditions a medicine is indicated for on the packaging.
6. NZNO does not agree with the need to avoid negative labelling in some cases.

DISCUSSION

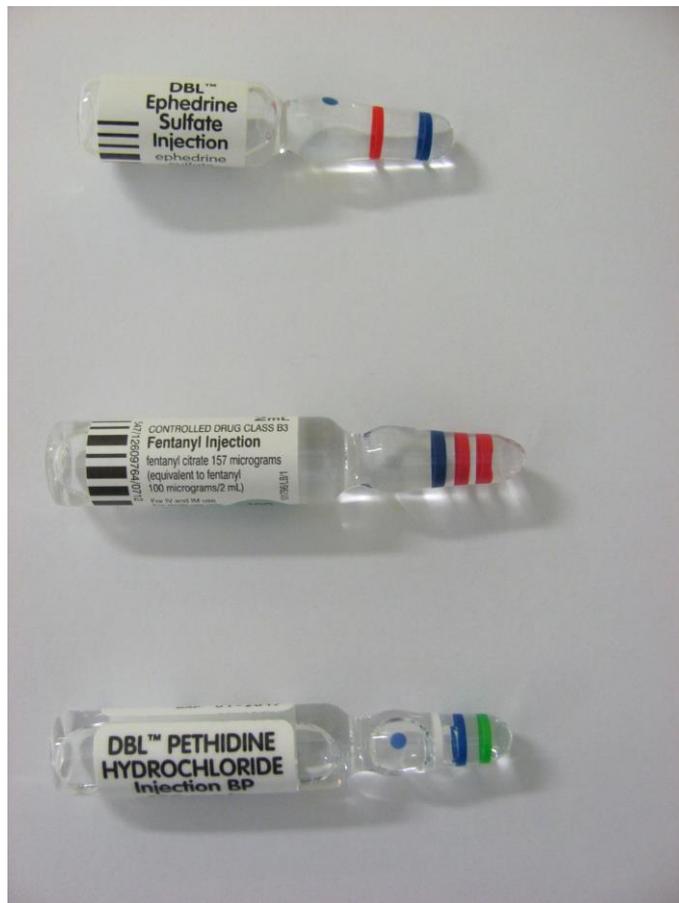
7. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on PHARMAC's proposal to develop pharmaceutical labelling preferences.
8. NZNO members have provided a range of comments in regard to labelling that will help inform PHARMAC's preferences.
9. NZNO is concerned that consumers have not been consulted. Local research shows the majority of New Zealanders have limited ability to obtain, process and understand basic health information (Ministry of Health, 2010). Many who take medications may not have sufficient levels of health literacy to understand even simple instructions making it even more important for labelling to cater to consumer needs. Māori are at particular risk given their lower levels of health literacy when compared with non- Māori (Ministry of Health, 2010). Plain language is essential to ensure good understanding – for example, the use of mouth instead of oral may be helpful. NZNO recommend further thought be given to ensuring a balance between plain language for consumers/public and clinical language for clinicians.
10. NZNO do not agree with the need to avoid negative labelling and note that including “DO NOT give by mouth” or similar can be very clear, strong and useful messages for consumers. This warns them against

inappropriate and possibly dangerous application in clear terms. NZNO is aware of a recent case where a new graduate nurse gave a drug orally instead of intravenously – clear labelling may help avoid such situations.

11. The following are of particular concern to NZNO members:
- a) Clear labelling that can be read in all situations and particularly in low lighting situations – specific concerns include small font size, inappropriate use of colour,
 - b) The importance of having expiry dates that are readable – particularly on plastic vials and where indented (e.g. metoclopramide)
 - c) Improved labelling on inhalers
 - d) Poor ingredient labelling e.g. lack of information regarding the presence of lactose
 - e) Lack of expiry dates on some drugs e.g. paracetamol 500mg suppositories only has the expiry date on the box, not on the blister pack
 - f) The importance of multi-blister packs (eg. Douglas Medico Pak) used in many aged and residential care facilities for individuals on multi-medicines being accompanied by information regarding all medicines included in the pack.

Further detail on each of these points follows:

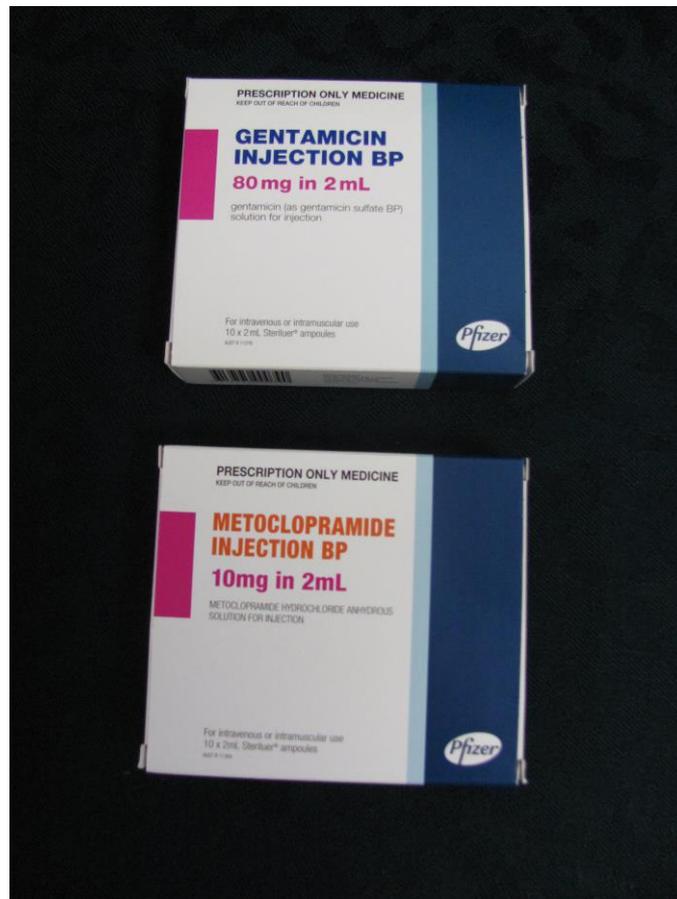
12. Clear labelling is a significant concern for NZNO members. It is essential that labels can be read in all situations and particularly in low lighting situations. With a rapidly ageing nursing population (Walker & Clendon, 2013), the need for improved labelling is paramount. Small font size is of particular concern. The following example shows both the poor readability of small font size when compared to larger, and poor use of colour – members were unclear why coloured rings are present on these ampoules:



13. A further example of the poor use of colour can be seen in the example below. The use of red/green/yellow-orange compared with blue or black is significant. In the example below, the darker colour is significantly easier to see. Further, those who are colour blind would be unable to read red/green colouring at all.



14. NZNO recommends the minimal use of colours to define dosage and the use of distinctively different colours rather than hues of the same colour. Similar packaging on completely different drugs has also been noted as a concern. In this example you can see similarities between gentamicin and metoclopramide:



15. Expiry dates that are readable is also an area of particular concern. Indented expiry dates are the most problematic whether on cardboard or plastic. Add in an ageing workforce, low lighting in some areas and/or an emergency situation, and the risks of errors increase.
16. The NZNO Respiratory Nurses Section would like to see improved labelling on inhalers with a sticker including instructions on the inhaler itself, or a label (especially on inhaled cortico-steroids) to take every or twice daily. The time should also be included ie. morning and night or morning only. The example below shows how this could be achieved:



17. NZNO would like to see more accurate labelling for patients with severe allergies to common fillers like lactose and starch. NZNO received feedback from a member who has a severe allergy to lactose and on a recent hospital admission found herself having to check the ingredients of prescribed medicines online. Eventually all pain medicine had to be given IV as the prescribed oral medications all contained lactose. More accurate ingredient labelling would improve quality of life for allergy sufferers.
18. Many consumers, along with aged and residential care facilities, use multi-blister packs to enhance medicines delivery. With multiple different medicines contained in one large multi-day pack, it is essential that the appropriate information on each medicine is included with the pack. This ensures nurses administering medicines from these packs are able to quickly and effectively ensure any questions can be answered immediately and consumers can look up further information if required. Once again, this has the potential to avoid harm due to medication error.
19. The Aotearoa College of Diabetes Nurses (ACDN) have a number of specific concerns relating to the labelling of insulin. A common concern is with the varying representations of Humalog, Novomix30 and glipizide/glicazide. Some clients think they are on a new insulin because their GP has given them a disposable Novorapid pen. It is also difficult to read the actual insulin name on cartridges themselves. Once out of the packaging it is possible to see why basal is confused with bolus if eyesight is poor, even with colour coding.
20. The ACDN would also like to see the addition of more consistent information on the packaging regarding the condition/s a particular drug is indicated for. This information is on some packaging and not on others. The ACDN are concerned about the high number of clients who are unaware of what the medicines they have been prescribed are for.
21. The ACDN note while generic names have advantages, insulins need names that easily identify the type of insulin and that differentiate them from other types of insulin as often people are using more than one. Complex, long generic names may be confusing particularly when using mixes of insulin (for example, Humalog mix would be lispro protamine sulphate). Having said that, the current labelling regime used with insulin does cause errors. Members have seen dispensing errors from pharmacies around Humalog, Humalog mix, Novorapid and Novomix. There have also been nurse administration errors with inpatients and patients making errors at home.
22. The use of disposable insulin pens has advantages with the elderly and are quicker to teach people to use however they are not always well identified in their labelling such as the Novorapid and Novomix

flexpens with potential for errors - they are predominantly a blue colour with some orange labelling to identify the Novorapid pen. The current Lilly, Sanofi and Novonordisk mechanical insulin pens provide a range of colours that assist in identifying the insulins, providing the correct cartridge is inserted into the pen. The Lantus and Apidra Solostar disposable pens are easier to identify with different colours. In summary, the ACDN believe names need to be simple, but different enough to identify them from others and colouring is important on pens and cartridges to assist in identification.

23. NZNO acknowledge that it is the role of the person administering the medicine to ensure accurate checks are completed prior to and post administration. These include the 5 Rs + 3:
- i) Right person
 - ii) Right medicine
 - iii) Right dose
 - iv) Right time
 - v) Right route
 - vi) Right to refuse
 - vii) Right indication
 - viii) Right documentation

And the 3 checks:

- ix) Check the label when getting the medicine from storage
- x) Check the medicine label with the medicine order (prescription)
- xi) Re-check the medicine order and medicine after preparation but before administering.

However, a range of risk factors exist that can contribute to medication errors including short staffing, staff working extra hours beyond their original shift, fatigue (a recent systematic review identified a significantly higher risk of error in nurses who worked more than 12 hours on a single shift [Clendon & Gibbons, 2015]), patients with increased co-morbidities and multiple medications, high numbers of junior or inexperienced staff, and poor lighting. While many of these are environmental issues, improved labelling is likely to mitigate some risk of error in the above circumstances.

CONCLUSION

24. In conclusion NZNO recommends:

- greater consultation with consumers;
- greater thought be given to ensuring a balance between plain language for consumers/public and clinical language for clinicians;
- larger font size on lettering;
- greater differentiation between products with similar names including tall lettering in the case of similar drug names;
- a review of the effective use of expiry dates including ensuring they are present on all packaging and are readable – particularly where indented and on plastic vials;
- improved labelling on inhalers;
- the inclusion of content information on packaging eg. the presence of lactose;
- the inclusion of information sheets on all medicines included in a multi-blister pack; and
- inclusion of information on the types of conditions a medicine is indicated for on the packaging.

25. NZNO does not agree with the need to avoid negative labelling in some cases.

NZNO would be happy to meet with you in person to discuss any of these points.

Dr Jill Clendon

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REFERENCES

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on a single shift in an acute care hospital setting on rates of error among nurses: a systematic review. *International Journal of Nursing Studies*, 52(7), 1231-1242.

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