Medicines Safety Newsletter
Issue 2 – August 2023

NHS North East London

Promoting Safe Use of Medicines Across Primary Care

Welcome to the second edition of our Medicines Safety Newsletter produced by 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

Contents

Latest News

For Medicine Supply Shortages: The SPS Medicines Supply Tool offers up-to-date information on Medicines Shortages, provided by DHSC and NHSE/I. To access Click here

World Patient Safety Day 2023: To be observed on **17th September 2023** under the theme "Engaging patients for patient safety", in recognition of the crucial role patients, families and caregivers play in the safety of health care. Click here for details.

Tackling Overprescribing (polypharmacy) in NEL: he first NEL webinar 'Introduction to polypharmacy 'Understanding polypharmacy causes, consequences and remedies' is to be hosted on 5th September 2023. This informative session will include talks from a multi-disciplinary team of local clinicians. Click to **Book Here**
The aim of the session is to:

- appreciate the scale of the polypharmacy problem in our local area
- recognise the drivers of polypharmacy and barriers to stopping medicines in older patients
- applying concept to real cases and what to consider when stopping and starting drugs in the polypharmacy context

Improving valproate safety in NEL: NEL Medicines Safety and Quality Group is working collaboratively with ICS stakeholders and the Pan-London group via the High Risk Medicines network, to improve valproate safety. The focus is to increase the number of patients on valproate with a current Pregnancy Prevention Programme (PPP) and to develop a valproate register to improve monitoring. Valproate review has been included as part of the NEL Prescribing Quality and Efficiency scheme 2023/24 (PQES) to support practices to ensure key areas of the PPP criteria are effectively managed in primary care.

Learning from Patient Safety Events (LFPSE) – National Highlights

Incident – Infant Morphine Overdose:

A serious incident involving a 4-week-old baby from the North East and Yorkshire region following an overdose of morphine sulphate oral solution, at a dose 20 times higher than the intended dose. The baby parents were supplied with a bottle of **10mg/5ml** oral solution instead of the **100mcg/ml** oral solution. The 100mcg/ml oral solution is a 'Specials item' and often 'HOSPITAL ONLY' on most regional formularies. The baby survived following treatment with Naloxone. National incident review data has shown that this is the fifth occurrence of such incidents which has led to a death of a baby in one of the cases. Access to the full alert can be found here.

Action for practices:

- To conduct face to face medicines reconciliation with patients/parents/carers where there are concerns or complex prescriptions identified on discharge summaries. E.g. for paediatric prescriptions, ask parents to bring in medicines supplied by the hospital
- To ensure prescriptions contain the full drug name, formulation, strength, daily maximum doses for PRN (when required) medication and **for liquid prescriptions, doses are both in quantity and volume** (e.g.mg/mcg and ml) must be included.
- **Prescriptions be written in full with no abbreviations e.g. micrograms not mcg**
- To add weight and date of weighing on paediatric prescriptions to aid pharmacist's complete clinical assessment of prescriptions
- To consider developing a register for babies and children with complex conditions, so these patients can have improved access to a named GP or clear handover arrangements.

Learnings from Incidents across North East London Integrated Care System

As part of our key agenda, MSQG supports the 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 – End of Life (EoL) prescription on MAAR Chart

A patient was referred to the District Nurses for end-of-life care, had their pan-London MAAR chart **handwritten** incorrectly by the GP instead of using the template that can be found on EMIS and SystemOne GP IT systems. The chart was illegible and doses unclear, i.e. morphine dose intended as 2.5-5**mg** appeared as 2.5-5**g**.
No administration of the incorrect dose was given as the district nurses identified the mistake and the chart was corrected.

Action for practices:

- Use electronic EoL Pan London MAAR charts that can be found on EMIS / SystemOne
- Write doses in full with no abbreviations i.e micrograms not mg
- Where issues arise, staff should contact the **prescriber directly** and not go through third parties. Incidents or risks should be reported and escalated as appropriate.
- The practice manager or practice prescribing lead must ensure that all relevant staff are trained on the electronic template for End of Life prescriptions.

Incident 2 – Insulin Safety:

Due to the increase of medicine issues related to insulin, the Bart's Health Insulin Safety Committee in collaboration with the Diabetes Network and Medicines Safety and Quality Group have agreed key actions to improve the safety of insulin use:

- Reducing insulin related incidents by 20%
- Reduce the incidence of diabetic ketoacidosis (DKA), hyperosmolar hyperglycaemic state (HHS) and severe hyperglycaemia in inpatients by 20%.

One of the key factors highlighted that increase the risk of incidents relating to insulin, is ambiguous or lack of information on discharge summaries or information relayed to patients. Therefore, the committee in collaboration with ELFT is undertaking a transfer of care project and conducting deep dives into the quality of information provided on discharges.

Action for practices:

- To identify any issues or incidents relating to insulin especially those that arise once patients are discharged from hospital via the LFPSE portal.

Incident 3 - Varicella Post Exposure Prophylaxis:

A serious incident occurred involving a pregnant woman who was exposed to varicella, and referred to her local A&E for varicella immunoglobulin (VZIG). A&E sought advice from the obstetrics and gynaecology team and agreed to treat with VZIG. The A&E consultant discussed VZIG supply with a junior pharmacist, who dispensed the live vaccine instead of the VZIG which is contraindicated in pregnancy. This led to the administration of the wrong product to the patient. The patient suffered harm which may have been contributed by the incorrect drug being administered. In this case, acyclovir tablets could have been prescribed instead and referral to A&E may have been unnecessary.

Key contributing factor in this incident was not accessing the most up to date online information from the most appropriate source e.g. the UKHSA or Green Book etc.

Action for practices:

- GPs and prescribers must refer to the most up-to-date online UKHSA / Green Book guidelines for advice.
- Do not rely on hardcopies or downloaded versions of resources e.g. the Green Book which may not have the most current advice.
- Staff should always escalate queries and complex prescriptions to the appropriate member of staff.

MHRA Latest Drug Safety Updates

MHRA Latest Safety Alert – August 2023

Please find information on the latest Drug Safety Updates from the MHRA. Click here

- Fluoroquinolone antibiotics: reminder of the risk of disabling and potentially long-lasting or irreversible side effects
- Methotrexate: advise patients to take precautions in the sun to avoid photosensitivity reactions
- Valproate: re-analysis of study on risks in children of men taking valproate

Other information from the MHRA you may find helpful:

- Hyoscine hydrobromide patches (Scopoderm 1.5mg Patch or Scopoderm TTS Patch): risk of anticholinergic side effects, including hyperthermia
- Non-steroidal anti-inflammatory drugs (NSAIDs): potential risks following prolonged use after 20 weeks of pregnancy
- Adrenaline auto-injectors (AAIs): new guidance and resources for safe use

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** – for Medication Safety Updates click here
- **PrescQIPP** - for medicines safety tools and resources, click here
- Report suspected adverse effects with medicines, devices or COVID-19 vaccines via the **Yellow Card scheme** **or** **Coronavirus Yellow Card reporting site**

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