PostScript Safety

NHS Greater Glasgow and Clyde

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Similar Drug Names

Can you read the following sentence?

Rsreeach has swohn that as lnog as the fsrit and lsat lteter of a wrod is in the crorcet pcale tehn the wrod can be raed whuoitt a pbelorm.

This may explain why the following medicines are often confused:

Aminophylline	Amitriptyline
ISMN	Istin
Amiloride	Amlodipine
Risperidone	Risedronate
Mercaptopurine	Mercaptamine
Ciprofloxacin	Clarithromycin

However, reasons for mix-ups between medicine names are complex. Other medicine names which also look similar are azithromycin and azathioprine.

The following should help reduce the number of incidents relating to similar sounding drug names:

- Write legibly on the Kardex
- Read the whole name
- Consider whether the medicine fits the patient's medical condition(s)
- Confirm the medicine using at least 2 information sources e.g. patient / carer and the Emergency Care Summary
- Store medicines with similar sounding names separately

If in doubt – DON'T GUESS!

Are you double dipping?

A practice called 'Double-Dipping' has been highlighted as being responsible for the transmission of hepatitis C to 116 patients in the US. Double-dipping is the term given to inappropriately using single-use injections, multiple times. In this case, a single-use vial was contaminated with blood from a patient with hepatitis C, which was then transmitted to 116 patients when it was inappropriately used multiple times http://www.bmj.com/content/341/bmj.c4057.full.

Here are some safe practice points when using injections:

- Vials should only be used once unless they are licensed for multi-use
- Vials licensed and labelled for multi-use should only be used for one patient and never shared between different patients
- A single-dose product should only be used to prepare one dose for a single patient (increased risk of bacterial contamination)
- A single-dose product should not be used to administer doses to more than one patient (increased risk of cross-infection)
- For further advice, or assistance in undertaking a risk assessment, please contact your local clinical pharmacist or a member of the Pharmacy Clinical Governance Team (see page 2 for contact details).

Don't abbreviate

Did you know that only certain abbreviations are accepted and endorsed by GGC? Use of abbreviations in healthcare is a risky business and can lead to serious medication incidents. Refer to Safe and Secure Handling of Medicines, the last page on the medicines kardex and the last page of the BNF for a list of accepted abbreviations. The list below outlines some of the problems:

4 0	Intention: 4 hours Problem: The 'o' is larger than intended and could be read as '40' and lead to an incorrect infusion rate or dose of medication
1000 IU	Intention: 1000 international units Problem: 'IU' could be read as IV and result in the incorrect route of administration.
200 ng.	Intention: 200 nanograms Problem: This could easily be interpreted as 200 milligram and result in overdose
2U	Intention: 2 units of insulin Problem: The 'u' could be read as a zero and 20 units could easily be administered in error with potentially fatal consequences.
. 5 mg	Intention: 0.5mg or 500microgram Problem: The decimal point can easily be missed and a ten times overdose administered

Please consider the following safety tips:

- DO NOT use unapproved abbreviations
- Ensure handwriting is legible
- Avoid decimal points where possible e.g. always write 500 micrograms rather than 0.5mg
- Report any incidents related to the use of abbreviations

Please note: Abbreviation of drug names can also lead to medication incidents and will be covered in a future edition.

Report Hospital Acquired VTE on DATIX

The Board has operated a policy of mandatory reporting for a set of specific adverse clinical incidents for the last five years. It has now been agreed by the Acute Division Clinical Goverance Committee and the NHSGGC Thrombosis Committee that all cases of Hospital Acquired Venous Thromboembolism (VTE) must also now be reported.

Please ensure that all VTE diagnosed in patients under your care, which occurs within three months of a previous hospital admission or surgical procedure, are reported on DATIX as soon as possible. VTE diagnosed during the current admission should also be reported on DATIX as Hospital Acquired, as long as the VTE was NOT the original reason for the admission and was unlikely to have been present at admission.

Contacts

For guidance and advice on reporting medicines incidents contact your Clinical Risk Manager or Pharmacist.

Comments and suggestions for future editions are welcome and we would also love to hear from you if you have any examples of good practice that you would like to share.

Please email:
catherine.mclaughlin@ggc.scot.nhs.uk

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