Medication Safety Today

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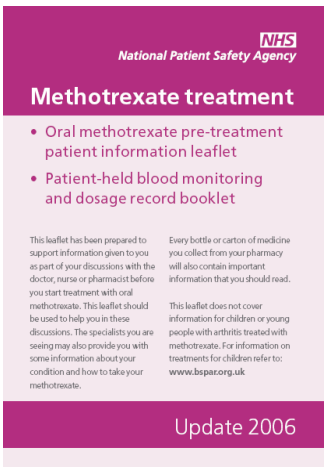
Methotrexate

NPSA Patient Safety Alert 13 'Improving compliance with oral methotrexate guidelines' http://www.nrls.npsa.nhs.uk/resources/?entryid45=59800 advises that patients on oral methotrexate are given a patient held blood monitoring and dosage record booklet (shown):



To ensure patients receive the Northern Ireland oral methotrexate blood monitoring and dosage record booklets:

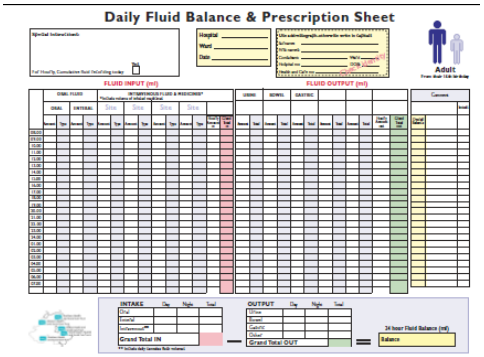
- Order these via BSO stationery helpline (028 9053 5652 answer phone). Remember if non BSO sources are used to order this booklet, the specific information in relation to strengths used in Northern Ireland will be missing.
- Remember there are two strengths of oral methotrexate tablets – 2.5mg and 10mg. In Northern Ireland, only methotrexate 2.5mg should be used; similarly where a liquid preparation is required, methotrexate 10mg/5ml is the recommended strength.

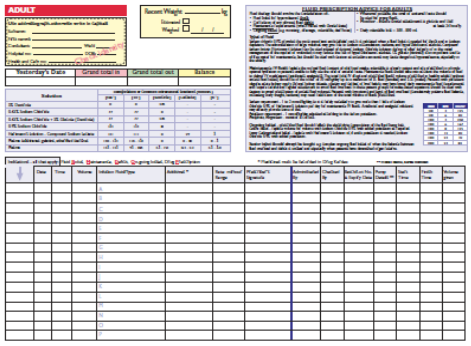
If you have any comments on this newsletter, please contact Sharon O'Donnell, Medicines Governance pharmacist on Ext: 38129 at the Royal Hospital or by e-mail at Sharon.ODonnell@belfasttrust.hscni.net Further copies of this newsletter can be viewed at www.medicinesgovernanceteam.hscni.net or on your Trust intranet.

IV Paracetamol in neonates

Guidance on the administration of intravenous (IV) paracetamol to neonates has changed. The Summary of Product Characteristics for IV paracetamol (Perfalgan®) and the Medusa IV guide now recommend further dilution with sodium chloride 0.9% or glucose 5% before administering to a neonate weighing less than 10kg. The Electronic Medicines Compendium contains the most up to date and comprehensive information about medicines, available at: http://www.medicines.org.uk/emc/

Coming to a hospital near you





Regional adult and paediatric fluid prescription and balance charts have been developed by a collaborative to standardise how intravenous fluids are prescribed and fluid balance documented in Northern Ireland. A training package has also been developed. These will replace all current fluid prescriptions and balance charts.

Look out for these in your hospital and attend local training sessions, or access training on your Trust intranet.

Overdoing it again - ketamine

Medication incidents continue to be reported involving a significant overdose of oral ketamine. Ketamine is a short acting anaesthetic with analgesic properties at low doses. It is used particularly for neuropathic pain, ischaemic limb pain and refractory cancer pain and as an adjunct to opioid therapy. Ketamine for these indications is administered orally or via subcutaneous syringe driver and is unlicensed.

Oral ketamine is started at low doses (10-25mg three to four times daily) and is titrated upwards in increments of 10-25mg to a typical dose of 50mg four times daily.

The standard strength of oral ketamine solution is 50mg/5ml. This means that only a small volume is required for administration, especially at low initial doses, for example, a 10mg dose is 1ml and a 25mg dose is 2.5ml.

- Care should be taken when calculating the volume of oral ketamine solution to be administered.
- When dispensing, always provide an oral syringe and a bottle adaptor / bung.

Remember: Each 5ml contains 50mg!

There's something missing

Medicines Reconciliation is well recognised as a safeguard against medication being omitted whilst in hospital. This often involves obtaining the patient's medication history from their GP. In the majority of cases this information can be accessed from the Emergency Care Summary (ECS). This is the GP medication record that can be accessed out of hours and allows Trust staff to print off a patient's medication record.
If the ECS is not obtainable, medication history information is often faxed between primary and secondary care. Medication incidents have been reported whereby the medication history from the GP is 'incomplete' due to a simple fault in the transmission of the faxed information.

Safety tips

- When requesting the GP medication history by fax, always ensure you have received all the necessary pages. Each fax should carry a cover sheet noting the number of pages being sent.
- Consider the patient's medical history: are the medications on the list appropriate to treat the patient's condition? Do any medications appear to be missing from the GP history when the patient's medical condition has been taken into consideration?
- Find out if ECS is available in your trust and how you can access it.

That's not my name

Addressographs are a useful method of ensuring all necessary patient identification details are attached to, e.g. the medicines Kardex, discharge prescription or other patient documentation. However, the wrong addressograph placed on any of these documents can have the potential to cause patient harm.

Safety tips

- When applying an addressograph, always double check that it is for the correct patient. Medication incidents have been reported where a patient received medicine meant for another patient as a result of an incorrect addressograph attached to their prescription.
- Be aware that a sheet of addressographs for one patient may be misfiled in another patient's notes.
- When applying addressographs to duplicate or triplicate forms such as discharge prescriptions, ensure the same, correct addressograph is applied to all copies. Medication incidents have been reported where the top copy addressograph was correct but the other copies on the form had incorrect addressographs. All copies of the discharge prescription should be checked to ensure the addressographs are correct when completing the pharmacist clinical check, whether carried out at ward level by pharmacy staff or in the dispensary.

What do the following medicines have in common?

- Dabigatran
- Acenocoumarol
- Apixaban
- Warfarin
- Rivaroxaban
- Phenindione

They are all oral anticoagulants. While warfarin is still the most commonly prescribed oral anticoagulant, increasingly you may see patients taking one of the newer oral anticoagulants.

Medication incidents have been reported where patients taking other oral anticoagulants have inadvertently been prescribed VTE prophylaxis because staff did not realise that these medicines are oral anticoagulants. It is also important to be aware of these other oral anticoagulants when planning for surgery and refer to Trust guidelines or the Summary of Product Characteristics for the management of these medicines.