Medication Safety Today

Issue 23 **The Northern Ireland Medicines Governance Team Newsletter** **May 2008**

Allergy awareness

Previous newsletters have highlighted various medication incidents that have occurred relating to allergy.

DHSSPS recently issued a health circular[1] to raise awareness of best practice guidance on severe allergy, which includes advice on:

- recognising the symptoms of severe allergy
- referral criteria to specialist services
- promoting safe and effective use of adrenaline (epinephrine) auto-injectors (Anapen®/Epipen®)
- signposting patients, their families and friends to relevant support services.

This circular also makes reference to a number of print and media resources to increase patient and safety awareness of allergy, one of which includes a poster campaign that has been developed in partnership with DHSSPS and the Medicines Governance Team.
There are two posters:

- one for patients to remind them to inform healthcare professionals if they have an allergy
- one for staff to remind them to ask, document and check a patient's allergy status, prior to prescribing, dispensing and administration of a medicine (shown below).

Look out for posters in your area.

1. HSS(SQSD) 20/2008 'Recognising and Managing a Severe Allergy (i.e. anaphylaxis) in Children and Young People: Providing Information, Advice and Follow-up Services to Patients, Family and Friends'.

How's it going?

Medication incidents continue to be reported involving the use of brand names.

For example, confusion between

- glimepiride and candesartan (brand names Amaryl® and Amias®)
- chlorpromazine and lamotrigine (brand names Largactil® and Lamictal®)

This is a particular problem where similar brand names are available in the same strength, as in the examples above.

In 2006, DHSSPS launched the 'Go generic' initiative to promote generic prescribing. While this should bring overall financial benefits, it also has an important safety component, which is that we all talk the same language when prescribing, dispensing and administering medicines.

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

Have you 'Gone generic'?

Fire!

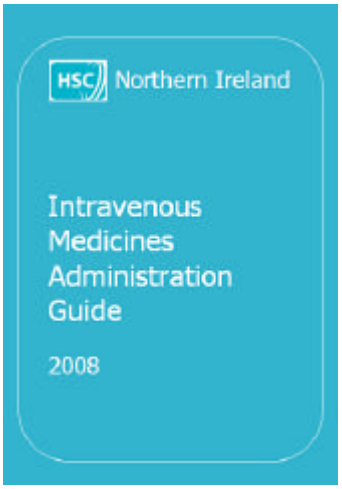
In January 2008, DHSSPS distributed a Rapid Response Report from the National Patient Safety Agency.[1] This report highlights a potential fire hazard with large quantities of paraffin based skin products, for example White Soft Paraffin, White Soft Paraffin/Liquid Paraffin 50:50 and Emulsifying Ointment are easily ignited with a naked flame or cigarette.

The report highlighted actions to be taken for patients being dispensed, or treated with, large quantities (100g or more) of paraffin based products.

Find out what is happening in your Trust in response to this Rapid Response Report.

1. http://www.dhsspsni.gov.uk/hsc__sqsd__01-08.pdf

IV Guide



Have you seen the new Northern Ireland Intravenous Medicines Administration Guide? This guide aims to provide essential technical information for preparation and administration of intravenous medicines in clinical areas.

The guide is based on one produced by the Pharmacy Department, Imperial College Healthcare NHS Trust and is the result of extensive work by an editorial board of Northern Ireland Medicines Information Pharmacists chaired by Mrs Eilish Smith, Principal Pharmacist, Regional Medicines and Poisons Information Service.

Ask your pharmacist or contact pharmacy for further information.

Intravenous magnesium

While most medicines have a wide safety margin, there are some that have a high risk of causing patient harm if prescribed, dispensed or administered incorrectly.[1] A lot of work has been done with these high-risk medicines since 2002, for example, many Trusts have implemented policies to avoid accidental overdose of IV strong potassium, but other high risk medicines remain. One of these is IV magnesium.

Safety tips

- Be aware that the dose can be expressed in different ways such as 'grams', '%', or 'mmols'.
  1. How many mmols of magnesium in a 10ml ampoule of magnesium 50%, 2mmol/ml?
  2. How many grams of magnesium in a 10ml ampoule of magnesium 50%, 2mmol/ml?

  Answers at the bottom of the page.
- Make sure when double checking a magnesium infusion, as with any other infusion that the check is complete and independent, from preparation to administration to the patient.

1. Cohen MR (Ed.). *Medication Errors*. Washington: American Pharmaceutical Association; 1999.

Erratum

In some editions of Issue 22, in the article 'Something's missing', the text stated that the prescription was nicorandil 10mg twice a day when it was 20mg twice a day.

Answers

(a) 20mmol (b) 5g

Self-service

Medication incidents continue to be reported where patients have self-administered medicines in hospital (not as part of a self-administration scheme or procedure).

Incidents include:

- Overdose - A patient taking their own regular medication in addition to the doses administered by nursing staff, thinking that they weren't receiving their regular doses.
- Underdose – A patient administering their pre-admission dose of insulin, not realising that the dose had been increased by medical staff.

Programs for self-administration of medicines by patients can be very beneficial in improving patient compliance with their medication. In hospital however, patients should only self-administer medicines where this is part of a self-administration scheme or procedure.

It may be entirely appropriate to involve a patient in the administration process, for example to educate them in the administration of insulin. In these situations, the administration must be under direct supervision of an approved practitioner such as a nurse or midwife, who retains full responsibility for the administration process and must sign the Kardex as a record of the dose administered (marking only 'self' on the Kardex is not an acceptable record of administration).

It is equally important to explain to patients where a self-administration scheme or procedure does not operate and that while a patient's own medicines are in hospital, they must be stored safely and securely.

Thank you

During October to December 2007, a random sample of staff was sent a questionnaire to seek their views on Medication Safety Today. A good response was received and the team is analysing the returned questionnaires.

Thank you to everyone who completed and returned the questionnaire. Feedback on the results will appear in future editions.

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@belfasttrust.hscni.net Further copies of this newsletter can be viewed at www.medicinesgovernanceteam.hscni.net or on your Trust intranet.