PHARMACY

Contacting a Pharmacist

Monday – Friday 9am -5pm	Saturday & Sunday 10.30 – 4pm	Out of hours
ACCU ward pharmacists (Susan, Lauren, Rory)	Weekend pharmacy team	On Call Pharmacist
Bleeps: 4E (1193) 4F (1667) Extension: 60135	Extension: 42323	Via switch

Pharmacy Induction

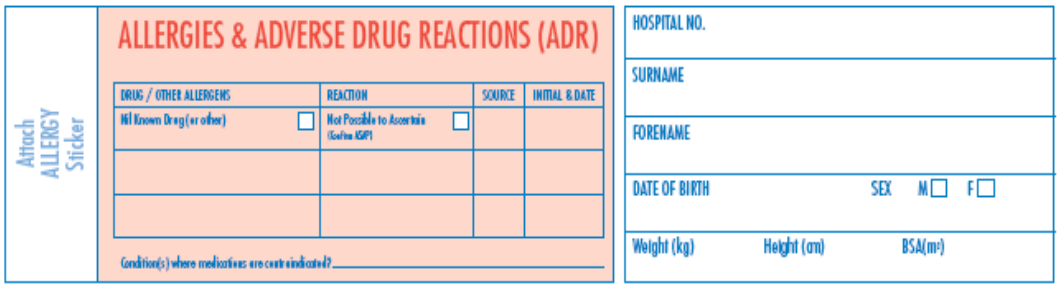
A talk for ACCU doctors can be found here:

I:\surgery & anaes\ACCU\ACCU Trainees\Induction\Pharmacy Introduction for ACCU Drs.ppt

This contains useful medicines related information. A brief summary of the important policies can be found below.

Drug Charts

- ACCU drug charts should be used for all patients
- Please ensure drug charts are re-written in a timely manner during the dayshift – there's nothing worse than having to do them overnight.
- Always complete the allergies section accurately (including detailing the nature of the allergic reaction, if known)



- Print the name of the medication and do not use commercial names (e.g. Augmentin / Tazocin)
- Print your name next to your signature
- Always double check and sign the "allergies checked" box for every drug prescribed
- For ease, the drug charts have pre-printed sections but signatures and start dates are still required

Prescribing Issues

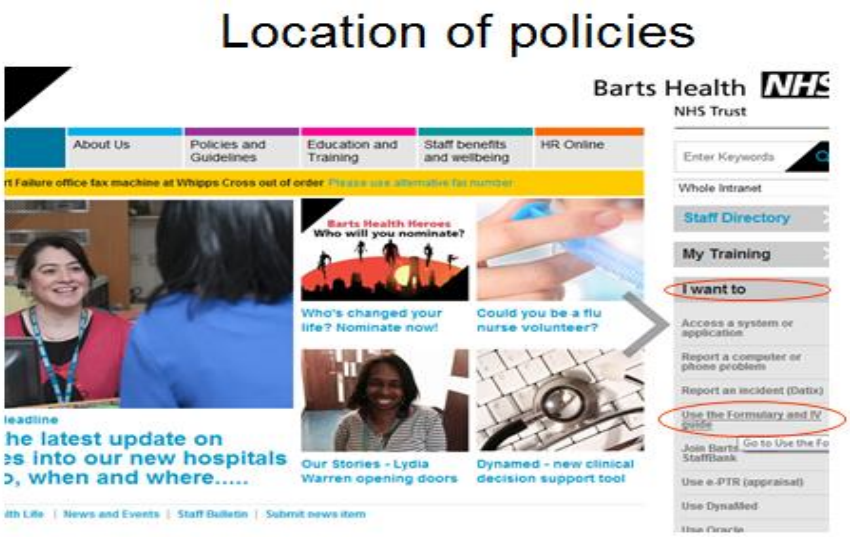
A table of routine prescriptions on ACCU can be found in the policies and guidelines folder at:

I:\surgery & anaes\ACCU\Policies and Guidelines\Medicines

This covers MRSA prophylaxis, thromboprophylaxis, eye protection, GI protection, mouthcare and Arterial/CVC flush.

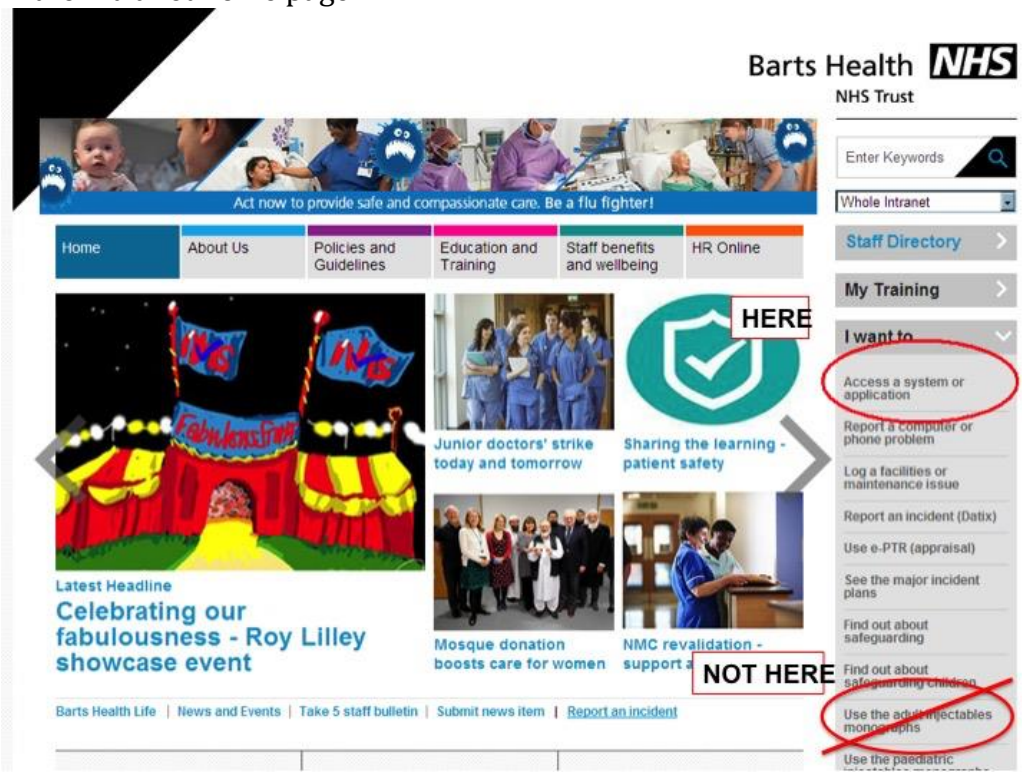
Drug	Dose	Route	Frequency	Comments
Chlorhexidine body wipes	✓	Topical	OD	MRSA prevention protocol
Corsodyl dental gel (chlorhexidine)	✓	Topical	QDS	VAP prevention, mouth care protocol.
Lacrilube	✓	Topical eyes	QDS	If sedated/low GCS
Ranitidine	50mg	IV	TDS	Until absorbing full feed.
or Lanzoprazole	30mg	NG	OD	If admitted on it / high risk for GI bleed.
or Pantoprazole	40mg	IV	OD	
NaCl 0.9% flush bag	500mls	for arterial & CVC flush.	-	On continuous IV infusion page.
Consider: TEDS Flotrons Tinzaparin	Weight based	s/c	OD	If not contra-indicated. Reduce dose in renal impairment or less than 50kg Increase dose if >109kg

Links to Medicines Related Policies



- **IV guide**

1 – from the intranet home page

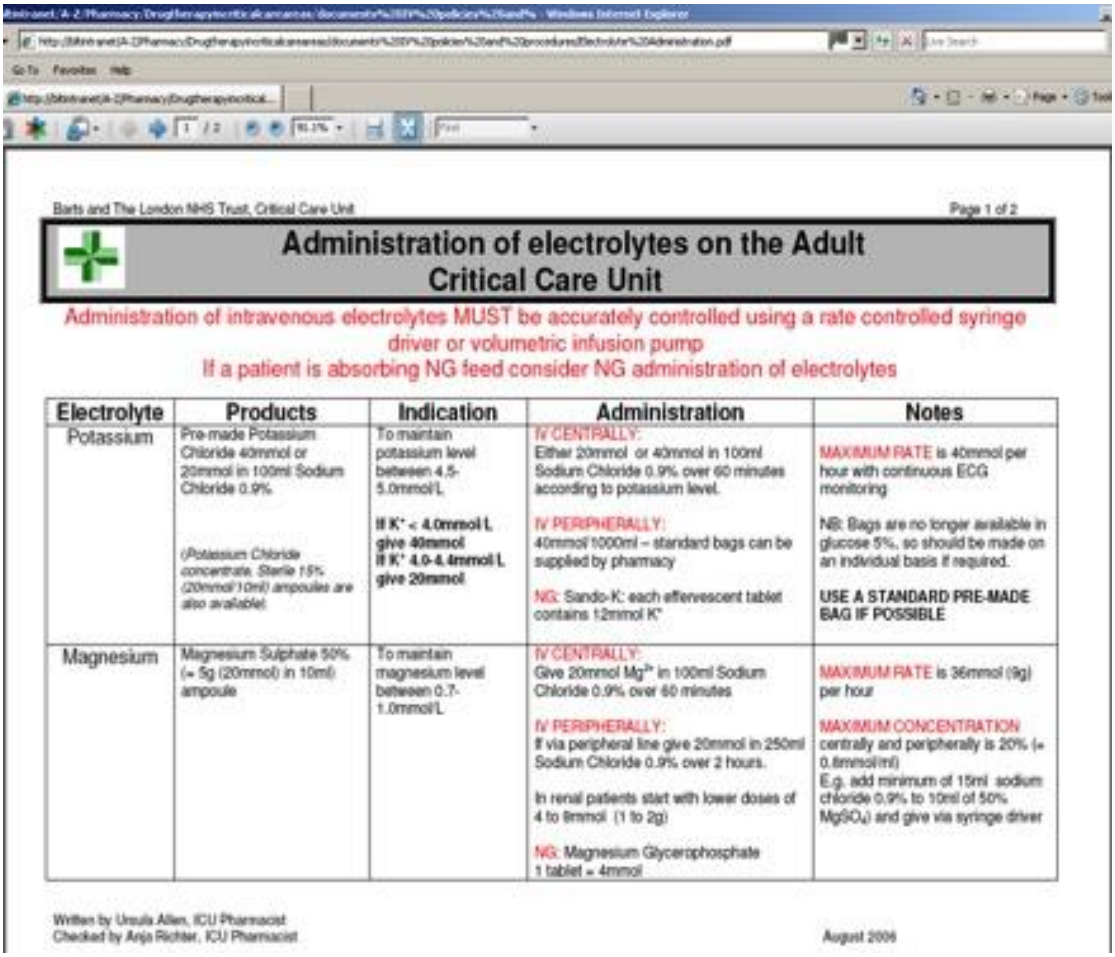


2

Electrolytes

Electrolyte administration on ACCU is different to that on the general wards
This policy is currently under review but can be found here:

http://rl1vmsps02/BHFileshare/Shared%20Documents/All%20Trust/Pharmacy%20Intranet/BLT/Critical%20Care/Electrolyte%20Administration.pdf



Barts and The London NHS Trust, Critical Care Unit — Page 1 of 2

Administration of electrolytes on the Adult Critical Care Unit

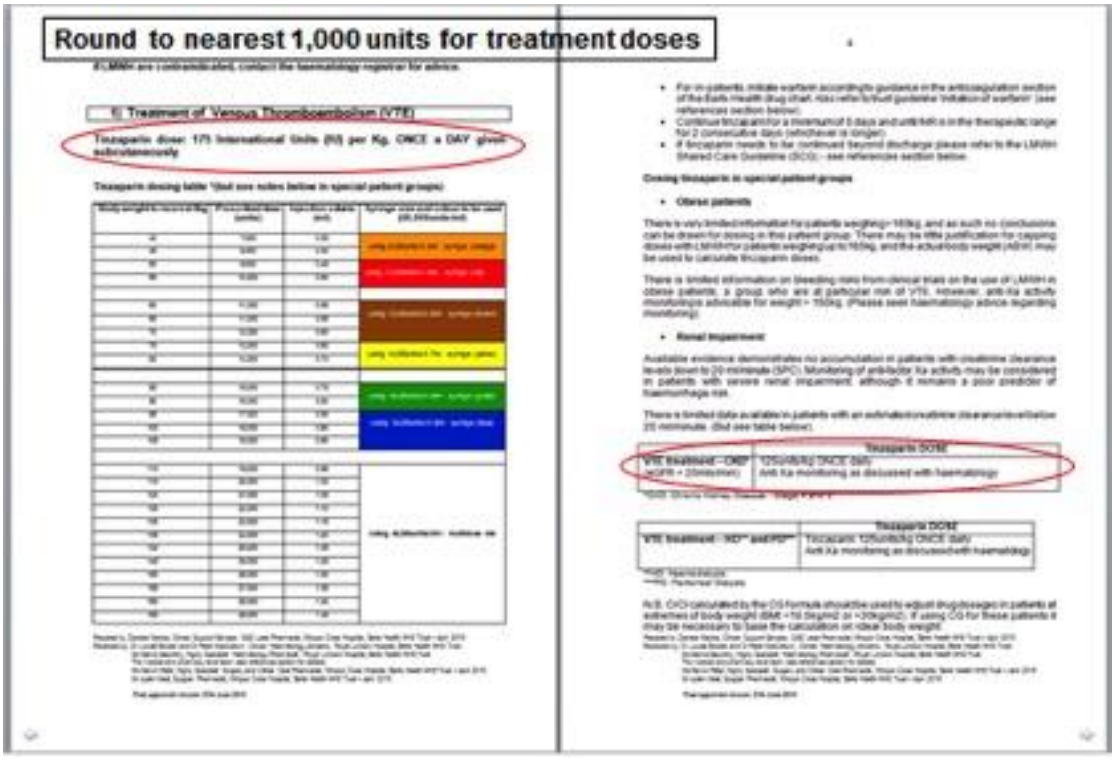
Administration of intravenous electrolytes MUST be accurately controlled using a rate controlled syringe driver or volumetric infusion pump
If a patient is absorbing NG feed consider NG administration of electrolytes

Electrolyte	Products	Indication	Administration	Notes
Potassium	Pre-made Potassium Chloride 40mmol or 20mmol in 100ml Sodium Chloride 0.9% (Potassium Chloride concentrate, Sterile 15% (20mmol/10ml) ampoules are also available)	To maintain potassium level between 4.5-5.0mmol/L **If K⁺ < 4.0mmol/L give 40mmol** **If K⁺ 4.0-4.4mmol/L give 20mmol**	IV CENTRALLY: Either 20mmol or 40mmol in 100ml Sodium Chloride 0.9% over 60 minutes according to potassium level. IV PERIPHERALLY: 40mmol/1000ml – standard bags can be supplied by pharmacy NG: Sando-K: each effervescent tablet contains 12mmol K⁺	MAXIMUM RATE is 40mmol per hour with continuous ECG monitoring NB: Bags are no longer available in glucose 5%, so should be made on an individual basis if required. **USE A STANDARD PRE-MADE BAG IF POSSIBLE**
Magnesium	Magnesium Sulphate 50% (= 5g (20mmol) in 10ml) ampoule	To maintain magnesium level between 0.7-1.0mmol/L	IV CENTRALLY: Give 20mmol Mg^{2+} in 100ml Sodium Chloride 0.9% over 60 minutes IV PERIPHERALLY: If via peripheral line give 20mmol in 250ml Sodium Chloride 0.9% over 2 hours. In renal patients start with lower doses of 4 to 8mmol (1 to 2g) NG: Magnesium Glycerophosphate 1 tablet = 4mmol	MAXIMUM RATE is 36mmol (9g) per hour MAXIMUM CONCENTRATION centrally and peripherally is 20% (= 0.8mmol/ml) E.g. add minimum of 15ml sodium chloride 0.9% to 10ml of 50% $MgSO_4$) and give via syringe driver

Written by Ursula Allen, ICU Pharmacist
Checked by Anja Richter, ICU Pharmacist — August 2006

- **Low Molecular Weight Heparin**
  - Thromboprophylaxis and treatment – **Tinzaparin (innohep®)**

Tinzaparin thromboprophylaxis in standard patients			
< 50kg	51-109kg	110-149kg	≥150kg
3500 units od	4500 units od	7000unit od	9000 units od



  - ACS – **FONDAPARINUX**
    See separate guidance

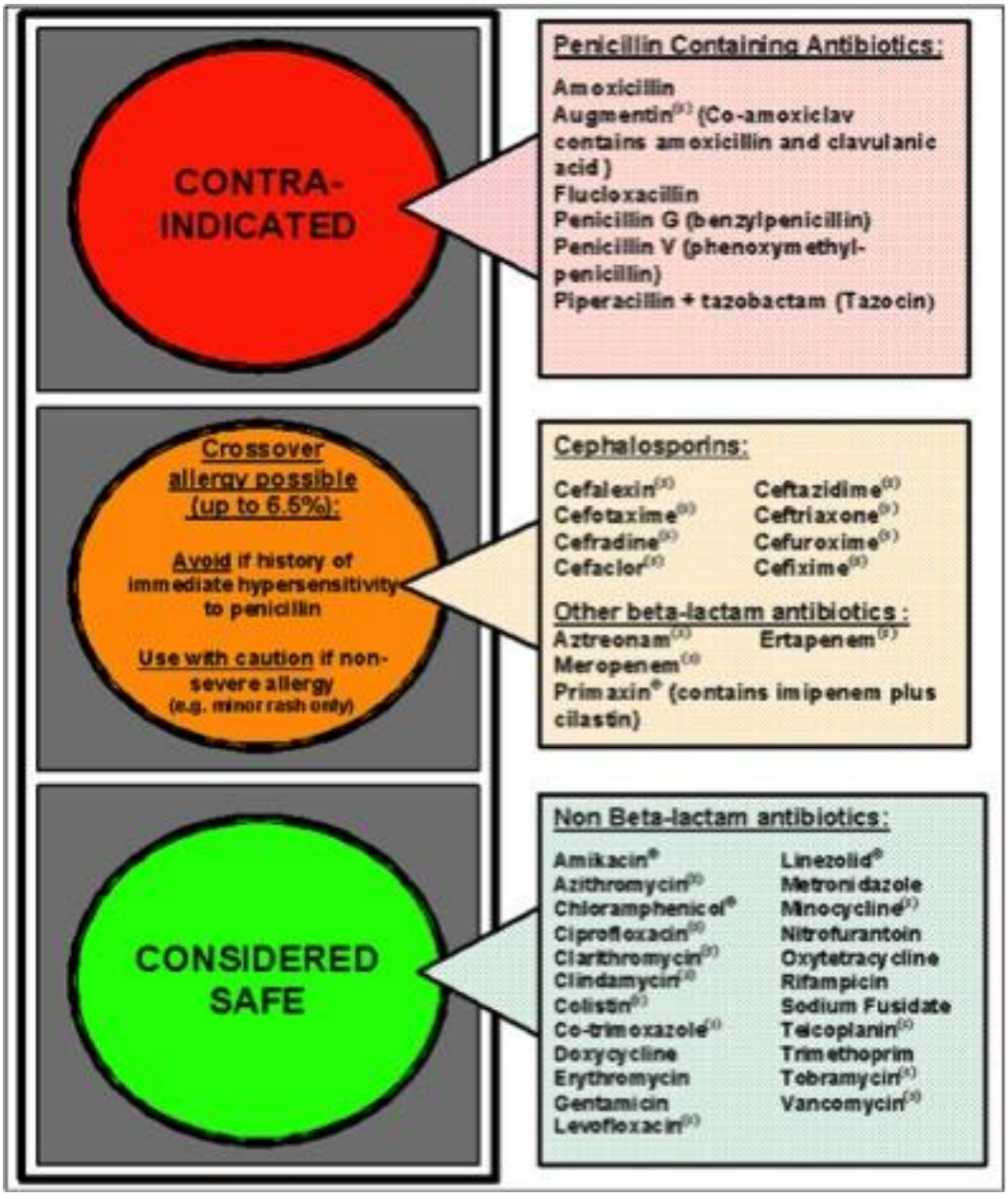
- **Prokinetics**
  - If a patient is not absorbing their feed prescribe metoclopramide 10mg IV tds (reduced to 5mg IV tds if less than 50kg).
  - Prescriptions should be regularly reviewed and stopped as soon as possible with a 5 day maximum in routine cases.

http://rl1vmsps02/BHFileshare/Shared%20Documents/All%20Trust/Pharmacy%20Intranet/BLT/Surgery%20and%20anaesthetics/Prokinetics.doc

Antibiotics

MICROGUIDE - See infection control section

When prescribing antibiotics in penicillin allergy please refer to the traffic light poster:



- **Renal doses for antibiotics**
  - This pharmacy guide can be used as a starting point when prescribing in renal impairment

http://rl1vmsps02/BHFileshare/Shared%20Documents/All%20Trust/Pharmacy%20Intranet/BLT/Antimicrobial/Dosing%20in%20renal%20impairment.doc

Vancomycin

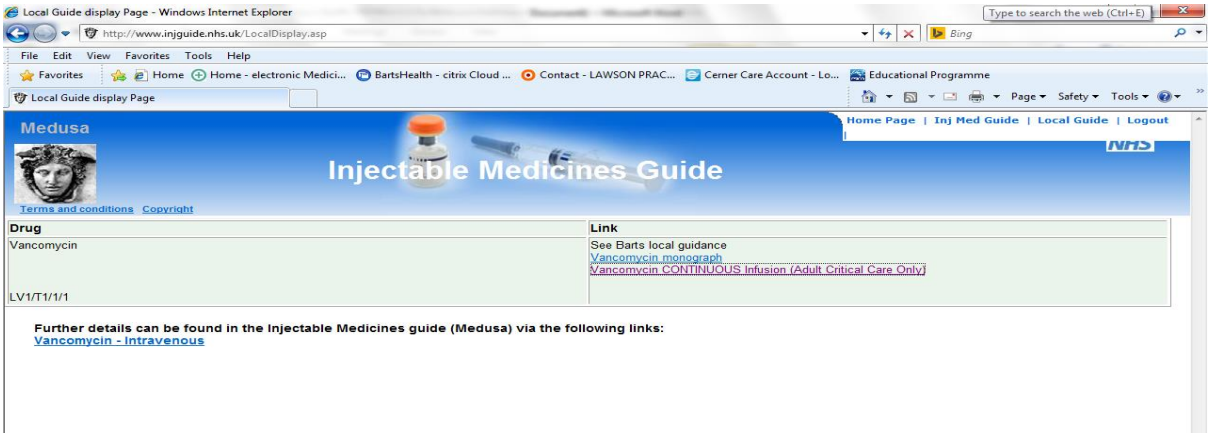
Continuous vancomycin infusions are used on ACCU

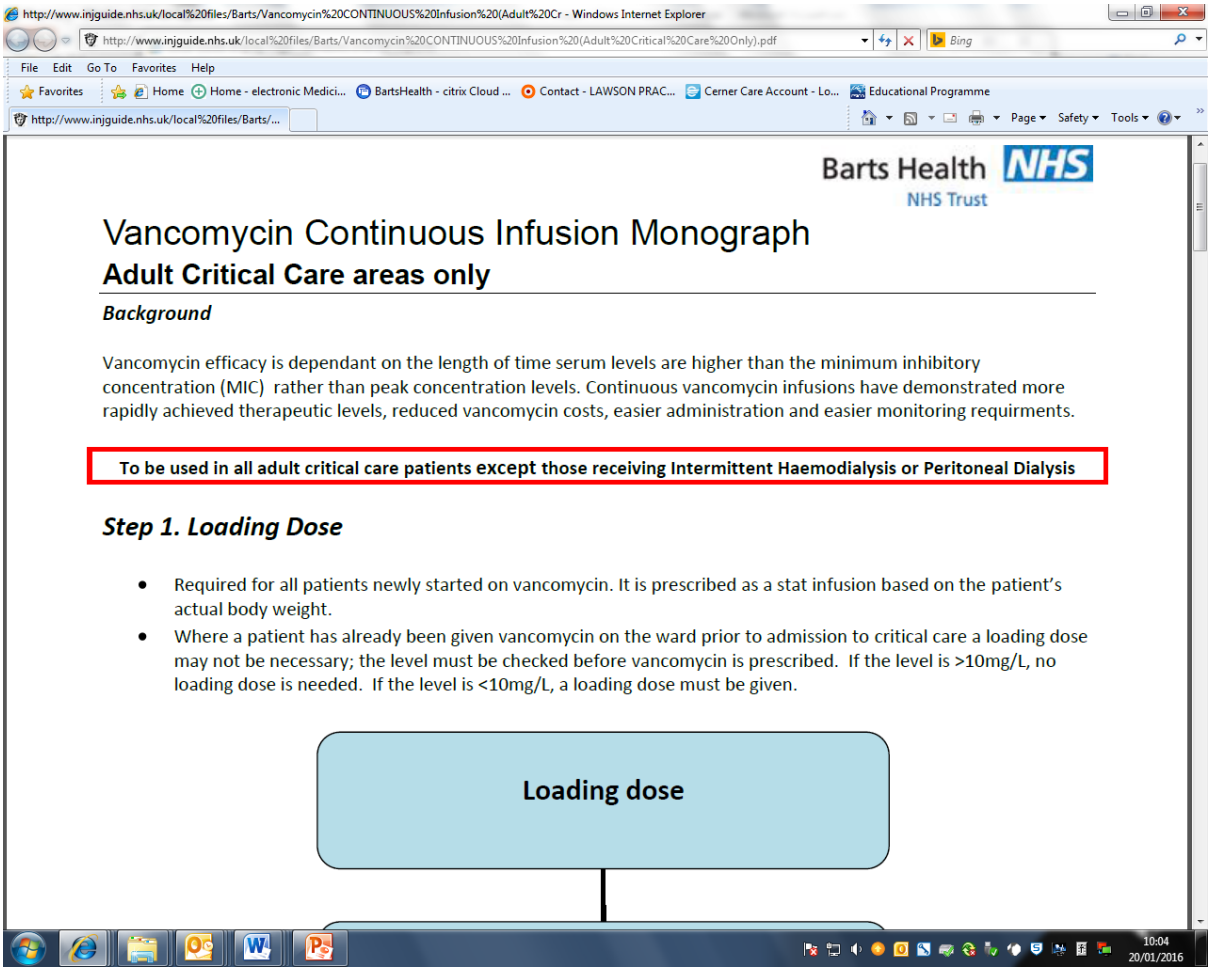
Key points:

- Continuous infusions are not suitable for end stage renal patients who are normally on PD/HD unless they are receiving CVVH/HDF (intermittent dosing should be used in ESRD)
- Ensure allergies are checked before prescribing
- All patients require a loading dose unless they have received intermittent vancomycin preadmission
- In cases of previous vancomycin use, a level must be done before prescribing the loading dose for the infusion (if they level is in range no loading dose is required)
- The loading dose is prescribed on the stat side and the continuous infusion is prescribed on the infusion page.
- Bolus dose is 25mg/kg (max of 2g). There is one standard concentration and a standard starting rate for the continuous infusion. The first level will be sent after 12 hours and the rate adjusted accordingly.
- Daily vancomycin levels are done and the infusion rate is altered accordingly (target concentration range – 15-20mg/L)

Current policy:

Access via medusa on the intranet





Barts Health NHS
NHS Trust

Vancomycin Continuous Infusion Monograph

Adult Critical Care areas only

Background

Vancomycin efficacy is dependant on the length of time serum levels are higher than the minimum inhibitory concentration (MIC) rather than peak concentration levels. Continuous vancomycin infusions have demonstrated more rapidly achieved therapeutic levels, reduced vancomycin costs, easier administration and easier monitoring requirments.

To be used in all adult critical care patients except those receiving Intermittent Haemodialysis or Peritoneal Dialysis

Step 1. Loading Dose

- Required for all patients newly started on vancomycin. It is prescribed as a stat infusion based on the patient's actual body weight.
- Where a patient has already been given vancomycin on the ward prior to admission to critical care a loading dose may not be necessary; the level must be checked before vancomycin is prescribed. If the level is >10mg/L, no loading dose is needed. If the level is <10mg/L, a loading dose must be given.

Loading dose

Emergency Drug Box

There are THREE silver-lidded Tupperware boxes in the pharmacy fridge on ACCU for use in EMERGENCY AIRWAY SITUATIONS.

These boxes MUST NOT be used for routine airway management on ACCU

The boxes contain propofol, etomidate, suxamethonium, rocuronium, atropine and metaraminol along with pre-labelled syringes and drawing-up needles. The drugs should not be drawn up until needed for clinical use.

The task of checking that the boxes are stocked sealed and up to date should be allocated to a specific trainee during the morning drill **(usually the first runner)** and this task should be performed immediately after handover.

Restocking the drug box after use is the responsibility of the DOCTOR using the drugs and should be completed as soon as possible after the emergency is resolved so that the drugs are immediately available if there is another airway emergency.