Medication Safety Today

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The long and the short of it

Medication errors continue to be reported where unapproved abbreviations have been used instead of writing the term in full. This is because the unapproved abbreviation leaves the prescription open to misinterpretation.

This can lead to patients potentially receiving an incorrect dose of their medication, most often an overdose, or an incorrect medication.

Examples of unapproved abbreviations include:

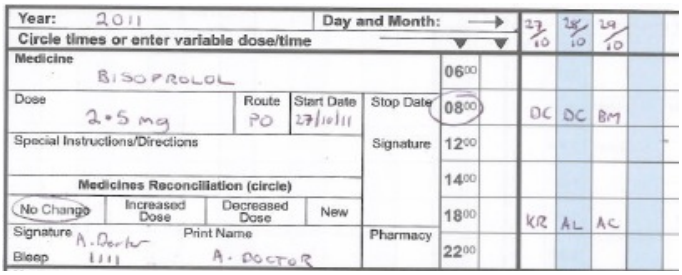
Abbreviation	Common error	Correct form
U	Mistaken as a zero (0) resulting in an overdose.	Units
Mcg or µg	Mistaken for mg(milligrams) resulting x1000 overdose	Micrograms
MSO4	Mistaken as magnesium sulphate	Morphine sulphate
MgSO4	Mistaken as morphine sulphate	Magnesium sulphate
BDZ	Bendroflumethiazide or benzodiazepine	The medicine name written in full
AZT	Zidovudine, azathioprine, aztreonam or azithromycin	The medicine name written in full

Safety tips

- Do not abbreviate units of measurement when prescribing or writing in patients notes.
- Do not abbreviate medicine names when prescribing or writing in patients notes.
- Ensure you are familiar with approved abbreviations for route and frequency.
- Medication should not be dispensed or administered where unapproved abbreviations have been used.

Follow the Leader

Can anyone spot the problem with the kardex below?



Year: 2011 | Day and Month: | Circle times or enter variable dose/time

Medicine: BISOPROLOL | Dose: 2.5 mg | Route: PO | Start Date: 27/10/11 | Stop Date | Special Instructions/Directions | Signature | Medicines Reconciliation (circle): No Change / Increased Dose / Decreased Dose / New | Signature: A. Doctor | Print Name: A. DOCTOR | Bleep: 1111 | Pharmacy

	27/10	28/10	29/10
0600			
0800	DC	DC	BM
1200			
1400			
1800	KR	AL	AC
2200			

Sometimes, what would otherwise have been a single medication incident can continue for several days if staff follow the pattern of administration signatures to determine what medicine doses are due.

Safety tip

- When administering medicines from a kardex always check the prescribed time column to see what doses are due for administration.

A 60 year old female patient with a history of COPD is prescribed a reducing dose of corticosteroids for an acute exacerbation.

The patient is prescribed 40mg once a day for five days reducing by 5mg per week until taking a maintenance dose of 5mg once a day.

The patient is being discharged having received the initial 5 day course as an in-patient.

How many 5mg tablets are required to complete the reducing dose and provide one week of the maintenance dose?

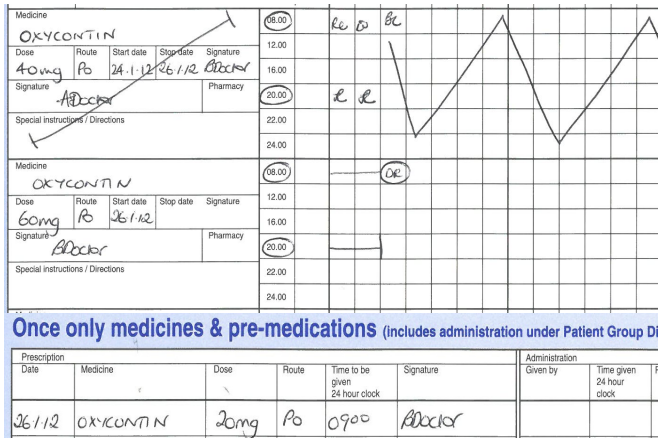
Answer overleaf

Stepping up

Medication incidents have occurred with increasing doses of regular medicines where a patient receives the new dose having already been administered the previous dose a short time before.

Medicine doses are often reviewed during a ward round and a decision may be made to increase a dose. However a ward round commonly occurs after the medicine round has already taken place. When writing a new prescription, it is important to consider if any doses have already been administered that day.

For example, if increasing a dose of OxyContin® from 40mg to 60mg as shown below, the new prescription for 60mg is written but the 40mg dose already administered that day is taken into account by writing 'DR' in the administration record for the morning dose of the new prescription. This prevents the 60mg being administered in addition to the 40mg dose. A separate STAT dose of 20mg is prescribed to supplement the 40mg already administered.



you have any comments on this newsletter, please ontact Anna Lappin, Medicines Governance harmacist on Ext: 4926 at Antrim Area Hospital or y e-mail at anna.lappin@northerntrust,hscni,net urther copies of this newsletter and past editions an be viewed at ww.medicinesgovernanceteam.hscni.net on your Trust intranet.

Answer

To complete the reducing course and supply one week of maintenance:

- 5mg x 196 tablets

A caffeine hit

Most of us tend to think of caffeine in a Cappuccino, Americano or Espresso. However caffeine is used to treat idiopathic apnoea in preterm neonates and can also be used to improve trigger ventilation or assist extubation in ventilated infants.

Previously doses were expressed as caffeine citrate and preparations were labelled as caffeine citrate with

caffeine citrate 2mg = caffeine base 1mg.

However in BNF for children 2011-2012, doses are now expressed as caffeine base and the preparation is also labelled as caffeine.

Safety tips

- Check prescribing guidelines to ensure doses are expressed as caffeine base.
- When prescribing, be aware that doses should always be stated in terms of caffeine base.

One on, one off

Medication incidents have occurred whereby patients have inadvertently ended up wearing two opioid patches as a result of a new patch being applied, without removal of the existing patch which was in place. Opioid patches contain potent medicines, for example fentanyl 25 microgram/hour patch is equivalent to 90mg oral morphine a day

Because transdermal opioid patches are not applied daily, there can sometimes be confusion about when a new patch is due to be applied and the existing patch overlooked. In addition the patch is quite often skin-coloured or transparent for better patient comfort/compliance, making it more difficult to see the patch on the patient's skin.

Safety tips

- Always check the patient for any transdermal patches in place before applying a new patch.
- Remove the old patch before applying the new patch.
- Record the site of application of transdermal patches in the additional notes section of the prescription entry in the kardex.
- Ensure transdermal medications are included in medication reconciliation processes so that they are not overlooked on admission; often patients can forget to tell staff about patches unless prompted.
- Check and document the site of any existing patches in place on admission to hospital.