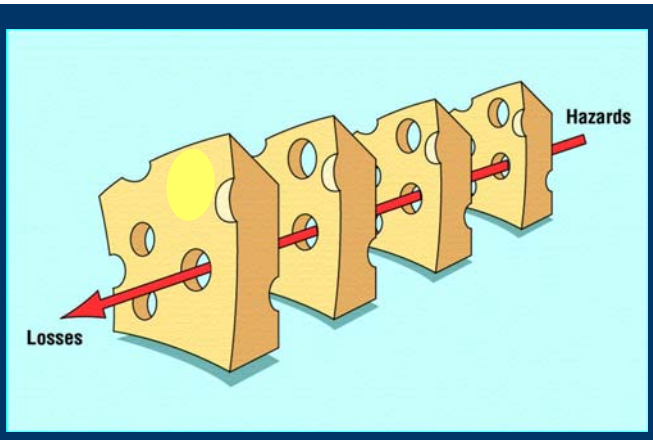
Medication Safety Today



Issue 15 **The Northern Ireland Medicines Governance Team Newsletter** **May 2006**

Still a serious issue.

This newsletter often describes medication incidents where harm has not occurred either by chance or because of the vigilance or quick action of staff. It can be easy to forget that medication incidents do still cause serious harm to patients.

Recently a newspaper reported the death of a 51-year old woman in Scotland[1] who received medication prescribed for a patient who was previously in her bed. The medication was administered using the previous patient's Kardex, which was still hanging on the end of the bed.

Remember when administering medicines to patients, always confirm the patient's identity by checking the

- patient's name,
- date of birth and
- hospital number on their identity bracelet against the Kardex or prescription.

You cannot assume that the Kardex at the end of a bed is the Kardex for the patient that is in the bed.

Wherever possible, the patient's date of birth and name should also be confirmed verbally with the patient. Remember to ask the patient to tell you their name and date of birth rather than asking them to answer yes or no to the name and date of birth that you tell them.

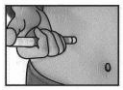
[1] http://news.scotsman.com/latest_scotland.cfm?id=222332006

Update on phytomenadione use in newborns.

Konakion® Neonatal (phytomenadione) was discontinued on 31st March 2006. It was replaced by Konakion® MM Paediatric, which was previously only licensed to be given by mouth or as an injection to premature babies / babies at special risk. Konakion® MM Paediatric has now also been approved for use as an intramuscular injection in healthy babies of 36 weeks gestation and older.

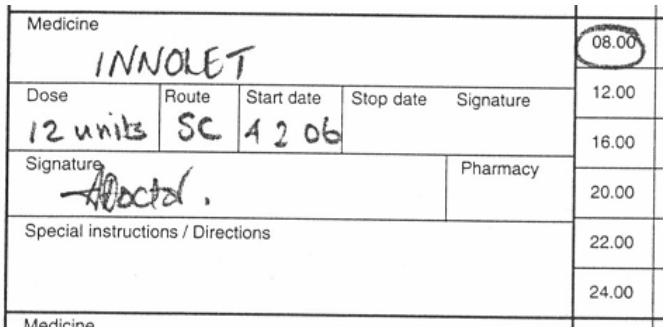
Check your hospital's regimen for the prevention of vitamin K deficiency bleeding in newborns.

More options, more confusion



There is an increasing range of insulin preparations and administration devices.

Medication incidents have been reported where the name of the administration device was prescribed, incorrectly thinking it was a type of insulin.


Medicine INNOLET

Dose	Route	Start date	Stop date	Signature
12 units	SC	4 2 06		

Signature Pharmacy

Special instructions / Directions

08.00
12.00
16.00
20.00
22.00
24.00

Medicine

The prescribed dose was then administered using that device, however the device contained a different type of insulin to the patient's usual insulin and so the wrong insulin was administered.

Do you know which of the following is a type of insulin and which is an administration device?

1. NovoMix®
2. Insulatard®
3. Innovo®
4. NovoPen®
5. NovoRapid®
6. Innolet®

Take time to familiarise yourself with the different types of insulin and devices.

Answers
1, 2 and 5 are types of insulin, 3, 4 and 6 are administration devices.

If you have any comments on this newsletter, please contact Sharon O'Donnell, Medicines Governance pharmacist on ext 2600 at Belfast City Hospital or by e-mail at Sharon.odonnell@bch.n-i.nhs.uk.

The Medicines Governance Team website and previous newsletters can be viewed at www.dhsspsni.gov.uk/index/pas/pas-governance.htm

Did you know?

Acetylcysteine (Parvolex®), used to treat paracetamol overdose, is available as a liquid injection. It must be further diluted before administration by intravenous infusion. The preferred infusion fluid is glucose 5%. The dosing regime for adults is:

Initially	**150mg/kg in 200ml given over 15 minutes**
Then	**50mg/kg in 500ml given over 4 hours**
Then	**100mg/kg in 1Litre given over 16 hours**

Please see SPC or BNF for fluid volumes in children and further information.

Use Units

The abbreviations 'IU' and 'U' continue to be used for 'international units' or 'units.' This can lead to ten fold over doses being administered.

This dose of 8 units could be misread as 81 units.

Insulin and heparin are examples of medicines that are measured in units.

Always print the word **UNIT** in full.

Allergy

Medication incidents continue to be reported involving patients receiving medicines they are known to be allergic to. Some examples include:

- Valoid® administered to a patient documented as allergic to cyclizine
- Co-fluampicil administered to a patient documented as allergic to penicillin

Safety tips

- ☑ Always check the allergy status of a patient before prescribing or administering a medicine.
- ☑ Take particular care with brand names and combination products where it may not be immediately obvious that the patient is allergic to the medicine you are about to prescribe or administer.

I don't like Mondays

Oral methotrexate for non-malignant conditions is given as a weekly dose. It should not be prescribed on a Monday. Why? 'Monday' or 'Mon' when handwritten can be misread as 'morning' or 'mane' leading to the patient receiving a daily dose.

Monday should also be avoided for other medicines where a dose is prescribed weekly, such as alendronate 70mg or risedronate 35mg to avoid the possibility of a patient getting a daily dose.

Calculations

1. A child requires a dose of paracetamol 60mg. Paracetamol infant suspension is available containing 120mg/5ml. How many mls are required?
2. A patient requires their oral methotrexate 15mg once weekly dose. They have been prescribed the liquid preparation. The standard strength of oral liquid methotrexate is 10mg/5ml. How many mls are required?
3. IV clindamycin is available on your ward as a 150mg/ml, 2ml ampoule. The patient has been prescribed clindamycin 600mg in sodium chloride 0.9% over at least 30 minutes. How many mls are required to make up the infusion?
4. A 12kg child requires a 500microgram/kg dose of furosemide. Furosemide injection is available as 10mg/ml, 2ml ampoules. How many mls are required?

Answers at the bottom of the page.

HELP !

Help from colleagues is essential for an efficient service but be aware of some pitfalls that can occur.

These are all examples of medication incidents that have occurred when someone has tried to help.

- Medications prescribed for wrong patient because the wrong Kardex was handed to the prescriber.
- Wrong medication or diluent used because someone had assembled them on the bench, ready for preparation.
- Medication recommended in wrong patient's notes because the notes were obtained by a second person.

Help is invaluable particularly when we are busy and rushing from one job to the next or in an unfamiliar environment however:

Always check.
Don't assume the helping hand is right.

Answers

(1) 2.5ml (2) 7.5ml (3) 4ml (4) 0.6ml