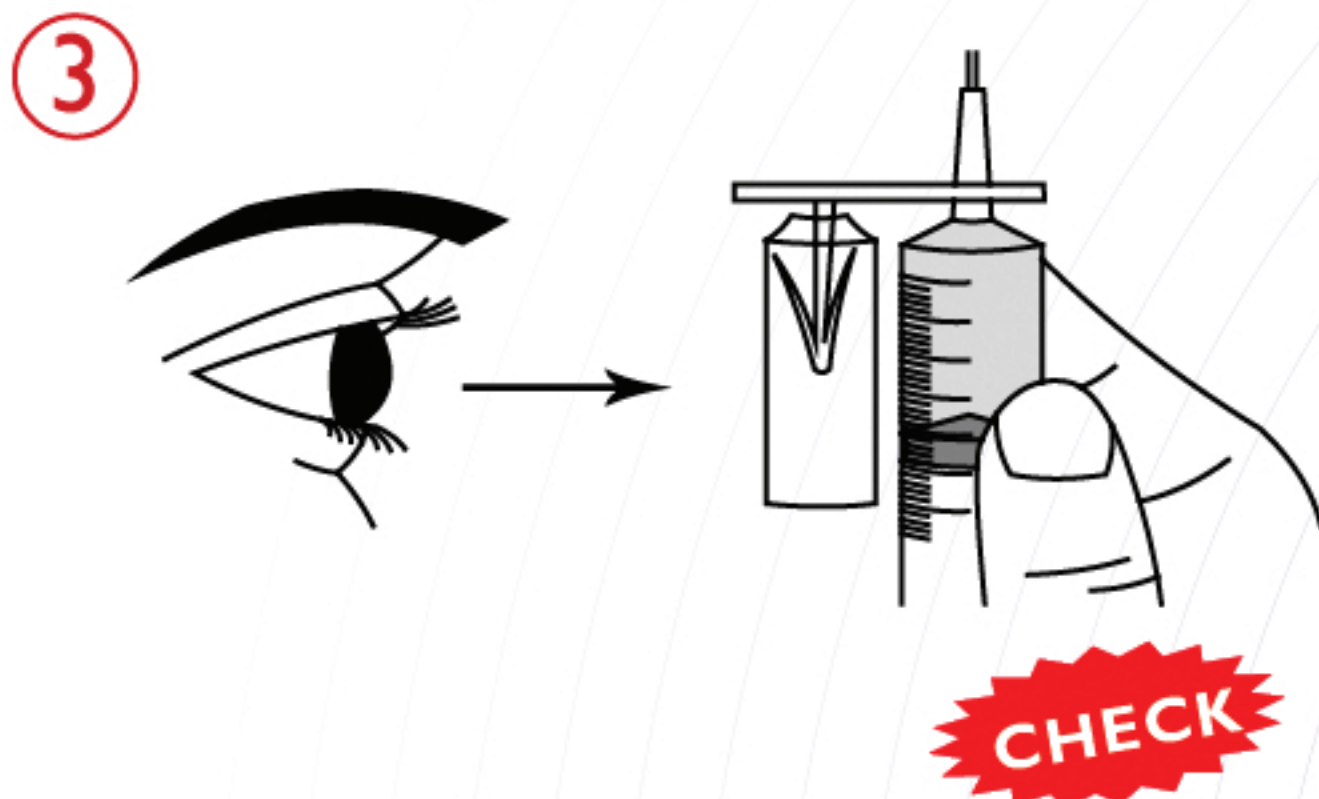
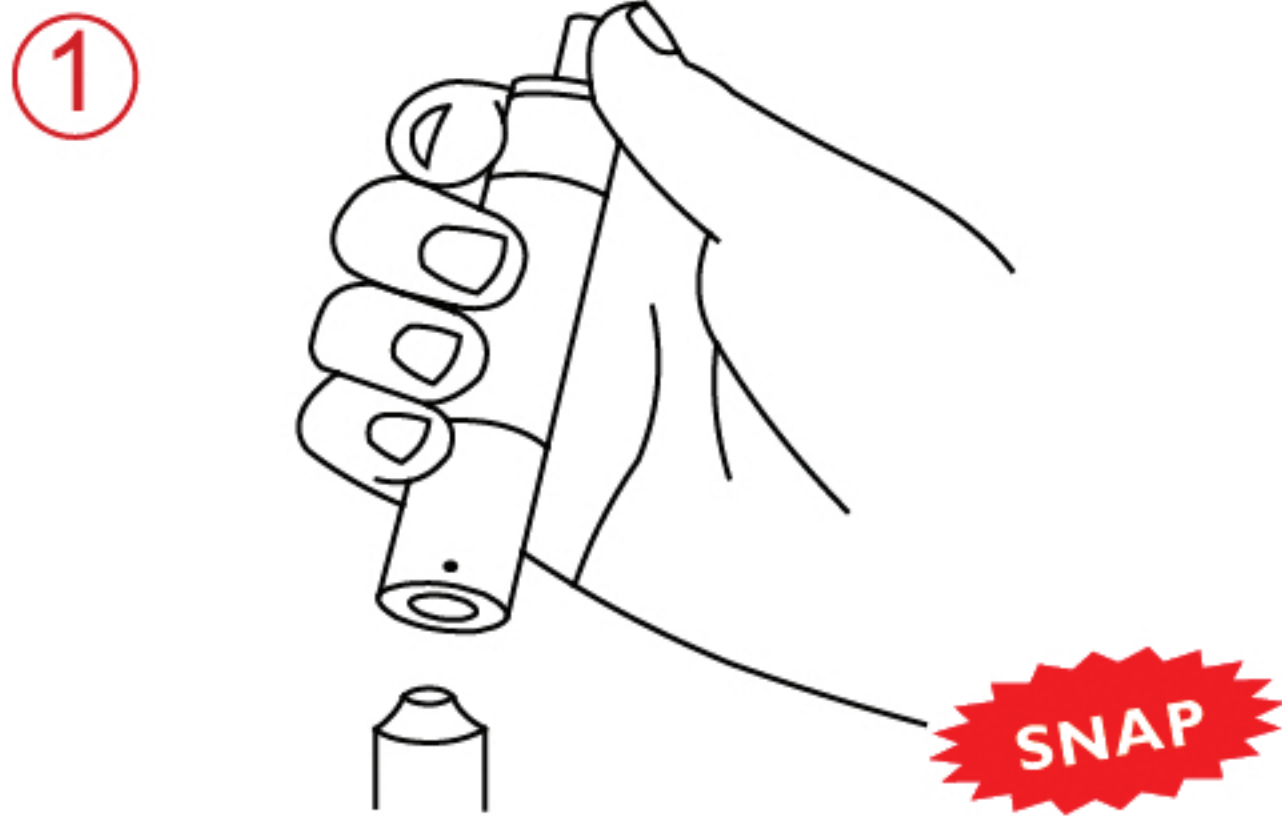




Total Ampoule Solution



Ampoule Injuries

- 26% of needlestick and sharps injuries (NSIs) were due to opening an ampoule or broken ampoules.¹
- Most frequently reported circumstances of sharps injuries were opening of ampoules and vials.²
- 54% of incidents to anaesthesia personnel were caused by broken ampoules.³
- The incidence of hand laceration as a result of opening glass ampoules is significant, occurring in approximately 6% of anaesthetic sessions. The prevalence of old hand injury was 25 in 97 anaesthetic sessions (26%).⁴

The Solution: Open ampoule using Snapit

Ampoule / Syringe Labelling Error

- 85% or more anaesthetic participants had experienced at least one drug error or 'near miss'; syringe swaps and misidentification of label (ampoule swaps) were common contributing factors.^{5,6}
- Jensen et al.⁷ recommended:
 - a) label should be carefully read before a drug is drawn up or injected;
 - b) legibility and contents of labels on ampoules should be optimised according to agreed standards including font size, colour and information;
 - c) syringes should be labelled, always or almost always.
- A review of 896 reports from the Australian Incident Monitoring Study database⁸ showed 37% of drug errors were due to syringe swap errors and 41% were due to ampoule labelling error.

The Solution: Label syringes using CHECK CLIP

References:

1. Smith D.R., Smyth W., Leggat P.A. and Wang, R.S. (2005). "Needlestick and sharps injuries among nursing students." *Journal of Advanced Nursing* 51 (5), Pg 449-455.
2. Guo Y.L., Shiao J., Chuang Y.C. and Huang K.Y. (1999). "Needlestick and sharps injuries among health-care workers in Taiwan." *Epidemiol Infect* 122, 259-265.
3. Pulnitiporn A., Chau-in W., Klanarong S., Thienthong S. and Inphum P. (2005). "The Thai Anesthesia Incidents Study (THAI Study) of anesthesia personnel hazard." *J Med Assoc Thai* Vol. 88 Suppl 7.
4. Parker M. R. J. (1995). "The use of protective gloves, the incidence of ampoule injury and the prevalence of hand laceration amongst anaesthetic personnel." *Anaesthesia* 50: 726-729.
5. Gordon P.C., Llewellyn R.L., James M.F.F. (2006). "Drug Administration errors by South African anaesthetists – a survey." *South African Medical Journal* Vol. 96 No. 7.
6. Orser B.A., Chen R.J. and Yee D.A. (2001). "Medication errors in anesthetic practice: a survey of 786 practitioners." *Canadian Journal of Anesthesia* 48: 139-146.
7. Jensen L.S., Merry A.F., Webster C.S., Weller J. and Larsson L. (2004). "Evidence-based strategies for preventing drug administration errors during anaesthesia." *Anaesthesia* 59: 493-504.
8. Abeysekera A., Bergman I.J., Kluger M.T. and Short T.G. (2005). "Drug error in Anaesthetic practice: a review of 896 reports from the Australian Incident Monitoring Study database." *Anaesthesia* 60: 220-7.

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TOTAL AMPOULE SOLUTION

Qlicksmart Snapit

Easy to Use

- With Snapit, anyone can snap open an ampoule without worrying about injuring themselves:
 1. Insert the ampoule top into Snapit
 2. Snap open the ampoule
 3. Eject the ampoule lid
 It's as easy as that!

Reduces Sharps Injuries

- Both hands are kept away from the ampoule neck where the glass breaks
- The ampoule lid with the sharp edge is held inside Snapit until ejected into a sharps bin

More Features

- Snapit works with most common ampoules
- Extended lever action means an effortless open
- Cleanest possible open without scoring
- Reusable and washable
- No stress on wrists when snapping off the ampoule lid

Qlicksmart CHECK CLIP

Easy to Use

- Reduce medication errors using by attaching the ampoule directly onto the syringe:
 1. Clip CHECK CLIP onto syringe
 2. Draw up the drug
 3. Without letting the ampoule leave your hand: Slide ampoule to top of the barbs of the CHECK CLIP
 4. CHECK the drug before administering

No more Labels, Taping or Cuts

- No more labels - The details of the drug in the syringe are originally presented on the ampoule
- No more taping - the ampoule is attached directly onto the syringe
- No more cuts - CHECK CLIP covers the jagged sharp edge of the ampoule when it's attached, preventing cuts to the user or patient during drug administration

Universal Protection

- CHECK CLIP works with most syringes and ampoules, including both luer-lock & luer-slip syringes
- CHECK CLIP works in all environments including wet, dry, dusty, grassy and snowy.

For Further Information on Qlicksmart's Total Ampoule Solution

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