Medicines Safety Alert

No. 1

Health and Social Care Board

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To: **All GPs and Practice Managers for onward cascade to Nurse/Independent Prescribers and relevant reception staff.**

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Dear Colleague

Clinical Risk Assessment When Issuing Repeat and Acute Prescriptions

The Board has recently reviewed several cases where excessive quantities of medication were prescribed and dispensed for patients over a prolonged period.
GPs, and their practice staff, have both an opportunity and an obligation to take action to protect the patient where there are concerns about the quantities of medicines being requested. In the past, failures to observe this obligation have come to the attention of the HSCB Local Advisory and Investigative Panel (LAIP).
Some significant learning points for GPs and their practice staff were identified in these reviews and I am now writing to bring these to your attention. They can be summarised as follows:

- **Always check when the drug was last issued to the patient and if a repeat drug is requested "early" ask why the early request is being made. The GP should be made aware of this reason.**

- **If a patient requests a drug that does not appear on their "repeat" medication screen, no prescription should be issued; this request should be noted for the GP to deal as per practice policy.** Items which have been issued "acutely" in the past should not be printed off by practice staff.

- **Pay particular attention to medicines which have the potential for over-use or abuse (such as paracetamol/opioid combinations; benzodiazepines etc) and those medicines which otherwise can present high risk to patients in over-use**. If a clinical decision has been made that these items are suitable for repeat prescribing, ensure that these medications are only "authorised" as repeat drugs for a limited time period, after which a review should occur to assess continuing indication.

- **When a hospital letter, or information from an out-patient clinic, is received into the practice, only a GP, or other qualified prescriber, should add the drug information onto the patient's medication record.** Several incidents have occurred recently in general practice in Northern Ireland when a member of the practice team other than a prescriber has entered medication history from a hospital letter onto the patient's medication record and an error has occurred in the resulting prescription.

- **Extra caution is required for drugs which have similar names.** Appendix 1 contains further information on the drug names which commonly cause confusion and have previously led to patients being issued, and then consequently dispensed, with the wrong medication.

- **The re-printing of prescriptions should be kept to a minimum.** Prescriptions should only be re-printed in exceptional circumstances. If a prescription appears to have been printed off, but is not in the "prescription collection" box, a thorough search should be done (in GP consultation rooms etc); a check should be made if the prescription has already been collected (by local pharmacy or patient representative) and only when all of these have been exhausted should the prescription be re-printed. A note should be made that the prescription has been re-printed.

- **In exceptional circumstances only, it may be necessary to telephone a prescription through to a community pharmacy from the GP surgery.** When these occasions arise, the ideal situation is that the GP telephones the pharmacy and asks to speak to the pharmacist to discuss the details on the prescriptions. A conversation should NEVER occur between a member of the practice administrative staff and one of the pharmacy assistants.

- **If the patient is taking a RED list medication (supplied by the Trust) a note should be made on their medication history to indicate that the patient is taking the RED list medication.** This is to ensure that anyone assessing the patient's clinical condition is aware of the full medication history for the patient and any potential drug interactions or side effects that may arise from the RED list medication

All of the above issues should be addressed in the practice's Repeat Prescribing Protocol. If appropriate, you may wish to review your protocol and make the appropriate amendments.

If you have any queries, please contact a member of the Prescribing Team .

Yours sincerely

Mr Joe Brogan
Asst Director Integrated Care
Pharmacy and Medicines Management

APPENDIX ONE

Examples of drugs with similarities in names which may be a contributory factor in medication incidents

The pairs of drugs most commonly involved in 'wrong drug' or 'wrong strength' dispensing errors are:

Amiloride and Amlodipine
Fluoxetine and Paroxetine
Hydralazine and hydroxyzine
Carbamazepine and carbimazole
Omeprazole 10 mg and 20 mg
Atenolol 100 mg and 50 mg
MST 10 mg and 30 mg
Paroxetine 20 mg and 30 mg
Warfarin 3 mg and 5 mg
Diazepam 2 mg and 5 mg
Co-codamol 30/500 and 8/500

Reference
Building a Safer NHS for Patients: Improving Medication Safety. A report by the Chief Pharmaceutical Officer. Department of Health 22 January 2004

The following list highlights some similarities in drug names; it is not exhaustive:

Aminophylline……Amitriptyline
Amiloride ……...Amlodipine
Clarithromycin ……..Ciprofloxacin
Amlodipine…….. ..Amiodarone
Lamisil®…….. …..Lamictal®
Risperidone……. ..Risedronate
Procyclidine…….. Prochlorperazine
Sulfasalazine…….Sulfadiazine
Dopamine ……Dobutamine
Celectol® ……...Celebrex®

Reference
Multidisciplinary eLearning programme on Medicines Governance NICPLD QUB

Others that have been identified through local adverse incidents:

Pregaday® ……..Pregabalin
Repevax® ……...Revaxis®
Mercaptamine …….Mercaptopurine
Amitryptiline …….Atenolol
Clobetasone…….Clobetasol