Medication Safety Today

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Express yourself

Medication errors have occurred when the dose of a medicine has been expressed incorrectly.

The BNF sets out guidelines on the safe way of expressing doses that avoids unnecessary use of decimal points:

- Quantities of 1 gram or more should be written as 1g etc.
- Quantities of less than 1 gram should be written as milligrams e.g. 500mg not 0.5g.
- Quantities of less than 1 milligram should be written as micrograms e.g. 100micrograms not 0.1mg.

Express the following 'doses' in their acceptable format:

(1) 0.0625mg (2) 2000mg (3) 0.25micrograms

(Answers at bottom of page)

The computer says so

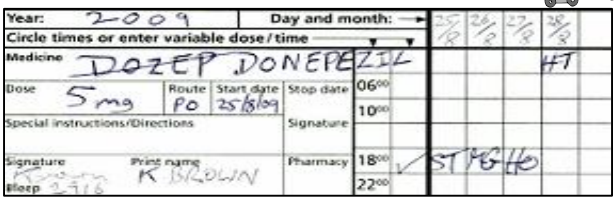
Print-outs from GP computers can be an invaluable source of information about a patient's medication history but there are some important points to note when using these:

- Check the patient details to confirm it is for the correct patient. Confirm the name, date of birth and address, as there may be more than one family member registered with the same practice.
- Is it complete, does it include 'acute' prescription items as well as repeat prescriptions?
- It may not contain strengths and/or directions.
- Is it up to date? What is the date of issue? Has the patient been admitted to hospital recently and has the computer been updated with any changes in medication?
- Is the patient on a repeat dispensing scheme? If so, the date of prescribing may be some time ago but the patient may still be taking the medicine.
- Is the patient still taking the medicines?
- Is the patient taking the medicines as detailed on the print-out, for example has the frequency or dose changed but not been updated on the computer?

GP computer print-outs remain extremely useful but remembering these points can help to make them even more useful. Remember that GP computer print-outs may not contain details of specialist medicines supplied by a hospital and will not include medicines purchased over the counter by a patient. All of these points highlight the importance of using, wherever possible, more than one information source to compile an accurate medication history.

More Haste, Less Speed

What has happened with this prescription?



Year: 2009 Day and month: 25/6 26/6 27/6 28/6

Circle times or enter variable dose / time

Medicine: DOZEP DONEPEZIL HT

Dose: 5mg Route: PO Start date: 25/6/09 Stop date:

Special instructions/Directions: Signature:

Signature: Print name: K BROWN Pharmacy: ST PGHE

Bleep 2918

06[00] 10[00] 18[00] ✓ 22[00]

1. When the prescription was written, donepezil was mis-spelled and was scored out. Donepezil was written in the remaining space but ran into the time box.
2. The frequency was later misinterpreted as twice a day. A dose was administered in the morning.
3. Later that day the discharge prescription was written, as follows:

DONEPEZIL 5mg bd for one month then 10mg bd thereafter.

The incorrect frequency was detected at the point of discharge and amended accordingly.

Safety tips

- ✔ Always write prescriptions clearly.
- ✔ If a mistake is made, discontinue the prescription and re-prescribe in full in the next section of the kardex.
- ✔ Always check the prescribed frequency. Do not simply follow the pattern of administration signatures.
- ✔ Check the BNF for recommended frequency.

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.

Answers

(1) 62.5micrograms
(2) 2g
(3) 250nanograms

Back to Basics (Part 5) – The right route

The 'five rights' are used to describe the basic principles of medication safety; right patient, right medicine, right dose, right time and right route.

Wrong route incidents have resulted in serious harm and fatalities, for example:

- Epidural medicines administered intravenously[1].
- Intravenous chemotherapy administered intrathecally[2].
- Liquid oral medicines have been injected[3].
- Intravenous medicines administered via arterial lines[4].

Each of these has been the subject of either safe practice alerts or rapid response reports from the National Patient Safety Agency (NPSA), available at:

[1] http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59807&p=4
[2] http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59890&p=2
[3] http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59808&p=3
[4] http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59891&p=2

Incidents can involve the wrong route being prescribed, abbreviations for route being poorly written, misread or misunderstood, selection of the wrong medicine or the wrong administration line, unlabelled or poorly labelled administration lines and using the wrong administration device.

Other wrong route incidents involve unsupervised self-administration by patients or leaving medicine doses unattended, for example patients swallowing tiotropium capsules or glycerin suppositories.

Remember the following to ensure you have the right route when prescribing, dispensing and administering medicines:

- ✓ Use and be familiar with accepted abbreviations for routes of administration.
- ✓ Label administration lines.
- ✓ Check you have selected the correct line before administering medicines.
- ✓ Use the correct device for different routes of administration, e.g. use an oral syringe for oral liquid medicines.
- ✓ Consider separate storage for medicines to be administered by different routes – this has always been done with internal and external medicines and is now extended to epidural infusions that are stored separately from intravenous infusions.

Find out what is happening in your area to implement the NPSA alerts and reports for preventing specific types of wrong route incidents.

Triple whammy

Stalevo® is a combination product of levodopa, carbidopa and entacapone used to treat Parkinson's disease. It is available in four different strengths:

Stalevo® strength	Levodopa component strength	Carbidopa component strength	Entacapone component strength
Stalevo® 50/12.5/200mg	50mg	12.5mg	200mg
Stalevo® 100/25/200mg	100mg	25mg	200mg
Stalevo® 150/37.5/200mg	150mg	37.5mg	200mg
Stalevo® 200/50/200mg	200mg	50mg	200mg

Problems may arise if the strength is omitted or incorrectly written when prescribing. The recent introduction of Stalevo® 200/50/200mg may be particularly problematic. For example, an incorrectly written strength, 'Stalevo® 200mg', could refer to Stalevo® 200/50/200mg or to any of the strengths, as they all contain entacapone 200mg. Confusion around the strength intended may lead to a delay, omission or the wrong dose of this antiparkinsonian medicine.

To avoid medication incidents with this medicine:

- Prescribe by brand as there is no approved generic name for this combination product.
- Ensure the strength of each component is listed in the order shown above when prescribing or on dispensing labels.
- Be aware that all three strengths must be present when prescribing this medicine to ensure the correct strength is administered or dispensed.
- If confirmation of the strength of Stalevo® leads to a delay in its administration, inform the prescriber, so that appropriate action can be taken.

Book Club

The National Patient Safety Agency (NPSA) has recently produced a report detailing medication incidents. In one year, 86,085 medication incidents were reported in England and Wales. While the majority of incidents (96%) resulted in no or low actual harm, there were 100 reports of death or severe harm. The report is available at: http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=61625

The NPSA has also published 'Review of patient safety for children and young people'. This includes a section on paediatric medication incidents reported within one year. The report is available at: http://www.nrls.npsa.nhs.uk/resources/patient-safetytopics/medicationsafety/?entryid45=59864

Both reports also include recommendations for learning from the incidents reported.