Medication Safety Today

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Oral Anticoagulants

Problems have occurred when patients have been discharged on oral anticoagulants such as warfarin. These include:

- oral anticoagulant discharge / referral form not sent to GP / anticoagulant clinic or only partially completed
- further INR monitoring not arranged with GP / out-patients
- no arrangements made to monitor INR and adjust dose until GP/ out-patient appointment
- monitoring arrangements that have failed to take account of, for example, difficulties in checking an INR in primary care over a weekend or public holiday.

These types of incidents may result in the GP not being made aware that warfarin has been initiated, receiving incomplete information or the patient's doses not being adjusted appropriately after discharge and before the primary care/out-patient monitoring arrangements begin or resume.

Safety tip

- Complete the oral anticoagulant referral form every time a patient is discharged, which:
  - Enables communication with the GP / anticoagulant clinic.
  - Acts as a prompt to ensure that appropriate monitoring arrangements are made.
  - Documents further doses until the next INR check.

If INR monitoring is required over a weekend or public holiday, discuss with primary care how these monitoring arrangements could be best organised.

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.

Update

NHS National Patient Safety Agency

DHSSPS has issued three Rapid Response Reports from the National Patient Safety Agency.

- **Prevention of over infusion of intravenous fluid and medicines in neonates**
http://www.dhsspsni.gov.uk/hsc_sqsd_14_10_prevention_of_over_infusion_of_intravenous_fluid__and_medicines_in_neonates.pdf

- **Reducing treatment dose errors with low molecular weight heparins**
http://www.dhsspsni.gov.uk/hsc_sqsd_13_10_reducing_treatment_dose_errors_with_low_molecular_weight_heparins.pdf

- **Safe administration of insulin**
http://www.dhsspsni.gov.uk/hsc_sqsd_12_10_safer_administration_of_insulin-2.pdf

Baffled by insulin?

1. What is the onset of action of Novorapid®?
(a) 5minutes (b) 15minutes (c) 30minutes (d) 60minutes

2. What is the duration of action of Lantus®?
(a) 3-5hours (b) 6-8hours (c) 10-12hours (d) 24hours

3. How frequently are the following insulins normally prescribed? Pick the answers from the following list

(a) once daily (b) twice daily (c) three times daily

(i) Novomix® 30
(ii) Levemir®
(iii) Humalog®

4. Which of the following combinations of insulin therapy is correct?
(a) Lantus® and Novorapid®
(b) Novomix® 30 and Levemir®
(c) Humalog® and Novorapid®
(d) Humalog® Mix 25 and Novomix® 30

Answers on the back page

Medicines interrupted

It makes sense that if you are interrupted while prescribing, preparing, administering or dispensing a medicine, you may be more likely to make a mistake.[1]

This problem is recognised in a recent NPSA patient safety alert 'Safer use of intravenous gentamicin for neonates'.[2] In this alert the NPSA have recommended that, for example, when staff are preparing and administering IV gentamicin to neonates that they wear a disposable, coloured apron to indicate that they are not to be interrupted.

Safety tips

- Do not interrupt another member of staff, except in an emergency, when they are prescribing, preparing, administering or dispensing a medicine.
- If you are interrupted, for example, when preparing a medicine and have to leave this task, dispose of the dose and begin the process again, rather than trying to remember where you left off.
- Think about your working environment – are all staff who work or visit the ward aware that interrupting a member of staff can increase the chance of a medication incident occurring?
- How many times are you interrupted, for example, when carrying out a medicines round? How do you handle this?

1. NPSA 2004. Seven steps to patient safety. Available at: http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787 [Accessed 07 October 2010].
2. NPSA 2010. Safer use of intravenous gentamicin for neonates. Available at: http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=66271 [Accessed 07 October 2010}.

Drug Not Available

Medicine doses can be omitted or delayed for a number of reasons. Although for many medicines this may not lead to harm, for a number of conditions, delay or omission of a medicine can lead to serious harm. DHSSPS[1] issued a rapid response 'Reducing harm from omitted and delayed medicines in hospital' from the National Patient Safety Agency recommending a number of actions.

Sometimes a dose is omitted and the reason documented on the kardex is 'D' – drug not available when the dose was later found to have been available on the ward all along.
Remember that before recording 'D' on the administration record, check:

- Is the medicine on ward stock?
- Is it in the bedside locker?
- Is it in another medicine trolley?
- Has it been delivered and not unpacked?

If the medicine is not available, ensure that a supply is ordered as soon as possible or if the medicine is not available, ensure the patient is reviewed and alternative treatment started if required.

1. http://www.dhsspsni.gov.uk/hsc_sqsd_27_08.pdf

Flushed away

In 2008, the National Patient Safety Agency issued a Rapid Response Report on risks with intravenous heparin flush solutions[1]. This followed medication incidents where other medicines, including therapeutic strengths of heparin, were selected by mistake instead of the intended heparin flush solution.

The report highlighted that Trusts should review local policies to minimise the use of heparin flush solutions. Sodium chloride 0.9% is as effective as heparin flush in maintaining patency of peripheral venous catheters although for arterial and central venous catheters, the role of heparin flushes is unclear[1, 2].

As part of this work, some heparin flush products were also renamed and repackaged. Canusal® is now known as 'heparin sodium flushing solution 100units/ml'. Hepsal® is now known as 'heparin sodium flushing solution 10units/ml'.

Safety tips

- Make sure you check your Trust policy or guideline for flushing.
- Where a heparin flush is indicated, do not use old proprietary names – use 'heparin sodium flushing solution' and specify the strength.
- Where heparin flushes are required, ensure these are stored separately from therapeutic strengths of heparin to minimise confusion.
- When using drug dictionaries in dispensing and prescribing software, be aware that heparin flushing solutions will appear with other heparin products. Take care to select the correct product.

1. http://www.dhsspsni.gov.uk/microsoft_word_-_hsc_sqsd__43-08_heparin_flush_solutions.pdf
2. British National Formulary 60, September 2010

Answers

1) b 2) d 3i) b 3ii) a 3iii) c 4) a