Medicines Safety Matters

A Newsletter from the Derbyshire and Nottinghamshire CCGs Medicines Safety Officers

Welcome to our first 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 health care 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.

Derbyshire

NHS Erewash CCG– Harriet Murch

eccg.mso@nhs.net

NHS Southern Derbyshire CCG—Steve Hulme/Jaskiran Dhamrait

mso@southernderbyshireccg.nhs.uk

NHS North Derbyshire / NHS Hardwick CCGs—Kate Needham

NDCCG-.SafetyOfficer@northderbyshireccg.nhs.uk

Nottinghamshire

NHS Mansfield and Ashfield CCG – Tom Goodwin

Tom.goodwin@mansfieldandashfieldccg.nhs.uk

NHS Newark and Sherwood CCG – Coral Osborn

Coral.osborn@mansfieldandashfieldccg.nhs.uk

NHS Nottingham City CCG– Mindy Bassi

Mindy.bassi@nottinghamcity.nhs.uk

NHS Nottingham North and East CCG- Shelley Gibson

Shelley.gibson@nottinghamnortheastccg.nhs.uk

NHS Nottingham West CCG- Dawn Gajree

Dawn.gajree@nottinghamwestccg.nhs.uk

NHS Rushcliffe CCG- Gill Gookey and Stacey Sadler

Medicines.safety@rushcliffeccg.nhs.uk

NHS England – Sam Travis, Samantha.travis@nhs.net

Learning the lessons - Azithromycin

We have had an incident shared with us from our regional CCG colleagues involving the incorrect dosing of azithromycin . This resulted in a patient losing their hearing .One of the recommendations from the investigation was to share the learning.

The patient was seen in clinic and in view of repeated respiratory infections prophylactic azithromycin therapy was recommended. An appropriate prescription was issued to the patient with the correct dose for ***azithromycin 500mg to be taken 3 times a week (Monday, Wednesday, Friday)****. This regime was discussed with the patient.*

*The clinic letter was authorised by the consultant and faxed to the GP . The letter unfortunately contained a drug dosage error for "****azithromycin 500mg x3 times per day (Monday, Wednesday, Friday).****"*

The error in the letter was missed by the GP, who did not appreciate this was a larger than usual prophylactic dosage of azithromycin and a prescription was issued.

The patient therefore took 1500mg of azithromycin 3 days per week instead of 500mg three times per week, for approximately one month. The patient began to feel unwell .They reduced their dose and contacted the department.

The patient was seen the same day and azithromycin was discontinued. The patient had developed diarrhoea, shivering episodes, and had noticed a decline in their hearing. The consultant explained what had happened to the patient and apologised for the error.

As there had been some hearing loss the patient was referred to the ENT/Audiology department. Hearing loss is a recognised complication of chronic azithromycin use in large doses, but is generally reported as reversible usually within 5 weeks of discontinuation.

As a result of this Derbyshire and Nottinghamshire CCGs are in the process of including information in their GP clinical system formularies, websites and clinical software to support prescribers and prevent recurrence of this incident.

MHRA guidance

Sodium Valproate and Pregnancy

The MHRA has launched a toolkit to ensure female patients are better informed about the risks of taking valproate medicines during pregnancy.

https://www.gov.uk/drug-safety-update/valproate-and-of-risk-of-abnormal-pregnancy-outcomes-new-communication-materials

The MHRA strengthened warnings on the risks of valproate in pregnancy last year , as understanding of the extent of these risks had increased. Up to 4 in 10 babies are at risk of developmental disorders and approximately 1 in 10 are at risk of birth defects, if valproate is taken during pregnancy.

The toolkit addresses concerns that the risks of valproate are not being adequately explained to female patients. The toolkit includes a credit card sized patient card to be issued by pharmacists, booklets for healthcare professionals and patients, together with a checklist of important questions and discussion points to be kept in the patients file. Warnings will appear on the medicines packaging later this year.

Anyone who has experienced any side effects to this medicine can report these to the MHRA using the yellow card scheme.

EpiPens *(info updated July 2016)*

Are you prescribing the correct one?

Prescribers are reminded that if an adrenaline pen is required to be prescribed that consideration must be given to the current weight of the patient. The pen should also be prescribed by brand .This to ensure the patient is dispensed the auto-injector device they have received training on, as some organisations are now prescribing the Jext brand.

We have recently had an incident where a patient received too low a dose of their EpiPen as their weight records had not been updated.

EpiPen

This delivers a single dose of 0.3mg of adrenaline BP 1:1000 (0.3ml) in a sterile solution and should be prescribed for adults and children over 25kg in weight.

EpiPen Jr

This delivers a single dose of 0.15mg of adrenaline BP 1:2000 (0.3ml) in a sterile solution and should be prescribed for children between 7.5mg to 25kg in weight.

It is recommended that patients carry two of their EpiPens all the time, in case a second dose is needed after 5-15 minutes. After every use of an adrenaline auto-injector an ambulance should be called , even if symptoms are improving, the individual should lie down with their legs raised and ideally not left alone.

Ranitidine Liquid in Children

It is estimated that sixty dispensing incidents may occur every year affecting children and babies prescribed ranitidine liquid preparations. This has resulted in the creation of a top tips for liquid medications http://www.pharmacyvoice.com/images/resources Liquid_preparations_Top_Tips_FINAL.PDF

What is the problem?

There are two strengths of ranitidine being used in children:

Ranitidine **75mg/5ml**

- This strength is a licensed product but it is not licenced for use in children younger than three years old.
- This product contains alcohol (Zantac® brand contains 800mg of ethanol in 10ml).
- This is the product most commonly used by the Derbyshire and Nottinghamshire Acute trusts even in young babies. The alcohol content in the small doses required for young children is considered to be within acceptable limits.
- Due to the high strength of the product, the dose in children is likely to be a very low volume and should be measured in an appropriately sized oral syringe.

Ranitidine **5mg/5ml**

- This product is unlicensed and compared to the licensed product is more expensive.
- This product does not usually contain alcohol.
- This product is not routinely prescribed for children by secondary care in Nottinghamshire or Derbyshire.

What is the solution to the problem?

- Ensure the correct strength is selected when prescribing and take extra care to ensure the same strength is continued when patients are discharged from hospital. (N.B. In Nottinghamshire and Derbyshire the use of a licenced product even out of licence is preferred whenever possible over an unlicensed product.)
- Ensure the prescribed dose is very clear and preferably stated in ml on the directions.
- Inform and then reassure parents receiving the 75mg/5ml strength regarding the alcohol content.
- Be very careful if switching between the strengths and ensure that the parents are fully informed of the change in volume to ensure that the same dosage is given.