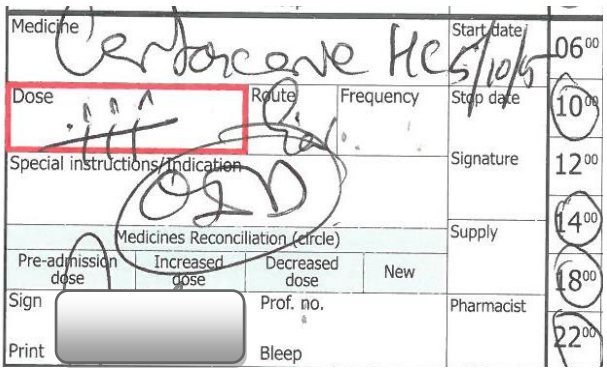
# Medication Safety Today

**Issue 53** **The Northern Ireland Medicines Governance Team Newsletter** **November 2015**

## And the prize goes to ……

You may remember entering competitions for handwriting as a child. Nowadays it is probably more useful to have a speed contest for typing as so much more documentation becomes electronic. As work continues towards an electronic prescribing and administration system for HSC trusts, it is important to remember that currently, the majority of in-patient prescriptions in hospital are handwritten. While there are no prizes for handwriting, prescriptions do need to be written in a way that others can clearly understand and read the intentions of the prescriber so that the patient receives the right medicine, at the right dose and time and by the correct route. Lack of clarity and illegibility on prescriptions can lead to medication incidents.




**What medicine is this prescription for?**
Answer overleaf.

## Up in the air


The regional acute Kardex includes an oxygen prescription section. This includes an alert to identify patients at risk of hypercapnic respiratory depression, commonly referred to as '$CO_2$ retainers', who should have a lower target oxygen saturation. It is important to also consider if it may be more appropriate for these patients to have any nebulisers driven by medical air instead of via oxygen. If so, endorse the prescription for any nebulised medicines 'via medical air'.

## Vaccines

The newly-introduced MenACWY vaccine (Nimenrix®) comes in packaging that is similar to that of the Hib/MenC vaccine (Menitorix®). When taking these vaccines from the fridge always make sure you select the correct one for the patient, one of whom who will be for 14 years or older and the other for 12 to 13 months old.

Please highlight these similarities to all healthcare professionals working with the vaccines.

**Patient will be 14 years or older**


**Patient will be 12 to 13 months old.**


Public Health England issue regular vaccine updates which can be accessed using this following link: https://www.gov.uk/government/collections/vaccine-update

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

# Confirmation Bias

Would you ever squeeze the nozzle of the petrol or diesel pump once it's in the car fuel tank without carrying out a final check to confirm that you have selected the correct fuel pump? Most of us probably do check first.

Would you ever hand a patient their medication without carrying out a final check just before administration to confirm that you have selected the correct medicine?

Medication errors continue to be reported where an incorrect medication has been administered. There may be a number of reasons behind these types of incident, but a number of them can be accounted for as a result of a ubiquitous phenomenon known as 'confirmation bias'.

PARIS
IN THE
THE SPRING

If asked what is the phrase above, at a glance most people would say 'Paris in the spring' because it's a familiar phrase. Closer reading however reveals that the word *the* appears twice. This is confirmation bias in action and it results in us seeing what is familiar to us or what we want to see.

Medication errors associated with confirmation bias have resulted in product mix-ups and one that has been reported a number of times recently is where Sando K® was dispensed or administered instead of the prescribed Phosphate Sandoz®.


The use of similar colour and design of packaging of different medicines can lead to confusion. Quite often we see what we think we should see, rather than what is actually in front of us.

In order to avoid mix-ups between products, it is important to observe the following good practice:

- Do not rely on packaging to recognise a product – be aware of confirmation bias, where you see what you expect to see.
- Always read the label and check the name of the medicine carefully to ensure it matches what has been prescribed.
  - ➢ Check it once it is removed from the storage location
  - ➢ Check it again at the point of administration or dispensing
  - ➢ Check it again before returning it to its storage location
- Report incidents involving similar packaging.

**Make sure you 'see' what you are 'looking' at!**

Answer: Gentisone HC ear drops

# Calling Number…..


A Health and Care Number (H&CN) is used throughout healthcare and is often entered to select patients in electronic systems such as prescribing systems, pharmacy dispensing systems and the Electronic Care Record (ECR). It is very easy to enter an incorrect H&CN, for example with a typing error or because you have misread a handwritten H&CN. Medication incidents have occurred including medication prescribed for one patient on another patient's record or medicines labelled with another patient's name.

**Safety tip:**

- ✔ When entering a H&CN to select a patient, always confirm that the patient details brought up are correct.

# High Strength Insulin

In the last couple of years high strength insulins have been introduced either as a new medicinal product e.g. insulin degludec (Tresiba®) or as a further presentation of an existing insulin e.g. insulin lispro (Humalog®) or insulin glargine (Toujeo®). The strengths of these new insulins are shown in the table below:

| Insulin | Brand name | Strengths available | Device |
|---|---|---|---|
| Insulin degludec | Tresiba® | 100units/mL | FlexTouch prefilled pen; cartridge |
| | | 200units/mL | FlexTouch prefilled pen |
| Insulin lispro | Humalog® | 100units/mL | KwikPen prefilled pen; vial; cartridge |
| | | 200units/mL | KwikPen prefilled pen |
| | Humalog® Mix25 | 100units/mL | KwikPen prefilled pen; vial; cartridge |
| | Humalog® Mix50 | 100units/mL | KwikPen prefilled pen; cartridge |
| Insulin glargine | Lantus® | 100units/mL | SoloStar prefilled pen; vial; cartridge |
| | Toujeo® | 300units/mL | SoloStar prefilled pen |

Toujeo® is not bioequivalent to Lantus® meaning dose adjustment is required when patients switch from Lantus® or other basal insulins to Toujeo® or vice versa.

**Remember:**

- There are higher strength insulins available
- Doses must always be administered from higher strength insulin prefilled injection pens.
- Never attempt to withdraw a dose from these devices by any other means