Greater Manchester Critical Care Network

RICON

Medicine Safety Bulletin

Medication incidents across the GM Critical Care Units

Adrenaline nebuliser for stridor prescribed on **IV section** of paper drug chart. **Nebuliser fluid administered IV to patient**

Regardless of electronic or paper chart ensure

Right person, right route, right dose, right time, right prescription, right preparation

Incorrect dose of IV Paracetamol administered to a patient <50kg

Paracetamol dosing is weight dependent.

Caution when prescribing PRN doses.

Prescribe as 6 hourly rather than 4 times a day, to prevent overdose

Remember to check LFTs

HARTMANS USED IN TRANSDUCER

Utilise a safety sticker

Second independent check has to be an active participant at the patients bedside

Patient administered 20mls of Frusemide instead of 20mg resulting in 160mg being administered

Remember in drug calculations :

What you want divided by what you have then multiply by stock solution

PATIENTS MISSING DOSES OF MEDICATION

Do not prescribe as stat but as once only with a time to be given

Ensure one off medication doses are communicated to bedside nursing staff

Ensure drug charts are reviewed on ward rounds

Heparin infusion delivered at wrong rate due to misinterpretation of APTT result

Anticoagulants are high risk medications where errors are common

Ensure you always refer to your units protocol even if you are familiar with the drug

Utilise MDT to ensure infusion rate and dose is correctly infused and prescribed

KEY POINTS

It is everyone's responsibility to check drug charts // The second independent check person is legally as responsible as the first person

Think if a drug can be given enterally rather than IV