Medicines Safety Newsletter

NHS North East London

Issue 1 – May 2023

Promoting Safe Use of Medicines Across Primary Care

Welcome to the first edition of our Medicines Safety Newsletter produced by the NEL Medicines Safety and Quality Group. Our aim is to highlight medicines safety concerns and updates raised nationally and locally to support and promote safer use of medicines across North East London

Medicines Safety & Quality Group (MSQG)

The group: is a subgroup of the Integrated Medicines Optimisation and Prescribing Committee (IMOC) with members from across the Integrated Care System (ICS) to include primary, secondary and community care.
Our purpose is to improve the quality of prescribing and the safe use of medicines, by working collaboratively with our partners and local communities, to ensure the best possible health outcomes for our local population.
Our priorities:
Our strategy includes **7 key priorities** to support the implementation of the national Medicines Safety Improvement Plan (Med SIP) consisting of: risk and incident management**,** high risk medicines**,** Dependence Forming Medicines (DFMs) prescribing safety**,** improving medicine optimisation at discharge, overprescribing, and medication safety in care homes.

Latest News

Tackling Opioid Medicines Prescribing in NEL:

The MSQG is taking a system-wide approach to reduce harm from opioids in line with NHSE medicines safety programme. We have engaged with key stakeholders across the system, community services and public health to form a NEL Opioid Stewardship group. The key aims of this group are to promote good opioid prescribing practice, improving staff and patient education on opioid use for chronic pain. A range of resources will be developed and shared to support prescribers when prescribing opioids.

Monitoring High Risk Medicines (HRMs) with Eclipse Live:

Eclipse Live is a digital risk stratification tool that is compliant with our local NEL GP clinical systems. It uses clinical algorithms to identify patients at risk of potential medicine-related hospital admissions. Monitoring of HRMs has been a Key Line of Enquiry (KLOE) of recent Care Quality Commission (CQC) inspections where improvements were required. Eclipse Live offers an audit trail of actions taken by a practice that can be used as evidence as part of CQC inspections.

Action for practices:

- MSQG encourages practices to use Eclipse Live to identify patients requiring HRM monitoring Structured Medication Reviews (SMR) and to prepare for CQC inspections. For more information click **Eclipse Live**

Learning from Patient Safety Events (LFPSE)

Harm caused by medication errors is recognised as a global issue amid increasingly complex healthcare needs and the introduction of many new medicines.
More than 237 million medication errors are made every year in England (as per **research paper**), with 66 million of these potentially clinically significant, the avoidable consequences of which cost the NHS upwards of £98 million and more than 1700 lives every year. Prescribing in primary care accounts for 22.4million (34%) out of 66 million potentially clinically significant errors.
LFPSE is a **central online service** for health care professionals to record, review and share learning from medication related incidents and patient safety events that occur across the NHS whether they result in harm or not.
The MSQG would like practices to share any learning from incidents with their immediate and wider teams in order to improve prescribing and reduce the risk of future/similar incidents. To facilitate this shared learning, practices are encouraged to record any medication incidents on LFPSE.

Key Learnings from Incidents – 3 incidents in the last quarter

As part of our key agenda, MSQG supports sharing and learning from medicines safety incidents that occur across the ICS to raise awareness of avoidable medicines safety issues and reduce the risks of unintended harm from medicines use.

Incident 1 - Lithium Toxicity:

A patient on long term lithium and clozapine, was seen in an outpatient setting and discharged with no concerns and stable mental health. Patient was later admitted to hospital with dehydration, myoclonic jerk and low sodium. On investigation, it was identified that the patient had developed acute kidney injury (AKI) with a toxic lithium level of 1.84 mEq/L. (0.6 to 1.2 mEq/L) and that neither the outpatient clinic or the GP surgery had monitored the patient's lithium levels.

Action for practices:

- To review Eclipse Live on a **weekly** basis to ensure all patients on high risk medicines have regular blood tests. Lithium is one of these number of high risk medications
- Further details for the prescribing and monitoring of lithium can be found here. link

Incident 2 - Zopiclone Toxicity:

Following the death of a patient who had been prescribed zopiclone PRN for insomnia for approximately 20 years, the medical certificate stated zopiclone toxicity as the cause of death. This patient had a past medical history of schizoaffective disorder and previous suicide attempts.
A recent Public Health England (PHE) report highlighted that more people are being prescribed medicines associated with dependence and withdrawal symptoms inappropriately and for longer than recommended – including cases with fatal outcomes. This class of medicines were antidepressants, benzodiazepines, gabapentinoids, opioids and 'Z' drugs.
The MSQG has identified this as a priority area to be reviewed as part of the DFMs and overprescribing workstreams.

Action for practices:

- To identify and review patients on long-term use of Z-drugs and benzodiazepines - initiate a conversation on harm with long-term use and consider de-prescribing.
- To ensure patients have a clear treatment plan, on initiation, with rationale for short-term use to manage insomnia, offering patient information for potential dependence.
- Information at transfer of care with relevant primary and secondary care contacts should include - duration, review date, review by, tapering/ stopping regime.
- Avoid adding DFMs as a repeat item on patients record.
- Additional resources Zopiclone NICE Guidance

MHRA Latest Drug Safety Updates

- Xaqua® (metolazone) 5mg tablets: rate and absorption are formulation dependent. Prescribers and dispensers to exercise caution if switching patients between preparations LINK
- Topical testosterone (Testogel®): risk of harm to children following accidental exposure LINK
- Electronic Prescribing & Medicines Administration Systems: (ePMAS) may qualify as medical devices. Report adverse incidents involving these devices to the MHRA's Yellow Card scheme LINK

Additional Medicines Safety Resources

- **MHRA** - for all MHRA updates on alerts, recalls and safety information on drugs and medical devices, click here
- **Specialist Pharmacy Service -SPS** - Medication Safety Updates click here
- **PrescQIPP** - for medicines safety tools and resources including audit templates and searches on PrescQIPP, click here
- Report suspected adverse effects with medicines, devices or COVID-19 vaccines via the **Yellow Card scheme** **or** **Coronavirus Yellow Card reporting site**