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PharmacyVoice
Speaking up for community pharmacy

PREVENTING DISPENSING INCIDENTS INVOLVING LIQUID PREPARATIONS

- Analysis of data from 6,796 pharmacies suggests that around **60 dispensing incidents occur every year** involving ranitidine liquid for children in England
- Around **40 of these incidents** affect children under two years old.
- Further implementation of **robust procedures in community pharmacy** could help to reduce the prevalence of these incidents, and other incidents involving liquid preparations.

RECOMMENDATIONS

Community pharmacy teams should note the following when prescriptions for liquid preparations for children and babies come in:

Always **check the date of birth** on a prescription and consider this when completing all clinical checks. If the prescription is for a patient under the age of 12, this should be **highlighted by the branch colleague** who receives the prescription, or an **age sticker** can be used during the prescription assembly process.

Any medication which has been prescribed outside the recommended age range should be **discussed with the prescriber**. The prescriber should also be reminded that this is an **unlicensed indication**, and carries additional liabilities and responsibilities for healthcare professionals involved. Any discussion with the prescriber should be recorded on a child's **Patient Medication Record (PMR)** and discussed with the parent or carer.

Consider the **suitability of the prescribed medication** for the individual child or infant, including the active and other ingredients. If the product **contains alcohol**, consider whether this is a suitable product and whether there is any risk of potential harm. Many liquid preparations are available in **paediatric formulations**.

Calculations of dosage taking into consideration body weight of patient should be **double checked by another pharmacist** if possible. The **actual weight of a child** should be obtained in order to carry out an accuracy check on the dosage. Any calculations made should be **recorded in the Patient Medication Record** (PMR).

Clarification should be made to parents or carers on the exact volume in **ml** needed to give the intended dose in **mg**, especially if a dose is prescribed only in mg. If the parent or carer is unsure, the volume required in ml should be added to the labelled instructions.

All pharmacies should **ensure that small enough syringes are always in stock** and supplied with the prescription to make measuring out prescribed doses easier for the parent or carer. If necessary some pharmacies may need to contact a wholesaler to acquire these. Parents or carers should be **taught how to use these oral syringes** correctly.