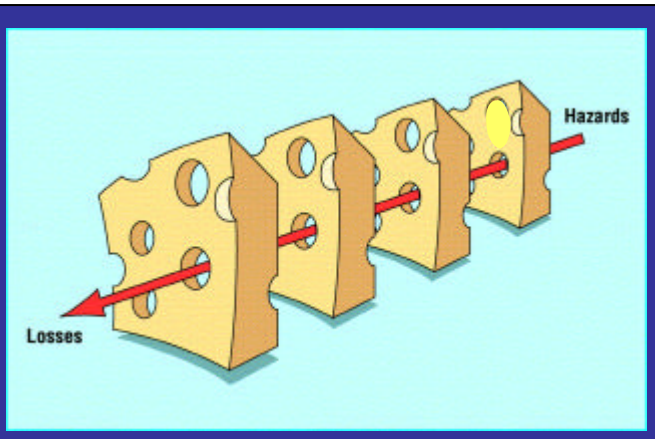
Medication Safety Today



The Northern Ireland Medicines Governance Proiect Newsletter Issue 2. Feb 2003

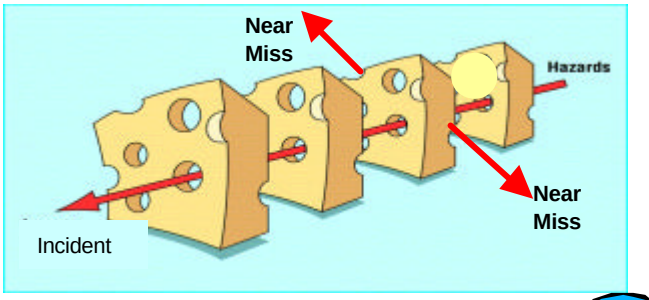
CHEESE!!

"What has cheese got to do with medication risk management?" This has been a common question since the first edition of Medication Safety Today. The logo shows the 'Swiss Cheese' model of why incidents occur.

Each slice of cheese represents a safety measure in place. This could be a policy, a checking mechanism, specifying a certain grade of staff to carry out a procedure etc. The holes in each slice represent weaknesses or loopholes in the safety measures.

When a hazard arises, it will become an actual incident if it penetrates through each slice, that is, when a series of holes in each slice line up. Near misses occur when a hazard is deflected off a 'slice' i.e. stopped by a safety measure.

The Medicines Governance Project is concentrating on closing the holes in existing 'slices' or placing new 'slices' into medication related activities.



Did you know...

That the maximum rate of infusion for intravenous frusemide is 4mg/minute. Therefore a 40mg dose should be given over a minimum of 10 minutes.

Double Trouble

"Double, double toil and trouble!" William Shakespeare wasn't writing about drug names but he had the right idea. Today, many drugs have names that look or sound like other drugs. There have been numerous reports of medication incidents occurring due to the mix-up of drug names. Some of these have caused fatalities. Examples, of confusing name pairs: -

Aminophylline	Amitriptyline
Amiloride	Amlodipine
ISMN	Istin ®
Clarithromycin	Ciprofloxacin
Amlodipine	Amiodarone

Many of these look-alike or sound-alike drugs are used to treat different conditions: -

Lamisil ®	Lamictal ®
Risperidone	Risedronate
Procyclidine	Prochlorperazine

One reason these mix-ups occur is because of poorly written prescriptions. But they also occur because people tend to see what they expect to see, known as confirmation bias. Below are some learning points that all of us can use to prevent medication incidents occurring with drugs which have look or sound-alike names.

? All prescriptions should be written clearly
? Do not rely on packaging to recognize the product
? Always read the label and check the name of the drug carefully
? Be vigilant, and if in doubt ask
? Report it, so others can learn

Did you know...

That many drugs interact with warfarin and cause changes in a patient's INR. This can lead to bleeding complications or place the patient at risk of having a clot. These drugs include:

- Aspirin
- Ciprofloxacin
- Clarithromycin
- Metronidazole
- Fluoxetine
- Fluconazole
- Simvastatin

- A list of drug interactions can be found in Appendix 1 in the BNF.

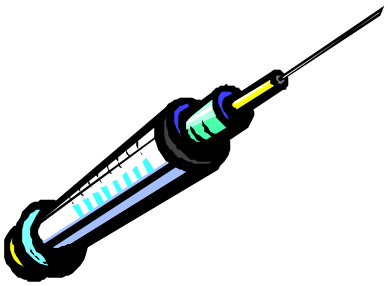
- Further information on drug interactions is available from the Pharmacy Department.

What dose of insulin is this?

a. 2 u

b. 2 in

c. 2U



Answers at the bottom of the page.

Remember!!

Always write 'units' in full.

@ Website @

The Medicines Governance project now has a website which can be viewed at:
www.dhsspsni.gov.uk/pgroups/pharmaceutical

Answer
a, b and c are all 2 units

Medication Incidents

What is a medication incident?

A medication incident is any preventable medication related event that could, or did, lead to patient harm, loss or damage

How common are medication incidents?

Extremely common!

It is estimated that medication incidents occur in 2-14% of patients admitted to hospital. Fortunately most do not result in injury.

Examples of medication incidents

- A patient is given their night time medication in the morning
- A patient's allergy status is not documented
- A patient is prescribed methotrexate tablets daily instead of weekly
- A patient who is allergic to penicillin is prescribed co-amoxiclav
- A patient receives intravenous vancomycin as a bolus instead of an infusion.
- Clarithromycin 500mg is dispensed instead of Ciprofloxacin 500mg

How can I help prevent medication incidents?

Be vigilant when involved in any part of the medication use process i.e. prescribing, transcribing, dispensing or administration

Never guess – unclear prescriptions are unacceptable

Report all medication incidents you encounter.