Medication Safety Today

Issue 57 **The Northern Ireland Medicines Governance Team Newsletter** **November 2016**

Mix ups

Medication incidents have been reported where patients have received the wrong formulation of Parkinson's medication.

For example, a patient was prescribed the brand Sinemet Plus® (immediate release), but Caramet CR® 25mg/100mg (modified release) was ordered and administered to the patient.

Medication ordered from pharmacy

Medication required from pharmacy

- A large range of Parkinson's medicines are available in various formulations (including branded and non-branded generics):

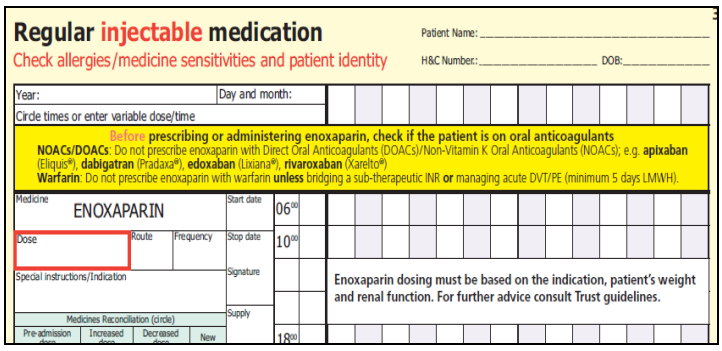
Safety Tips

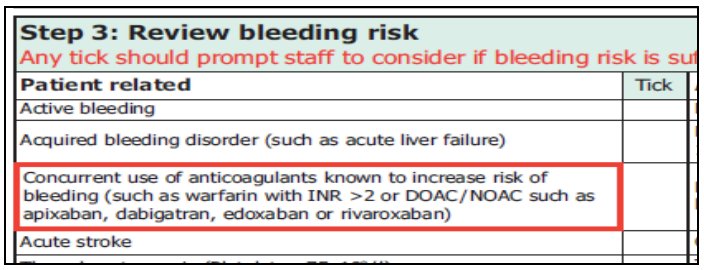
- ☑ Be aware of different formulations and brands of Parkinson's medications
- ☑ Always check brand and strength
- ☑ Always endorse generic medication on kardex if brand prescribed

Not a good combination

Medication incidents continue to be reported where patients have been prescribed enoxaparin when the patient is already taking another anticoagulant.

- The Regional Acute Kardex now has the new warning that enoxaparin should not be co-prescribed with **DOACs/NOACs e.g. apixaban, dabigatran, edoxaban, rivaroxaban.**
- Enoxaparin should not be co-prescribed with warfarin unless bridging a sub therapeutic INR or managing acute DVT/PE (minimum 5 days LMWH).





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.

Insulin Safety

The Department of Health recently issued two Patient Safety Alerts related to insulin.

Alert 1 - 'Safe Administration of Insulin' highlights:

! The extraction of insulin from pen devices using an insulin syringe is <u>not</u> permitted.

- Extraction of any strength of insulin from a pen device using an insulin syringe and needle damages the mechanism of the pen device. Subsequent use of the damaged pen device can result in dosing errors and causes patient harm.

- A number of high strength insulins are now available as pen devices (see table below). Extraction of high strength insulin from pen devices using an insulin syringe results in the incorrect dose of insulin being administered to patients.

Alert 2 – 'Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulins'.

! A number of high strength, fixed combination and biosimilar insulin products are now available

Differences in strength, formulation and dosing of these new insulin products when compared with the existing standard strength insulins means there is potential for medication errors.

Key Feature	Active substance	Brand name	Strengths available (units/ml)
High Strength	Insulin degludec	Tresiba®	100 & 200
	Insulin lispro	Humalog®	100 & 200
	Insulin glargine	Lantus®	100
		Toujeo®	300
Fixed combination	Insulin degludec and liraglutide	Xultophy®	100 units/mL of insulin degludec and 3.6mg/mL of liraglutide
Biosimilar	Insulin glargine	Abasaglar®	100

Actions required to minimise the risks include:

✓ Prescribe insulin by brand, specifying the strength, device and dose in units.

✓ Provide patients with written (insulin passport or safety card) and verbal information on their prescribed insulin, strength, dose, how to use the device and monitoring of blood glucose.

✓ Ensure storage arrangements for insulin facilitates correct selection.

The full alerts can be found at: Insulin Safety Alerts

Counting on You!

Medication incidents can occur where a medicine dose is based on weight or may be due to calculation errors. To avoid these:

- It is essential that patient weight is accurately measured and documented on the Kardex using metric units (kg)
- Medicine calculations should always be double checked.

Test yourself (*see answers below):

1. Patient prescribed Oramorph® 10mg/5ml, at a dose of 2.5mg four hourly. What volume should be administered?

2. Patient prescribed IV Phenytoin 300mg. Product available as 50mg/ml in a 5ml vial. How many vials, and what volume would you need to administer the dose?

3. Adolescent weighing 48kg, prescribed co-amoxiclav IV every 8 hours. Dosing 30mg/kg (maximum 1.2g). What dose should be prescribed for this patient?

What's in a name?

Quite a lot actually. Medication incidents have occurred when **immediate release** oxycodone has been confused with **modified release** oxycodone. The brand of oxycodone immediate release capsules is changing from OxyNorm® to Shortec® and this name change should help to reduce the risk of confusion between immediate release and modified release oxycodone. OxyNorm® will still be the brand of oxycodone liquid and injection. Longtec® will continue to be the brand of oxycodone modified release used in hospitals.

✓ Prescribe opioids by brand name.

✓ Remember the clue is in the name:

- **Shortec®** = immediate release or **short acting** oxycodone capsules prescribed as required or every 4-6 hours

- **Longtec®** = modified release or **long acting** oxycodone prescribed twice a day.

*Answers: (1) 1.25ml (2) 6ml, 2 vials (3) 1.2g (maximum dose)