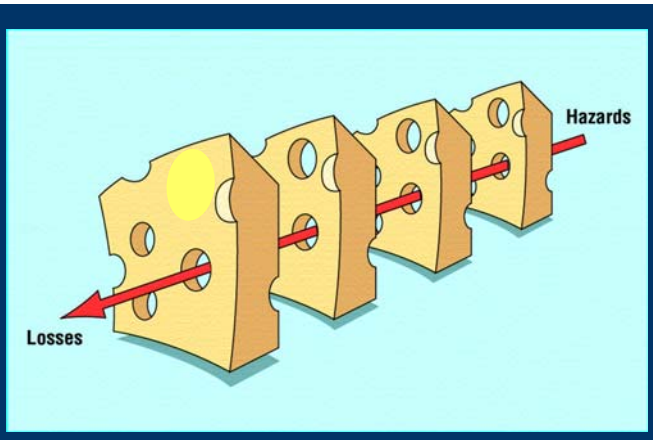
# Medication Safety Today

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## Medication Incidents

**What is a medication incident?**

A medication incident is a preventable medication related event that could or did lead to patient harm, loss or damage. Examples include:

- a patient allergic to penicillin receives co-amoxiclav
- intravenous clarithromycin is administered as a bolus instead of a 2 hour infusion
- a patient is given the incorrect inhaler device
- a dangerous abbreviation such as 'iu' instead of 'units' is used when prescribing insulin
- the intended drug was Largactil® but the patient received Lamictal®.

**How common are they?**

Extremely common. Approximately 1% of patients admitted to hospital experience a medication incident that causes harm.

**What should I do the next time I encounter one?**

Ensure that the patient has come to no harm or that appropriate treatment is given. **Report** the incident according to the Trust incident policy

**Why report it?**

To improve safety, risks must first be identified. This relies on staff reporting all medication incidents, even those which did not cause patient harm. It is your opportunity to highlight risks to patient safety - **Please use it.**

There have been many medication safety initiatives undertaken in the last 18 months, some as a direct result of reported medication incidents. If you want any further information on these initiatives or on medication incident reporting in your Trust please contact your Medicines Governance Pharmacist.

If you have any comments or would like to suggest an article for the newsletter, then please contact the Medicines Governance pharmacist, Lisa Smith on ext 2491 at the Ulster Hospital or by e-mail at Lisa.smith@ucht.n-i.nhs.uk

## Did you know?

**Metoclopramide** should be avoided where possible in patients under 20 years (see BNF for exceptions).When necessary the dose should be adjusted for patient weight.

**Why?**
The incidence of dystonic reactions such as spasm of facial muscles, unnatural positioning of the head and shoulders and oculogyric crisis are more likely to occur in patients under 20 years.

## Insulin WATCH OUT! Insulin

Insulin packaging is changing.
This is due to a standard colour scheme for human insulin that has been agreed worldwide.

The new packs are being phased in as existing stocks are exhausted.

**Be careful with these changes.**

- **New *Humulin M3*®** packs are a similar colour to the **old *Humulin Lente*®.**
- **New *Humulin Lente*®** packs are a similar colour to the **old *Humulin Zn*®.**
- Wards, departments and clinics may have stocks of both the old and the new packs at the same time.

**Please take care when selecting insulin preparations, colour is only a guide – always read the label.**

The good news is that some packaging now includes Braille, to aid visually impaired insulin users.

Patient information leaflets and ward/clinic posters are available. Contact your Pharmacy Department for more information.

# Safety with Oral Methotrexate

In April 2000, a Cambridgeshire patient died as a result of an accidental overdose with oral methotrexate. The patient was taking 10mg of methotrexate every day instead of their correct dose of 17.5mg once a week.

This case followed other reports of serious and fatal outcomes as a result of methotrexate overdoses which have involved:

- 10mg tablets being confused with 2.5mg tablets.
- Weekly doses being taken on a daily basis.
- Higher doses for malignant conditions being confused with doses for non-malignant conditions.
- 'Monday' being misread as 'morning'.

A policy to reduce the potential for a methotrexate incident in Northern Ireland has been developed. The safety points include:

- Use of 2.5mg tablets only
- A standard strength of liquid (10mg/5ml) is used when liquid is required
- ONCE a WEEK doses must specify the day of the week on which the dose is to be taken – Monday should be avoided
- Weekly doses must include the warning 'To be taken ONCE a week'.
- Patient's own supplies of oral methotrexate must **not** be used in hospital.

This policy is currently being implemented in hospitals and primary care across Northern Ireland ensuring a consistent approach to the prescribing and supply of oral methotrexate.

# Aminoglycosides and vancomycin

Aminoglycosides (such as **gentamicin**, amikacin, netilmicin and tobramycin) and **vancomycin** are drugs used to treat serious systemic infections. These intravenous antibiotics can damage the kidneys and hearing if the drug levels are too high. Low drug levels can lead to the infection not being treated effectively.

Safety tips when prescribing or administering these antibiotics include:

- ! Check the patient's renal function.
- ! Be aware of the patient's age (renal function is reduced in the elderly).
- ! Look for additive toxicity with other drugs e.g. frusemide, ciclosporin.
- ! Find out when to take blood samples and how often this should be done.
- ! Check for a recent drug level where appropriate.

This list is not exhaustive. Sources of information for dosing, administration and monitoring include Trust antibiotic policies, Microbiology/ Laboratory and the Pharmacy Department.

# Drug calculations

1. A patient requires salbutamol infusion at an initial rate of 5 micrograms per minute. After preparing a solution of 5mg in 500ml, at what rate do you set the pump?

2. A patient requires 450mg clindamycin IV. The injection on the ward is 150mg/ml (2ml). What volume is required?

3. A child weighing 25kg requires rifampicin 10mg/kg every 12 hours for 2 days. What volume of 100mg/5ml syrup is required for each dose?

Answers at the bottom of the page

# Right medicine...right patient?

Checking a patient's identity is an important, but sometimes overlooked, part of the medicine use process.

**Remember:**

- Drug charts can be moved – does the chart correspond to the patient?
- Patients can be moved – have you made an assumption?
- Dispensed doses can be moved – has drug administration been completed?
- There may be more than one patient with the same name on the same ward at any one time.

**Safety tips include:**

- ✓ If possible, ask patients to give their name. Stating a name and asking the patient to confirm 'Yes' or 'No' is a potential risk.
- ✓ Patients with the same or similar names should also be asked to give their date of birth.
- ✓ Check the patient's wristband for name and hospital number.
- ✓ Consider a system to highlight when patients with the same or similar names are on the same ward.

# *Congratulations!!!*

Thank you to everyone who took part in the Christmas quiz. The winners of the three £20 Marks and Spencers vouchers are:


Nan Simpson, Royal Hospitals
Tracy Murray, Ulster Hospital
Kate Scullion, Muckamore Abbey Hospital.

A copy of the Christmas quiz answers is attached for your information

Answers: (1) 30ml/hr (2) 3ml (3) 12.5ml