Medication Safety Today

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Look again

The similarity in packaging between different medicines produced by the same manufacturer can often increase the risk of selection errors in pharmacy and on wards.

Safety Tips

- Be aware of the risk of selection error.
- Try reading the name of the medicine to yourself to confirm the medicine you have selected.
- Report medication incidents involving similarity in packaging.

MHRA e-learning

The MHRA has launched a number of online medicines modules over the last 12 months. These include:

- Oral anticoagulants
- Opioids
- Antipsychotics
- Benzodiazepines
- Selective serotonin reuptake inhibitors

To access the full range of MHRA modules, visit the 'education' section of their website:

http://www.mhra.gov.uk/ConferencesLearningCentre/LearningCentre/index.htm

A loading dose is an initial large dose of a medicine used to achieve a quick therapeutic response. Loading doses may be used for medicines such as warfarin, phenytoin, amiodarone or digoxin.

A loading dose is usually given for a short period, before therapy continues with a lower maintenance dose. Depending on the medicine a single loading dose or a series of loading doses may be required.

Medication incidents have been reported where the loading dose has been inadvertently continued leading to toxic serum levels. The NPSA issued a Rapid Response Report on this in 2010.

Safety tips

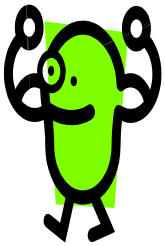
- Be aware of medicines that require a loading dose.
- Ensure the loading dose is prescribed either as a STAT dose or with a clear STOP date, after which the maintenance dose should commence.
- Some medicines that require a loading dose have dose calculation tools or separate prescription charts to aid prescribing, administration and monitoring; use these where available.
- When prescribing a medicine ensure you are familiar with the indication, usual dose for that indication and the potential side-effects of that medicine. If unsure CHECK.

If you have any comments on this newsletter, please contact Sharon O'Donnell, Medicines Governance pharmacist on 02890638129 at Royal Hospitals 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.

Not ‘U’ again

Neorecormon® (epoetin beta), used for the prevention and treatment of symptomatic anaemia in certain conditions, is available in a range of pre-filled syringes:

- 500 International Units
- 2,000 International Units
- 3,000 International Units
- 4,000 International Units
- 5,000 International Units
- 6,000 International Units
- 10,000 International Units
- 20,000 International Units
- 30,000 International Units

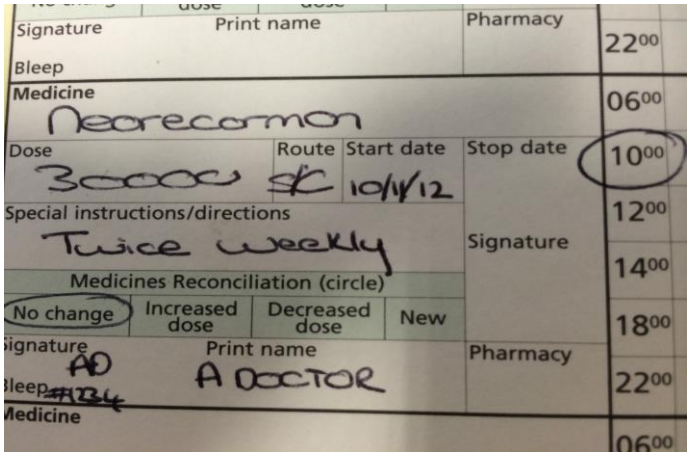


As the dose is in ‘units’ this can cause problems if units is abbreviated.

Safety Tips:

- Take the time to write doses/strengths legibly.
- Incidents can occur where ‘IU’ or ‘U’ has been abbreviated and mistaken as a zero. Do not abbreviate ‘units.’

What would you administer from the Kardex below? (see answer below)



Did you know?

…that there are two formulations of exenatide injection? There is a standard release product (Byetta®) usually administered twice daily and a modified formulation (Bydureon®) which is administered once weekly. Exenatide is used in the treatment of type 2 diabetes mellitus.

3000 units twice weekly is the intended dosage.
U or IU are not suitable abbreviations

HSC MedSafe: sharing learning

All Trust reported medication incidents are reviewed and analysed regularly by the regional Medicines Governance Team.

‘MedSafe’ is a new quarterly bulletin that aims to raise awareness of known reported medication safety risks and advise on how to prevent their re-occurrence.

The newsletter has been distributed via medical, nursing and pharmacy leads in each of the Trusts.

Syringe pumps

Medication incidents have occurred where CME McKinley T34 syringe pumps have been incorrectly programmed due to confusion about the ‘RESUME or NEW SYRINGE’ prompt.

> Press YES to Resume
> Press NO for New Syringe

To avoid confusion:

A. When you are replenishing a syringe or setting up a new infusion:

- Stop the pump
- Unlock it,
- Turn it OFF and then turn it ON again.

This avoids the ‘RESUME or NEW SYRINGE’ prompt.

B. At the end of an infusion:

- Stop the pump
- Unlock the pump using the INFO button
- Turn the pump OFF
- Remove the syringe

This ensures the pump will recalibrate to a new 24 hour duration of infusion when replenished or next used, therefore avoiding error.

C. When temporarily stopping an infusion e.g. to change a battery and you are restarting the same syringe:

When you have stopped the pump and are then restarting the same syringe, you will be asked ‘RESUME or NEW SYRINGE’? Answer YES to this prompt because you are resuming the infusion of the same syringe. This will retain the current infusion program.