South Eastern Health and Social Care Trust 5

PREVENTING FATALITIES FROM MEDICATION LOADING DOSES

Recomm No.	Recommendation/Good Practice	Action	Responsibility & Timescale	Progress Update (also indicate progress by coding red, amber, green (with red indicating no progress and green indicating full compliance)
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 to be used (published April 2011) to identify those medicines likely to cause harm if loading doses / subsequent maintenance doses are not administered correctly The potential for regional collaboration on this process has been discussed – the team lead for the regional Medicines Governance Team is to discuss this issue at the regional medicines safety forum June 2011. The regional medicines governance team intends to factor into their work plan for this year (2011/12) other injectable medicines which weren't classified as high risk by the NPSA Alert 'Promoting safer use of injectable medicines' (NPSA 2007 / 20) but are known to have led to patient safety incidents. This medication loading doses RRR will also be considered when defining those medicines that need to be	SET lead : Medicines Governance Pharmacist Regional lead : Team leader Medicines Governance Team	Red

		addressed. The regional group nominated to design safety solutions for those injectable medicines classified as high risk by the NPSA Alert 'Promoting safer use of injectable medicines' (NPSA 2007 / 20) have agreed to include medicines identified as high risk in this 'loading dose' alert. Action taken will include purchasing for safety initiatives	Tracey Boyce / Anne Friel	
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.	Those medications identified as high risk will be examined to see what appropriate actions can be undertaken to improve the safe use of the individual drug. Regional collaboration will again help ensure a consistent approach to this task.	SET lead : Medicines Governance Pharmacist Regional lead : Team leader Medicines Governance Team	Red
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.	Those medications identified as high risk will be examined to see what appropriate actions can be undertaken to improve the safe use of the individual drug. Regional collaboration will again help ensure a consistent approach to this task	SET lead : Medicines Governance Pharmacist Regional lead : Team leader Medicines Governance Team	Red

4	Healthcare professionals in the community know when to challenge abnormal doses of the identified critical medicines.	Dr B Bradley Pharmaceutical Public Health and Governance Lead has been contacted June 2011 by the Regional Medicines Governance Team to advise if this action point has been considered for implementation within primary care. She has also been asked to suggest any other action to assist with this recommendation.	SET lead : Medicines Governance Pharmacist Regional lead : Team leader Medicines Governance Team	Red