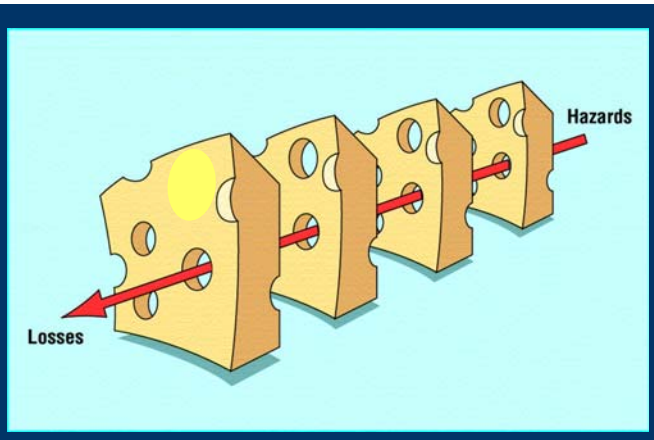
Medication Safety Today



Issue 8 **The Northern Ireland Medicines Governance Team Newsletter** **August 2004**

Potassium

Intravenous potassium concentrate can be fatal if given inappropriately.

Reported incidents include:

- excessively rapid infusions;
- inappropriate bolus injections;
- inadvertent use as a diluent in place of sodium chloride 0.9% or water for injection; and,
- inadequate mixing of potassium added to infusion bags causing rapid administration of high doses.

In July 2002, the National Patient Safety Agency issued a patient safety alert on the use of intravenous potassium chloride and other strong potassium solutions. At the same time the Department of Health in Northern Ireland advised all Trusts that they must comply with the alert.

The alert:

- restricts potassium concentrates to critical care areas;
- requires them to be stored separately from other solutions (as a controlled drug);
- prohibits their transfer between wards; and,
- requires that a second check takes place when potassium infusions are being prepared.

A recent audit has shown that:

- the majority of hospitals in Northern Ireland have policies in place that comply with the alert;
- the number of wards and departments holding potassium concentrates as stock items has fallen by 60%;
- there is variation in the types of wards and departments which stock potassium concentrate solutions. These areas should be kept to a minimum and regularly reviewed; and,
- the use of premixed potassium bags has increased. All areas should use premixed potassium infusion bags where possible.

All staff, including locums and bank staff, have a responsibility to familiarise themselves with their Trust's potassium policy.

Have you read your Trust's potassium policy?
If not – do it now!

Insulin

Serious medication incidents have occurred when insulin is used as part of hyperkalaemia treatment (high potassium levels). Remember:

- Typical adult doses of insulin range from 5 – 15 units. Soluble insulin contains **100 units/ml**.
- Always draw up the dose using an **insulin syringe**.
- Insulin must be infused in **glucose 50%**. This high concentration of glucose is used to prevent hypoglycaemia.

Not another new pack...

You may currently be noticing some packaging changes. Why do medicine packs keep changing?

- The NHS buys its medicines in bulk to get the best value for money so that savings can be directed to patient care. If, when contracts are awarded, a different manufacturer is selected, packaging will change.
- Sometimes the usual manufacturer is unable to supply a medicine. Pharmacy departments have to buy it from a different manufacturer rather than leave the hospital without an important medicine.
- Manufacturers are redesigning packaging so that medicines can be identified more accurately and efficiently.

No one can assume that a medicine will always be available in the same packaging. Don't use packaging as the only basis for identifying medicines.

What you see is what you get.

Can you spot the difference?

A Candesartan 4mg

B Ondansetron 4mg

(Answer on the reverse)

What do you see?

	Two faces or a wine goblet?
Hydroxocobalamin 1mg IM 8 weekly	Eight doses of 1mg per week or One dose of 1mg every 8 weeks?
	Elderly lady or young lady?

Ambiguous prescriptions may cause mistakes.

Do not guess – always clarify.

Co-dydramol
Co-proxamol
Kapake®

Paracetamol

Solpadol®
Co-codamol
Tylex®

Paracetamol is a commonly used analgesic and anti-pyretic. It is available as tablets, capsules, liquids, suppositories and now as injection.

Medication incidents have been reported where too much paracetamol has been given in a 24 hour period.

Safety tips:

- Be aware of the recommended maximum dose. The adult oral dose is 0.5 – 1g every 4 to 6 hours to a maximum of 4g daily. For children's doses refer to Medicines for Children (2nd Edition).
- Before prescribing, administering or dispensing paracetamol or paracetamol containing products, check that the patient is not already receiving paracetamol or a combination product such as co-codamol or co-dydramol.
- Take special care with 'once only 'and 'prn' doses – check regular, once only and when required sections of the prescription to confirm when the last dose of paracetamol was given.
- Prescribe using the generic name.

Answer

Always print medicine names clearly

A – candesartan B – ondansetron

What's in a name?

Medicines generally have two names; the ingredient name commonly known as the generic (approved) name and the brand name given by the company who manufacture the medicine.

Use of brand names has been associated with medication incidents, such as:

- **Overdose** – patient receives a double dose of carvedilol, if prescribed as Eucardic® and carvedilol.
- **Duplication** – patient receives two medicines from the same therapeutic class, for example Zoton® and omeprazole. Generic names help to identify medicines of the same class (lansoprazole and omeprazole), whereas brand names do not (Zoton® and Losec®).
- **Omission** – patient does not receive a dose as it cannot be found, because the medicine is stored and dispensed by generic name, but prescribed by brand name.
- **Patient confusion** – using a mixture of brand and generic names can confuse the patient.

The generic name must be used for a medicine wherever possible to avoid confusion and minimise risk to patients.

Exceptions when a brand name should be used:

- When bioavailability problems are so important that the patient should always receive the same brand, for example, ciclosporin and lithium.
- Combination products where there is no recognised 'co-' name, for example, the HRT preparation Kliovance®.
- Insulin preparations.

☺ Here to Stay! ☺

The Northern Ireland Medicines Governance Project, which commenced in August 2002, was initially funded for a two year period.

Earlier this year the Department of Health in Northern Ireland provided permanent funding to the Medicines Governance Team, to ensure that its medication safety initiatives can continue.

@ 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.

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