

incidence of graft failure, biliary complications and arterial thrombosis [6]. Despite this there is growing evidence that it is possible to safely transplant patients using cadaveric ABO-incompatible grafts.

There is growing interest in auxiliary, partial, liver transplantation and extracorporeal liver supportive therapies as an alternative to whole liver grafts. As for NHBD liver transplantation there needs to be careful selection of patients and grafts that would be suitable for use as an auxiliary graft. The recipient considerations fall squarely on the failing damaged liver in ALF driving haemodynamic instability and the neurological insult of cerebral oedema. The improvement in haemodynamics and cerebral oedema seen after a whole liver transplant in conjunction with explanting the native damaged liver may not be realised with auxiliary grafts. They are also technically more difficult and associated with more complication, especially biliary leak. The graft needs to be of

an appropriate size for the patient to provide sufficient functioning liver parenchyma to improve the clinical condition.

Summary

Liver transplantation is the best therapeutic option for patients with acute liver failure and multi-organ and metabolic failure if the disease process has not extended beyond the point of benefit. Donor liver resources are scarce, compounding the difficulty for those endeavouring to ensure the right individual decision is reached regarding the risks and benefits of liver transplantation. Extracorporeal therapies continue to be researched to provide an alternative, but this has as yet to be realised.

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Medication Safety

Ambiguous drug doses on discharge lists

Hospitals may need to improve the way medication lists are given to patients and other providers when discharging patients from the hospital. Using a computer-generated list or copying from the medication administration records (MARs) might lead others to confuse drug doses if different strengths of the medication are available. Due to cost containment and space limitations in automated dispensing cabinets, some hospital pharmacies stock a minimum variety of dosage strengths for a drug. Thus, nurses are directed to use multiple dosage units or half tablets to administer the prescribed dose. For example, a hospital may stock 100 mg tablets of Seroquel (quetiapine fumarate) but not the 200 mg, 300 mg, and 400 mg tablets. A patient who needs a 200 mg dose would be given two tablets of the 100 mg strength. MARs fre-

quently list the number of tablets to give along with the dose, as in the following example: 'Seroquel 100 mg, 2 tablets twice daily'. Although not recommended, the MAR may even just list '2 tablets = 200 mg'. Healthcare providers in outpatient settings may find this confusing, making the MAR a less-than-ideal document from which to prepare a discharge medication summary. One hospital recently reported that a patient discharged to a long-term care facility received Seroquel 400 mg twice daily instead of 200 mg twice daily. The nurse misunderstood the hospital's summary sheet, compiled from the MAR listing, which listed the dose as 'Seroquel 2 tablets = 200 mg, bid'. The nurse thought this entry meant that the patient should receive two tablets of the 200 mg strength. Another patient received Risperdal (risperidone) 0.25 mg twice daily because the medication entry was listed as '0.5 tablet = 0.5 mg twice

daily'. In this case, the nurse thought the patient was supposed to receive half of a 0.5 mg strength tablet, but in the hospital, the patient was receiving half of a 1 mg tablet. To minimise problems, do not include the tablet strength or liquid concentrations used in the hospital to provide the patient's dose on discharge lists. Instead, include only the drug name, dose, route of administration, and frequency that each medication should be given.

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