JAN-JUNE 2017 ISSUE 1

MINSIG
Malaysian Infusion Nurses Special Interest Group

NEWSLETTER

MINSIG 2017/2018 EXECUTIVE COMMITTEE MEMBERS

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CONTENTS

Chairman's Message

Welcome to our first issue of Malaysian Infusion Nurses Special Interest Group (MINSIG) newsletter for 2017. This year MINSIG will be having the 2nd MINSIG Congress with the theme "Developments in Infusion Management" at Berjaya Times Square Hotel. Do join us and hear from respected speakers regarding developments in infusion management!

Today's healthcare system is a complex entity with patients admitted for various conditions requiring sophisticated medical interventions and needing intravenous therapy and intravenous drugs. As clinicians, managers and educators we are constantly finding loopholes in infusion therapy care and management that needs to be addressed in terms of patient comfort, asepsis and safety. Like any other patient safety issue, infusion therapy safety cuts across several departments and does not solely rests with one department. To reduce any adverse events there is a need to work collaboratively with each other. In theory, it appears there is adherence to policies and procedures pertaining to infusion therapy. However, general observation and discussions with colleagues in various organisations indicate variation in practices not only from organisation to organisation, but within each department and even within each unit of the department. Most of the time these variations in practices are taken for granted and goes unnoticed or ignored until something goes drastically wrong resulting in negative patient outcome. As usual the blame game starts and the individual who is believed to have caused the negative outcome becomes the target. The individual is reprimanded to be more vigilant and some form of training is recommended, but not made compulsory. In addition, the organisation may relook at existing policies and procedures and attempts are made to strengthen them with focus on one individual's mistake rather than the system. There is failure to recognise adverse events, violations and safety problems are a result of interaction among processes and workflows, technology designs, teamwork, staff, patients, financial restraints, training and education. It is timely the systems approach recommended by patient safety council be applied also to infusion therapy safety rather than using the traditional approach.

MINSIG is especially concerned about the "near misses" pertaining to infusion safety such as drugs given as bolus doses without dilution, use of incorrect diluent, incorrect volume used for dilution of intravenous drugs, incorrect administration rate of bolus drug exceeding manufacturers recommendation, the same syringe used to administer the same intravenous drug to different oncology patients who were prescribed the same drug and incorrect setting of the rate of medication on the infusion pump. This list continues. Leaders in the department or unit need to take the extra effort to monitor the many "near misses" related to intravenous infusion therapy that could have negatively impacted patient outcomes. Why wait for an adverse event to occur before reacting! With a rich mine of data gathered from incident reports on "near misses" proactive actions can be taken and implemented through continuous training. It is not unheard of leaders at every level of the hierarchy ignoring or pushing "near misses" under the carpet. Continuous evaluation of outcomes with proper measurement tools based on standards and processes developed from best practices need to be implemented immediately in the clinical areas. Any data gathered and actions implemented with positive results should be shared with other colleagues during continuing education programmes.

MINSIG, a special interest group under Malaysian Nurses Association (MNA) had published and disseminated to every healthcare organisation in Malaysia the evidence-based guidelines on "Insertion and management of peripheral intravenous cannula for adult patients by Registered Nurses". It is also used in all training programmes by MINSIG and the copy is given free to the participants. The first guideline was published in 2011 and the updated version in 2015. It is thus disheartening to hear that many nurse leaders are not aware of these guidelines.

The members are now working on the third guidelines based on recent evidences and recommended best practices put forward by Infusion Nurses Society (INS) and Royal College of Nursing (RCN). The 2016 version of INS and RCN guidelines are available online. The focus of MINSIG's guidelines will be wider and will cover all aspects of infusion care rather than insertion and management of peripheral intravenous cannula. It should be ready mid-2018 for review by peers and other healthcare professionals followed by publication.

MINSIG would like to thank nurses and corporate partners who have shared pictures and local issues concerning the management of intravenous therapy. Do continue sending your concerns or views through our email, minsig2015@gmail.com. Let us learn from each other and improve patient outcomes.

Jeya Devi Coomarasamy
Chairman, MINSIG

"The only person who is educated is the one who has learned how to learn and change" Carl Rogers

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EVIDENCES FROM PUBLISHED MALAYSIAN ARTICLES

In the light of improving intravenous therapy care and management, MINSIG would like to highlight areas of concern based on findings published from 2009 to 2016 by local researchers. To find out more information of these studies please see the reference list given at the end.

Hand Washing

1. Only 42% of the nurses in the medical wards observed washed hands prior to palpating, inserting, replacing or dressing an intravascular device (n=66). After training programme, only 89% of the nurses remembered the need to wash hands (Coomarasamy, Wint & Mohamad Saleh, 2014).

2. 26% (81) of the nurses observed did not wash hands when preparing and administrating intravenous drugs (n=311)(Ong & Subasyini, 2013)

3. Only 20.9 % of the healthcare professionals washed their hands when doing a venipuncture or during insertion of intravenous cannula in a pediatric unit (n-91) (Chang et al., 2012),

Use of Gloves

1. Sterile gloves was not worn (26%) (81 samples) during preparation and administration of intravenous drugs (n=311) (Ong & Subasyini, 2013).

2. 64.8% did not wear gloves when performing venipuncture venipuncture or during insertion of intravenous cannula in a pediatric unit (n=91) (Chang et al., 2012).

Aseptic Technique

1. In 14 (11%) doses (n=122) aseptic technique was not followed in preparation and administration of parenteral medications in GICU of a teaching hospital (Tan, Mohd Said, Abdul Rahman, & Taha, 2016).

2. In a prospective audit only 42% of the nurses in the medical wards observed followed aseptic technique prior to palpating, inserting, replacing or dressing an intravascular device (n=66). After training program, only 89% of the nurses adhered to aseptic technique (Coomarasamy, Wint & Mohamad Saleh, 2014).

3. 91.7% of the nurses had no knowledge that aseptic technique has to be maintained during preparation, insertion and removal of an intravenous cannula (n=120) (Arbaee, I. F & Mohd Ghazali, A. N., 2013).

Use of Same Syringe

1. A observational study done in a teaching hospital found nurses were using the same syringe to administer the same intravenous drug to different oncology patients who were prescribed the same drug (4 cases during the study period (Chua, Tea & Rahman, 2009).

Disinfection of Vials

1. Majority (98.7%) of the drug vial covers were removed without swabbing or the ampoules were broken without swabbing either with alcohol swabs or cotton balls (n=307). (Ong & Subasyini, 2013).

Wrong IV Drug

1. Wrong drug (IV Tienam instead of IV meropenem) was attempted to be given to a patient (Ong & Subasyini, 2013).

Incorrect Dose

1. 4mg of IV metoclopramide given as 8 mg in a haematology ward of a teaching hospital (Chua, Tea & Rahman, 2009).

2. 750 mg of IV vancomycin given as 1 gm in a haematology ward of a teaching hospital. (Chua, Tea & Rahman, 2009)

Wrong Diluent

1. Instead of using 10ml physiological NaCl solution as instructed by manufacturer, 10 ml water for injection used (Ong & Subasyini, 2013).

2. 40% of the 246 nurses in a teaching hospital did not realize that NaCl 3% cannot be used as an alternative to NaCl 0.9% for diluting intravenous antibiotics (Shamsuddin & Shafie, 2012).

Inappropriate Amount of Diluent

1. Errors were highest during the reconstitution and dilution of parenteral medications. More than half (57%) (n=122) of all doses were prepared erroneously either using the incorrect diluent, the incorrect volume or were mixed insufficiently (Tan, Mohd Said, Abdul Rahman & Taha 2016)

2. 61 (54.5%) of the 112 drug preparation observed were diluted with inappropriate amount. (Ong & Subasyini, 2013)

Drug Given As Bolus and Not Diluted

Drugs such as ranitidine (95%) promethazine (5%) of the 20 samples observed were not diluted prior to administration but given as bolus dose. (Ong & Subasyini, 2013)

Incorrect Administration Rate

1. Bolus drugs (33%, n=122) were administered at a rate that exceeded 3-5 min as recommended by the manufacturers (Tan, Mohd Said, Abdul Rahman & Taha, 2016)

2. Over 50% of the nurses (n=246) did not understand the rate of bolus administration should be longer than one minute and specific to the types of administration (Shamsuddin & Shafie, 2012).

3. Some infusion pumps did not produce the rate of infusion stated and this led to incorrect rate of administration. For example, a setting of 180 mL/h for 500 mL of cytarabine should take about 3 h to complete the infusion instead of around 2 h. (Chua, Tea & Rahman, 2009)

Syringes Not Labelled

1. In 15 (12%) doses (n=122) the syringes were not properly labeled (Tan, Mohd Said, Abdul Rahman, & Taha, 2016).

Checking and Double Checking

1. Nurses did not perform a double check in the preparation/administration of all 122 parenteral doses (100%) (Tan, Mohd Said, Abdul Rahman, & Taha, 2016).

2. In 9 doses (7%), medication not rechecked for patient's prescription, identity (ID), and allergy status prior to administration (Tan, Mohd Said, Abdul Rahman, & Taha, 2016).

Complications

1. In 2014, the percentage of intravenous complications (needles out, redness of skin, infection at cannula site, extravasation) ranged from 1.6% to 3.4% of patients on intravenous therapy. In 2015, complications ranged from 2.2% to 3.8%. One of the contributory factors was frequent change of antibiotics and other drugs with high osmolality causing phlebitis (Abdul Aziz, A.R., 2016).

2. The rate of intravenous thrombophlebitis in KPJ Seremban Specialist Hospital for year 2011 was 6.8%. After the implementation of the special protocol (integrated intravenous care) the rate of intravenous thrombophlebitis reduced to 3.1% in year 2012 and further reduced to 2.52% for the first half of year 2013. (Abdul Aziz, Nishazini, Fazira & Azizan, 2013).

3. 35.2% of 428 patients on intravenous line in medical and surgical wards in a tertiary hospital in Negeri Sembilan developed thrombophlebitis (Yoong, Yeap & Syed Aznal,2012)

References:

1) Abdul Aziz, A.R. (2016). Monitoring Of Clinical Indicators to Improve Nursing Services in Hospital A, Sharing Malaysia Experience. *IOSR Journal of Business and Management (IOSR-JBM) 18 (3), Ver. I (Mar.), 94-101.*
2) Abdul Aziz, A.R., Nishazini M.B., Fazira, S, Azizan N.A. (2013). Impact of a Special Protocol (Integrated Intravenous Care) to Reduce Intravenous Thrombophlebitis: Sharing the Experiences of KPJ Seramban Hospital Malaysia. *IOSR-JBM 13 (5): 60-64*.
3) Arbaee, I. F & Mohd Ghazali, A. N. (2013). Nurses Knowledge and Practice towards Care and Maintenance of Peripheral Intravenous Cannulation in Pantai Hospital, Batu Pahat, Johor, Malaysia. https:///www.researchgate.net/publication/23692617
4) Coomarasamy, J.D., Wint, N.N., & Mohamad Saleh, Z. (2014) Insertion and management of peripheral intravenous cannula in the adult medical wards of Universiti Kebangsaan Malaysia Medical Center: a best practice implementation project. *JBI Database of Systematic Reviews & Implementation Reports 12(7) 534 – 551*.
5) Chang, D.T.S., Lai, N.M., Ng, N.S.Q., Ho W.P., Tan, T.T., Chua, J & Mat Bah, M.N. (2012). Adherence to major standard precautions: an audit of venepuncture and intravenous cannula insertion in the paediatric unit of Hospital Sultanah Aminah, Johor Bahru. *Malaysian Journal of Paediatrics and Child Health Online Early*.
6) Chua SS, Tea MH, Rahman MHA. An observational study of drug administration errors in a Malaysia hospital (the study of drug administration errors). *Journal Clinical Pharmacy Therapy 2009; 34:215-23*.
7) Ong W.M., & Subasyini, S. Medication errors in intravenous drug preparation and administration. *Med J Malaysia 2013; 68:52-7*.
8) Shamsuddin, A.F., & Shafie, S.D. (2012). Knowledge of nurses in the preparation and administration of intravenous medications. *Procedia-Social and Behavioural Sciences, 60. 602-609*.
9) Tan S.Y., Mohd Said, M., Abdul Rahman, R., & Taha, N.M (2016). An investigation of errors: the preparation and administration of parenteral medications in an intensive care unit of a tertiary teaching hospital in Malaysia. *International Journal of Pharmacy and Pharmaceutical Sciences, 8 (3)*.
10) Yoong, J.T., Yeap, J.W., & Syed Aznal, S.S. (2012). Risk factors for peripheral venous catheterisation thrombophlebitis, *IeJSME 6(1), 24-30*.

RECOMMENDED READINGS

EXTRACTED ABSTRACTS
Do go online and read the following articles!

1. Murdoch, F., Danial, J., Morris, A.K., Czarniak, E., Bishop, J.L., Glass, E. and Imrie, L.J. (2017) The Scottish enhanced Staphylococcus aureus bacteraemia surveillance program: The first 18 months data in adults. *The Journal of Hospital Infection. June 8th.* [Epub ahead of print]. doi: 10.1016/j.jhin.2017.06.008.

   Background: Staphylococcus aureus bacteraemia (SAB) is the second most common source of positive blood cultures after Escherichia coli (E. coli) reported within NHS Scotland. Laboratory surveillance has been mandatory in Scotland for SAB since 2001.

   Aim: To gain an understanding of the epidemiology of SAB cases and associated risk factors for healthcare and true community onset. Identifying these factors and patient populations most at risk allows focused improvement plans to be developed.

   Methods: All NHS Boards within NHS Scotland take part in the mandatory enhanced surveillance collecting data by trained data collectors using nationally agreed definitions.

   Findings: Between 1st October 2014 and 31st March 2016, 2256 episodes of SAB in adults were identified. The blood cultures were taken in 58 hospitals and across all 15 Scottish health boards. The data demonstrated that approximately one third of all SAB cases are true community cases. Vascular access devices (VAD) continue to be the most reported entry point (25.7%) in persons who receive healthcare, whereas, skin and soft tissue risk factors are present in all origins. Significant risk factors unique to community cases are in people who inject drugs (PWID).

   Conclusion: Improvement plans for reduction of SAB should be more widely targeted than solely in hospital care settings.

2. Kaur, R., Razee, H. and Seale, H. (2016) Development and appraisal of a hand hygiene teaching approach for medical students: a qualitative study. *Journal of Infection Prevention. 17(4)*, p.162-168. doi: 10.1177/1757177416645345

   Background: Poor hand hygiene (HH) practices among medical students have previously been attributed to students not being exposed to sufficient teaching materials during their training.

   Aim: To develop and evaluate a teaching module directed at improving the knowledge and attitudes of undergraduate medical students towards HH.

   Methods: The HH teaching module was designed based on educational materials used by the World Health Organization and other patient safety organisations. The development was also informed by the findings from two previous studies including qualitative interviews with staff and students and a survey of Australian medical schools. In-depth group interviews were undertaken with 24 undergraduate medical students.

   Results: Favourable feedback was received from the interviewed medical students towards the developed scenario-based learning activity; however, the group interview activity was not received well by students. They suggested that the HH teaching activities should be compulsory and not optional for medical students. In order to reinforce good HH practices and to improve knowledge around HH and healthcare-associated infections, they felt that the activities should be repeated during each phase of their degree.

   Conclusions: There is a need to change the approach to training in education, particularly to engage students in topics such as HH which are often seen as unimportant.

3. Kutsuna, S., Hayakawa, K., Kita, K., Katanami, Y., Imakita, N., Kasahara, K., Seto, M., Akazawa, K., Shimizu, M., Kano, T., Nei, T., Hayashi, T., Mori, N., Yabuki, T. & Ohmagari, N. (2017) Risk factors of catheter-related bloodstream infection caused by Bacillus cereus: Case-control study in 8 teaching hospitals in Japan. *American Journal of Infection Control. June 5th.* [Epub ahead of print]. doi:10.1016/j.ajic.2017.04.281.

   Background: The recognized international organizations on infection prevention recommend using an observational method as the gold standard procedure for assessing health care professional's compliance with standard infection control practices. However, observational studies are rarely used in Jordanian infection control studies. This study aimed to evaluate injection practices among nurses working in Jordanian governmental hospitals.

   Methods: A cross-sectional concealed observational design is used for this study. A convenience sampling technique was used to recruit a sample of nurses working in governmental hospitals in Jordan. Participants were unaware of the time and observer during the observation episode.

   Results: A total of 384 nurses from 9 different hospitals participated in the study. A total of 835 injections events were observed, of which 73.9% were performed without hand washing, 64.5% without gloving, and 27.5% were followed by needle recapping. Hand washing rate was the lowest (18.9%) when injections were performed by beginner nurses. Subcutaneous injections were associated with the lowest rate (26.7%) of post injection hand washing compared with other routes.

   Conclusions: This study demonstrates the need for focused and effective infection control educational programs in Jordanian hospitals. Future studies should consider exploring the whole infection control practices related to waste disposal and the roles of the infection control nurse in this process in Jordanian hospitals.

4. Okogbaa, J.I., Onor, I.O., Arije, O.A., Harris, M.B. and Lillis, R.A. (2016) Phenytoin-Induced Purple Glove Syndrome: A Case Report and Review of the Literature. *Hospital Pharmacy. 50(5)*, p.391-5. doi: 10.1310/hpj5005-391.

   Objective: To present a case report and literature review of phenytoin-induced purple glove syndrome (PGS).

   Case Summary: A 54-year-old African American male presented to our hospital's emergency department (ED) following a seizure episode, cardiac arrest, and loss of consciousness. On arrival to the ED, the patient's total phenytoin level was sub-therapeutic at 4.1mcg/mL and his corrected total phenytoin level was sub-therapeutic at 5.1mcg/ml. In the ED, the patient received a loading dose of intravenous (IV) phenytoin 1,000 mg once via the left cephalic vein, at a rate of 50 mg/min, and was admitted to the medicine service. A day following IV phenytoin administration, a nurse noticed an IV fluid infiltration on the skin tissue around the left cephalic vein. The area appeared dark blue and purple in colour, swollen, erythematous, and warm to touch. An ultrasound of the left upper extremity was performed and revealed subcutaneous fluid collection without evidence of thrombosis.

   Discussion: The Naranjo Adverse Drug Reaction Probability Scale assigned a score of 7, indicating phenytoin as the probable cause of purple glove syndrome (PGS). The patient's PGS was managed with a combination of dry dressing material, left forearm elevation, collagenase topical cream, 0.1% IV bupivacaine, and IV fentanyl. The patient's injury was resolving at the time of discharge to a rehabilitation facility.

   Conclusion: PGS is a rare complication of IV phenytoin therapy. The risk of PGS for this patient may have been abated by decreasing the phenytoin infusion rate from 50 mg/min to less than 25 mg/min.

5. Fwo, Y.T., Siew, L.L., & Matizha, P. (2015). Patient Perceptions and Experience of Pain, Anxiety and Comfort during Peripheral Intravenous Cannulation in Medical Wards: Topical Anaesthesia, Effective Communication, and Empowerment. International Journal of Nursing Science, 5(2): 41-46. doi: 10.5923/j.nursing.20150502.01

   Background: Peripheral intravenous cannulation (PIVC) is one of the most common invasive procedures that healthcare personnel perform daily, often a source of patients'pain, anxiety, dissatisfaction and discomfort. Despite the importance of increasing patient's comfort in medical care, this need has being increasingly overlooked during PIVC, especially in the current busy clinical settings. Doctors and nurses play a significant role in providing effective, easy-to-implement pharmacological and non-pharmacological management to help patients cope with pain, distress, and anxiety in the frequently performed cannulation.

   Objective: To assess adult patient perceptions and experience of comfort, pain and anxiety during PIVC in medical wards. Design and Setting: A cross-sectional descriptive study was carried out on 120 adult patients admitted to medical wards.

   Methods: Patients aged 18 to 65 who had undergone PIVC for 24 to 48 hours, with an 18 gauge Vasofix cannula and were alert and conscious during cannulation were included in the study. The study was guided by Kolcaba's Theory of Comfort. A structured face-to-face survey was used to collect data. Descriptive statistics were used to analyse the data.

   Results: One hundred and fourteen patients (95%) experienced pain and 88 patients (73.3%) reported anxiety during PIVC. Forty-seven patients (53.2%) stated that they were afraid of needle pain, 26 patients (30.2%) were afraid of staffs' ability during PIVC, and 12 (13.5%) were afraid of blood or bleeding. Ninety-two patients (76.6%) indicated that their healthcare professional only pricked them once during cannulation. Only a small number of patients (11.7%) were offered topical anaesthesia and very few patients (15.8%) were given the option to choose their preferred site for cannulation. The majority of patients, 110 (91.7%), expressed the need for topical anaesthesia and 116 patients (96.7%) reported effective communication for pain relief. One hundred and eighteen patients (98.3%) said they thought they would have been more comfortable if they had been able to choose the site for cannulation.

   Conclusions: The results may raise awareness of the need to reduce patients'pain and anxiety during PIVC. Using both pharmacological and non-pharmacological approaches, including topical anaesthesia, effective communication (friendly and informative staff) and empowerment to choose the site for cannulation; patients will be more relieved and subsequently reduce negative experiences that aids recov

HIGHLIGHTS

CORPORATE SOCIAL RESPONSIBILITY PROJECT

On Saturday 21 January 2017 seven members from MINSIG paid a visit to Rumah WAKE 3, a home for HIV positive transsexuals under Pertubuhan Wanita dan Kesihatan Kuala Lumpur. MINSIG donated a refrigerator to the home. Since it was immediately after Chinese New Year, the members also presented the home with boxes of cake and mandarin oranges.

67TH ANNUAL GENERAL MEETING OF MALAYSIAN NURSES ASSOCIATION

The 67th Annual General Meeting of Malaysian Nurses Association was held in Kuching from 24-26 March 2017. During the Special Interest Group meeting that was held on the second day, interested MNA members from all over the country came forward to give support and join the growing MINSIG family.

SPECIAL PROJECT WITH NATIONAL HEART INSTITUTE, KUALA LUMPUR

National Heart Institute (NHI) chief nursing officer Lim Yet Foong took the initiative to organise a session for 26 of her nurses who had not completed according to the requirements set by MINSIG to receive certificates of accomplishment. On Saturday 13 May 2017, these nurses sat again for theory and practical examination prior to sending their 20 logs of cannulation done on patients under supervision. With the monitoring done by Ms Lim 25 nurses successfully completed as per requirement to receive their certificate of accomplishment instead of cannulation.

CERTIFICATES OF ACCOMPLISHMENT FOR 2016 AND 2017

WORKSHOP ON INSERTION AND MANAGEMENT OF PERIPHERAL INTRAVENOUS CANNULA

Congratulations to the following 25 nurses from Malacca Hospital who had submitted their logs late and did not have the names published in the July to December 2016 newsletter. Good work Matron Hee Kim Lan, Chief Matron, Malacca Hospital and team! Now your department have 57 nurses who can be privileged to perform peripheral intravenous cannulation on adult patients.

PERIOD OF VALIDITY 1/11/16 TO 31/10/18

No.	Name	Certificate No
1.	Nurkhairul Arif	MINSIG/065/2016
2.	Rosnita Bt Nikmat	MINSIG/066/2016
3.	Tan Siong Neo	MINSIG/067/2016
4.	Noor Saidatur Akmar Zamri	MINSIG/068/2016
5.	Nurul Jannah Bt Rosli	MINSIG/069/2016
6.	Nor Azhani Bt Abdul Rahim	MINSIG/070/2016
7.	Indok Meriak Bt Bachok	MINSIG/071/2016
8.	Nor Hayati Semah	MINSIG/072/2016
9.	Ummi Iffah Bt Yunus	MINSIG/073/2016
10.	Zasliza Sulaiman	MINSIG/074/2016
11.	Siti Munirah Bt Othman	MINSIG/075/2016
12.	Masturah Bt Hamzah	MINSIG/076/2016
13.	Rosyati Bt Khamis	MINSIG/077/2016
14.	Baridah@ Faridah Bt Khamis	MINSIG/078/2016
15.	Punitha Krishnasamy	MINSIG/079/2016
16.	Siti Zailah Bt Zakariah	MINSIG/080/2016
17.	Aniszah Bt Abdullah	MINSIG/081/2016
18.	Noor Syuhaida Noor Din	MINSIG/082/2016
19.	Izammer Kamaruzaman	MINSIG/083/2016
20.	Noor Farahida Saudi	MINSIG/084/2016
21.	Nabila Bt Abdullah	MINSIG/085/2016
22.	Syakila Amira Bt Abd Talib	MINSIG/086/2016
23.	Nor Syuhada Bt Mohtar	MINSIG/087/2016
24.	Nursyazwani Bt Osman	MINSIG/088/2016
25.	Ruzaini Azhan Kamarudin	MINSIG/089/2016

ANNOUNCEMENTS

DATE OF WORKSHOP: 13 MAY 2017
VENUE: NATIONAL HEART INSTITUTE

Congratulations to the following 25 nurses from National Heart Institute, Kuala Lumpur who have successfully completed the programme and can be privileged by the organisation to perform peripheral intravenous cannulation on adult patients.

Validity Period: 1.7.17 to 30.6.19

No	Name	Certificate Number
1.	Siti Mariam Ramli	MINSIG/001/2017
2.	Nur Faliza Razali	MINSIG/002/2017
3.	Rosediana Alias	MINSIG/003/2017
4.	Nor Farida Mhd Aripin	MINSIG/004/2017
5	Rosni Abdullah	MINSIG/005/2017
6.	Rosidah Md Taha	MINSIG/006/2017
7.	Farizahanom Joppery	MINSIG/007/2017
8.	Norazlina Susila Razali	MINSIG/008/2017
9.	Nordiyana Zubir	MINSIG/009/2017
10.	Norliza Abdullah	MINSIG/010/2017
11.	Sazalia Mohamad Saad	MINSIG/011/2017
12.	Suliyana Soib	MINSIG/012/2017
13.	Salbiah Hashim	MINSIG/013/2017
14.	Nurfazlina Mohd Zolkafeli	MINSIG/014/2017
15.	Vishaalini Devarajoo	MINSIG/015/2017
16.	Nadzirah Jusoh	MINSIG/016/2017
17.	Effany Eva Anak Dehan	MINSIG/017/2017
18.	Masyila Mohamed Syamsudin	MINSIG/018/2017
19.	Siti Fatimah Talib	MINSIG/019/2017
20.	Puanamalar Mutaragan	MINSIG/020/2017
21.	Sulizawati Nain	MINSIG/021/2017
22.	Raja Nur Farihan Raja Semail	MINSIG/022/2017
23.	Nurul Nadia Sabaruddin	MINSIG/023/2017
24.	Choong Shiau Yin	MINSIG/024/2017
25.	Sharulbariah Abdullah	MINSIG/025/2017

2ND MINSIG CONGRESS

THEME: DEVELOPMENTS IN INFUSION MANAGEMENT

PRE CONGRESS PROGRAM
THURSDAY: 17 AUGUST 2017
WORKSHOP 1: IMPLEMENTING IV GUIDELINES: KEY GOVERNANCE TO IV PRACTICES (BRONX ROOM 5)

Time	Topic /Activity	Key Person
1300	Registration and Welcoming note	Secretariat
1310	INS 2016: Standards of Practices: India INS Practices In VAD Management and Challenges	Col (Rtd) Binu Sharma, President INS India
1400	Current Practices in IV Line Management	Ms. Goveelaneawary S. Pillay Infection Control Officer, KPJ Ampang Puteri Specialist Hospital
1440	IV Catheter Securement Technology With Evidence-based Practices to Prevent Phlebitis	Mr Adam Low Regional Clinical Consultant 3M APAC
1520	**Tea Break**	
1540	Group Discussion: Reviewing Current Guidelines & INS 2016 Guidelines	Facilitator: Sandra So & Adam Low
1640	Hands on Session • Securement of IV • Prevention of MARSI on IV Lines	3M Malaysia Team
1730	**End of Workshop**	

WORKSHOP 2: GO SAFETY INFUSION (BRONX ROOM 6)

Time	Topic/Activity	Key Person
1300-1330	Registration	Secretariat
1330-1400	A Systems Approach to Infusion Therapy Safety	Dr Jeya Devi Coomarasamy Chairman, Malaysian infusion Special Interest Group
1400-1430	Adverse Events Related to Intravenous Infusions Care Practices in an Emergency Department	Dr Abdul Rashid Abdul Kader Head of Patient Safety, UKM Medical Centre
1430-1500	Safe Intravenous Infusion Practice in Critically Ill Patients	Associate Professor Dr Raha Abdul Rahman Consultant Anaesthesiologist, Faculty of Medicine, UKM
1500-1530	Safety Features of an Infusion Pump	Puan Norkatijah Ri Nursing Sister, General Operating Theatre, National Cancer Institute, Putrajaya
1530 - 1700	Hands on Sessions on Safety Features • Infusion Pumps • Syringe Pumps • IV Cannula • Needleless Connectors	Terumo Malaysia Team
1700	**Afternoon Tea & End of Workshop**	

2ND MINSIG CONGRESS

THEME: DEVELOPMENTS IN INFUSION MANAGEMENT

DAY 1: FRIDAY: 18 AUGUST 2017 (MANHATTEN BALLROOM 1)

Time	Topic	Speaker
0800	**Registration**	**MINSIG Secretariat**
0900	Welcoming Address	Dr. Jeya Devi Coomarasamy Chairman, Malaysian Infusion Nurses Special Interest Group (MINSIG)
0920	Address by President MNA	Puan Sharipah Asiah Al Junid Syed Junid President, Malaysian Nurses Association (MNA).
0930	Official Opening Address by Director General of Health, Malaysia	YBhg Datuk Dr. Jeyaindran Tan Sri Sinnadurai, Deputy Director General of Health (Medical) Ministry of Health Malaysia
1030	**MORNING TEA**	
1100	**Keynote Address I** ***Moderator: Associate Prof Raja Lexhimi Raja Gopal***	
	Developments in Infusion Management: Past, Present and Future.	Professor Dr Samantha Keogh, President of Australian Vascular Society (AVAS) & Professor of Nursing, Queensland University of Technology
1100	**Plenary 1: Loop Holes in Clinical Practice: Challenges Faced** ***Moderator: Ms Hee Kim Lan***	
	1. Closing Loopholes in Infusion Care Practices: The Indian Experiences	Colonel (Rtd) Binu Sharma President, Infusion Nurses Society India.
	2. Gap in Recommended and Actual Practices in Infusion Management and Care in the Emergency Department.	Assistant Professor Dr. Mohd Said Nurumal Dean, Nursing Department International Islamic University Malaysia
	3. Catheter Related Infections: Recent Advances and Obstacles to Patient Outcomes.	Dr Shanthi Ratnam Head of Intensive Care Unit. Hospital Sungai Buloh.
	4. Challenges towards Standardised Infusion Therapy Practices.	Ms. Sin Lian Thye Chief Matron, National Cancer Institute, Putrajaya
1300	**LUNCH BREAK & FRIDAY PRAYERS**	
1430	**Plenary 2: Applying Clinical Research to Enhance Clinical Practice** ***Moderator: Ms Sin Lian Thye***	
	1. Ultrasonic Classifications of Subcutaneous Oedema Caused by Infusion.	Assistant Professor Dr Koichi Yabunaka Department of Gerantological Nursing/ Wound Care Management, Graduate School of Medicine, The University of Tokyo.
	2. Replacement of Administration Set for Arterial Catheter 4 Days Versus 7 Days	Assistant Professor Dr Azlina Daud. Deputy Dean (Research & Post Graduate), Nursing Department. International Islamic University Malaysia
	3. The Preparation and Administration of Parenteral Medications in an Intensive Care Unit.	Ms Tan Suet Yin Chief Pharmacist, Institute of Respiratory Medicine. Kuala Lumpur
	4. Nurses Knowledge and Practice on Peripheral Intravenous Cannula Insertion.	Ms Nor Haty Hassan Lecturer, Department of Nursing, National University Malaysia
1645	**AFTERNOON TEA and END OF DAY 1**	

DAY 2: SATURDAY: 19 AUGUST 2017 (MANHATTEN BALLROOM 1)

Time	Topic	Speaker
0800	Registration	Secretariat
0900	***Moderator: Dr. Jeya Devi Coomarasamy***	
	Keynote Address II	
	Role of Clinical Research Centre in Implementing Evidence-Based Clinical Practice in Malaysia.	Dr Goh Pik Pin Director, National Clinical Research Centre. Malaysia
0945	Robust Clinical Research Findings for Development of Clinical Standards.	Professor Dr Samantha Keogh President of Australian Vascular Society (AVAS) & Professor of Nursing, Queensland University of Technology.
1015	**MORNING TEA**	
1100	**Plenary 3: Infusion Devices: Benefits and Pitfalls** ***Moderator: Assistant Professor D. Mohd Said Nurumal***	
	1. Extending Peripheral Catheter Dwell Time with Closed IV Catheter Systems	Dr. Jayant R Giri, MD Associate Director / Clinical Initiatives – Central South East Asia & Japan. BD Medication and Procedural Solutions. Singapore
	2. Impact of Disinfecting Port Protectors for Reducing Intraluminal Catheter-Related Infection	Ms. Sandra So Clinical Nurse, 3M Critical & Chronic Care Solution, Malaysia
	3. IV Catheter Fracture Risk, Safety Features and Current Practice	Mr Vincent Low Sales & Marketing Manager, Medical Pharma Division, Summit Company (Malaysia)
1300	**LUNCH BREAK**	
1400	**Plenary 4: Quality Improvement and Patient Safety Initiatives Related to Intravenous Infusion Care** ***Moderator: Ms Jagjit Kaur Najar Singh***	
	1. Strategies by KPJ Ampang Puteri Specialist Hospital towards Reducing Intravenous Line Related Infections.	Ms. Goveelaneawary S. Pillay Infection Control Officer, KPJ Ampang Puteri Specialist Hospital
	2. Quality Improvement Initiatives to Reduce Intravenous Phlebitis at National Cardiac Institute.	Ms. Lim Yet Foong Chief Nursing Officer, National Cardiac Institute
	3. Role of Education in Ensuring Competency in IV Cannulation and Monitoring at KPJ Tawakkal Specialist Hospital.	Ms. Goventhamah Subramaniam Deputy Chief Nursing Officer KPJ Tawakkal Specialist Hospital
1530	**Forum: Intravenous Infusion Management and Care Practices: The Way Forward** **Moderator:** ***Dame Hjh Ramziah Hj Ahmad, President, Commonwealth Nurses and Midwives Federation (CNF).*** **Panellist** 1. Ms. Hee Kim Lan: Chief Matron, Hospital Malacca 2. Assistant Professor Dr. Azlina Daud: Deputy Dean (Research & Post Graduate), Nursing Department International Islamic University Malaysia 3. Ms. Goventhamah Subramaniam: Deputy Chief Nursing Officer, KPJ Tawakkal Specialist Centre 4. Mr Zamri Shahri: Staff Nurse, Hospital Tuanku Ja'afar Seremban.	
1630	Closing Remarks	Ms Sin Lian Thye Deputy Chairman, MINSIG
1645	**AFTERNOON TEA and END OF DAY 2**	