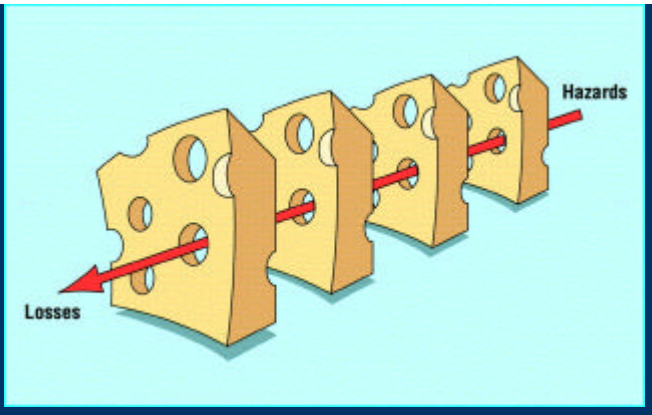
# Medication Safety Today

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## Perplexing prescriptions

The BNF includes guidance on prescription writing that is recognised as good practice and covers many issues such as legibility and clarity. Most Kardexes confirm this advice. This guidance can seem unimportant and trivial but when not followed has the potential to cause serious patient harm.

Patient safety often relies on frontline staff identifying and resolving problems before patients come to harm. The examples of unsafe practice given below are real. Can you spot the risks? (answers below)

1. What is this medicine?

| Drug | | |
|---|---|---|
| Dose | Start Date | Start Signature |
| Route | Stop Date | Stop Signature |
| Special directions | Pharmacy | |

2. What is the dose?

| Drug | Clexane | |
|---|---|---|
| Dose | Start Date | Start Signature |
| Route | Stop Date | Stop Signature |
| Special directions | Pharmacy | |

Safety tips

- Ensure your prescriptions are legible. Include all necessary information, making sure the medicine and the dose cannot be misinterpreted.
- Under no circumstances should guesses be made. Always seek clarification. Illegible prescriptions should not be accepted.

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@bcht.n-i.nhs.uk

Further copies of this and previous newsletters can be viewed at www.dhsspsni.gov.uk/index/pas/pas-governance.htm or on your Trust intranet.

Answers

(1) Ensure ® drinks
(2) Enoxaparin 20mg or enoxaparin 70mg
Remember: prescribe generically

## Stopping steroids?

On admission to hospital, patients are sometimes commenced on high dose oral corticosteroids as part of their treatment.

Where a patient is usually on a maintenance dose of oral corticosteroids:

- Note the maintenance dose on the Kardex
- Document the maintenance dose as part of the medication history.

This highlights that when the high dose course is completed, the oral corticosteroids should not be stopped abruptly and appropriate follow-on dosing can be considered.

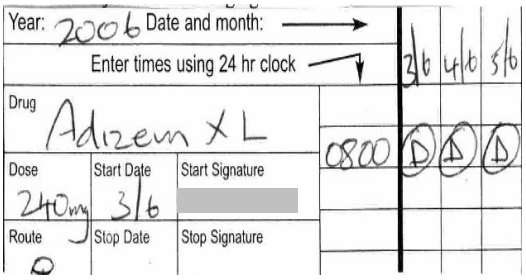
Further information is available on withdrawal of oral corticosteroids from the Committee on the Safety of Medicines in section 6.3.2 of BNF 51.

## Insulin in hyperkalaemia

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

- Licensed soluble insulin contains 100 units/ml. Each 10ml vial contains 1,000 units of insulin.
- The adult dose of insulin used to treat hyperkalaemia is 10 units, which must be measured using an insulin syringe.
- Insulin must be infused in 50ml of glucose 50%. This high concentration of glucose is used to prevent hypoglycaemia.
- Obtain a second check at every stage of the preparation and administration. One of the practitioners involved must be a senior nurse on duty.
- Refer to CREST 'Guidelines for the treatment of hyperkalaemia in adults' January 2006 for further information. Available at http://www.crestni.org.uk/publications/hyperkalaemia-booklet.pdf

# Any alarm bells ringing?




(D)= Drug unavailable

The most common administration related incident reported in Northern Ireland is omission of prescribed inpatient medication. Patients can come to serious harm when vital medicines are omitted.

Safety tips

- ☑ If a medicine is not available, do not assume that someone else has organised the supply. Find out when the dose will be available.
- ☑ If a dose is unavailable, annotate the Kardex.
- ☑ Inform the prescriber if a dose is unavailable so that another medicine can be prescribed if necessary.
- ☑ When reviewing patients, always check the administration record to confirm that the patient has actually been receiving the medicine.

# Go generic

There is a current DHSSPS initiative to promote generic prescribing. While this should bring overall financial benefits to HPSS, it also has an important safety component, which is that we all talk the same language when prescribing, dispensing and administering medicines. Below are just a few incidents that have been reported where use of brand names has caused a problem.

**Overdose** - Tenormin® (atenolol) and atenolol prescribed for the same patient.

**Omitted dose** - Dose of Eltroxin® (levothyroxine) not given and recorded as 'drug not available' as not recognised as levothyroxine which was available.

**Duplication** - Zocor® (simvastatin) and atorvastatin prescribed for the same patient.

**Allergy** – Patient prescribed Valoid® (cyclizine) when documented as allergic to cyclizine.

There are a number of exceptions to generic prescribing where the brand name should be used. Check the BNF or your own Trust guidance.

Answers

(1) 3 (2) 1.5ml (3) 5ml (4) 120mg

# Calculations

(1) A patient requires co-trimoxazole IV 1.44g. Each ampoule contains co-trimoxazole 480mg. How many ampoules are required to prepare the dose? (Note further dilution required before administration).

(2) Oral liquid ketamine is an unlicensed product with a standard strength of 50mg/5ml. Your patient has been prescribed 15mg three times daily. What volume of ketamine is required for each dose?

(3) A patient has been prescribed bumetanide 1mg daily. They are to receive the oral liquid medicine which is available as 200micrograms/ml. What volume of bumetanide is required?

(4) A 80kg patient requires enoxaparin 1.5mg/kg to treat a DVT. What dose is required?

Answers at the bottom of the page

# Feeding times

Did you know that medicines can interact with enteral feeds?

Insufficient time between medicine and feed administration can affect the amount of active medicine entering the body. Listed below are some common medications and the time that should be allowed before and after administration.

| Medication | Time gap before feed | Time gap after feed |
|---|---|---|
| Ciprofloxacin | 1 hour | 2 hours |
| Penicillin V | 1 hour | 2 hours |
| Phenytoin | 2 hours | 2 hours |

(Information taken from: 1. The NEWT Guidelines for administration of medication to patients with enteral feeding tubes or swallowing difficulties, First Edition – 2006. 2. Administering Medicines Through Enteral Feeding Tubes 2nd edition. The Royal Hospitals.)

➢ Always check with your ward pharmacist or medicines information service in pharmacy before administering medication via this route.

# Labelling of IV infusions

All intravenous infusions with additives must be labelled. Labels should contain, as a minimum, the following information:

1. Patient's name, hospital or unit number and ward.
2. Date and time of preparation
3. Name and quantity of additives
4. Name of person(s) who prepared and checked the infusion.

IV additive labels should be available in all clinical areas using IV infusions with additives.