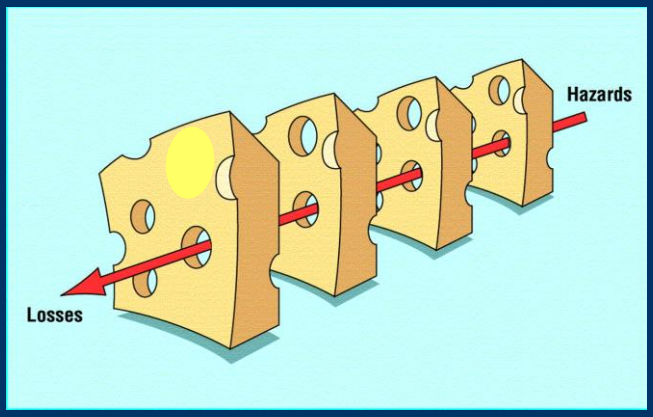
Medication Safety Today



Issue 1 **The Northern Ireland Medicines Governance Team Newsletter** **Nov 2002**

What is Medicines Governance?

In August this year the Medicines Governance Project commenced. This project is funded by the Department of Health for a 2 year period. It provides a dedicated **risk management** function for the use of medicines.

There are 6 senior pharmacists on the project team, located in hospitals throughout Northern Ireland. They are working in conjunction with current Trust Risk Managers and with all professions involved with the use of medicines.

The project will initially focus on

- Developing and promoting the reporting of medication incidents and near misses.
- Reviewing past incidents and near misses to identify trends and to develop areas for action.

The Medicines Governance Pharmacists are supported by a local project group, which brings together medical, nursing and pharmacy staff to assist in achieving the aims of the project locally.

A key element for the success of the project is the involvement of all staff in promoting the safe use of medicines.

If there are any issues that you think the project could help with, contact the Medicines Governance Pharmacist for your hospital.

Medicines Governance Pharmacists:
Left to right, standing:
Brendan Moore, Barbara Milliken,
Jillian Redpath
Seated: Sharon O'Donnell, Tracey Boyce (Team Leader),
Lisa Smith

!!! Potassium !!!

Intravenous potassium is a potentially toxic electrolyte if used inappropriately. Problems associated with potassium include:

- Excessively rapid infusions.
- Inappropriate bolus injections
- Inadvertent use as a diluent in place of sodium chloride 0.9% solution or water for injection.
- Inadequate mixing of potassium added to infusion bags causing rapid administration of high doses.

In July 2002 the National Patient Safety Agency (NPSA)* issued a patient safety alert on the use of intravenous potassium concentrate and other strong potassium solutions.

(Continued overleaf)

Requirements of the NPSA potassium alert

→ Potassium chloride concentrate and other strong potassium solutions (greater than 10% w/v) should be restricted to pharmacy and certain defined critical areas.

→ Potassium concentrate should be removed from routine stock on wards and clinical departments not listed in your Trust as a critical area for storage.

→ Potassium concentrate solution should be stored in separate locked cupboard away from common diluting solutions such as sodium chloride (normal saline) solution.

→ Potassium concentrate must be treated as a Controlled Drug.

→ Commercially prepared ready to use preparations should be used where possible.

→ The Department of Health has advised that all Trusts must have operational arrangements in place to comply with the action required.

REFER TO YOUR LOCAL TRUST POLICY FOR POTASSIUM CONCENTRATE

QUESTIONNAIRE

An effective reporting system for medication related incidents and near misses is one of the most effective ways to prevent and protect patients from medication errors.

In November 2002, the Medicines Governance Team will distribute a questionnaire, which has been designed to assess the attitudes of medical, nursing, pharmacy and senior management staff within the HPSS Trusts, towards reporting medication incidents.

The majority of the Trusts in Northern Ireland are participating in this research and all replies are strictly confidential.

Your opinions are vitally important, and will help shape the development of medication incident and near miss reporting.

PLEASE TAKE A FEW MINUTES TO COMPLETE AND RETURN THIS QUESTIONNAIRE

I.V. VANCOMYCIN

Did you know that ……

- I.V. VANCOMYCIN should ALWAYS be well diluted before administration.
- The infusion concentration should be less than or equal to 5mg/ml
- It should never be given as a bolus
- The brand of vancomycin that pharmacy supply may change in the coming months
- **CARE!!** – New brands of vancomycin may not have this warning about further dilution pre-printed on the packaging.

REMINDER

Pneumococcal Vaccine

Before pneumococcal vaccination is given, check that the patient has not received pneumococcal vaccination within the last 3 years.
If the pneumococcal vaccination is given within 3 years of a previous dose, there is a risk of severe reactions in some individuals. Revaccination is only appropriate for a selected number of patients – see Immunisation against Infectious Disease (1996) or contact your Medicines Information Centre for advice.

**What is the National Patient Safety Agency?*

The National Patient Safety Agency (NPSA) is a special health authority created to co-ordinate the efforts of all those involved in health care, and most importantly, learn from adverse incidents occurring in the National Health Service