Medication Safety Today

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'Ear 'ear!

Did you know that chloramphenicol is available as ear drops (5%, 10%) and eye drops (0.5%)? If prescribing, dispensing or administering chloramphenicol drops, always check you have selected the correct product for the prescribed route of administration. Chloramphenicol 5% ear drops and chloramphenicol 0.5% eye drops are shown below.

Mix-ups between these products are reported to have caused harm to patients in the past where chloramphenicol ear drops have been administered into the eye. Other examples of medicines available in different formulations for different routes of administration include aciclovir available as aciclovir 3% eye ointment and aciclovir 5% cream.

Better together

Some medicines are prescribed on separate prescriptions, referred to as supplementary prescriptions. This is usually when prescribing, monitoring and administration records are required that do not fit within the usual Kardex. However medication incidents can occur where medicines prescribed on supplementary prescriptions can be overlooked or mixed up with another patient also on that medicine.

Safety Tips

- Always reference supplementary prescriptions in use in the relevant prescription section of the main Kardex, for example 'Gentamicin – see chart' in the injectable section.
- Ensure supplementary prescriptions are kept with and attached to the main Kardex for each patient.

Already done that!

Medication errors have occurred where patients have received an overdose of a medication due to further administration in hospital of a medicine already given in the ambulance.

It is important that on admission to hospital, all previous administration of medicines is confirmed with ambulance staff before prescribing and recorded in the patient's notes.

Safety Tip

- Confirm with ambulance staff and check all relevant documentation where medication is recorded as administered by the ambulance service before prescribing in the Emergency Department.

Passport to safer insulin

Medication incidents continue to occur where patients are prescribed the wrong type of insulin or device. These incidents can occur on admission to hospital. The National Patient Safety Agency developed recommendations to prevent these incidents which have been issued by DHSSPS[1].

Patients commenced on insulin will now be issued with an insulin passport. This is a credit card sized card that shows the name of insulin, the type of device and patient details. If a patient is on more than one type of insulin, a separate card will be issued for each insulin. The passport does not contain details of the insulin dose. Patients who are already on insulin will be issued with their insulin passport at their next review appointment.

The insulin passport should be used by staff along with other information sources such as the patient's own insulin and GP print-outs to confirm the correct insulin and device on admission to hospital.

1. http://www.dhsspsni.gov.uk/hsc-sqsd-3-11-adult-patient-passport-safer-use-of-insulin.pdf

SAFER TIMES

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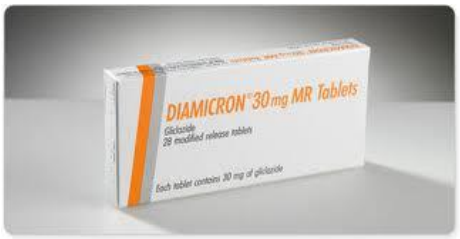
ONE LUMP OR TWO?

A

B



Which is more potent A or B?

Would you be surprised to learn that they are equivalent! The oral diabetes medicine gliclazide is manufactured as both a standard release 40mg and 80mg tablet and a modified release (MR) 30mg preparation. Gliclazide MR 30mg may be considered approximately equivalent in therapeutic effect to standard release gliclazide 80mg.

- A recent near miss highlighted the potential for confusion when a patient was prescribed gliclazide 60mg but received 2 x 30mg (MR) tablets. In real terms this was equivalent to giving the patient 160mg of standard release preparation as opposed to the 60mg that was prescribed. Fortunately the error was spotted quickly without the patient suffering any ill effects.
- Another example of this is where a patient is prescribed gliclazide MR 120mg but administered standard release gliclazide 120mg which is equivalent to only 45mg of the modified release formulation.

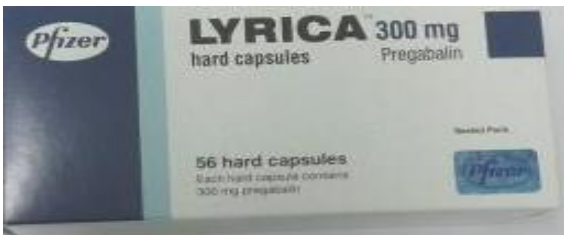
Learning from these incidents highlighted a general lack of awareness of the potency of these different preparations.

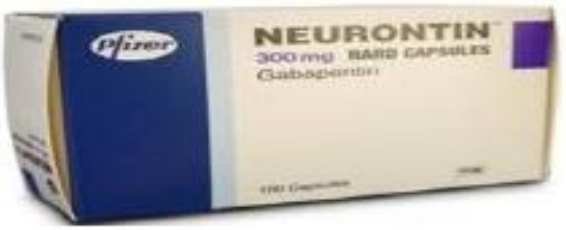
Safety Tips

- ✔ Always check that you have the correct formulation
- ✔ Double check with someone if you are unsure

SPOT THE DIFFERENCE

Pregabalin and gabapentin are medicines used in the treatment of epilepsy and neuropathic pain. While they have similar uses they have very different dosing regimens. Medication incidents have occurred where a patient has been prescribed one but dispensed the other, or has been prescribed a dose appropriate to the other product. These may be picked up on admission to hospital.





Safety Tip

- ✔ Look out for these products when admitting a patient or compiling a medication history and check the dose is within the usual dose range.

If you have any comments on this newsletter, please contact Sharon O'Donnell, Medicines Governance pharmacist on Ext: 38129 at the Royal Hospital or by e-mail at Sharon.ODonnell@belfasttrust.hscni.net

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