

Safer dispensing labels and paediatric prednisolone

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We thank Adam La Caze for his article on safer dispensing labels for prescription medicines.¹ As pharmacists working at the Queensland Poisons Information Centre, we fully support the introduction of patient-centred labels. In particular, we refer to the specific example of paediatric dosing errors involving prednisolone.²

In 2017, our centre alone received 70 calls about paediatric therapeutic errors involving prednisolone. We classify a therapeutic error as administration of a medicine at the wrong dose, the incorrect frequency, the incorrect route or a patient inadvertently receiving the incorrect medication. Of these 70 cases, most involved errors in interpretation of instructions on the label. Most commonly, prednisolone liquid was given to children three times daily instead of once daily for three days. This seems to be a recurring theme as noted by our colleagues at the Victorian Poisons Information Centre in 2016.²

Along with verbal counselling, we endorse Adam La Caze's recommendation of patient-centred

instructions for prednisolone as – 'For 3 days: Give 3 mL in the morning for asthma (or croup)'. As the author notes our patients are often confused and worried following the initial consultation and with the additional stress of having a sick child. We believe these changes to medicine labels will reduce dosing errors, especially when prednisolone liquid is involved.

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REFERENCES

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2. Robinson J, McKenzie, C MacLeod D. Paediatric dosing errors with oral prednisolone mixture. *Aust Prescr* 2016;39:176. <https://doi.org/10.18773/austprescr.2016.062>

Adam La Caze, author of the article, comments:

 Thank you to Genevieve Messina and Carol Wylie for sharing their experience. The frequency of calls regarding paediatric dosing errors for prednisolone illustrates the importance of improving communication on dispensing labels.