# High Risk Drugs List

## Methotrexate
- **Guidance**
  - Patient Safety Alert – Update on producing patient information on Methotrexate usage.
  - Patient Safety Alert – Improving compliance with oral methotrexate guidelines: alerting NHS staff to risks in the storing and administration of oral methotrexate.
  - Improving compliance with oral methotrexate guidelines

### CSM Advice
In view of reports of blood dyscrasias (including fatalities) and liver cirrhosis with low-dose Methotrexate, the CSM has advised:
- Full blood counts and renal and liver function tests before starting treatment and repeated weekly until therapy stabilised, thereafter patients should be monitored every 2-3 months
- That patients should be advised to report all symptoms and signs suggestive of infection, especially sore throat

**IMPORTANT**
The dose is a **WEEKLY** dose. It is recommended that:
- The patient is carefully advised of the dose and frequency and the reason for taking methotrexate and any other prescribed medicine (e.g. folic acid)
- Only one strength of methotrexate tablet (usually 2.5mg) is prescribed and dispensed- **ALWAYS** check that this is what the patient is used to
- The prescription and the dispensing label, and discharge information clearly show the dose and frequency of methotrexate administration
- The patient is warned to report immediately the onset of any features of blood disorders (e.g. sore throat, bruising and mouth ulcers), liver toxicity (e.g. nausea, vomiting, abdominal discomfort, and dark urine), and respiratory effects (e.g. shortness of breath).

## Diamorphine & Morphine Injections
- **Guidance**
  - Safer Practice Notice – NPSA alerts NHS to risks with high dose morphine and diamorphine injections: ensuring safer practice with high dose ampoules of diamorphine and morphine.
  - Ensuring safer practice with high dose ampoules of morphine and diamorphine

## Measurement & administration of
- **Guidance**
  - Patient Safety Alert – Promoting safer measurement and administration of liquid medicines via oral and other enteral routes: Advice on how the design of medical devices and the methods used to
| **Liquid Medicines** | measure and administer oral liquid medicines can improve patient safety.  
*Patient Safety Alert* |
|----------------------|------------------------------------------------------------------|
| **Injectable Medicines** | **Patient Safety Alert – Promoting safer use of injectable medicines**: Recommendations to make the use of injectable medicines safer.  
*Patient Safety Alert*  
E-learning recommended by the NPSA:  
**Safe use of injectable medicines**  
Work competencies for injectable medicines:  
**Preparation of injectable medicines**  
**Prescribing of injectable medicines**  
**Monitoring the administration of injectable medicines**  
**Standard Operating Procedure Template** |
| **Vaccine Cold Storage** | **Rapid Response Alert – Vaccine Cold Storage**: Recommendations that Trust Policies are adhered to ensuring vaccines are stored safely and appropriately and that Cold Chain Storage is maintained when transporting to reduce wastage, costs and ensure that vaccines are effective and uncontaminated.  
*Rapid Response Alert*  
**Trust Policy**  
**Medicines Code** |
| **Dosing of Opioids** | **Rapid Response Alert - Reducing Dosing Errors with Opioid Medicines**: Recommendations to reduce the risk of patients receiving unsafe doses. The guidance applies when the following opioid medicines are prescribed dispensed or administered: Buprenorphine, diamorphine, dipipanone, fentanyl, hydromorphone, meptazinol, methadone, morphine, oxycodone, papaveretum, pethidine.  
*Rapid Response Alert* |
| **Midazolam Injection** | **Rapid Response Alert - Reducing Risk Of Overdose With Midazolam Injection In Adults**: Recommendations to reduce the risk of overdose when using Midazolam for adult conscious sedation:  
*Rapid Response Alert* |
<p>| <strong>Lithium</strong> | <strong>Alert – Safer Lithium Therapy</strong>: Recommendation to reduce harm because patients have not had their dosage adjusted based on recommended regular blood tests: |</p>
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### Insulin

**Rapid Response Alert – Safer Administration of Insulin:** Recommendations to reduce the administration errors of clinical staff which can be severe and even cause death:

- [Rapid Response Alert](http://www.diabetes.nhs.uk/safe_use_of_insulin/)

### Anticoagulants

**Patient Safety Alert – Actions that can make anticoagulant therapy safer:** Helps staff manage the risks associated with anticoagulants and reduce the risks of patients being harmed in the future.

- [Patient Safety Alert](http://www.diabetes.nhs.uk/safe_use_of_insulin/)

E-learning recommended by the NPSA:

- [Starting patients on anticoagulants](http://www.diabetes.nhs.uk/safe_use_of_insulin/)
- [Maintaining patients on anticoagulants](http://www.diabetes.nhs.uk/safe_use_of_insulin/)

Work competences for anticoagulant therapy:

- Initiating anticoagulant therapy
- Maintaining oral anticoagulant therapy
- Managing anticoagulants in patients requiring dental surgery:
- Dispensing oral anticoagulants
- Preparing and administering heparin therapy

### Low Molecular Weight Heparins

**Alert:** Reducing Treatment Dose Errors With Low Molecular Weight Heparins: Recommendations to reduce the risk of under dosing which can lead to an increased risk of further thromboembolic events, while overdosing can increase the risk of bleeding.


### Omitted Doses

**Rapid Response Alert - Reducing Harm From Omitted And Delayed Medicines In Hospital:**
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This table was last updated on July 2011; for more recent reports check the NPSA web-site on [www.npsa.nhs.uk](http://www.npsa.nhs.uk)