Health and Social Care Board

Medicines Safety Matters

Newsletter for Prescribers & Community Pharmacists

Vol 3 Issue 2 Sept 2013

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HSCB Primary Care Medicines Governance Team

Different indication - different dose

A 39 year old patient was prescribed ropinirole for restless legs syndrome. The prescription was issued for ropinirole 5mg tablets with the directions 'Take one tablet five times daily' (i.e. total daily dose of 25mg). The prescriber had intended to prescribe the 1mg strength giving a total daily dose of 5mg.
The maximum daily dose recommended for ropinirole is **4mg** for restless legs and **24mg** in 3 divided doses for Parkinson's disease.
The pharmacist did query the unusual dose with the patient but did not contact the prescriber to check their intention. The patient took the higher dose for one week and required treatment in a psychiatric unit for the adverse drug effects.

Maximum dose of ropinirole for Parkinson's disease is 24mg daily - six times the maximum dose for restless legs syndrome

Ropinirole recommended doses:		
	Parkinson's disease	**Restless legs syndrome**
Usual Dose	9-16mg daily in 3 divided doses	2mg at night
Maximum dose	24mg daily in 3 divided doses	4mg daily

Advice for prescribers:

- Check the indication when prescribing ropinirole; see BNF or SPC for information
- Check the dose prescribed is as intended.

Advice for pharmacists:

- Check the dose matches the indication for ropinirole prescriptions
- Where a discrepancy is noted, contact the prescriber directly to clarify the intention.

Reminder: Immunosuppressants & vaccination

The use of live vaccines is contraindicated with immunosuppressants and for a number of these medicines, until at least six months after stopping treatment (see chapter 6 of Green Book for further details). Two of the newer vaccines that fall into the live strain category are Fluenz® and Zostavax®

GP practices and pharmacists are reminded of this contraindication but also that many of the medicines involved are either **red list** (biologic therapies e.g. adalimumab, etanercept) or **amber list** (e.g. ciclosporin, azathioprine, cyclophosphamide, leflunomide) medicines, which may be supplied by the hospital pharmacy. A search of the medication record on the GP or community pharmacy system may not identify these medicines. In addition, if they have not been issued by the GP practice in the last 6 months, they will not be included in the ECS or ECR.

If there is any doubt, contact the hospital prescriber and as a final check, always ask the patient/carer.

The Green Book
https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

Immunosuppression & flu vaccination – PHA Letter 30 August 2013
http://primarycare.hscni.net/2956.htm

Caution re Shingles Vaccination and immunosuppressive treatment
PHA Email to GP Practices 20 September 2013
http://primarycare.hscni.net/2713.htm

Take care with immunosuppression and vaccines
Medicines Safety Matters March 2013
http://www.hscboard.hscni.net/medicinesmanagement/

Steroid mix-ups

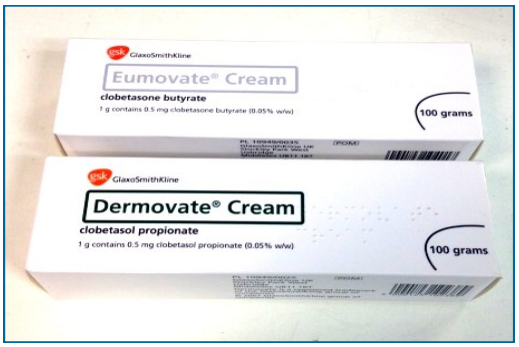
There have been incidents reported by Trust dermatologists where patients have been prescribed or dispensed the incorrect steroid preparation due to a mix up between the names of **clobetasone butyrate** and **clobetasol propionate**.

As the two steroids have different potencies, mix-ups could result in a reduced treatment effect or increased side effects.

Generic name	Brand Name	Potency
Clobetasone butyrate	Eumovate®	Moderately potent
Clobetasol propionate	Dermovate®	Very potent

Factors contributing to mix-ups:

- Similar generic names
- Similar brand names
- Similar packaging, same manufacturer
- Positioned closely together on shelf



Insulin card introduced as 'Passport'

By now, many patients using insulin will have been given their insulin card which has been introduced in Northern Ireland as our regional arrangement for the NPSA 'Insulin Passport'. The insulin cards, produced by the various insulin manufacturers, are usually issued to patients by the diabetic team. Healthcare staff should refer to the insulin card at the point of prescribing, dispensing and administering insulin to ensure the correct product has been selected.

Long time - No see

60% of dispensing errors reported to the HSCB are selection errors, a number of which have included medicines that are less commonly used.

In one example, a patient received bumetanide 5mg tablets when the prescribed medicine was buspirone 5mg. The patient took the incorrect medicine for over 3 weeks before the error was noticed and required hospital admission due to severe dehydration and interaction with concurrent medicines.

This incident highlights the importance of vigilance if you are asked to prescribe or dispense medicines that are less commonly used.

Examples from local incidents
IV heparin injections
Bendroflumethiazide 5mg
Bumetanide 5mg
Atenolol 100mg
Slow Na®
Sulfadiazine 500mg
Methotrexate 10mg

Advice for prescribers and pharmacists:

- Confirm the validity of any prescription or recommendation for medicines that are less commonly used.

Did you know? When to use high strength oxycodone injection

A medication incident has been reported which highlights the possible risk of confusion between different strengths of oxycodone ampoules.

Both strengths can be used for subcutaneous injections and in syringe drivers, however, the more concentrated preparation (50mg/1ml) is used less frequently and only in the following circumstances:

Syringe Driver:

- When higher doses of oxycodone are needed
- When use of the weaker strength would result in an infusion volume which is too large for the syringe or driver in use.

Breakthrough Pain:

- Where using the weaker strength would result in a volume too large to be administered by subcutaneous injection

For further information on the use of oxycodone in palliative GAIN guideline: Management of Pain at the End of Life in Adult Patients. www.gain-ni.org

Oxycodone Injection
10 mg/ml (1ml and 2ml amps)
50 mg/ml (1ml amp)

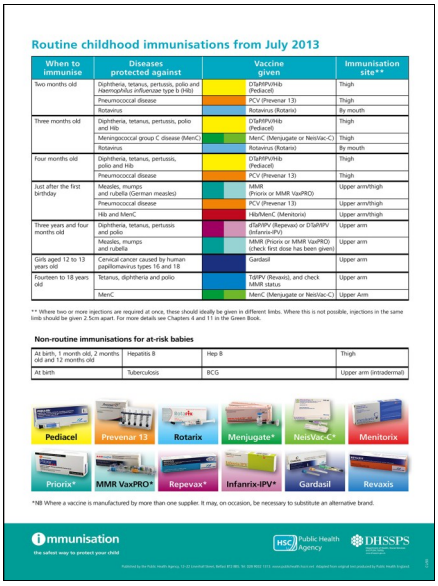
Advice for prescribers, pharmacists & nurses:

- Take care when the higher strength of oxycodone (50mg/1ml) is used, especially where lower dose ampoules are also in use for the same patient
- Calculations should be checked carefully to confirm the correct volume for the dose prescribed
- Take care when using generic versions of oxycodone injection which may look different to the brand preparations.

Avoiding vaccine mix-ups

This year sees three new vaccination programmes introduced to Northern Ireland, protecting against flu, shingles and rotavirus, as well as an update to the current meningitis C vaccine schedule.
Two new vaccines will appear in many practice fridges for the first time; Rotarix® for rotavirus and Zostavax® for shingles.

To coincide with the changes, the Public Health Agency has produced a poster outlining the new routine childhood immunisation schedule, highlighting the range of vaccines now available and using colour coding to distinguish between them.



Displaying the poster prominently, along with a fridge tidy-up, will help to reduce the risk of the wrong vaccine being selected, particularly when vaccines have similar names or packaging.

Practices and pharmacies are encouraged to look at their refrigerators and how they are organised:

- Clear out clutter and check expiry dates
- Allocate a place for each vaccine, using printed shelf labels if possible
- Set a stock level for each vaccine; a maximum of two week's supply should be plenty if the practice gets a delivery once a week
- For the seasonal flu and shingles vaccines, practices should order sufficient supplies to meet **weekly** needs, storage space permitting
- Separate similar names e.g. Prevenar® and Priorix;® Repevax® and Revaxis®
- Allowing space for air to circulate is important for temperature regulation and also makes it less likely that the wrong vaccine will be picked
- Once you have the fridge in good order put a photograph of your hard work on display to encourage others to keep it that way!

Poster available at www.publichealth.hscni.net/publications/immunisation-poster-professionals-july-2013

Confused by antipsychotics?

Recently the HSCB has been notified of number mix ups involving antipsychotic injections. In three cases the patient received flupentixol (Depixol®) when the intended medicine was zuclopenthixol (Clopixol®). In the fourth mix up, the patient was administered Clopixol Acuphase® instead of their usual depot formulation. A summary of the formulations of these medicines is given in the table below:

Flupentixol and zuclopenthixol injection preparations		
Flupentixol		
Depixol®	Flupentixol decanoate 20mg/ml 1ml or 2ml amps	Long acting Depot
Depixol Conc®	Flupentixol decanoate 100mg/ml 0.5ml or 1ml amps	Long acting Depot
Depixol Low Volume®	Flupentixol decanoate 200mg/ml 1ml amp	Long acting Depot
Zuclopenthixol		
Clopixol®	Zuclopenthixol decanoate 200mg/ml 1ml amp	Long acting Depot
Clopixol Conc®	Zuclopenthixol decanoate 500mg/ml 1ml amp	Long acting Depot
Clopixol Acuphase®	Zuclopenthixole **acetate** 50mg/ml 1ml or 2ml amp	**Shorter acting**

Factors contributing to the mix ups:

- Incorrect medication specified on the note from outpatients. Although the correct medication was stated on the full discharge letter, this was not received for several weeks, by which time the patient had received an incorrect prescription and the wrong depot injection.
- A dispensing error occurred when flupentixol decanoate was dispensed instead of zuclopenthixol.
- The wrong preparation was selected on the GP clinical system.

Learning points:

- Antipsychotic injections can be easily mixed up and care should be taken when prescribing, dispensing or administering
- Always prescribe by brand name to reduce the risk of confusion
- There are two different esters of zuclopenthixol available - the decanoate and the acetate. In some clinical systems, the word 'depot' does not appear in the description of the injection, which can lead to further confusion.
- If an incorrect preparation is prescribed, ensure this is placed into 'past drugs' to prevent another incorrect re-issue.

How to report faulty medicines

What to do if you discover a faulty or defective medicine

Defective medicines incidents are rare and as such healthcare professionals may be unaware of what guidance to follow.
When a defective or faulty medicine is discovered, the priority for wider patient safety is for an accurate on line report to be sent as soon as possible to MHRA and to inform DHSSPSNI by telephone.

This allows MHRA to act quickly to issue a recall if necessary and DHSSPSNI to be forewarned of any likely action that may follow.

Details of the MHRA online reporting system and contact telephone numbers are available on the BSO website:

http://www.hscbusiness.hscni.net/services/2455.htm