Health and Social Care Board

Medicines Safety Matters

Sharing Learning Across Community Pharmacy In Northern Ireland

Vol. 2 Issue 1 Jan 2013

This newsletter is sent to all Community Pharmacies in NI.

Please share with your colleagues

Inside this issue:

What happens with dispensing incident reports at HSCB?

Research has shown that the most effective way to improve safety across any discipline is to encourage reporting of incidents and then disseminate the learning.[1]

This article describes how reports received by HSCB about dispensing incidents & near misses are managed and how the information from them is shared with other pharmacists.

The reports received fall into two categories:

1. Reports from another body/ person where the pharmacy has been named e.g.

- RQIA e.g. following care home inspections
- hospitals e.g. following review of patients' own drugs
- other health care professionals
- patients.

As the Board has a responsibility for its contractors in respect of governance, these named incidents are reviewed with the pharmacy. In most cases, they will be followed up 'in house' by the pharmacists in the HSCB Medicines Governance Team. However, if the incident has resulted in serious harm to a patient or if there were other serious factors involved, then the incident will be discussed with DHSSPS and the Pharmaceutical Society of N.I. as well as the pharmacy.

2. Anonymous reports from pharmacists

The anonymous reports sent in by community pharmacists are the main source of the learning points shared regionally with other pharmacists and they provide a highly valued contribution to patient safety.

Pharmacists can be assured that their anonymous reports are not scrutinized or investigated in any way (except in rare circumstances where a 'named report' also comes in from another source for the same incident). Any post received into the HSCB offices is opened by clerical staff and postmarks on envelopes etc are not available to the HSCB Medicines Governance Pharmacists. Information from these anonymous reports is reviewed to establish any trends and identifying learning that can be shared across the profession in the following way:

Medicines Safety Matters Newsletters

A community pharmacy edition which is based on pharmacy learning and a joint pharmacy & prescriber edition which includes incidents that also have a prescribing element.

Medicines Safety Alerts

These alerts cover serious incidents or where there have been a number of similar incidents reported.

1. Seven steps to patient safety in primary care NPSA

How can pharmacists get involved in anonymous reporting?

Download the form

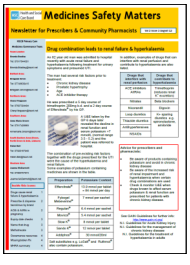
link to HSCB internet site on front & back page -look under 'Medicines Governance'

Use the pad of forms issued to pharmacies

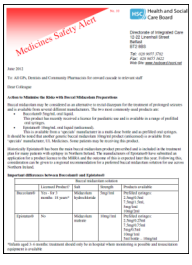
Can't find it?
Need more?
Contact us for further supplies

Thank You!

Community Pharmacists



Primary Care Prescribers & Community Pharmacists



Medicines Safety Alerts

All learning resources are posted to community pharmacies in N.I. and are also available to download from the HSCB website:

http://www.hscboard.hscni.net/medicinesmanagement/index.html

Beta blocker incidents resulting in patient harm

As a profession, we are all aware of the devastating effect that a beta blocker dispensing error had when a locum pharmacist in England dispensed propranolol instead of prednisolone to a 91 year old woman. The dose of the prednisolone was 8 tablets per day and the patient died as a consequence of taking the incorrect drug. The pharmacist was initially convicted of a criminal offence and given a custodial sentence which was then dropped on appeal. The outcome of the case gave impetus to the ongoing campaign to decriminalise inadvertent dispensing errors.

The table below lists some of the incidents involving beta blockers that have been reported to us. A number of these cases have caused harm and resulted in the patient being admitted to hospital.

Pharmacists should be mindful of this risk and be vigilant when checking and dispensing prescriptions for beta blockers.

Drug dispensed	Drug prescribed	Incorrect drug taken	Harm to patient
Atenolol syrup 50mg bd	Atenolol syrup 10mg bd	**Yes**	**Yes**
Atenolol 100mg mane	Allopurinol 100mg mane	**Yes**	**Yes**
Allopurinol 100mg	Atenolol 100mg	unknown	
Atenolol 25mg	Atenolol 100mg	unknown	
Bisoprolol 2.5mg	Bendroflumethiazide 2.5mg	**Yes x 2**	**1 Yes** 1 No
Bisoprolol 1.25mg	Not on a beta blocker – wrong patient	**Yes**	No
Atenolol & bisoprolol	Bisoprolol only (atenolol had been changed to bisoprolol)	**Yes**	**Yes**
Metoprolol 50mg	Metoclopramide 50mg	**Yes**	**Yes**
Propranolol 80mg bd	Propranolol 40mg bd	**Yes**	No
Propranolol 40mg	Pantoprazole 40mg	No	No
Pravastatin 40mg bd	Propranolol 40mg mane	No	No

Latest dispensing mix-ups

Intended Medication	Dispensed Medication
Alendronic acid	Risedronate
Escitalopram	Citalopram
Hyoscine Hydrobromide (Kwells®)	Hyoscine Butylbromide (Buscopan®)
Levocetirizine	Desloratadine
Meloxicam	Mirtazapine
Quetiapine XL	Quetiapine (standard release)
Plaquenil®	Priadel®
Plendil®	Pletal®
Sectral®	Securon®
Vermox®	Venlafaxine

Good Practice Points:

- Be aware of look-alike/sound-alike products
- Review pharmacy storage areas to identify possible risks
- Consider placing warning labels on products or their storage areas (regardless of whether they are stored separately or in close proximity)
- Talk to the patient or carer about their medicine as a way to detect potential errors. This gives an opportunity for the patient or carer to say if the medication is not one that they are expecting.
- Consider use of bar-coding technology to allow for automated checks.

Use of caffeine-based substances leads to deaths

The recent death of a young woman in Northern Ireland due to a seizure and ventricular fibrillation is being investigated by a hospital Trust as suspicious. The woman was said to have taken a "speedball". Traditionally this term is used to describe a combination of cocaine / morphine, but is also used to refer to diet pills which often contain caffeine. The toxicology report of the woman showed a fatal level of caffeine only. A second, similar case has also been reported.

The Drug and Alcohol Monitoring and Information Service (DAMIS), has received anecdotal information on the use of caffeine substances among their clients in Northern Ireland and on the availability of substances with high caffeine levels. Reports received indicated a range of caffeine misuse including excessive energy drink, diet pill and caffeine tablet intake.

Advice for pharmacy staff:

Community pharmacists and pharmacy staff should be aware of the potential toxic effects when caffeine is consumed in very large amounts, and the fact that the general population may be unaware of this. Advice and education is likely to be the best approach in the vast majority of cases.

The Professional Standards and Guidance for the Sale and Supply of Medicines issued by the Pharmaceutical Society of N.I. allows for refusal to supply where abuse/misuse is suspected of an OTC preparation.

Pharmacists should be mindful of the general availability of caffeine in both OTC medicines and supplements (see below) and the need to reinforce with advice on potential harm where necessary.

For further information from DAMIS, or to report concerns about the use of high caffeine substances in your area, contact Victoria Creasy (DAMIS) by email: victoria.creasy@hscni.net

Caffeine content of food and drinks	
Substance	**Caffeine content**
Ground coffee	60-180 mg/150 ml cup
Instant coffee	30-120 mg/150 ml cup
Tea	20-60 mg/150 ml cup
Cola	30-40 mg/330 ml can
Energy soft drinks	80 mg/250 ml can
Chocolate (plain)	up to 50 mg/50 g (milk chocolate contains about half the caffeine content of plain chocolate)

A fatal dose of about 5-10 g (or 150-200 mg/kg body weight) is usually quoted in the literature.

Suspected overdoses should be referred for urgent medical assessment.

Refs:
NPIS/Toxbase, accessed 19 July 2012
http://www.medicines.org.uk/emc/

Examples of caffeine-containing medicines/ products	
Product	**Caffeine content**
Alka Seltzer XS®	40mg
Anadin Original®	15mg
Anadin Extra®	45mg
Beechams Active Cold Relief®	25mg
Beechams Flu® cap	25mg
Beechams Powders®	50mg
Benylin Cold & Flu Max®	25mg
'Diet Pills'	Up to 250mg
Hedex Extra®	65mg
Lemsip Max Cold & Flu®	25mg
Migril®	100mg
Panadol Extra®	65mg
Pro Plus®	50mg
Solpadeine®	65mg
Syndol®	30mg
Sudafed Day & Night®	25mg

Oxycodone Mix-Ups

A number of incidents have been reported involving an incorrect oxycodone formulation being supplied to the patient.

Contributory factors identified:

- Use of generic nomenclature on the prescription for oxycodone
- Selection error at the point of labelling/dispensing.

The outcome of these errors could have been serious, especially in an opiate naïve patient.

Oxycodone Brands:

Oxycontin®* *tablets
(sustained-release)
Available as 5mg, 10mg, 15mg, 20mg, 30mg, 40mg, 60mg, 80mg, 120mg
Dosing regime: 12 hourly

Oxynorm®* *capsules
(immediate release)
Available as 5mg, 10mg, 20mg
Dosing regime: 4-6 hourly when required

A second person should always check the quantity or volume and strength of a CD when dispensing

Learning Points

- Certain CDs should be prescribed by **brand name** due to differing dosage regimes (see Items Unsuitable for Generic Prescribing list):

  http://primarycare.hscni.net/pdf/Generic_Exception_List_Nov2011.pdf

- If an oxycodone product is prescribed generically, the pharmacist should check with the prescriber which preparation is intended if this is not clear from the prescription directions

Good practice points:

- CD cabinets should be kept tidy and stock separated to highlight the different brands/ strengths
- A second person should check the quantity/volume and strength of a CD being dispensed
- Pharmacists should maintain a running balance of stock in their register and check the CD register balances with the physical amount of stock after each transaction **and** at regular intervals to ensure irregularities are identified quickly. These checks should be initialled & dated.
- CD SOPs should be in place and all staff trained in these.

http://www.dhsspsni.gov.uk/safer-management-of-controlled-drugs-a-guide-to-good-practice-in-primary-care-version-2-july-2011.pdf

Who to contact when you have an incident involving a CD:

1. DHSSPS Pharmacy Inspectorate

Joe Gault
joe.gault@dhsspsni.gov.uk
tel: 028 9052 0768

Tony Wallace
anthony.wallace@dhsspsni.gov.uk
tel: 028 9052 8688

2. HSCB local Medicines Governance Pharmacist (details below)

Other CD mix-ups reported recently	
Palexia®	Palexia SR®
Sevredol®	MST®
MXL®	MST®

Medicines Safety Matters on the web: http://www.hscboard.hscni.net/medicinesmanagement/index.html

Primary Care Medicines Governance Team Contact Details

Lead:	Belfast Area:	Northern Area:	Southern Area:	South Eastern Area	Western Area
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