Medication Safety Today

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Hyperkalaemia in adults

Serious overdoses of insulin have occurred in the past in the treatment of hyperkalaemia in adults. To avoid recurrence, a hyperkalaemia kit (shown below) and regional guidance[1] were introduced in Northern Ireland a number of years ago.

Remember: to treat hyperkalaemia in adults the dose of soluble insulin is **10units** and this dose must be **second checked** with the senior nurse on duty.

It is important to refer to and be aware of the Trust's policy regarding the monitoring and documentation of blood glucose post-administration of insulin/glucose infusion and the intervals at which these should be monitored.

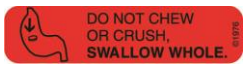
1. https://www.rqia.org.uk/RQIA/files/6f/6f51b366-f8bf-44de-a630-6967d5353a87.pdf

Did you know?

The list of critical medicines where timeliness of administration is crucial has been updated. This replaces the list produced by the Medicines Governance team in November 2010 and previously updated in March 2016.

The latest version now includes: 'end of life medication' and 'parenteral electrolyte replacement', examples of medicines for each medication class listed and a brief explanation of the potential consequence of omission or delay. Click here Critical Medicine Poster Link

Hard pill to swallow



Medication incidents have been reported related to crushing and administering medicines such as MST® and other modified release tablets. Crushing MST® may lead to an immediate release of morphine and this could result in a serious overdose.

To avoid this situation, consider:

- Is the medication absolutely necessary?
- Can it be switched to another agent, formulation or route?

Sources of information on crushing tablets include:

- BNF
- SPC
- NEWT guidelines
- Trust Medicines Information services
- Advice for Health Professionals: Choosing medicines for patients unable to take solid oral dosage forms – Click here

New puffers

Many patients refer to their inhalers as 'puffers'. In recent years a number of new inhaler devices have been introduced for example, Ellipta, Novolizer, Modulite, Respimat.

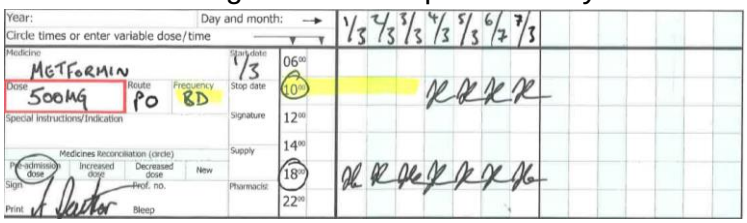
Medication incidents have occurred where staff have selected the wrong medicine by focusing on the name of the inhaler device. For example, Anoro Elipta® (vilanterol/umeclidinium) prescribed and Incruse Elipta® (umeclidinium) selected or Spiolto Respimat® (olodaterol/tiotropium) prescribed and Spiriva Respimat® (tiotropium) selected.

Be aware of the names of these new inhaler devices. There can be several different medicines available that use the same device.

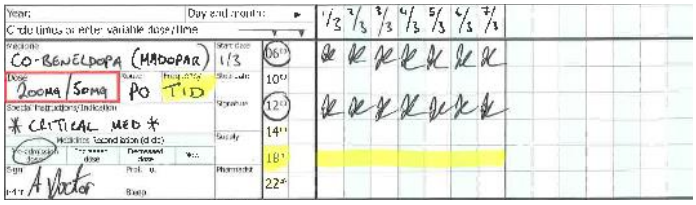
Don't follow the leader

Medication incidents have occurred where staff administering a medicine have 'followed the leader'. This means they have followed the pattern of administration signatures from previous medicine rounds and haven't checked the actual prescribed frequency and times of administration.

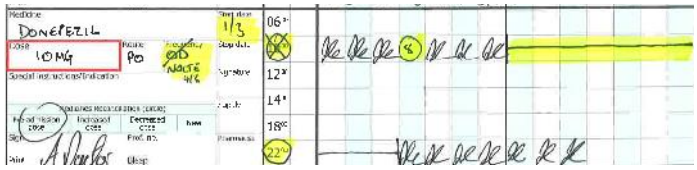
Example 1: The patient missed their morning doses of metformin for several days. They had been admitted to hospital during the afternoon of the first day having taken their morning dose at home. Staff followed the administration signatures from previous days.



Example 2: The patient missed their evening dose of co-beneldopa 200/50mg, a critical list medicine, for seven days. The prescriber had circled two instead of three administration times. Staff administered according to circled times although the frequency section stated 'TID'.



Example 3: Donepezil was prescribed initially as 'OD' at 10:00. After several days it was noted that it should have been prescribed at night. The prescriber omitted the morning dose with an '8' code, crossed out the 10:00 admin time, circled the 22:00 admin time and amended the frequency from 'OD' to 'nocte'. However, they did not score through the remaining 10:00 signature boxes. Donepezil was administered at 10:00 and 22:00 for a number of days.



Safety tips:

- Check the prescription to see what medicines are due for administration.
- Always check the prescribed frequency matches the number of administration times circled.
- Where a prescription time requires an amendment, it should be cancelled and a new prescription written as a separate entry in the Kardex.

Don't eat that

Staff are encouraged to review medicines for patients who are 'nil by mouth' and ensure alternative routes of administration or alternative medicines are prescribed to avoid unnecessarily omitting doses.

Patients who are fasting in preparation for surgery or an investigative procedure are also having doses omitted unnecessarily. Staff should check trust guidelines for specific advice on administering medicines prior to surgery or procedures and ensure doses are administered as appropriate. Some patients' usual medicines may need to be withheld due to for example, risk of bleeding. Pre-assessment teams and/or the responsible anaesthetist will usually review patients to identify any medicines that need to be withheld.

Safety tips:

- Check your local guidelines on the peri-operative management of medicines.
- Ensure patients who are fasting are administered their usual medicines unless being intentionally withheld according to trust guidelines.

Clozapine

Medication incidents involving omission of clozapine (Zaponex®) continue to be reported.

When clozapine is omitted or there is a treatment break of greater than 48 hours, re-titration and increased frequency of monitoring may be required. This can result in a return of psychotic episodes or increased psychological harm for the patient.

Remember

- Clozapine is a critical medicine and it should only be omitted or withdrawn when clinically indicated.
- Clozapine is only dispensed from hospital pharmacies therefore it may not be listed on the GP medication list on NIECR.
- Use all available sources when confirming a medication history. Many patients on clozapine bring their supply with them on admission.

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.
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