Reference	**HSC (SQSD) 17/10 (NPSA 2010 RRR 018)**
Title of Circular	**Preventing fatalities from medication loading doses**
Date of Issue by DHSSPSNI	**22 December 2010**
Date Implementation Due By:	**22 June 2011**
Directorates where alert is relevant	**All**
Operational Director/s	**All**
Clinical / Operational Leads	**Associate Medical Directors**

	Current Control Measures Systems in Place	Current Compliance Rating											Further Action Required	Person Responsbile for taking forward action	Designated Completed Timescale
		100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%	N/A			
1. All medicines used by the organisation that are likely to cause harm if loading doses and subsequent maintenance doses are not prescribed and administered correctly are risk assessed and used to produce a list of critical medicines (which may contain speciality subsections). This must include warfarin, amiodarone, digoxin, phenytoin and any other medicines identified locally.	UKMi risk assessment tool has been reviewed and completed by pharmacists working in the areas where those medicines are used and priority medicines identified for further work (June 2011).													Risk assessment to be confirmed by clinicians	Associate Medical Directors	Sep-11
2. There is effective communication regarding loading dose and subsequent maintenance dose regimens when prescribing, dispensing or administering critical medicines. This should include handover of patients between healthcare organisations. Tools such as loading dose work sheets, loading dose prescription charts, handover and clinical protocols, and patient-held information should be considered.	Existing tools summarised within UKMi risk assessment tool (June 2011). For other medicines, information on loading doses and maintenance dose regimens is contained with BNF and BNFc. Communication of dosing information outside the trust is on a discharge prescription, discharge summary, out-patient communication form or referral letter. Within the trust, handover sheets are in use for patient transfer between clinical areas. Medication is prescribed or referenced on a Kardex with the exception A&E flimsy and anaesthetic record. Medication prescribed on A&E flimsy should be included on handover sheet. Anaesthetic sheet is transferred with patient to ward area.													Further tools e.g. dose calculation sheets, guidelines and protocols to be developed as identified by risk assessment tool	Director of Pharmacy	Dec-11
3. Clinical checks are performed by medical, nursing and pharmacy staff (when available) so that loading and maintenance doses are correct. Appropriate information should be available to support these checks.	Existing tools summarised within UKMi risk assessment tool (June 2011) For other medicines, information on loading doses and maintenance dose regimens is contained with BNF and BNFc.													Further tools e.g. dose calculation sheets, guidelines and protocols to be developed as identified by risk assessment tool. Feasibility of independent double checking for loading doses by medical, nursing and pharmacy staff to be reviewed and agreed.	Operational Directors (Acute Services, OPPC, CYP, MHD)	Dec-11
4. Healthcare professionals in the community know when to challenge abnormal doses of the identified critical medicines.	**SHSCT registered community nursing staff** SHSCT Medicines Code Section 6.2 (Administration of medicines in residential care homes, nursing homes and day care centres) and 6.3 (Administration of medicines by community nursing staff) states: 'Any ambiguities, lack of clarity or doubt as to the accuracy, safety, completeness or appropriateness of a prescription should be referred to the prescriber or a pharmacist, as appropriate, before administering the medicine.' **General Practitioners, Community Pharmacists, General Dental Practitioners (non-SHSCT staff)** Request made by SHSCT Medicines Governance Pharmacist to Pharmaceutical Public Health and Governance Lead HSCB to consider distributing advice suggested in NPSA supporting information to alert primary care, including community pharmacists, to be wary of loading doses and to have a low threshold to challenge doses which are high dose therapy/abnormal with examples of threshold doses of digoxin, amiodarone, phenytoin and warfarin.													Await response from HSCB and consider issue of any HSCB advice to SHSCT registered community nursing staff	Director of Pharmacy	Sep-11