Poison HOTLINE

1-800-222-1222

March 2017

Did you know ......

The Iowa Poison Control Center now has a toxicology pocket card available for health care providers.

The card contains sections on toxidrome presentations, antidote use, a flow chart for an unknown ingestion, and surveillance.

These cards can be downloaded from the IPCC website or by clicking HERE. The card is best printed on legal size (8"x14") paper cardstock. Bulk cards can be ordered through the IPCC education office at (712) 279-3717.

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When calling the poison control center please provide the following if available:

- Facility name and if referring to another facility
- Patient's name and age
- Drugs or chemicals involved
  - Quantity
  - Strength
  - formulation (e.g. IR, SR, XR)
- Route used (e.g. ingested, snorted, inhaled, injected)
- Time of exposure
- Medical history and allergies
- Present condition and mental status
- Vital signs
- Fluds and medications given
- Laboratory results
- X-ray and CT results

MEDICATION ERRORS IN CHILDREN

According to studies performed by the American Academy of Pediatrics more than 40% of parents inadvertently make errors when giving medications to their children. Last year, poison centers reported more the 60,000 calls regarding therapeutic errors caused by the parent or caregiver of children 5 years of age and younger. One of these errors even resulted in a death of a child.

A very common cause for these errors is giving an incorrect dose. For example, both parents give the same dose, not realizing the other parent already gave the same dose. Unintentionally giving too large of a dose can also occur because: the wrong dosing cup was used, there is a misunderstanding of the dose, or there is a misunderstanding of the concentration of the product being given. Many children's and infant's pain relievers have standardized concentrations to help eliminate confusion. However, parents may inadvertently use an adult product with higher concentrations or they may use an old pediatric formulation of the medicine.

Another common issue is giving multiple medications with the same active ingredient. For example, parents might give the child a plain acetaminophen product, and then also give a cough and cold combination product which also contains acetaminophen. This results in the child receiving acetaminophen twice, which may exceed the maximum amount of acetaminophen that the child should be given.

Transferring a medication to a different container with no instructions can be a problem. NEVER transfer any product to a container that is not the original container the product was purchased in. Parent's understanding of terminology can also be an issue. There can be confusion between teaspoon versus tablespoon, mL versus mg, and generic versus brand names. Instructions on the box or those given by a medical professional may sound like a foreign language and parents may be too embarrassed to ask for clarification. When discharged from an ER or physician's office it is important to clarify generic vs brand names of drugs. For liquid medications, make sure the parents understand the prescribed dosing in mL and how to use the dosing syringe or cup. Encourage the parents to call the poison control if any questions.

Denise Brumm, RN, CSPI
Certified Specialist in Poison Information

POISON Help®
1-800-222-1222

Hotline Editor: Kimberly Zellmer, PharmD; Deputy Editor: Edward Bottei, MD
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