Medication Safety Today

50th Issue

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Methotrexate and trimethoprim

Medication incidents have occurred where trimethoprim has been prescribed for patients currently taking methotrexate.

Trimethoprim increases the anti-folate effect of methotrexate. The interaction has the potential to lead quickly to bone marrow suppression, even with short courses or low doses of trimethoprim.

Action for healthcare professionals:

- ✓ Trimethoprim must NOT be prescribed with methotrexate; even a short course or a low dose has the potential to cause adverse outcomes.
- ✓ Double check all available sources of medication history to make sure methotrexate is not prescribed. Remember that a patient on methotrexate may not be prescribed this by their GP but by for example, a hospital consultant or private healthcare.
- ✓ Pharmacists must not dispense these medicines in combination and must always query the co-prescription of methotrexate and trimethoprim directly with the prescriber.
- ✓ Be aware that co-trimoxazole (Septrin®) contains trimethoprim.
- ✓ Make sure that all patients on methotrexate have a methotrexate monitoring booklet.

Adapted from HSCB Medicines Safety Matters Vol 4, issue 3 Nov 2014

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Is this yours?

Medication incidents continue to be reported where patients are administered the wrong insulin. Wherever possible, patients should be shown the insulin to be administered and asked to confirm that it is their usual type of insulin before a dose is administered.

Learning from SAIs

The Health and Social Care Board and the Public Health Agency have issued a report highlighting the learning from Serious Adverse Incidents (SAIs) in Northern Ireland (April 2014-Sept 2014). A number of the SAIs involve medications and are listed in the report:

- Head injury in patients on warfarin.
- Dispensing beta blockers – selection errors.
- Prescribing and dispensing incidents involving buccal midazolam products.

Further detail can be found in the report at:

http://www.hscboard.hscni.net/board/meetings/December%202014/Item%2010%20-%2002%20-%20HSCB-PHA%20SAI%20Learning%20Report%20Apr%20-%20Sept%202014%20PDF%20727KB.pdf

It is often necessary to transcribe medication information from one document to another e.g. when rewriting a kardex or when completing a discharge prescription. Medication incidents have been reported where medicines have been missed during this step resulting in omitted doses or a patient missing a medicine altogether.

Safety tips

- ✓ Check each medicine transcribed from the original to the copy document to ensure accuracy.
- ✓ Review and confirm that each medicine is still appropriate for the patient.

More than 3

Most medicines are made so that the amount of medicine in each dose unit (tablet, capsule or ampoule) is usually the same as a typical adult dose.

The 'more than three' rule states that if you need more than three tablets, capsules or ampoules of any one medicine to administer a dose, **STOP** and **CHECK** that you have the correct preparation, that the prescribed dose is correct and that you have read the prescription correctly.

Failure to consider this rule has led to patients receiving the wrong dose. However this rule has also helped to prevent a medication incident from reaching a patient.

- Patient prescribed lorazepam 15mg, the nurse questioned giving fifteen 1mg tablets and discovered the prescription should have been lansoprazole 15mg.
- Patient prescribed bumetanide 10mg. This would have required ten 1mg tablets to be administered. Nurse double checked and correct dose was bumetanide 1mg.
- Nicorandil 150mg (fifteen 10mg tablets) twice a day prescribed on kardex, nurse queried the dose and the prescription should have been 10mg (one tablet) twice a day.

There are some exceptions to this rule that often require multiple dose units, these include:

- Prednisolone 5mg tablets
- Methotrexate 2.5mg tablets

The rule may not work for children as many medicines are made for adult doses.

Safety tips

Before prescribing, dispensing or administering **MORE THAN 3** dose units of a medicine:

- ☑ Confirm the dose with a reliable source e.g. BNF, the prescriber or pharmacist.
- ☑ Confirm that you have the correct formulation.
- ☑ Get an independent double check to confirm that calculations are correct.
- ☑ Independent means that each practitioner should do the calculation and then compare the answer at the end.
- ☑ If possible, ask the patient if this is the dose they normally take at home.
- ☑ If still in doubt – <u>CHECK AGAIN.</u>

Did you know?

Before prescribing/administering botulinum toxin (type A or type B), check that the patient has not already received a botulinum injection in the area to be injected or another part of the body. Consult product SPCs for recommended intervals between administrations. Be aware patients may have received botulinum toxin from cosmetic/beauty clinics; also products are not interchangeable and should be prescribed by brand.

Mix - up

Oral opioids, do you know the difference? Medication incidents have been reported with administration mix-ups between Oramorph® (morphine) and Oxynorm® (oxycodone). Morphine 10mg is equivalent to oxycodone 5mg therefore this could result in a patient receiving an underdose or overdose.

Safety tips

- ☑ When prescribing controlled drugs always state the brand name.
- ☑ When administering opioids ensure that you have carefully read the kardex and selected the correct medicine. A double check must happen at the selection, preparation and administration stages.

RIVAROXABAN REMINDER

Rivaroxaban is a newer oral anticoagulant (NOAC), indicated for the prevention and treatment of VTE and in the prevention of stroke and systemic embolism in non-valvular AF.

In the treatment of VTE, patients require a loading dose of 15mg twice daily for 21 days and then a maintenance dose of 20mg once a day. Consideration should be given to reducing the maintenance dose to 15mg once a day in patients with moderate renal impairment (CrCl 30-49ml/min) or severe renal impairment (CrCl 15-29ml/min), if the patient's assessed risk for bleeding outweighs the risk for recurrent DVT and PE.

Medication incidents have occurred where patients have inadvertently been continued on their loading dose and this has not been reduced to the maintenance dose. Many patients commenced on rivaroxaban in hospital for treatment of VTE will still be on the loading dose at the point of discharge.

Safety tips

On discharge:

- ☑ Prescribe the remainder of the loading dose and the maintenance dose with stop and start dates.
- ☑ Dispense the remainder of the loading dose and sufficient maintenance dose to provide a total of one month supply on discharge.
- ☑ Ensure dispensing labels clearly indicate stop and start dates for the loading dose and maintenance dose; use the preset label codes on JAC.
- ☑ Ensure all patients are educated about rivaroxaban, including explanation of the dosing schedule.
- ☑ Provide a patient held card alerting others that the patient is taking this newer oral anticoagulant.