Medicines Safety Matters

A Newsletter from the Derbyshire and Nottinghamshire CCGs Medicines Safety Officers Network. Issue 4, March 2017.

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 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.

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Citalopram Oral Drops 40mg/ml:

Dose error: 'millilitres' instead of 'drops'

Incidents have been reported locally whereby patients have been incorrectly prescribed the dose of Citalopram Oral Drops in 'millilitres' instead of 'drops' e.g. 0.5mls (equivalent to 25mg in tablet form) daily instead of the correct dose of 8 drops (16mg = equivalent to 20mg tablet in tablet form).

Why should the dosage be in 'drops' and not in 'millilitres'?

The dose for citalopram oral drops should be stated in drops, not in millilitres to avoid confusion for patients and also for ease of administration (doses cannot accurately be prescribed or administered by volume of the liquid). The bottle is fitted with a dropper to facilitate this and to ensure accurate dosing. Also, the oral drops should be mixed with water, orange juice or apple juice before taking or administering via a feeding tube. The resulting solution must be drunk by the patient or administered via a feeding tube immediately.

Citalopram Oral Drops 40mg/ml (citalopram hydrochloride, corresponding to 40 mg citalopram base) contain the following:

1 drop = 2 mg citalopram

1 ml = 20 drops = 40 mg citalopram

Citalopram oral drops have approximately 25% increased bioavailability compared to the tablet formulation. **NOTE:** For patients aged >65 years of age, the maximum dose of Citalopram is 20mg in tablet form OR 8 drops (16mg) when using oral drops.

Table to show dose of Citalopram for tablet vs. oral drops:

Citalopram dose in tablet form	Equivalent Citalopram dose in oral drops form	No. of drops to deliver required dose
10mg	8mg	4 drops
20mg	16mg	8 drops
30mg	24mg	12 drops
40mg	32mg	16 drops

Learning the Lessons:

Drug Induced Gastro-intestinal (GI) bleed & Acute Kidney Injury (AKI)

We have had an incident shared with us involving the concurrent prescribing of a Non-Steroidal Anti-Inflammatory Drug (NSAID) with a Direct Oral Anticoagulant (DOAC) which resulted in AKI and a GI bleed:

"Elderly co-morbid patient prescribed regular ibuprofen for gout despite having heart failure and being on apixaban for Atrial Fibrillation. Admitted to secondary care with AKI and GI bleed after 14 days. Became moribund, too unwell for endoscopic investigation. Seen by Gastroenterology team, conservative management, later deterioration and put on end of life care pathway with family agreement. Although frail, the ibuprofen was considered to be a major contributory factor in both AKI and GI bleed"

Case review confirmed that a handwritten prescription had been issued by the GP who visited the patient in their nursing home. Although the consultation was retrospectively logged in the patient's electronic medical records there was no record of ibuprofen being prescribed. The prescriber therefore did not receive the standard alerts regarding contra-indications, cautions or allergies with concurrent prescribing from the electronic clinical system.

<u>As part of the shared learning, primary care prescribers are reminded to:</u>

- Update the patient's electronic medical record with an account of the home / care home visit at the earliest opportunity including all medicines prescribed.

- Avoid issuing handwritten prescriptions where possible. If deemed essential, enter details onto the computer system to reduce inadvertent duplication of prescribing, to reduce the possibility of unintentional drug interactions and to provide an adequate audit trail.

- Explore the use of remote access when undertaking home visits to ensure contemporaneous record-keeping and prescribing.

- Avoid the combined use of an NSAID with an anticoagulant due to the high risk of GI bleeding. Where such a combination cannot be avoided, gastro-protection should be prescribed and patient closely monitored for signs/ symptoms of bleeding.

- Avoid using NSAIDS in patients with acute or severe heart failure. Consider and document the risk / benefit in milder forms of heart failure prescribing the lowest possible dose for the shortest possible time period.

- Educate carers about Acute Kidney Injury in high risk patients - Care Homes - Acute Kidney Injury

Recording allergies within GP Clinical systems

A near-miss incident has been reported whereby a patient with a penicillin allergy was prescribed flucloxacillin by a GP. The community pharmacy picked up this error and the patient was prescribed an alternative antibiotic. One of the contributory factors to this incident occurring was that the penicillin allergy was added to the patient record by 'free texting' the allergy instead of using the clinical systems prepopulated list of allergies with read codes attached to them. Therefore, an alert did not appear at the point of prescribing flucloxacillin to warn the prescriber of the patient's penicillin allergy.

<u>Key learning points</u>

In order to reduce the risk of this incident occurring please be aware of the following information and share this with members of staff within your GP practice:

(a) Allergies should not be added by 'free text', as this will not trigger a warning alert if/when prescribing medication the patient is allergic to.

(b) Patient allergies should be recorded using the options already available within the clinical systems list of allergies (with read codes attached to them) in order for a warning alert to 'pop up' at the point of prescribing. This is especially important for serious allergies that can cause anaphylaxis e.g. penicillin.

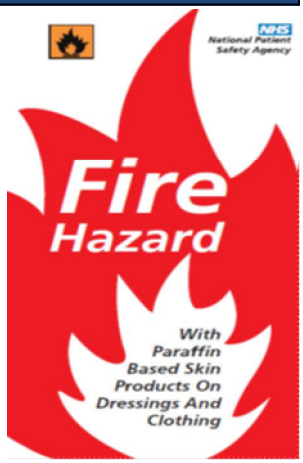
Suitability of Medicines in patients with Nut or Soya allergies

We have had some 'near miss' incidents locally, whereby patients with nut or soya allergies have been prescribed or dispensed medication that is unsuitable for them to take e.g. Neovent® inhaler contains soya lecithin and is contraindicated in patients with a nut or soya allergy.

It has also come to our attention that there are inconsistencies in the way different GP clinical systems alert prescribers to medicines containing allergens for patients suffering from nut or soya allergies. As different medicines contain different excipients, which can change from time to time, it is not possible to provide an exhaustive list of all medication that contain nut/nut derivatives or soya/soya derivatives. Therefore, it is important that prescribers advise patients with nut or soya allergies to ask their community pharmacist/ dispensing doctor to check that their prescribed and/or over the counter (OTC) medicines are suitable for them to take.

As with any medication allergies, patients with nut or soya related allergies, should also be recorded in the GP-held patient record within the Clinical System—using the appropriate read code for the allergy.

Safety concerns with paraffin containing emollients



As a result of some incidents locally, prescribers are reminded of the risks when prescribing paraffin containing emollients for patients, particularly those who smoke or are receiving oxygen therapy. The National Patient Safety Alert (NPSA) in 2007 highlighted that topical administration of paraffin based skin products have a potential fire risk as bandages, dressing and clothing that come in to contact with them are easily ignited with a naked flame or cigarette. The risk is greater when these preparations are applied to large areas of the body and clothing or dressings become soaked with the preparation.

This information was reiterated by the MHRA in their April 2016 Drug Safety Update.

The current evidence only relates to white soft paraffin (WSP) and there is no data to show that there is a fire hazard risk with preparations containing less than 50% WSP however the NPSA took the view that this risk applied to all paraffin "based" products.

What's the paraffin content of the different emollients?

The list below identifies the paraffin content of the most commonly prescribed products.
Please refer to your local formulary for further information.

Emollient	Paraffin content
Aveeno® cream	N/A
Balneum Plus® cream	<2% LP
Eucerin Intensive® lotion	<10%
Dermol® 500 lotion	10% LP
Dermol® cream	10% LP
QV® 5% lotion	5% WSP, 10% LLP
Cetraben® cream	13.2% WSP, 10.5% LLP
Zerocream®	14.5% WSP, 12.6% LP
Zerobase®	14.5% WSP, 12.6% LP
Doublebase® gel	15% LP
Hydromol Intensive®	27.15% WSP
Hydromol® ointment	30% YSP, 40% LP
Emulsifying ointment	50% WSP
WSP/LP 50:50	50% WSP
Emollin® spray	50% WSP

WSP = white soft paraffin
LP = Liquid paraffin
LLP = Light liquid paraffin,
YSP = Yellow soft paraffin

Please note that patients may be using a non-formulary product or may have purchased an over the counter emollient. Please refer to the BNF or manufacturer's information for the paraffin content of other products. Paraffin products can also be found as constituents in some commonly prescribed 'specials' creams and ointments, for example emulsifying ointment is often used as a diluent to lower the strength of a ready prepared ointment.

What advice should I give to patients?
<u>All patients and their families should be warned of the potential risks:</u>

- Using large quantities of any paraffin-based emollient (e.g. application of 100g or more at once or over a short period of time) increases the fire risk.
- Bedding and clothing should be washed regularly to minimise the build up of impregnated paraffin.
- Patients should be told to keep away from open or gas fires or hobs and naked flames, including candles, and not to smoke when using these paraffin containing preparations.

What about Oxygen Therapy?
Medical oxygen is non-flammable but strongly supports combustion (including some materials that do not normally burn in air). It is highly dangerous in the presence of oils, greases, tarry substances and many plastics due to the risk of spontaneous combustion with high pressure gases. Therefore, patients on medical oxygen who require an emollient should not use any paraffin based product. Naked flames and smoking are prohibited when medical oxygen is in use.

Patients who use nasal cannulae for oxygen administration can apply a water based moisturiser (such as KY jelly) to the lips and nose to prevent drying and cracking. Paraffin based products are not recommended as they can plug air holes and are a fire hazard.

Further information and resources can be found at the following address by inputting keywords - fire hazard
http://www.nrls.npsa.nhs.uk/resources/