Health and Social Care Board

Medicines Safety Matters

Newsletter for Prescribers & Community Pharmacists

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Inside this issue:

Loading doses — risk of overdosing in community

Some medicines need to be given at higher doses at the start of treatment (loading dose) before being reduced to a lower maintenance dose. This is needed:

- When therapeutic levels of the drug are needed quickly e.g. phenytoin for seizure control
- For medicines that would otherwise take a long time to reach therapeutic levels e.g. amiodarone

Between January 2005 and April 2010, 1165 incidents were reported to NPSA relating to loading doses. Two incidents were fatal and an additional coroner's letter described one patient who was prescribed a loading dose of amiodarone 400mg daily for 12 months instead of a maintenance dose of 200mg daily.

The NPSA issued a report in November 2010 which noted that staff may mistakenly continue loading doses instead of lowering to maintenance doses, particularly when patients move between settings e.g. from hospital back to the community, and it recommended that healthcare professionals in community know when to challenge abnormal doses of critical medicines.

The medicines most frequently involved in the reported incidents were warfarin, amiodarone, digoxin and phenytoin (see table below).

Other medicines to be aware of that may be initiated in hospital by loading dose include: prednisolone, azathioprine, aspirin, clopidogrel, prasugrel & analgesics.

Medicine	When to query dose
Warfarin	Doses may vary considerably among patients. Any newly started treatment at doses greater than 5mg should be considered abnormal in community.
Amiodarone	Doses higher than 200mg daily should be queried.
Digoxin	Doses higher than 250micrograms daily in adults (higher than 125micrograms daily in those aged > 70yrs) should be queried.
Phenytoin	Doses greater than 500mg daily should be rarely seen and queried.

Drug Donations Abroad

The World Health Organisation provides advice on donating drugs abroad which includes:

- The donation should benefit the recipient & should be based on an expressed need. Unsolicited drug donations are to be discouraged
- A donation should be made with full respect for the wishes and authority of the recipient, and be supportive of existing government health policies and administrative arrangements.
- There should be no double standards in the quality e.g. expired drugs.
- There should be effective communication between the donor and the recipient.
- No drugs should be donated that have been issued to patients and then returned to a pharmacy or elsewhere.
- All drugs should be labelled in a language easily understood by health care professionals in the recipient country.
- Donors must comply with the UK and designation country legislation regarding transactions in medicines or export/import activities. Professional bodies and trade associations may be able to give advice. The MHRA can give advice about licence requirements.

www.who.int/en/

Mix-Ups Between Palliative Care Medicines

Symptom control in palliative care often involves the use of many different medicines used at a range of doses and in combinations tailored to the individual patient's needs. Many of the strengths and doses are not commonly used in primary care and as such, can cause confusion for pharmacy staff when they are prescribed. Levomepromazine and hyoscine have been the subject of local dispensing incidents reported recently.

Levomepromazine

Oral levomepromazine is available in **two** strengths; both can be used in palliative care to control nausea and vomiting.

Levomepromazine 25mg (Nozinan®)
A licensed formulation available in a pack size of 84 tablets from local wholesalers.

Levomepromazine 6mg (Levinan®)
An unlicensed product manufactured by Link Pharmaceuticals & available by special order on a named patient basis from UDG Ltd (Unidrug Distribution Ltd). It can be ordered by completing and faxing a 'special' product order form to UDG Ltd or, for pharmacies that do not have an account with UDG Ltd, supply can be charged via a local wholesaler. Delivery to N.I. usually takes 3-4 days.
UDG Ltd:
Telephone number 017 7351 0123
Fax order: 017 7381 0644

Hyoscine

Injectable hyoscine is available in two different formulations; both can be used in palliative care.

Hyoscine butylbromide injection 20mg/ml (Buscopan®)
Used primarily for bowel colic.

Hyoscine hydrobromide 400micrograms/ml
Used for excessive respiratory secretions and is sedative.

Alfentanil

Alfentanil injection is a controlled drug used for pain control and sedation and is available in 2 strengths; the higher strength is 10 times more potent. The products also have similar packaging increasing the risk of errors.

Alfentanil 500micrograms/ml (Rapifen®) (2ml & 10ml ampoules)

Alfentanil 5mg/ml (Rapifen®) (1ml ampoules)

Learning points:

- Reinforce the need for checking procedures when prescribing or dispensing palliative care medicines.
- Increase staff awareness that there are a number of strengths, similar names and similar packages that can cause confusion and dispensing errors.

Learning resources & further information:

www.nicpld.org Distance learning package "The Pharmacist in Palliative Care"
www.pallcareNI.net Information about palliative care in NI
www.book.pallcare.info Information about drugs used in palliative care in UK
www.palliativedrugs.com Information about drugs used in palliative care in UK

Drug name alert: Confusion between Pradaxa and Plavix

There is potential for confusion between the brand names of the new oral anticoagulant drug, **Pradaxa** ® (dabigatran etexilate) and the oral antiplatelet drug **Plavix** ® (clopidogrel). Both drugs are of a similar pharmacological class and both are available as 75mg. Reports of mix-ups are starting to be published worldwide and prescribing or dispensing the incorrect drug could have serious consequences for the patient.

Action:

- Prescribe by generic name (clopidogrel or dabigatran etexilate).
- Review storage locations for the two drugs and consider opportunities to differentiate the products or to use shelf warning labels.

Co-codamol 15/500mg (Kapake®) - Did you know?

Previously Co-codamol 15/500mg was only available as Codipar® but now another brand is available, ie Kapake®. Practices should prescribe generically so either brand can be dispensed. Care needs to be taken when patients order a repeat prescription as patients may order using the brand name eg Kapake® without specifying the strength; there is a risk that patients may inadvertently be issued with the higher strength of Kapake® (30/500mg).

Action:

- Take extra care with requests for Kapake® to ensure the correct strength is selected, prescribed and subsequently dispensed.