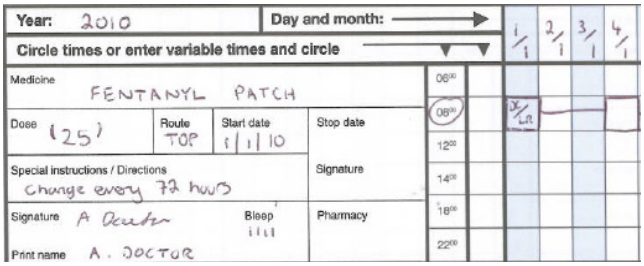
Medication Safety Today

Issue 30 **The Northern Ireland Medicines Governance Team Newsletter** **February 2010**

'Comma Chameleon'



Year: 2010			Day and month: →				1/1	2/1	3/1	4/1
Circle times or enter variable times and circle ▼										
Medicine: FENTANYL PATCH				0600						
Dose: (25)	Route: TOP	Start date: 1/1/10	Stop date	0800	25				
Special instructions / Directions: Change every 72 hours			Signature	1200					
				1400					
Signature: A Doctor		Bleep: 1111	Pharmacy	1800					
Print name: A. DOCTOR				2200					

Inverted commas around a dose can potentially lead to overdoses of medication if the inverted comma is mistaken for the number one. The kardex shown illustrates how a dose of 25 micrograms could be misread as 125 micrograms. The same problem can also occur with brackets.

When writing prescriptions, avoid unnecessary use of punctuation (!) (?).

Did you know?

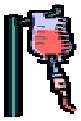
- The starting dose of both simvastatin and atorvastatin is 10mg when they are first prescribed for a patient already on amiodarone.
- The maintenance dose of simvastatin in a patient on amiodarone should not exceed 20mg.
- The maintenance dose of atorvastatin should not exceed the lowest dose to achieve the required lipid lowering effect.

These lower doses are required to reduce the risk of a serious adverse reaction such as myopathy or rhabdomyolysis when either simvastatin or atorvastatin are prescribed with amiodarone.

http://www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/CON2033505

If you have any comments on this newsletter, please contact Jillian Redpath, Medicines Governance pharmacist on Ext: 3737 at Craigavon Area Hospital or by e-mail at Jillian.Redpath@southerntrust.hscni.net Further copies of this newsletter can be viewed at www.medicinesgovernanceteam.hscni.net or on your Trust intranet.

Once in a lifetime



Intravenous aminoglycosides (e.g. gentamicin, amikacin) are often given using a 'once daily' or 'single daily dosing' regimen. After the initial dose the frequency of further doses is based on the measured level of the medicine. Further doses may be given less frequently than once daily. Many hospitals have a separate prescription chart that also records sample time, result and specifies the frequency of dosing.

Medication incidents have occurred where patients on 48 hourly dosing have been administered a dose too early or where doses have been inadvertently omitted for patients on 24 hourly dosing.

Safety tips:

- Where a separate prescription chart is in use:
  - ensure the day of the week is written on the prescription, where the chart allows
  - when prescribing the time the dose is due, use the 24 hour clock. Avoid noon or midnight to avoid confusion with 12.00; instead write 11.45 for noon and 23.45 for midnight
  - reference the separate prescription on the Kardex.
- Where prescriptions are written on the Kardex:
  - ensure the date, dose and time for next dose are clearly specified.
- When administering,
  - always check the day, date and time dose is due
  - if a dose is due at a time other that a scheduled medicine administration round, ensure this is highlighted in handover
  - record the actual time of administration.
- For all patients, ensure that samples are taken at the required time and the time of the sample is recorded.
- If you are unsure how to interpret sample results or the frequency of sampling, check guidelines or ask for advice.

Attention!

A recent change in the packaging of Rifinah® tablets could lead to potential prescribing, dispensing and administration errors.

Old packaging

New packaging 150

New packaging 300

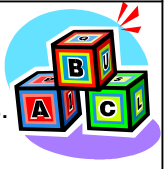
The new packaging has replaced the familiar name of Rifinah® 150 with Rifinah® 100/150mg (rifampicin 150mg/isoniazid 100mg) tablets and Rifinah® 300mg with Rifinah® 150/300mg (rifampicin 300mg/isoniazid 150mg) tablets.

The latest edition of the BNF and the SPC still refer to Rifinah® 150 and Rifinah® 300. Extra care is needed with this medicine to ensure that the correct strength has been prescribed, dispensed or administered.

Safety tip

- ☑ Include the strengths of the active ingredients rifampicin and isoniazid when prescribing Rifinah®.

Easy as A, B, C



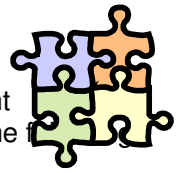
Remember A, B, C to avoid mismatch between patients and medicines.

A – **A**sk the patient verbally if possible to confirm their name and date of birth

B – Check the details are correct on the patient's identity **B**racelet

C – Confirm the patient's name, date of birth and hospital number on the bracelet match the details on the patient's prescription **C**hart (Kardex)

Potency Puzzles



Do you know the approximate equivalent dose of opioid analgesics for adults in the f[illegible] examples?

1. 60mg oral codeine = Xmg oral morphine
2. 30mg oral morphine =Xmg s/c diamorphine
3. 30mg oral morphine = Xmg s/c morphine
4. 30mg oral morphine = Xmg oral hydromorphone

(Answers are at the bottom of the page)

If you are unsure of the equivalent dose of an opioid analgesic, refer to regional palliative care guidelines on opioid conversion and the prescribing in palliative care section of the BNF. Or alternatively contact the ward pharmacist, Trust Medicines Information department or palliative care team for advice.

Following any opioid switch, always review the patient regularly for signs of opioid toxicity and effective pain relief. Conversion ratios are approximate and considerable inter-patient variation may occur.

The NPSA Rapid Response Report, *Reducing Dose Errors with Opioid Medicines*, provides additional guidance to ensure that the intended opioid dose is safe for the patient. It recommends:

- When opioid medicines are prescribed, dispensed or administered the healthcare practitioner should confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines.
- Where a dose increase is intended, that the calculated dose is safe for the patient e.g. for oral morphine in adult patients, not normally more than 50% higher than the previous dose.

This report is available at
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59888

Go generic

One of the safety benefits of generic prescribing is that we speak the same language when prescribing, dispensing or administering medicines. Incidents can happen if:

- The medicine is prescribed by brand as it may mistakenly be prescribed again for the same patient using the generic name, leading to an overdose e.g. bisoprolol and Cardicor®
- A brand name e.g. Tritace® is used within the allergy box, as the patient's allergy to ACE inhibitors may not be noticed.

Remember there are exceptions to generic prescribing, find out what these are in your Trust.

Answers (1) 6mg (2) 10mg (3) 15mg (4) 4mg