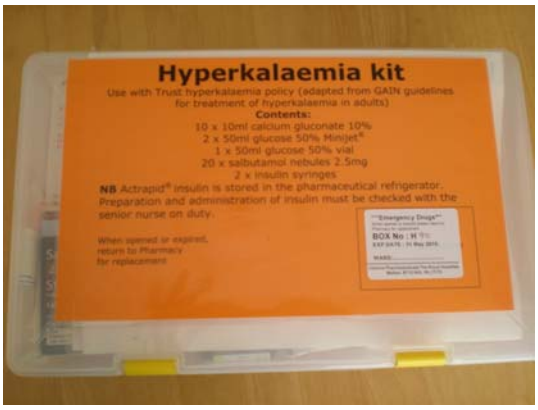
Medication Safety Today

Issue 25 **The Northern Ireland Medicines Governance Team Newsletter** **November 2008**

Hyperkalaemia kits

Hyperkalaemia kits are being introduced across Northern Ireland to assist staff in treatment of hyperkalaemia in adults and reduce risk.



The kit contains:

- Calcium gluconate 10% ampoules
- Glucose 50% Minijets®
- Glucose 50% vial
- Salbutamol 2.5mg nebules
- Insulin syringes

The insulin syringes are flag labelled with reminders that the dose of soluble insulin to be administered is 10 units and that a second check with the senior nurse on duty is required before proceeding. Insulin remains in the locked pharmaceutical fridge.

The kit also contains:

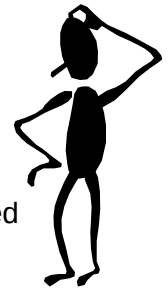
- An updated poster of the GAIN (formerly CREST) guideline for the treatment of hyperkalaemia in adults.
- An instruction sheet showing how to prepare the insulin/glucose infusion using a Minijet®.

An e-learning module is in development and should be available in the near future.

Once the kit has been used, return it to pharmacy and reorder a new one.

Remember to use the hyperkalaemia kit when treating hyperkalaemia in adults.

Once seen, never forgotten?



Medication incidents have been reported where 'once only' doses of medicines that have been prescribed have been overlooked and not administered.

Once only medicines & pre-medications (includes administration under Patient Group Directions)

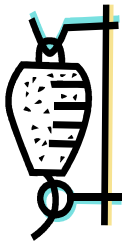
Prescription						Administration		
Date	Medicine	Dose	Route	Time to be given 24 hour clock	Signature	Given by	Time given 24 hour clock	Pharmacy
27.10.08	DIGOXIN	500 micrograms	PO	1100	[illegible]	A Nurse	1100	
27.10.08	DIGOXIN	250 micrograms	PO	1900	[illegible]			
28.10.08	DIGOXIN	250 micrograms	PO	0700	[illegible]	A Nurse	0700	

Often 'once only' doses are essential, for example to ensure treatment is started urgently before the next routine administration round, to provide 'loading' doses of medicines such as digoxin or as part of antibiotic prophylaxis.

Safety tips

- When prescribing a 'once only' dose of medication, ensure this is communicated to nursing staff.
- If a 'once only' dose of medication is to be administered after a shift change, ensure this is included in nursing handover.

Not so normal



Sodium chloride 0.9 % is often referred to as 'normal saline'. However, the BNF advises that the term 'normal saline' should not be used.
There are many different concentrations and the concentration should always be stated when prescribing or ordering these products, for example:

sodium chloride 0.9%,
sodium chloride 1.8%.

Back to basics (Part 1) - The right patient

'The 5 Rights' are commonly used to describe the basic principles of medication safety:

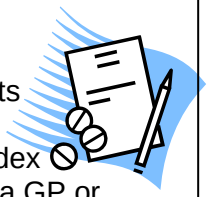
- Right patient
- Right medicine
- Right dose
- Right time
- Right route

Remember the following to ensure you have the **right patient** when prescribing, dispensing or administering medicines.

Administration

- Check the patient's ID bracelet,
- Ask the patient to tell you their name and date of birth (if possible).
- Check that the name and hospital number on the kardex match that on the patient ID bracelet.
- Complete the administration process for one patient before moving to the next patient, including medicines that require a second check (e.g. insulin, controlled drug). Never deal with more than one patient at a time.

Prescribing



- On admission, confirm any documents containing details of medication, for example MR48 or nursing home Kardex are for the right patient. If contacting a GP or community pharmacy, check you are both referring to the same patient.
- During admission, confirm the Kardex is for the right patient. You cannot assume that the kardex at the end of the bed is the kardex for the patient that is in the bed, check the patient details.
- Check each addressograph before attaching to kardex/charts to confirm it is for the right patient.
- When writing a discharge prescription, always ensure that you use the right patient's Kardex.

Dispensing

- When checking discharge prescriptions, wherever possible, confirm that the correct kardex has been used to write the prescription.
- When issuing medicines directly to patients, verbally confirm the patients name / date of birth / address. After calling out the patient's name, ask the patient to tell you their date of birth and address rather than asking them to answer 'yes' or 'no' to the details you tell them.

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.

NPSA oral anticancer medicines

DHSSPS have issued Best Practice Guidance, highlighting that the NPSA has published advice on the risks associated with incorrect dosing of oral anticancer medicines. The Rapid Response report is available on http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/rapidrr/risks-of-incorrectdosing-of-oral-anti-cancer-medicines/

Transplanting tacrolimus

There are now two oral formulations of tacrolimus; both are indicated for immunosuppression post solid organ transplantation.

Prograf® – tacrolimus ordinary release twice daily preparation.

Advagraf® – tacrolimus modified release once daily preparation

PROGRAF® tacrolimus capsules and injection

ADVAGRAF tacrolimus prolonged release

Tacrolimus has a narrow therapeutic index. These two formulations may not be interchangeable and patients must not be switched between products without specialist supervision.

The two formulations have sound alike brand names, similar packaging and are available in the same range of strengths, 0.5mg (500 micrograms), 1mg and 5mg capsules. Incidents have been reported where patients have been inadvertently switched between these formulations and have received Advagraf® instead of the twice daily Prograf®. This has happened both through incorrect prescribing and dispensing.

Actions

1. Ensure tacrolimus is prescribed clearly and legibly
2. Check that the frequency corresponds with the formulation
3. Confirm the dose, frequency and formulation is as expected with the patient/carer.
4. Take care with electronic pick lists when prescribing or dispensing to ensure you choose the correct preparation, especially if they are listed under their generic names.
5. If a change is made in formulation of tacrolimus supplied, confirm that arrangements are in place for appropriate monitoring.