Medication Safety Today

Issue 44 The Northern Ireland Medicines Governance Team Newsletter August 2013

Another Shot

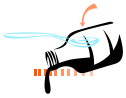
In February 2012, Medication Safety Today highlighted that doses of caffeine were to be expressed as caffeine base in accordance with BNF for children. The latest edition of the BNF newsletter (May 2013) has advised:

Expression of caffeine doses
Licensed preparations of both caffeine citrate and caffeine base are available for the treatment of neonatal apnoea. The MHRA have decided that all licensed preparations should be labelled as caffeine citrate, and have requested that the manufacturers change the labelling of their products accordingly. This change should take place during 2013.
In response to this, the caffeine monographs in *BNF for children* have been reviewed, and now only one monograph for caffeine citrate is included, with caffeine doses expressed in terms of caffeine citrate.

To minimise confusion and the risk of dosing errors during the changeover period:

- **Always state dose in terms of caffeine citrate when prescribing caffeine**. For further information, see **Caffeine citrate**.
- **Find out what is happening in your trust to implement this change.**

Phenytoin liquid



The licensed strength of phenytoin suspension is 30mg/5ml. However there is also an additional strength available as a 'Special' which is 90mg/5ml.

Safety tips

- Be aware of this additional strength of phenytoin liquid which may not be routinely stocked.
- Always check the strength of all liquids and suspensions carefully when prescribing, dispensing and administering.

Hyperkalaemia Kits

An insulin-glucose infusion is a safe, commonly used treatment for hyperkalaemia, defined as serum or plasma potassium greater than or equal to 5.5mmol/L. However serious problems may arise if too much insulin is administered in error. Hyperkalaemia kits and treatment guidelines are available in all trusts.

An audit across all acute adult wards in Northern Ireland evaluated the availability and accessibility of hyperkalaemia kits. Its key findings were:

- Trusts should ensure continued availability of hyperkalaemia kits and that staff continue to be informed of the need to use them.
- Staff should ensure that once the seal on a kit has been broken, that it is returned to pharmacy as soon as possible for replacement.

Safety tips

- Staff should ensure that they are aware of the exact location of the hyperkalaemia kit on the ward that they are working on and where to find the treatment guidelines.
- **Always remember that the dose of soluble insulin to treat hyperkalaemia is 10 UNITS and the dose must be second checked by the senior nurse on duty.**

If you have any comments on this newsletter, please contact Sharon O'Donnell, Medicines Governance pharmacist on 028 90638129 at the Royal Hospital or by e-mail at Sharon.ODonnell@belfasttrust.hscni.net
Further copies of this newsletter can be viewed at www.medicinesgovernanceteam.hscni.net or on your Trust intranet.

Paracetamol – still a pain

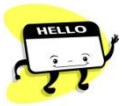
Medication incidents continue to be reported where the incorrect dose of paracetamol is prescribed and administered. These have occurred when paracetamol is prescribed for both oral and IV administration. For example:

- IV paracetamol 1g 4-6 hourly when required prescribed for a patient weighing 40 kg. Dose reduction is required for weight <50 kg and the dose should have been 600mg.
- A twelve year old child weighing 28kg prescribed oral paracetamol 750mg. Dose should have been 420mg.

Safety tips

- The most recent weight of the patient must be documented on the Kardex.
- Ensure that the correct paracetamol dose for the weight of the patient is prescribed. Check a current BNF or the Summary of Product Characteristics.
- Double check any calculations

For further information related to IV paracetamol, please see a previous Medication Safety Today at http://www.medicinesgovernanceteam.hscni.net/newsletters/newsletters/MST%2035.pdf or http://www.medicinesgovernanceteam.hscni.net/safety/Safety%20memo%2015%20-%20IV%20Paracetamol.pdf



SAME DIFFERENCE

Incidents have been reported where medicines with similar names and the same dose/strength have been mixed up when prescribing, dispensing or administering. For example:

Amitriptyline 10mg	Amlodipine 10mg
Atenolol 100mg	Allopurinol 100mg
Clonazepam 5mg	Clobazam 5mg
Hydralazine 50mg	Hydroxyzine 50mg
Pantoprazole 40mg	Propranolol 40mg

Safety tips

- Be aware that, when handwritten, some medicine names may be confused with a medicine with a similar name.
- Print medicine names and write doses/strengths legibly.

Switchover

The regional contract for prolonged release oxycodone tablets has changed brands from OxyContin® to Longtec®. Longtec® is licensed for the treatment of moderate to severe pain in patients with cancer and post-operative pain and for the treatment of severe pain requiring the use of a strong opioid and is bioequivalent to OxyContin® tablets.

Longtec® is colour coded to help differentiate between different strengths and the colours match that of OxyContin® to avoid confusion when patients switch from OxyContin® to Longtec®.

Safety Tips

- ✓ Brand names must be used for oral opiates to help differentiate between different preparations.
- ✓ OxyNorm® will remain the product of choice for the immediate release formulation of oxycodone.
- ✓ Look out for notification of the changeover in your Trust.
- ✓ Inform the patient so they are aware that Longtec® replaces OxyContin® and ensure they don't take both when they get home.
- ✓ All communication to primary care must specify that the patient has been switched to Longtec® so patients aren't switched back or prescribed both.

Drop, drop, drop…

Citalopram is available as both tablets and oral drops. Medication incidents have been reported where an incorrect dose of citalopram drops has been prescribed or administered. Citalopram oral drops come in a strength of 40mg/ml, four drops (8mg) is equivalent to a 10mg citalopram tablet. Dose instructions for citalopram drops can be found in the current BNF.

Remember

- When prescribing citalopram oral drops, specify the number of drops needed to make up the required dose in brackets beside the dose in mg.
- Only use the dropper provided when administering.