

Sharing Learnings from an Incident

This case study is from an incident reported by the Birmingham Community Healthcare Foundation Trust.

Contractors may be seeing more EPS prescription for BCHFT as they now have access to EPS prescriptions.

This means you may be dealing with NEW (paediatric) patients so please make sure dosage instructions (for parents/carer) are CLEAR and understood by those administering oral liquid medication.

A new prescription was issued for atomoxetine for a paediatric patient. The prescription was written as

500 ml Atomoxetine 4mg/ml oral solution sugar free

WEEK one: Give 10mg daily; Day 8 onwards: Give 20mg daily.

*Four weeks later a request was made for a further supply. The prescriber questioned why this was being requested so soon and it transpired that the parent had been administering the wrong amount. This was because they had misinterpreted the dosage on the dispensing label. The box had been labelled with the dose in mg, as written on the prescription, and not in ml. The parent had not realised the difference and consequently had administered **four times** the intended dose. **Thankfully, the child was not harmed.***

We are aware that a similar incident has occurred previously, with this same product, and so wanted to share as a reminder of the importance of making sure that patients and carers know how to measure the required doses correctly. There is helpful guidance on labelling liquid medicines from the Neonatal and Paediatric Pharmacy Group (NPPG) and is endorsed by RPS.

It is available at [Labelling-Position-Statement-V2.pdf](#)

patients, please visit the CP BSOL website.

[Visit CP BSOL Website](#)

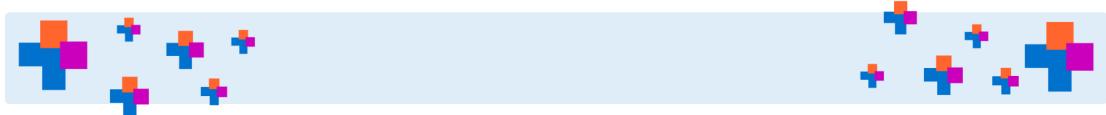
Community Pharmacy Birmingham & Solihull

Representing community pharmacy contractors across Birmingham and Solihull in partnership with the [NHS Birmingham and Solihull Integrated Care Board](#) and nationally with [Community Pharmacy England](#).



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