

Patients and medicine containers

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From Dr G. Fowler, Mr J. Kirwan and Dr I Ogunbiyi

A congenitally deaf 77-year-old lady was recently admitted to our unit with terminal ovarian cancer. On checking her medicines, we discovered that she stored her morphine sulphate 10mg blue (Sevredol) tablets in a "sweetie container" (left of picture), because the childproof bottle was difficult to open. A spearmint Tic Tac container is shown for comparison (right of picture).



This case acts as a reminder for us all to both check patient's medication on admission to hospital and to ensure they can manage to open the containers provided. Thankfully, no harm resulted in this case. However,

there have been several reports in the national press of children accidentally swallowing hazardous medication because they have mistaken the brightly coloured drug for a sweet.

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Mr P. Bullock, Ms R. Karia and Ms B. Dean reply

We read with interest the letter from Fowler, Kirwan and Ogunbiyi because it highlights one of the key areas that requires pharmacists' attention in hospitals. We have identified many examples of similar risks during our routine checking of patients' drug histories on admission to hospital. These include aspirin bottles being used to store various strengths of warfarin, because the patient found the aspirin container more convenient in which to store tablets, and a patient pack of carbimazole labelled as cyclizine. In the latter case, the GP's prescription had been for cyclizine; it was fortunate that the prescription was relatively recent and the patient had not taken many of the carbimazole tablets.

All health care professionals should be aware of the importance of obtaining an accurate medication history on admission to hospital. As recommended in "A spoonful of sugar",¹ many hospitals have in place, or are developing, various schemes involving the use of patients' own medicines. As well as helping to document an accurate medication history, a further advantage of these schemes is that pharmacists are able to check patients' own supplies of medicines, and identify and resolve problems such as that highlighted by Fowler, Kirwan and Ogunbiyi.

We must invest time in talking to patients and understanding the medication issues that are important to them as individuals, rather than assuming they are taking (and storing!) their medicines as prescribed. Only then can we find solutions that work for the patient without creating risks for the patient and those around them.

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REFERENCES

1. Audit Commission. A spoonful of sugar — medicines management in NHS hospitals. London: Audit Commission; 2001.