Medicines Safety Matters

A Newsletter from the Derbyshire and Nottinghamshire CCGs Medicines Safety Officers (Issue 2 August 2016)

Welcome to our second issue of Medicines Safety Matters a newsletter produced by your local CCG Medicines Safety Officers .

Our aim is to highlight to you what medication incidents have occurred both locally and nationally, thus promoting and supporting safer practice.

What are Medicines Safety Officers?

A Medicines Safety Officer`s (MSO) role is to improve the reporting and learning from medication incidents across healthcare professionals. They form part of a national network and are supported by the MHRA.

MSOs work within all sectors of healthcare and are based within all areas of the NHS including clinical commissioning groups, hospitals and community pharmacies .

Who are your Medicines Safety Officers?

We have established a local CCG network with MSO representatives from each of the CCGs within Nottinghamshire and Derbyshire and a representative from NHS England. If you have a concern related to a medication incident, or need advice on how or whether to report an incident please contact your local MSO for advice.

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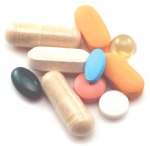

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Learning the lessons - Ciclosporin

We have had an incident shared with us involving the prescribing of ciclosporin in a local CCG.

A patient was prescribed ciclosporin in secondary care for the management of ulcerative colitis. They were issued an adequate quantity of medication to last until their next review in hospital. Prior to this, the patient attended their GP Practice and requested an additional supply as they had run out of tablets. The medication was prescribed and subsequently dispensed.

The patient attended the hospital for blood tests to monitor their ciclosporin levels and these were found to be high. The patient was advised to immediately stop the ciclosporin but a few days later became acutely unwell with severe bilateral pneumocystis pneumonia from which they subsequently died.

Pneumocystis is a recognised but rare complication of immunosuppressant medications such as ciclosporin.

The root cause analysis of this incident concluded that it is likely that the patient had been taking an excessive dose of ciclosporin which caused over-suppression of the immune system which may have resulted in a predisposition to more aggressive and unusual infections such as pneumocystis.

As part of the shared learning primary care prescribers are reminded:-

- A drug may have multiple traffic light classifications depending upon the indication. Check your local traffic light list / formulary before proceeding further with requests for supply of medication.
- Be alert to patients requesting supplies of medication usually prescribed in secondary care and explore if they have been taking their medication correctly.

Miconazole Oral Gel—potential for serious interaction with warfarin

There have been local cases of raised INR and bleeding when patients on warfarin are treated for oral thrush with miconazole oral gel. This is an important interaction and has the potential to lead to hospitalisation and serious harm.

The anticoagulant effects of warfarin can be markedly increased if miconazole is used as an oral (buccal) gel, and bleeding can occur. Miconazole oral gel should be avoided in patients taking warfarin.

The MHRA are currently reviewing available data to determine if further measures are required to minimise the risk of patient harm.

What are the alternatives for treatment of oral thrush?

Fluconazole also causes a dose-related reduction in the metabolism of warfarin, and increases its anticoagulant effect. Cases of minor to major bleeding have been reported and careful monitoring is recommended. When used in combination with warfarin

Nystatin liquid does not interact with warfarin and is a safer alternative

Epipen® Adrenaline auto-injectors Changes to weight range for dosing

In the last edition we featured an article reminding prescribers to check for a current weight before prescribing adrenaline auto-injectors for children.

The manufacturers of Epipen® changed the recommended paediatric weight range earlier this year. The current recommendations are summarised below. Currently, printed and online versions of the BNF do not reflect this change in weight range. However the editors of the BNF have been made aware and this will be updated in due course.

EpiPen® Jr—This delivers a single dose of 0.15mg of adrenaline BP 1:2000 (0.3ml) in a sterile solution and and is licensed for children weighing 7.5kg to 25kg .

Jext® 150micrograms -This delivers a single dose of 0.15mg of adrenaline BP 1:2000 (0.3ml) in a sterile solution and is licensed for children weighing 15 to 30kg.

Anecdotally audit work carried out in Derbyshire and Nottinghamshire practices has found a significant number of paediatric patients either with no recent documented weight or receiving the incorrect strength. This represents a serious risk of patient harm due to patients not receiving an adequate dose.

Opioids Aware— 5 top tips for prescribing

Opioids Aware is a web-based resource for patients and healthcare professionals to support prescribing of opioid medicines for pain.

1. Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain.

2. A small proportion of people may obtain good pain relief with opioids in the long-term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).

3. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.

4. If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.

5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high doses, a very detailed assessment of the many emotional influences on the pain experience is essential.

Reporting of CD incidents

The CD online reporting tool should be used to report all controlled drug related incidents. This can be accessed at **www.cdreporting.co.uk** . When registering please select the **NORTH MIDLANDS** region.

The tool also provides you with a secure way to raise any concerns you may have regarding a patients usage of controlled drugs, prescribing concerns or dispensing errors, fraud, theft etc. We would strongly encourage all primary care contractors to report any concerns which involve controlled drugs from Schedules 1 -5.

Salmeterol MDI — soya and peanut aller-

Salmeterol metered-dose inhaler is currently available as brands Serevent® and Neovent™. Neovent™ contains lecithin derived from soya and is contraindicated in patients with soya or peanut allergies.

A small proportion of those using salmeterol inhalers will be known to be allergic to peanuts or soya products, and they may be unintentionally given Neovent™ in response to a generic prescription for salmeterol MDI. To avoid the risk of this, patients requiring salmeterol should be prescribed this by brand, but there is a risk that they may be unwittingly changed to a generic sameterol MDI in the future. Alternatively, salmeterol may be switched to a different long acting beta agonist such as formoterol, however this is only available in dry powder inhaler (turbohaler or easyhaler)