Medicines Safety Matters

A Newsletter from the Derbyshire and Nottinghamshire CCGs Medicines Safety Officers Network. Issue 8 June 2018

NHS

Welcome to our regular edition of Medicines Safety Matters; a newsletter produced by your local CCG Medicines Safety Officers . Our aim is to highlight to you medication incidents that have occurred both locally and nationally, thus promoting and supporting safer practice.

Enoxaparin Incident

A high risk cardiology patient was recently discharged from hospital on 140mg Clexane® daily long-term. Prior to admission, the dose had been 120mg daily and this had been administered by the patient's carer using the 120mg pre-filled injection.

The discharge information did not provide any useful information as to what injections had been dispensed. The GP prescribed the 140mg dose as two separate syringes of 100mg and 40mg strengths as there is no 140mg strength syringe.

At a later review it was noticed that the 100mg strength had been issued but the 40mg strength had not. The patient was contacted and confirmed that they had only received one injection a day and had therefore been receiving 100mg daily not 140mg daily. Fortunately, this had been occurring for less than two weeks and the patient had suffered no consequences.

Issues to highlight:

- There is a 150mg syringe that is graduated to allow 10mg to be wasted before the 140mg is administered. This technique is likely to have been used in hospital but the patient and carer had not been made aware and shown how to do this prior to discharge.
- Avoid the need to administer two syringes where possible.
- Communication is necessary with both the patient (and carer) after discharge if confusion may occur e.g. after dose changes or with injections. In this case the district nurse visited the home to provide education to the patient and carer as to how to use the 150mg syringe to administer 140mg.

Prescribing in pregnancy or for women planning pregnancy

Following a local incident, where a woman who was trying to become pregnant was prescribed a potentially teratogenic drug, we would like to raise awareness of online resources that can help facilitate discussions and/or signpost patients to information with regards to medication that is either contraindicated in pregnancy or that should be avoided in a particular trimester

- http://www.uktis.org/
- http://www.medicinesinpregnancy.org/

Sodium Valproate - Women & Girls of childbearing age

The MHRA has determined that valproate medicines should now be contraindicated in women & girls of childbearing potential unless the conditions of a new Pregnancy Prevention Programme are met. Resources to support the Valproate medicines Pregnancy Prevention Programme are now available on the MHRA Valproate guidance page (scroll down to the 'Toolkit' section of the webpage).
For GP Practices, there is a 'Booklet for Healthcare Professionals' (for information) and also a 'Patient Booklet', which is the Patient Guide that is referred to in the MHRA Drug Safety Update that GPs must give to their patients at the point of review. Advice for healthcare professionals is that :-

- GPs **must** identify and recall all women and girls who may be of childbearing potential, provide the Patient Guide and check they have been reviewed by a specialist in the last year and are on highly effective contraception ie Long Acting Reversible Contraceptives (LARCs).
- Specialists **must** book in review appointments at least annually with women and girls under the Pregnancy Prevention Programme and re-evaluate treatment as necessary; explain clearly the conditions as outlined in the supporting materials; and complete and sign the Risk Acknowledgement Form—copies of the form must be given to the patient or patient/caregiver/responsible person and sent to their GP
- Use of valproate in pregnancy is ***contraindicated*** for bipolar disorder and must only be considered for epilepsy if there is no suitable alternative treatment

Importance of Medicines Reconciliation following Hospital Discharge

In a recent local incident, an elderly patient was admitted to hospital with cardiogenic shock following the unintentional co-administration of verapamil with bisoprolol. Verapamil had been changed to bisoprolol after a previous admission during which congestive heart failure was diagnosed but had not been removed from the patient's repeat prescription. The patient recovered after an adrenaline infusion was given in HDU.

In primary care, NICE advise to carry out medicines reconciliation for all people who have been discharged from hospital or another care setting. This should happen as soon as is practically possible, before a prescription or new supply of medicines is issued and within one week of the GP practice receiving the information. Medicines reconciliation, as defined by the Institute for Healthcare Improvement, is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines.

The cardiac depressant effects of verapamil and the beta blockers are additive. Concurrent use can cause serious bradycardia and cardiac depression and should only be considered under specialist supervision if myocardial function is well preserved.

Although unlikely this adverse interaction can also occur with beta blockers given as eye drops

References
Stockley's Drug Interactions – 10th Edition 2013
NICE Guideline NG5 - Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. March 2015

Controlled Drugs - Clear Dosing Instructions

NHS England recently circulated a report from a coroner whereby a patient was prescribed morphine 10mg/5ml solution by their GP, and later died through misadventure. The prescription was issued and dispensed in keeping with regulations, with a prescribed dose of *'take as directed by your doctor every four hours'*. The dose was discussed with the patient, however the coroner was concerned that neither the individual unit dose nor the maximum total daily dose was printed on the label of the medication.

ACTION: It is considered best practice to include clear dosing instructions on the prescription, such as the individual unit dose and maximum total daily dose. NHS England has acknowledged that the use of terms such as 'as directed' has reduced significantly in recent years. However, it is requested that as prescribers you:

1 Review the use of these phrases within your area of practice and wherever possible provide clear dosing instructions and a maximum total daily dose.

2. In any **exceptional cases** where it is deemed necessary to use 'as directed' or similar, provide the patient and/or their carer with explicit verbal and/or written instructions .

Inhalers – Risk of choking

There has been a rise in reports of patients inhaling foreign objects due to inhalers being stored incorrectly without the cap in place. Objects inhaled include coins, plastic, paperclips, tissue, false nails and a cockroach! Patients have needed the Heimlich manoeuvre and surgical removal in some cases.

The majority of cases occur with Ventolin®, possibly due to panic situations, using in the dark or whilst driving.

Cases have also occurred in GP surgeries when patients have been asked to demonstrate inhaler technique.

Please remind patients to replace caps on inhalers after use — this keeps dust and dirt off the mouthpiece and stops anything from getting into the inhaler and blocking the action. If an inhaler has been uncovered it should be checked prior to use and cleaned if necessary , the cap should then be placed on it.

Urgent Prescriptions & EPS System

We have had an incident, involving the death of a patient after an urgent prescription for antibiotics was sent via EPS to a pharmacy . This was never dispensed and subsequently not received by the patient,. Therefore please be aware that

the EPS system does not allow urgent prescriptions to be highlighted to the receiving pharmacy when sent from a GP system.

For patients who require an urgent prescription to be dispensed the pharmacy **must always be contacted** to highlight this.

Every effort has been made to ensure the information contained in this newsletter is accurate at the time of publication