Medicines Safety Newsletter

Issue 2 – February 2018

Welcome & Happy New Year

Before we welcome you to our second edition of the Community Pharmacy West Yorkshire Patient Safety Newsletter, may we take this opportunity to wish all our contractors and pharmacy teams a belated Happy New Year. Now that we are a month into the New Year, it's good to look ahead and think about what this year may bring us. But first, a quick look back.

2017 was quite a year for community pharmacy and a lot has been achieved despite less than favourable circumstances. The Medicines Safety Newsletter was developed as a forum for sharing learning from patient safety incidents which had happened locally, a requirement of the Written Patient Safety Quality Criterion in the Quality Payments Scheme introduced by the Department of Health in 2017. At time of writing no decisions have been made on the future of the Quality Payments Scheme beyond 2017.

Patient safety is fundamental to all that you do and you will no doubt recognise the importance of safely dispensing medication and providing appropriate advice to patients and the public. While things run seamlessly most of the time, it is important to learn the lessons when something does go wrong. This is why we would still like to encourage you all to continue to share with us any dispensing incidents or near-misses you may have been involved with so that we can share the learning locally.

Share and Learn

You will already be reporting patient safety incidents nationally, (to the NRLS), and/or via your local reporting system. **Please continue to follow your company's SOP for incident reporting.**

However, please also help us to support all our West Yorkshire Pharmacy Teams by "sharing and learning". If you have come across or been involved in a dispensing error (or other medicines related incident) it is likely that this may not be a "one off". The chances are that this may have already happened at the pharmacy over the road and may yet happen at the pharmacy in the next town. By reporting incidents and sharing the learning you can prevent this from happening and potentially save a patient from harm.

We would like to thank you all for your significant support and dedication during these challenging times. The year ahead will bring its own challenges but by working together, keeping focussed on our priorities and putting our patients first we can realise our ambitions.

Please continue to feed in to this newsletter and let us know about any significant medicines related incidents which have occurred in your place of work.

Report it – for everyone's sake!

If you wish to share any medicines safety incidents, (with your learning), with other West Yorkshire pharmacies via this newsletter please complete the Report, Learn, Share, Act, Review template (click here) and return to info@cpwy.org.

All reports will be treated completely anonymously and no details of who submitted the report will be shared outside of the Community Pharmacy West Yorkshire team. Please remember to NOT send any patient identifiable details.

IMPORTANT ALERT - FIRE RISK WITH PARAFFIN BASED EMOLLIENTS

PLEASE ENSURE ALL YOUR STAFF ARE AWARE OF THE RISKS AND PROVIDE APPROPRIATE COUNSELLING AND ADVICE TO PATIENTS.

Individuals using paraffin-based emollients should be advised to keep away from fire or flames as dressings and clothing soaked with the emollient can be easily ignited.

There has been another recent death, (in September), in West Yorkshire linked to fire and emollient use. We are unable to give any details of this case currently as the inquest has not yet been heard, however, there has now been **THREE deaths in the last 3 years in West Yorkshire and 37 fire deaths nationally in the last 10 years** which have been linked to the use of paraffin-based skin products.

This is Pauline Taylor who died in May 2015. Mrs Taylor was a 74 year old grandmother who lived alone in a flat in Huddersfield with a Care Line facility.

She was a regular smoker whose health had deteriorated and had recently become bedbound but had continued to smoke in bed.

Mrs Taylor was getting several daily visits from her family, care staff and the District Nursing Team and was receiving daily applications of Zerobase 11% paraffin base for psoriasis.

She had received a visit late on the evening of her death and was presenting as expected. Less than 5 hours later, the care line was activated and the fire service and members of Mrs Taylor's family were alerted. The fire crew entered Mrs Taylor's flat using breathing apparatus but unfortunately Mrs Taylor had burnt to death. The subsequent Coroner's hearing found that matches and emollient creams had accelerated the fire and contributed to its intensity.

The following main issues have been reported by West Yorkshire Fire Service following a review of Mrs Taylor's case (and other recent cases):

- ALL paraffin-based skin products, including those which contain a low level of paraffin, pose a potential fire hazard risk.
- Flammability warnings of risks are not always displayed on product packaging (or not clearly displayed).
- Health care professionals (both in the hospital and community setting) may not be aware of the potential fire hazard posed by paraffin-based skin products.
- Pharmacists and their teams are generally not counselling patients to make them aware of the potential fire hazards associated with these products.

When patients are being treated with a paraffin-based emollient, (including products with low levels of paraffin), covered by either a dressing or clothing, there is a danger that smoking or a naked flame could cause the dressings or clothing to catch fire. Community pharmacy teams have a role to play in advising patients not to smoke; use naked flames (or be near people who are smoking or using naked flames); or go near anything that may cause a fire while emollients are in contact with their medical dressings or clothing.

ACTIONS FOR THE PHARMACY TEAM

When dispensing/selling any paraffin-based product all patients should be advised of the:

- Risk of fire when using paraffin- based emollients
- Patients should be told to keep away from open or gas fires or hobs and naked flames, including candles etc. and **not to smoke** when using these paraffin containing preparations.
- Bedding and clothing should be washed regularly (preferably daily) to minimise the build-up of impregnated paraffin although it may not be completely removed.

There are some useful resources which pharmacy teams can distribute when counselling their patients on the risks which include posters, stickers and patient leaflets developed by the NPSA. Teams may wish to record in their PMR system each time these are distributed. Paraffin safety resources can be downloaded here.

Incident Sharing – Rivaroxaban, Rosuvastatin and Rabeprazole

We have been made aware of a recent incident in Wakefield where a patient was dispensed rivaroxaban instead of rosuvastatin. This follows a number of other incidents reported which involve a combination of rivaroxaban, rosuvastatin and rabeprazole; all have similar names and are available in 10mg and 20mg strengths. Please exercise caution when dispensing these medicines and consider the following good practice points below:

- Physically separate these products (and any other medicines with similar names) on the dispensary shelves.
- Highlight by using brightly coloured shelf edge labels to prompt vigilance when selecting these drugs (or other similar sounding medicines).
- Take extra care when checking prescriptions dispensed by inexperienced/trainee staff.
- Analyse errors which have occurred in your pharmacy and draw up a list of medicines which have been commonly involved in errors especially those with similar sounding names and similar packaging.
- Ensure that all members of the pharmacy team, especially pharmacists, are aware of this list and take additional care when dispensing them
- Take steps to minimise the risk of further errors with these medicines.

Incident Sharing - Emergency Supplies/NUMSAS Requests for Drugs Liable to Misuse

It has been recently been brought to our attention that a lady, registered with a Doncaster GP, has been regularly seeking emergency supplies of pregabalin. The usual story is that she has lost her medication or forgotten them and is about to get on a train for a trip, work or holiday, or frequently a family funeral in Ireland or Amsterdam. Apparently, she's quite convincing with her story - picking on times when the pharmacy is busy. She has a good understanding of the emergency supply process and is happy to pay for the medication.

She has also sought supplies via 111/NUMSAS (NHS Urgent Medicines Supply Advanced Service) and Out of Hours (OOHs) services as well as pharmacies across the Yorkshire and possibly wider area - sometimes successful, sometimes not.

Please can all pharmacies continue to be vigilant for **ANY** requests for drugs of abuse and view a patients' (Summary Care Record (SCR) and/or contact the practice if requested to make an emergency supply of pregabalin or gabapentin, or any other items subject to abuse potential.

It is the decision of each pharmacist as to whether supply is appropriate or not. The pharmacist needs to balance the potential for misuse versus the need and the impact on the patient of not supplying. A limited supply of 1 or 2 days, until the next working day for GP practices could be considered if a supply is deemed appropriate.

If you have any queries or concerns about NUMSAS please contact Melissa Burnley at melissa@cpwy.org.

Incident Sharing – Urgent Prescriptions & Electronic Prescription Services (EPS)

We have recently received notification of a serious incident which occurred in Nottingham, (resulting in the death of a patient), that has important learning points for anyone involved in EPS.

Details of the incident:

- Following a home visit a GP returned to the practice and issued an EPS prescription to the adjoining pharmacy.
- The prescription was urgent and for antibiotics
- The patient's family and GP expected the pharmacy team to deliver the medicines.
- The prescription was downloaded and sent to print but not labelled, dispensed, checked or delivered.
- The pharmacy had no record of any verbal request from the GP, patient or the patient's family requesting the medication be delivered urgently.
- The medication was therefore never dispensed or supplied.
- The patient collapsed 5 days later and was admitted to hospital. He sadly passed away 3 days later with the cause of death recorded as sepsis.

The 5 Whys:

1. **Why was the medication not delivered?**
   1.1. *The pharmacist and team did not know about the existence of the prescription or that there was any urgency, so did not prioritise dispensing, checking or to organise a delivery.*
2. **Why did the pharmacist and team not know?**
   2.1. *There is currently no way to flag any acute and urgent prescriptions on the EPS system.*
   2.2. *There was no message in the communications book regarding an urgent delivery for this patient.*
   2.3. *The token was not available for labelling and so the alert on the PMR to deliver prescriptions did not come into play.*
3. **Why was the token not available for labelling?**
   3.1. Investigation was inconclusive. The token either did not print, a printer error or was mislaid after printing.
4. **Why might the token not print?**
   4.1. There appeared to be no reason why the token did not print. No information to be able to investigate this further.
5. **Why was the token not available for labelling?**
   5.1. The prescription was downloaded and printed with one other, for a patient waiting in the pharmacy. It is possible that the token could have been mislaid at this point.
   5.2. As the token was not available for labelling, the dispensing process stopped here and the patient did not receive their antibiotics.

Learning Points

- The EPS system does not allow urgent prescriptions to be highlighted to the receiving pharmacy when sent from a GP system. This is independent of the pharmacy system supplier the pharmacy uses.
- Any notes on the prescription are not visible to the pharmacy until they print or open the prescription.
- Although the EPS system is very robust there are occasions when the system does not work as well as it should. This can be due to internet connection reliability and software or hardware failure which can result in prescriptions not being received or printed by the pharmacy.
- **Therefore, the EPS system alone cannot be solely relied upon to deliver important or urgent messages and prescriptions. All prescribers, clinicians and their teams must ensure these messages are conveyed directly to the receiving pharmacy by phone or face-to-face.**

Other learnings from the pharmacy investigation include:

- To check the system for printed but not labelled prescriptions
- To concentrate on one urgent prescription at a time.

Resources to Support the Care of Patients with Acute Kidney Injury

Acute kidney injury (AKI) is a sudden reduction in kidney function. It is not a physical injury to the kidney and usually occurs without symptoms, making it difficult to identify. Late diagnosis can miss opportunities for early treatment, leading to prolonged and complex treatment and reducing the chances of recovery.

In England over half a million people develop AKI every year and 5-15% of all admitted hospital patients are affected. Around 40,000 excess deaths per annum are associated with the condition, up to a third of which are thought to be preventable. Older people and those with chronic conditions such as heart failure, diabetes and chronic kidney disease are particularly vulnerable at times of acute illness such as sepsis.

A Patient Safety Alert was issued back in August 2016 to raise awareness of AKI and to signpost clinicians from all care settings, including community pharmacists, to a set of resources developed by "Think Kidneys" (the NHS campaign to improve the care of people at risk of, or with, AKI). The resources support the public and staff working in acute, primary and community care to better understand kidney health and to help prevent, identify and manage AKI.

Resources specifically for pharmacists and patients, (there are a number of patient advice leaflets), can be downloaded here. Public awareness posters, endorsed by the Royal Pharmaceutical Society, for display in pharmacies can be ordered by completing the online form here. The posters are free and pharmacies can order as many as required.

CPPE have also developed a number of educational materials for pharmacists and technicians on this topic:
CPPE Learning Campaign on Acute Kidney Injury
CPPE Educational Video - Ravinder's Story

Drug Safety Updates (MHRA)

The contents of the recent Drug Safety Updates (and some summaries) are listed below. For further information about any of these updates refer to MHRA Drug Safety Updates in full by clicking here.

October 2017 (click here for October Drug Safety Update)

- Methylprednisolone injectable medicine containing lactose (Solu-Medrone 40 mg): do not use in patients with cows' milk allergy.
- Gabapentin (Neurontin): risk of severe respiratory depression.
- Isotretinoin (Roaccutane): rare reports of erectile dysfunction and decreased libido.
- **Clozapine: reminder of potentially fatal risk of intestinal obstruction, faecal impaction, and paralytic ileus.** If constipation occurs during treatment with clozapine (Clozaril, Denzapine, Zaponex), it is vital that it is recognised and actively treated. Whilst community pharmacists may not know whether a patient is taking clozapine, (this is a red drug so prescribed in secondary care), it may be worth asking any patient who complains of constipation whether they are taking clozapine. Any affected patient should be advised to tell their doctor immediately before taking the next dose of clozapine.

November 2017 (click here for November Drug Safety Update)

- Gentamicin: potential for histamine-related adverse drug reactions with some batches
- Quinine: reminder of dose-dependent QT-prolonging effects; updated interactions.
- **Oral tacrolimus products: reminder to prescribe and dispense by brand name only**. The growing number of oral tacrolimus products available on the market increases the potential for inadvertent switching between products, which has been associated with reports of toxicity and graft rejection. Therefore, to ensure maintenance of therapeutic response when a patient is stabilised on a particular brand, oral tacrolimus products should be prescribed and dispensed by brand name only. Pharmacists should always dispense the exact brand prescribed; they should contact the prescriber if the prescription is not clear to ensure the appropriate medicine is dispensed. Patients should be advised to take careful note of the brand name of their usual tacrolimus medicine and should check with their doctor or pharmacist if they receive a different brand or if they have any other questions about the prescription, eg about the dose.
- Support our second social media campaign for suspected adverse drug reactions.
- **Antiepileptic drugs: updated advice on switching between different manufacturers' products.** Different antiepileptic drugs (AEDs) vary considerably in their characteristics, which influences the risk of whether switching between different manufacturers' products of a particular drug may cause adverse effects or loss of seizure control. AEDs have been divided into three risk-based categories to help healthcare professionals decide whether it is necessary to maintain continuity of supply of a specific manufacturer's product. See here for categorisation. In addition to the 3 risk-based categories of antiepileptic drugs, patient-related factors should be considered when deciding whether it is necessary to maintain continuity of supply for a specific product. Core advice from 2013 remains in effect for prescribing antiepileptic drugs to manage epilepsy. Pharmacists should ensure the continuity of supply of a particular product when the prescription specifies it. If the prescribed product is unavailable, it may be necessary to dispense a product from a different manufacturer to maintain continuity of treatment of that AED. Such cases should be discussed and agreed with both the prescriber and patient (or carer). Usual dispensing practice can be followed when a specific product is not stated
- Updates to Public Health England's Green Book chapter on live attenuated vaccines.

If you have any feedback, suggestions or wish to include anything in our next newsletter please email info@cpwy.org. Thank you.

Patient Safety Incident Reporting

REPORT Report all errors and near misses
Involve the whole team

LEARN Identify and investigate causes of errors
Use them as learning opportunities

SHARE Discuss with others and promote learning

ACT Make changes to practice

REVIEW Review changes to practice