Health and Social Care Board

Medicines Safety Matters

Sharing Learning Across Community Pharmacy In Northern Ireland

Vol 1 Issue 2 June 2012

This newsletter is sent to all Community Pharmacies in NI.

Please share with your colleagues

Also available on the internet, see link on the back page

Inside this issue:

Have you got the right patient?

29% of medication incidents reported anonymously by community pharmacists in NI have involved a patient receiving someone else's medicine

This type of incident can happen for a variety of reasons, the contributory factors and the actions taken to prevent reoccurrence reported by pharmacists are listed below:

Contributory factors

- Same medication but for two different people
- Two patients with the same or similar names
- Assumed all scripts received in a bundle were for the same person
- Patient collected the wrong script from the surgery and their identity was not checked properly when handing it out in the pharmacy
- Wrong label attached to the bag
- Prescription phoned through to pharmacy by the GP practice and the patient name was misheard
- Poor quality faxed prescription received from the surgery
- Pharmacy very busy
- Delivery to the wrong patient – e.g. delivered to a person living in a different street but with the same house number.

Actions taken to prevent reoccurrence

- Add warnings to the PMR if two patients have the same name
- When several prescriptions are handed in together don't assume they're all for one person. Separate them into different patients.
- Keep benches clear and use baskets or dispensing tubs to keep prescriptions and labels together for the same patient
- Always check address and DOB on both the script and the bag label
- When handing out a prescription, or during supervised administration, state the patient's name but ask **the patient** to confirm their address
- Ensure that 'phoned or faxed' prescriptions are the exception rather than the 'norm' (if phoning through a prescription is necessary, then the conversation should be between the two healthcare professionals i.e. pharmacist and GP, rather than support staff).
- Ensure delivery drivers follow the pharmacy's SOP for delivery of medicines and that they check patients' names and addresses carefully when delivering medication (see PSNI Guidance Supplementary Guidance for Pharmacists in NI on the Provision of Prescription Collection and /or Delivery Services February 2011).

HSCB letter Jan 2011 referring to dispensing without a prescription can be found at: http://www.hscboard.hscni.net/medicinesmanagement/Correspondence/024%20January%202011%20-%20Letter%20-%20Supply%20Medication%20Without%20a%20Prescription%20-%20PDF%2094KB.pdf

Obtaining urgent items for patients

A terminally ill patient experienced a long delay in obtaining medicines after being discharged from hospital over a weekend. Some of the options for obtaining urgent items are listed here as a reminder to staff.

During out of hours:
e.g. Saturday or during Sunday rota

- Contact another pharmacy or Palliative Care Network community pharmacy and direct the patient there if appropriate
- If the medicine is not available locally, your usual wholesaler should be contacted using their emergency number
- If your wholesaler is unable to supply, then contact your local Trust pharmacy
- If the medication still cannot be obtained, the local Out of Hours (OOHs) centre should be contacted to discuss if an alternative medication may be prescribed.

Note: if the prescriber is an OOHs GP who is available, you may wish to contact them before wholesaler/Trust pharmacy to discuss alternatives.

In hours:

- If your local wholesaler cannot deliver within an appropriate time, contact another pharmacy or Palliative Care Network community pharmacy and direct the patient there if appropriate
- If another pharmacy or the wholesaler cannot supply the medication, contact the patient's GP to discuss if an alternative medication may be prescribed
- If this is not possible, the local Trust pharmacy should be contacted.

Arrangements for collection or delivery of the medication should always be agreed with the patient.

Check methotrexate 10mg prescriptions

For almost ten years, prescribers in NI have followed NPSA and DHSSPS recommendations that only methotrexate 2.5mg tablets are prescribed and dispensed. The number of patients remaining on the 10mg tablet is very low and the majority of pharmacies no longer stock this strength of oral methotrexate. HSCB regularly monitors and provides information to GP practices about their methotrexate prescribing. However, the prescription data used is 3 months in arrears and is not the ideal way to spot inadvertent prescribing of the 10mg strength.

Advice for community pharmacists:
Community pharmacists continue to play a key role in ensuring patient safety with methotrexate and any <u>new</u> prescriptions for the 10mg strength should be queried directly with the prescriber.

Test your knowledge on factors that have featured in incidents with opioid transdermal patches

1. BuTrans® '10' patch is used for severe pain	True	False
2. An increase in external temperature effects drug absorption	True	False
3. An increases in body temperature effects drug absorption	True	False
4. Rotating the site of patch application is recommended	True	False
5. Opioid patches should be prescribed by generic name	True	False
6. Patches should be cut up into small pieces before disposal	True	False

7. How often should the following patches normally be changed?

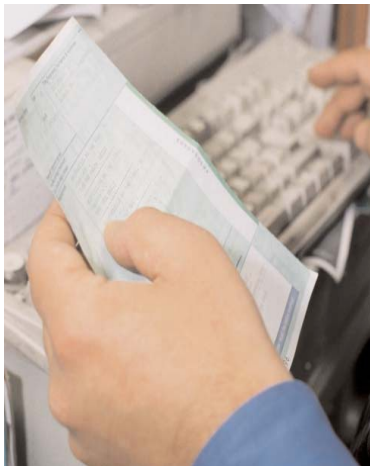
Transtec® Butrans® Durogesic DTrans® Mezolar®

Answers on page 4

Dispensing from the Patient Medication Record (PMR)

There have been 14 anonymous incidents reported to HSCB since October 2011 where pharmacists stated that the main contributory factor was generating dispensing labels from the PMR without checking for changes in the current prescription. In most cases the patient was taking the same medication but at a different dose or strength. The incidents are summarised in this table.

Reminder action: Labelling, assembly and checking should always occur against the current prescription.



Medication change intended	Medication dispensed
Adcal D3® chewable changed to Adcal® chewable	Adcal D3® chewable
Co-amilofruse 2.5/20mg changed from one every other day to one in the morning	Co-amilofruse 2.5/20mg one every other day
Co-codamol dose reduced from 30/500mg to 8/500mg	Co-codamol 30/500mg
Furosemide dose increased from 20mg to 40mg	Furosemide 40mg (but labelled incorrectly as 20mg)
Levothyroxine dose reduced from 50 micrograms to 25 micrograms	Levothyroxine 50 micrograms
Madopar® dose increased from 62.5mg to 125 mg	Madopar® 62.5mg
Metformin 500mg changed to modified release prep	Metformin 500mg ordinary release
Quetiapine dose reduced from 50mg to 25mg	Quetiapine 50mg
Quinine sulphate dose reduced from 300mg at night to 200mg at night	Quinine sulphate 300mg
Ranolazine dose increased from 375mg to 500mg	Ranolazine 375mg
Temazepam dose reduced from 20mg to 10mg.	Temazepam 20mg
Tramadol 50mg. Quantity reduced from 50 capsules to 28 capsules	Tramadol 50mg x 50 capsules
Zolpidem dose reduced from 10mg to 5 mg	Zolpidem 10mg

Risks when the wrong urinary catheter is dispensed

A Foley catheter is an indwelling urinary catheter that is retained by inflating an integral balloon at the tip of the catheter when it has been placed inside the bladder.

There are two sizes of Foley catheter balloon:

- **10ml balloon** - commonly used in primary care
- **30ml balloon** - rarely used in primary care. It is primarily used after urological surgery to help prevent bleeding in the bladder.

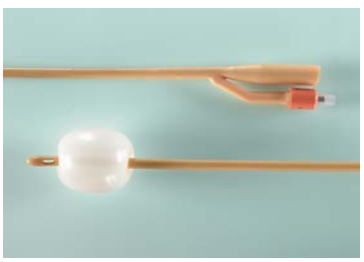
Risks associated with use of the larger 30ml balloon:

- Irritation in the bladder
- Pressure on the pelvic floor and bladder neck
- Infection - sitting higher in the bladder, they cause a residual pool of urine which can lead to increased risk of infection.

There have been a number of reports where pharmacists have supplied the Foley catheter with a 30ml balloon instead of the intended 10ml balloon size

Advice for community pharmacists:

- Query any prescription for a 30ml balloon catheter with the prescriber to ensure that it is the intended product
- Take care to order the correct catheters from wholesalers
- Take care to check product details when dispensing catheters.



Eye drop mix–ups reported

The following mix-ups with eye drop preparations have been reported recently by community pharmacists.

Betoptic® 0.25%	Betagan® 0.5%
Xalatan®	Xalacom®
Lumigan® 100mcg/ml	Lumigan® 300mcg/ml
Bimatoprost 100mcg/ml	Bimatoprost & timolol

Quiz–Answers

1. False — Butrans® '10' patch is not suitable for treatment of severe pain. It is licensed for moderate, non-malignant pain. A 10 microgram/hour patch is equivalent to 6 - 12mg per day of oral morphine or 60 - 120mg per day of oral codeine. Incidents have occurred when low strength buprenorphine has been prescribed when a strong opioid was required.
2. True — Increases in external temperature e.g. hot baths, saunas can increase drug absorption, see Medicines Safety Matters (Prescribers & Community Pharmacists) vol 2 issue 1 March 2012 for more information.
3. True — Increases in body temperature can also increase drug absorption e.g. fever
4. True — The main risk of using the same site repeatedly is due to an increase in drug exposure and absorption. Manufacturers have different advice for site rotation e.g. Transtec® - at least 1 week should elapse before site is reused, Butrans® - 3-4 weeks should elapse before site is reused. Check individual manufacturer's recommendations for advice to patients. It is a common misconception that site rotation is to reduce skin irritation.
5. False — HSCB recommends that opioid patches are prescribed by brand to reduce the risk of confusion between matrix e.g. Durogesic DTrans®, Mezolar® and reservoir patches e.g. Matrifen®.
6. False — Patches should be folded over on the sticky side prior to disposal to ensure that the adhesive/drug releasing side is not exposed. Incidents have occurred when discarded patches have been found by children and patches swallowed by pets.
7. Transtec® lasts for 4 days but changed twice per week
   Butrans® changed every 7 days
   Durogesic® & Mezolar® changed every 3 days (occasionally every 2 days if end of dose "tail off" is observed)
   Changing patches more frequently than recommended will not increase the analgesic effect.

Thank you for reporting

Thank you for all the anonymous reports that have been received for the newsletter.

Please continue to support learning by sharing your experiences of pharmacy incidents or near misses with other pharmacists.

Where to find the reporting form:

Pads of reporting forms have been sent to all pharmacies, if you need further copies, contact one of the Medicines Governance Team listed below.

Download the form from the internet:
http://www.hscboard.hscni.net/medicinesmanagement/Medicines%20Governance/index.html#P-1_0

HSCB Medicines Governance Team

Team Leader:	Belfast Area:	Northern Area:	Southern Area:	South Eastern Area	Western Area
Brenda Bradley	Briegeen Girvin	Contact another	Anne Marie Groom	Helen Bell	Joanne McDermott
Tel: 07917544301	Tel: 07748630415	pharmacist in the team	Tel: 07817428869	Tel: 07920187940	Tel: 07909757674
Brenda.Bradley@hscni.net	Briegeen.Girvin@hscni.net		Annemarie.Groom@hscni.net	Helen.Bell@hscni.net	Joanne.McDermott@hscni.net