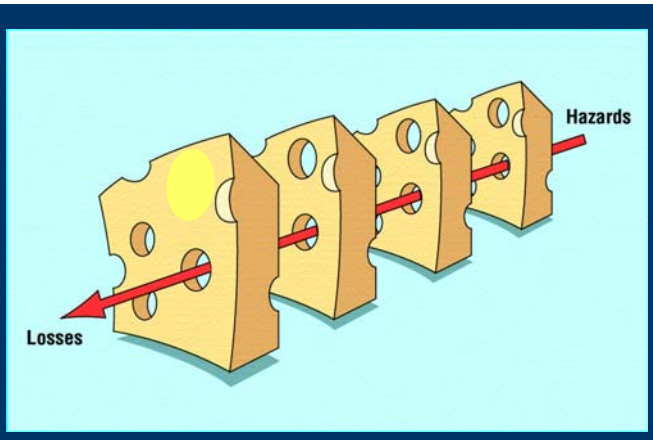
Medication Safety Today



Issue 7 The Northern Ireland Medicines Governance Project Newsletter **May 2004**

Changes to names of medicines

British Approved Names (BANs) of medicines are being changed to match recommended International Non-proprietary Names (rINNs) **where these differ**. In most cases the differences between BANs and rINNs are minor e.g. amoxycillin (BAN) and amoxicillin (rINN). However, some differences are more substantial as shown in the table below.

BAN (changing from)	rINN (changing to)
Bendrofluazide	Bendroflumethiazide
Benzhexol	Trihexyphenidyl
Cysteamine	Mercaptamine
Methotrimeprazine	Levomepromazine
Thyroxine sodium	Levothyroxine sodium
Trimeprazine	Alimemazine

Adrenaline (BAN) and **noradrenaline** (BAN) will retain their BANs.

During the changeover period there is potential for medication incidents to occur. For example:

- Patient receives a double dose - patient is prescribed trihexyphenidyl and benzhexol.
- Patient does not receive a dose - patient prescribed levothyroxine misses a dose because the manufacturer's pack still uses thyroxine OR the storage location has changed.

All staff should be aware that a combination of BANs and rINNs may be in use. This may be found on prescriptions, during the drug history taking process, within primary care information, in medicines packaging and on dispensing labels.

How to avoid medication incidents due to this change.

- Find out how your pharmacy department plans to manage the change from BANs to rINNs.
- Be familiar with the new medicine names.
- Check products using available reference sources which include BNF No.47 (March 2004), www.mhra.gov.uk (list of medicines affected and commonly asked questions) and the pharmacy department.
- Inform patients receiving a medicine whose name is changing.
- Report medication incidents that do occur.

Do not guess the names of medicines – if in doubt, check it out!

Watch Out!

As mentioned earlier in this newsletter, some names of medicines are changing. One name change in particular has already led to several medication incidents.

Mercaptamine is the new name for cysteamine, used in the treatment of the rare condition, nephropathic cystinosis. In the reported incidents, **mercaptamine** was accidentally selected instead of **mercaptopurine**. Both medicines are available as 50mg. This incident could have had serious outcomes for the patients involved. **Mercaptopurine** is mainly used for the treatment of acute leukaemias and some other non-malignant conditions. **Mercaptamine** may produce anaemia and leucopenia as side-effects.

Be careful when selecting medicines from electronic ordering, prescribing and discharge programmes – **mercaptamine** and **mercaptopurine** appear directly adjacent to each other in medicine lists.

Did you know?

Intravenous erythromycin must be given by infusion.

For intermittent infusion:
Reconstitute each 1g vial with 20ml water for injection to produce 50mg/ml.

Then further dilute to a maximum concentration of 5mg/ml with sodium chloride 0.9% (eg.500mg in 100ml). Administer intermittent infusion over 20 - 60 minutes.

For continuous infusion:
Reconstitute as above then dilute to a maximum concentration of 1mg/ml.

@ Website @

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

It contains back issues of this newsletter, safety memos, policies and other work that the team has produced. It also contains a page of useful links to other medication safety related websites.

Double-checking – make it worthwhile

Double-checking the prescribing, administration and dispensing of medicines has long been a subject for debate. Research has shown that people find about 95 percent of all mistakes when checking the work of others, supporting double-checking. Other work has shown that reported error rates with single-person checking were similar to those where double-person checking operated. So how do these apparently conflicting results add up?

The answer may lie in what is going on during the 'double-check'.

- If the double-check is carried out with both people working together, the second checking person may more easily repeat mistakes that the first person has made.
- There can be 'confirmation bias', where the second checker sees what they want to see and assumes the first person has got it right.
- Double-checking can create a false sense of security, where the first person relies on the second person to do a 'proper check', rather than checking their own work.
- Does double-checking involve all stages of the preparation and administration of medicines or just selected parts?

In a busy working environment, it is vital that double-checking does not become superficial and routine.

Safety tips

- ☑ Make sure you know which medicines and procedures require a double-check in your Trust.
- ☑ Never be afraid to ask for a double-check on other medicines and procedures.
- ☑ When performing double-checks, deal with one patient or procedure at a time
- ☑ Carry out double-checks **independently** from the first person, for example, work out the calculation yourself rather than look over the first person's work.
- ☑ Carry out double-checks **thoroughly**, don't assume the first person has got it right.
- ☑ Carry out double-checks **completely**, for example, from preparation of a dose through to administration to a patient.
- ☑ Check your own work before obtaining a double-check.

Erratum

Medication Safety Today Issue 6 stated that intravenous clarithromycin is administered as a 2-hour infusion.

Intravenous clarithromycin should be administered over 1 hour.

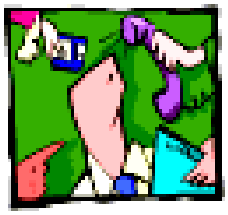
If you have any comments on this newsletter, then please contact the Medicines Governance pharmacist, Tracey Boyce on ext 5724 at the Royal Hospitals or by e-mail at Tracey.boyce@royalhospitals.n-i.nhs.uk

Spot the difference

DOSULEPIN	25mg	O	✓		.	✓
DOTHIEPIN	25mg	O	✓			✓

Answer at the bottom of the page.

Distractions



Have any of these happened to you?

- Asked to take a telephone call during a medicine administration round.
- Called away to attend to reception when dispensing/checking a prescription.
- Discussed one patient while transcribing a Kardex for another.

Distractions can be anything that causes an interruption in the process you were working on and such distractions may cause or contribute to a medication incident.

Take steps to decrease distractions and their impact in your ward or department.

- Recognise tasks within your ward or department, such as medicines administration/preparation, where interruptions are unacceptable.
- Make sure all staff are aware that it is not good practice to disturb others when they are prescribing, transcribing, administering or dispensing medication.
- Where possible place telephones away from areas where staff are prescribing, preparing or dispensing medicines.
- Ensure that the environment is suitable for the task you are performing and is not itself a cause of distraction. For example the nurses' station is not the ideal place to prepare an intravenous dose.
- Consider putting 'Do not disturb signs' on, for example, the medicines trolley to remind other staff that they should not interrupt medicines administration.

We will probably never totally eliminate distractions from our work environment. If you are called away, think about the process you are leaving. For example:

- Are medicines safely locked away?
- Will you know where you were in the process when you get back to it? It is safer to start again.

Answer:
There isn't one! Dosulepin (rINN) is the new name for dothiepin (BAN).