Surrey Heartlands Medicines Safety Programme – Prescribing Liquid Medicines Safely

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Background

- https://www.rcpch.ac.uk/resources/using-standardised-concentrations-unlicensed-liquid-medicines-children-joint-position

Neonatal and Paediatric Pharmacy Group (NPPG) and the Royal College of Paediatrics and Child Health (RCPCH) strongly recommend that when children require unlicensed liquid medicines, they should receive the RCPCH and NPPG recommended concentration, where one exists.

There are currently 12 such recommended concentrations.

Surrey Heartlands ICS Pledge

All patients will:

- Be prescribed unlicensed liquid by healthcare professionals who are fully aware of the benefits and risks of treatment and who have all necessary prescribing competence
- Receive the RCPCH and NPPG recommended concentration, where appropriate and one exists
- Be maintained on their existing concentration of medication where appropriate and have the dose clarified with the patient/parent/carer (both mass and volume of liquid prescribed)

Acute prescribing systems audit on RCPCH and NPPG recommended concentrations

- RSFT – an audit in 2020 identified that 4/12 liquids were available on JAC, 2 were of a different strength and 6 were unavailable in liquid form. Following on from this audit the 2 of a different strength were reviewed and the others are not currently in use at the trust. An appendix to one of the procurement SOPs will be written including standards for JAC.
- ASPH – an audit September 21 identified that 6/12 liquids were available but 4 were available in multiple strengths (perhaps for adults and children). 1 was available in a different strength and the others are not currently in use at the trust. All were reviewed.
- SASH – 7/12 liquids are available. 2 are available in different strengths which were reviewed, and the others were not currently in use at the trust. The recommendations were discussed at the next MSG meeting (Oct 21) and information included in the pharmacy newsletter.
- E&SH – 7/12 liquids are available. 2 are available in different strengths which were reviewed, and the others are not currently in use at the trust.
- Kingston – an audit September 21 identified that 1/12 liquids were available on JAC. As most are specialist medicines they are not used therefore not stocked.

Prescribing system support

GP prescribing support systems

- Liquid medicines often come in many different strengths. These are usually listed on GP prescribing systems in order of strength with all the different formulations, but this is not always the case. This often makes choosing the correct formulation and most appropriate strength difficult. We are investigating whether the prescribing systems can highlight the recommended unlicenced recommendations.
- System-wide formulary work is ongoing.
- Having checked EMIS there is no entry for Ethambutol 400mg/5ml. This was investigated with EMIS.
- Clinical systems usually describe the strengths of liquids per 5mls but occasionally this is not the case. It would improve safety if suppliers could standardise their drug descriptions so that the strength was per 5mls. This is being discussed with NHSE.

Key recommendations

- Care should be taken when choosing the correct strength of liquid to prescribe and dispense
- Doses prescribed should be checked and clarified for both mass and volume and clearly documented
- Unlicensed liquid medicines for children should only be prescribed by healthcare professionals who are fully aware of the benefits and risks of the unlicensed medicine and who have all necessary prescribing competence
- Where an unlicensed liquid medication is required, children should receive the RCPCH and NPPG recommended concentration, where one exists

Key recommendations

- Where an unlicensed liquid medication is required but a recommended concentration does not exist every effort should be made to ensure the maintenance of an existing concentration and the dose clarified with the patient/parent/carer (both mass and volume of liquid prescribed)
- Patient information leaflets (PILs) should be provided. Information can be found on Medicines for Children website Leaflets – Medicines For Children
- Patient/parent/carers should be advised to seek urgent medical attention if they think that too much or too little medication has been taken
- The need for a liquid should be regularly reviewed and the patient changed to an alternative formulation if more appropriate
    - Kidzmed is a programme developed for members of the multidisciplinary team to teach children and young people how to swallow pills. It was set up at the Great North Children's Hospital, Newcastle - www.e-lfh.org.uk/programmes/kidzmed/
    - How To Swallow Pills by Dr. Bonnie Kaplan (youtube.com)

Issues identified in adhering to the alert and mitigations of risks

- There are many strengths and formulations available on the General Practice clinical systems which increases the risk of picking error. We are investigating whether the prescribing systems can highlight the recommended unlicenced recommendations.
- RCPCH and NPPG recommended concentrations document link has been put on the Surrey PAD Guidelines : Unlicensed Medicines (res-systems.net) for ease of reference.
- Medicine's administration regimes often change when patients are transferred between health / care settings. Clear communication is necessary with all information accurately recorded on the clinical systems including information on the strength and dose of liquid medicines.
- Confusion occurs when administering - clear communication is needed at the point of dispensing including explaining how to interpret and measure the dose prescribed.