# Medication Safety Today

**Issue 63** **The Northern Ireland Medicines Governance Team Newsletter** **February 2019**

## NI Medicines Governance Annual Report

The NI Medicines Governance Team Annual Report outlines the key findings from the analysis of medication incidents reported in Northern Ireland between January and December 2017. It provides HSC organisations with a summary of key areas for improving medication safety. This report will also inform the work led by the Department of Health in its response to the latest World Health Organisation (WHO) Global Patient Safety Challenge: Medication Without Harm, which aims to reduce severe avoidable medication-related harm by 50% over the next 5 years.
https://www.who.int/patientsafety/medication-safety/en/


The report highlighted there were a total of 6148 medication-related incidents reported during this period, which is comparable with England in terms of population.

Administration related incidents accounted for 57% of all incidents reported, with prescribing at 21%, dispensing at 17% and monitoring and others accounting for the remaining amount.

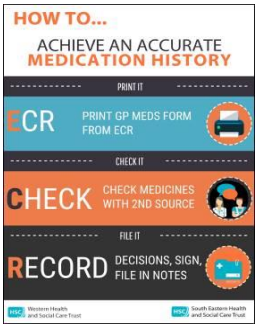
Within administration, 'administration-omission' accounted for 1266 incidents (21% of the total incidents reported) demonstrating this to be a key issue across the region and Health and Social Care Trusts. Wrong dose made up the most common prescribing incident reported, followed closely by omitted or delayed medicine or dose. Within the report, thematic analysis describes the key findings, outlines a summary of best practice and describes shared learning across the region. The full report and key findings can be accessed via:
http://insight.hscb.hscni.net/safety/safety-and-quality-correspondence/

## Medicines Reconciliation

Medicines reconciliation has links with all three of the priority areas of the WHO third Global Patient Safety Challenge which are transitions of care, polypharmacy and high-risk situations.

Data from the NI Medicines Governance Annual Report illustrates that inappropriate medicines reconciliation on admission and discharge was associated with multiple incidents of harm during this period. These included omission of a variety of critical medicines including insulin, anticoagulants, anti-epileptics and many other classes.

Following three simple steps can improve medicines reconciliation and help to ensure patients receive the right medicines at the right time.


If you have any comments on this newsletter, please contact Sharon O'Donnell, Medicines Governance pharmacist on 02890638129 at BHSCT or by e-mail at sharon.odonnell@belfasttrust.hscni.net.
Further copies of this newsletter can be viewed at http://www.medicinesgovernance.hscni.net or on your Trust intranet.

@MedGovTeamNI

# You are going the wrong way!

Wrong route incidents occur when a medicine is administered by a different route to the one intended. Certain 'wrong route' incidents are regarded as Never Events[1]. This means that they should NEVER occur since strong systemic protective barriers should be in place, as stipulated through guidance or safety recommendations.

One such example of a Never Event is the administration of oral/enteral medication or feed/flush by any parenteral route.

In 2007, the National Patient Safety Agency issued a patient safety alert relating to safer measurement and administration of liquid medicines via oral and other enteral routes. This followed several incidents involving the inadvertent administration of oral medication via the parenteral route resulting in serious harm or death. It recommended the use of oral/enteral syringes with a tip that is incompatible with intravenous connectors, as a physical barrier to prevent wrong route incidents.

**Safety Tips**

**Intravenous syringes must NEVER be used to measure or administer liquid oral medicines.**
A medicine cup or 5ml spoon should be used to measure and administer liquid oral medication except in the following situations where an oral/enteral syringe must be used:

- ✔ The dose cannot be accurately measured using a medicine cup or 5ml spoon, i.e. the dose is not 5ml or a multiple of 5ml.
- ✔ Administration is via an enteral feeding tube.
- ✔ Administration from a medicine cup or 5ml spoon is unsuitable e.g. babies and young children.
- ✔ Controlled Drug liquid medicines (bottle adaptor/bung must be in place in the bottle)

Where an oral/enteral syringe is used, it should have a PURPLE plunger to aid differentiation from other syringes and be clearly labelled "ENFit".
Remember... if you need to measure an oral liquid medicine or enteral feed in a syringe, **think purple!**

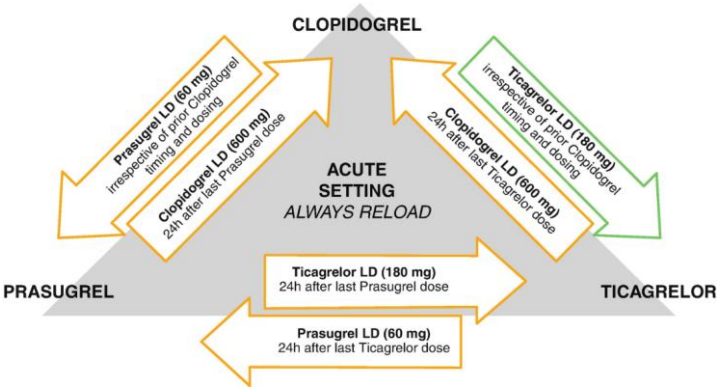
1 https://www.health-ni.gov.uk/sites/default/files/publicatic
18.pdf

# Rewriting the past

Medication incidents have occurred when Kardexes have been rewritten. Medicines have been omitted inadvertently from the new Kardex or prescribed at the wrong frequency. Before filing a Kardex that has been rewritten, ask another member of staff to check the new Kardex and confirm that all medicines have been prescribed correctly.

# 🤔 Did you know... 🤔

When switching an antiplatelet medication for a patient with coronary disease, you should reload in accordance with European Society of Cardiology guidance[1] and the diagram below.[1]





1. European Society of Cardiology. 2018. *ESC/EACTS Guidelines on myocardial revascularization*. [Online]. [Accessed 15 November 2018]. Available from: https://academic.oup.com/eurheartj/advance-article/doi/10.1093/eurheartj/ehy394/5079120#123502515


# Ketone meters

Blood glucose meters in wards and departments measure capillary blood glucose; they can also measure capillary blood ketones.

Medication incidents have occurred where staff who were intending to check blood glucose used a ketone strip by mistake and interpreted the ketone reading, for example 1.6, as a blood glucose reading. This has resulted in patients incorrectly being treated for 'hypoglycaemia' with glucose and then becoming hyperglycaemic and requiring treatment for that.

While some areas have disabled the ketone measurement function on the meter, other areas use this option. Where ketone measurement is available:

- ✓ Ensure ketone strips are stored separately from blood glucose strips.
- ✓ Only staff trained in the use of equipment should use it.
- ✓ If a result does not match the patient's clinical condition, recheck the result.