Medication Safety Today

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The robotic revolution

A number of hospital pharmacies have or are introducing robotic dispensing systems. These allow for increased dispensing speed, better stock control, increased accuracy with fewer dispensing incidents and better utilisation of staff time.

A reduction in dispensing incidents is expected as the robot will use bar code technology to pick the product chosen by the person generating the label. While this development improves patient safety, staff should be aware that other types of dispensing incidents can still occur.

Safety tips

- Be aware that when generating a label you can select the wrong product from a drop-down list. If you do, the robot will then pick the wrong product.
- When dispensing, the dispenser should always check that the correct label has been created by checking against the prescription and then attach this label to the correct product.
- Always check the product and label against the prescription.
- Other dispensing incidents, such as incorrect instructions on the label are unaffected by robotic dispensing and may still occur.

If you have any comments on this newsletter, please contact Anna Lappin, Medicines Governance pharmacist on Ext: 4926 at the Antrim Area Hospital or by e-mail at anna.lappin@northerntrust.hscni.net Further copies of this newsletter can be viewed at www.medicinesgovernanceteam.hscni.net or on your trust intranet site.

Opioids and syringe drivers

Medication incidents have occurred where an incorrect dose of opioid via subcutaneous syringe driver has been prescribed or administered. These may have arisen because the numbers of the dose of opioid are unclearly or illegibly written or where a decimal point is unclear.

Safety tips

- Write the opioid dose on a syringe driver chart in words and figures, as shown below.

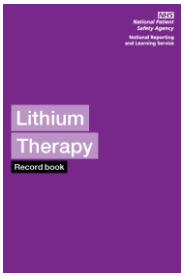
Prescription	
Medicines	Dose
1 DIAMORPHINE	10mg (TEN)
2	

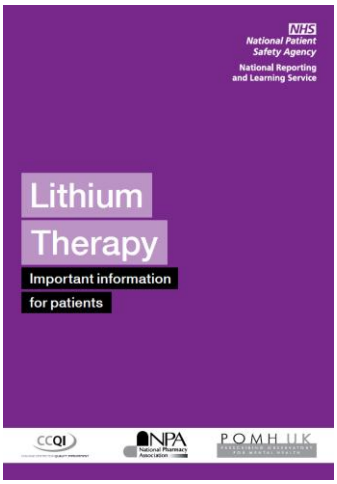
- Check back to the previous syringe driver chart to ensure that the dose has been transcribed accurately or, if it is a dose increase, that the new dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose).[1]
- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records.[1]
- Ensure you are familiar with the following characteristics of the opioid medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side effects.[1]

1. NPSA 2008. Reducing dosing error with opioid medicines. http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59888&g=0%c2%acdiamorphine%c2%ac

New look lithium

As part of the NPSA Patient Safety Alert: *Safer lithium therapy*[1] a new lithium information pack has been developed. This contains an information booklet on lithium therapy for patients, an alert card and a record book in which to record lithium blood levels and other relevant clinical tests.



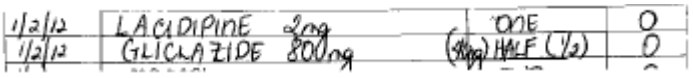


In Northern Ireland a Regional Lithium Care Pathway has also been developed to support implementation of the alert in primary and secondary care. Find out what is happening in your trust with lithium in response to this alert.

1. NPSA 2010. Safer Lithium therapy. http://www.dhsspsni.gov.uk/hsc_sqsd_84_09_safer_lithium_therapy-2.pdf

Loop the loop

What is the dose of gliclazide?



In the example shown from a nursing home, the loop from the 'g' of 'lacidipine 2mg' made the strength of gliclazide tablet look like '800mg' instead of '80mg'. On admission to hospital, gliclazide 800mg was prescribed on a Kardex but at administration it was recognised that this far exceeded the maximum dose*. This was checked and the correct dose of gliclazide 40mg prescribed, that is half an 80mg tablet.

Safety tips

- ☑ When writing a list of medicines, make sure the text from the line above does not affect the text below.
- ☑ Be aware of the maximum doses of medicines when prescribing and administering so that an incorrect dose such as the one shown above is recognised and appropriate action taken.

*maximum dose of gliclazide, as a single dose, is 160mg, and 320mg as total daily dose.

STOP Allergy STOP
Cross check and confirm

Medication incidents continue to be reported where a patient is prescribed and administered a medicine to which they have a known and documented allergy. Such incidents have the potential to cause serious harm or death to a patient.

The majority of cases are seen in those patients with an allergy to penicillin, particularly if a combination product is prescribed, where there is more than one ingredient and there may not be a recognised 'co-name'. Not all penicillin-based medications are easily recognisable as containing penicillin, for example, co-fluampicil, Tazocin®, co-amoxiclav. Below are some examples of commonly occurring penicillin or penicillin- containing antibiotics.

Check the patient's allergy status on the medication chart (kardex) EVERY TIME a medication is prescribed, administered or dispensed to avoid similar incidents.

Safety tips

- ☑ Confirm the patient's allergy status on admission to hospital.
- ☑ Document the allergy status on the front cover of the kardex or in the appropriate section of whichever prescription documentation is in use, using the generic name as appropriate.
- ☑ Check compound preparations for individual constituents.
- ☑ Always check the allergy status before prescribing, administering or dispensing a medicine to ensure that the patient has no known allergy to that medicine, except in an emergency.
- ☑ Always document the patient's allergy status on all discharge documentation.