

CheckCLIP

Single-Use | Medication ID


QLICKSMART[®]
Simply safer

A simply safer way of labelling syringes.

CheckCLIP safely attaches the ampoule to the syringe for accurate cross check without obscuring incremental dosage marks on the syringe to reduce medication errors.



Simply clip them together

Mistake-proof the labelling of syringes

Clicksmart CheckCLIP is a simply safer way to label syringes with the name of the medication that has been drawn up always visible. This significantly reduces the risk of morbidity and mortality caused by medication errors.

Patient safety

Traditional labelling techniques that involve handwriting on the syringe, attaching the ampoule with surgical tape or labelling with stickers are all prone to medication errors. Tape and stickers obscure incremental marks on the syringe and handwriting is time-consuming and open to transcription error. As a result, virtually every practitioner experiences a 'near miss' or worse at some stage in their chaotic work environment.

CheckCLIP avoids these traps by safely attaching the ampoule to the syringe for accurate cross checking without obscuring incremental dosage marks on the syringe and it covers any exposed sharp edges. With Clicksmart CheckCLIP the ampoule containing all the drug details remains with the syringe at all times.

Medication and syringe swap errors

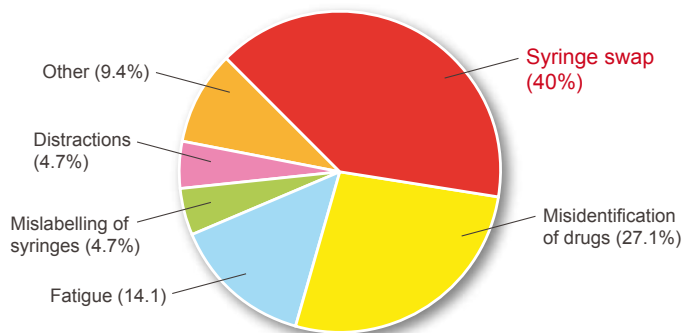
Medication errors kill at least 1 patient every day in American hospitals and another 1.3 million people are injured every year at a cost of \$6 billion annually.^{1,2}

A study conducted by Department of Anesthesia, Sunnybrook and Women's College Health Science Centre, University of Toronto, Ontario, Canada showed that 70.4% of 687 anaesthetists surveyed indicated syringe swap is one of the most common contributing factors to medication errors.³

A South African study found 94% of participants (125 of 133) admitted to having inadvertently administered a wrong drug. Contributory causes identified included⁴:

- Syringe swap - 40%
- Misidentification of drugs - 27.1%
- Fatigue - 14.1%
- Distractions - 4.7%
- Mislabelling of syringes - 4.7%

Factors Contributing to Medication Errors⁴



Staff safety - physical and psychological

Medication error poses serious risks to patient safety, regulatory compliance and hospital litigation exposure. It is also a significant occupational health and safety concern for practitioners. One third of all doctors who have experienced a 'near miss' medication error report that the stress and repercussions negatively impacted on their life. 97% of nurses worry about medication errors. 68% of health professionals believe medication error can be reduced by better labelling. CheckCLIP provides that better solution.

A study by the Joint Commission of 3,171 physicians who had experienced (committed) a medication error found that⁵:

- 61% reported increased anxiety about future errors
- 44% reported a loss of confidence
- 42% reported sleeping difficulties
- 42% reported reduced job satisfaction
- 13% reported harm to their reputations



A fatality or a near miss?

Common factors in medication errors

Study of Injectable Medication Errors done by the American Nurse Association and InViro Medical in 2007 showed the following results⁶:

- Too rushed / busy environment - 78%
- Poor / illegible handwriting - 68%
- Missed or mistaken physicians orders - 62%
- Similar drug names or medication appearance - 56%
- Working with too many medications - 60%
- Only 37% claim Injectable Medications are always labelled

1. Harden, S. (2006). "One Death Per Day Due To Medication Errors: Hospitals Seek Improvement By Learning From The Best In Aviation". Press Release Newswire.

2. Kohn, L. T., J. Corrigan, et al. (1999). To Err is Human - Building a Safer Health System. IOM HealthGrades Study. National Academy Press.

3. Orser, B. A., R. J. Chen, et al. (2001). "Medication errors in anesthetic practice: a survey of 687 practitioners." Can J Anaesth 48(2): 139-46.

4. Gordon, P. C., R. L. Llewellyn, et al. (2006). "Drug administration errors by South African anaesthetists—a survey." S Afr Med J 96(7): 630-2.

5. Waterman AD, G. J., Hazel E, et al (2007). "The emotional impact of medical errors on practicing physicians in the United States and Canada." Jt Comm J Qual Patient Saf 33: 467-476.

6. "2007 Study of Injectable Medication Errors - An Independent Study Sponsored by the American Nurses Association and InViro Medical Devices."

from <http://www.nursingworld.org/MainMenuCategories/OccupationalandEnvironmental/occupationalhealth/SafeNeedles/2007InViroStudy.aspx>

CheckCLIP

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Simply attach the ampoule to the syringe

CheckCLIP enables the ampoule to travel with the syringe for visual cross-checking and accurate administration to the patient. Simply:

- Enables visual cross checking of drug and dose details
- Ensures a clear unobscured view of syringe increments
- Prevents sharps injuries from opened glass ampoules
- Provides clear indication of drug expiry dates
- Avoids accidental ampoule swaps and syringe swaps



Mistake-proof process

Without ever letting go of the ampoule, you can:

- ATTACH the disposable CheckCLIP to the syringe
- SNAP the ampoule open and draw down the drug
- CLIP the ampoule safely to the CheckCLIP
- CHECK drug and dose with a clear view

There is no chance of syringe or ampoule swap error. By merely attaching then clipping, you not only save time but also lives in emergency situations.

Remember: double check and be sure.

Applications of CheckCLIP

CheckCLIP should be used wherever drugs are drawn into a syringe from an ampoule.

- Hospitals - including Emergency Department, Operating Room, Anaesthetics
- Paramedics
- Medical Centres
- Animal labs

CheckCLIP vs. Current Practices	CheckCLIP	Medical Sticky Tape	Hand Written Label	Drug Class Colour Coded Label
Attach ampoule to syringe	Yes	Yes	No	No
Visual cross checking of drug/dose details	Yes	Poor or obscured	No	No
View of syringe increments	Yes	No	No	No
Clear indication of drug concentrations	No	No	Yes, if written on label correctly	No
Prevent sharps injuries from glass ampoules	Yes	No	No	No
Clear indication of drug expiry date	Yes	No, obscured by taping	No	No
Risk of mix-up > Ampoule leaves hand during process	Almost nil > Ampoule does not leave hand	Potential > Ampoule leaves hand	Potential > Ampoule leaves hand	Potential > Ampoule leaves hand

Specifications

Product edition	For Ampoule	For Vial
Product code	QSCCGEN	QSCCVIAL
Compatible syringe sizes	1-10ml luer and luer lock (majority)*	
Compatible ampoule / vial sizes	Glass and plastic ampoules 1-10ml (majority)**	Vials with diameter of up to 28mm*** (The sum of the syringe radius and vial radius must be less than 23mm)
Size (per unit)	Length 3.7cm Width 2cm Height 2.5cm	Length 4.2cm Width 2cm Height 1.8cm
Weight (per unit)	Approximately 1g	Approximately 1g
GMDN code	46240	

Material	Borealis polypropylene (PPE)
Latex	No
DEHP	No
Sterile	No
Re-usable	No. Each unit attaches 1 ampoule or vial onto a syringe.
Disposal method	Once medication has been administered and drug identification is no longer required, the whole syringe unit (with CheckCLIP and ampoule or vial attached) is disposed of as medical waste in a sharps container.
Regulatory approvals	Australia - Listed under TGA ARTG NO: 134522 USA - FDA listed

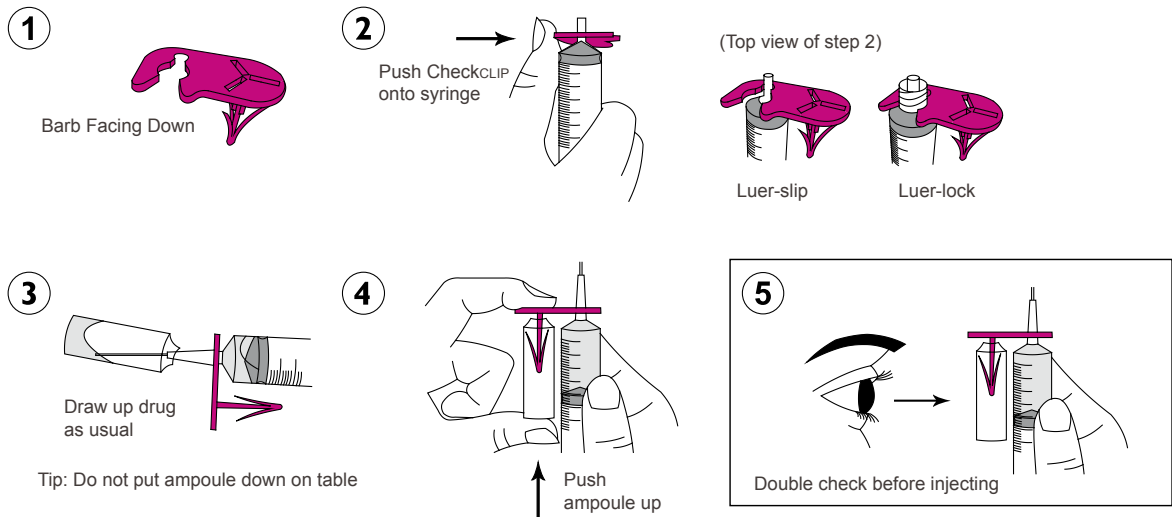
* Compatibility depends on geometry and diameter of the syringe

** Exceptions include ampoules 25ml or larger

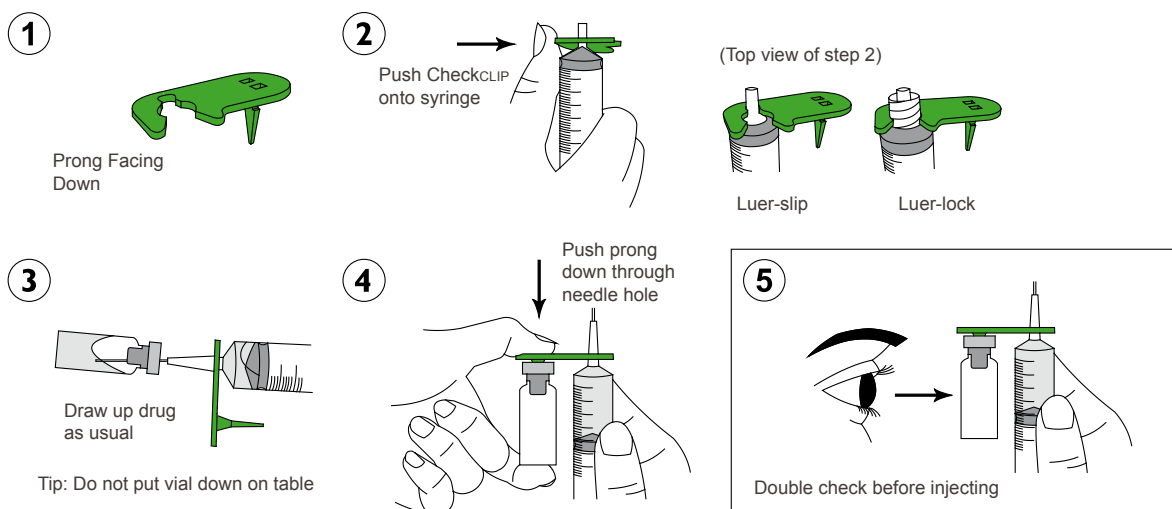
*** Compatibility depends on the geometry and diameter of the vial

Instructions for Use

CheckCLIP for Ampoule



CheckCLIP for Vial



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