National Medication Safety Network

Observatory
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Observatory of recent safe medication practice research, reports, and publications

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Recent regulator and statutory body activity

NHS England

MHRA
Regulating Medicines and Medical Devices

European Medicines Agency
Science Medicines Health
Stage One: Warning

Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder

05 February 2015

- A care home resident died following the accidental ingestion of the thickening powder that had been left within their reach. Whilst this death remains under investigation, it appears the powder formed a solid mass and caused fatal airway obstruction.

- NB – liquid medicines are often thickened with thickening powder.
Oxycodone prescribing incidents

- A number of CD incidents have been reported related to prescriber mistakes in picking oxycodone oral solution resulting in at least two admissions hospital.
- **Oxycodone 10mg/ml** (at top of pick list on EMIS) has been prescribed instead of oxycodone 5mg/5ml
- The next CD newsletter will include advice
- Please highlight the potential problem to GP practices
  - Via practice pharmacists
  - Via a message on ScriptSwitch (if you have it)
  - By altering the pick list on behalf of practices.
- Community pharmacies are asked to question all new scripts.
Drug Safety Update
February 2015

• INOmax (nitric oxide) cylinders: valve defect might stop gas delivery early in some cylinders
  – While this defect is still being investigated - always have a full spare cylinder loaded on the delivery device so the cylinders can be switched without delay
  
  Drug Safety Update volume 8 issue 7, February 2015: 2

• Drugs and driving: blood concentration limits set for certain drugs
  – A new offence will be enforced from 2 March 2015 in England and Wales.
  – Talk to patients who are on medicines with potential to impair driving and discuss the patient leaflet advice.
Drug Safety Update

February 2015

Prescribed medicines affected by the legislation include:

- Cannabis
- Cocaine
- Morphine
- Diamorphine
- Methadone
- Ketamine
- Amphetamine
- Flunitrazepam
- Clonazepam
- Diazepam
- Lorazepam
- Oxazepam
- Temazepam
• **Advice to give to patients** taking any medicine:

  – Continue taking your medicine as prescribed
  – Check the leaflet that comes with your medicine for information on how your medicine may affect your driving ability
  – It is against the law to drive if your driving ability is impaired by this medicine
  – Do not drive while taking this medicine until you know how it affects you (especially just after starting or changing the dose of the medicine)
  – Do not drive if you feel sleepy, dizzy, unable to concentrate or make decisions, or if you have blurred or double vision.
• New drugs and driving legislation: Advice for pharmacists and their patients

• Available to members at
http://www.rpharms.com/support-resources-a-z/drugs-and-driving.asp
‘Dear Healthcare Professional’ letters

• **Vismodegib** (**Erivedge ▼**), sent by Roche in January 2015
  – indicated for the treatment of adult patients with symptomatic metastatic basal cell carcinoma or locally advanced basal cell carcinoma inappropriate for surgery or radiotherapy.
  – important changes to the management of the UK pregnancy prevention programme (PPP) to minimise the risk of teratogenicity
  – the PPP has been revised to give pharmacists a role in ensuring that all patients are appropriately and adequately counselled, and pregnancy prevention measures documented
Pharmacovigilance Risk Assessment Committee (PRAC) recommendations

February 2015

• New measures to minimise known heart risks of hydroxyzine-containing medicines

  • Use at the lowest effective dose for as short a time as possible.
  • Not recommended in the elderly.
  • Maximum daily dose - no more than 100 mg in adults (50 mg in the elderly if use cannot be avoided), and 2 mg per kg body weight in children up to 40 kg in weight.
  • Avoid in patients with risk factors for heart rhythm disturbances or taking other medicines that increase the risk of QT prolongation.
  • Care in patients taking medicines that slow the heart rate or decrease the level of potassium in the blood, as these also increase the risk of problems with heart rhythm.
In Use Product Safety Assessment Report for Relvar® Ellipta® (fluticasone furoate/ vilanterol trifenatate inhalation powder)

From January 2015 - GSK has changed the product packaging of Relvar® Ellipta® which is now yellow (originally blue).
This months papers

- What are incident reports telling us? A comparative study at two Australian hospitals of medication errors identified at audit, detected by staff and reported to an incident system
  [http://intqhc.oxfordjournals.org/content/early/2015/01/12/intqhc.mzu098.abstract](http://intqhc.oxfordjournals.org/content/early/2015/01/12/intqhc.mzu098.abstract)

- Adverse drug events in patients admitted to an emergency department: an analysis of direct costs
  Pharmacoepidemiology and Drug Safety Feb 2015;24(2):176-186

- Omitted medications: a continuing problem
  [http://www.clinmed.rcpjournal.org/content/15/1/12.full.pdf+html](http://www.clinmed.rcpjournal.org/content/15/1/12.full.pdf+html)
This months papers

- Exploring safety systems for dispensing in community pharmacies: focusing on how staff relate to organizational components
  Research in Social and Administrative Pharmacy 2015; 11(2): 216-227
  [Link](http://www.sciencedirect.com/science/article/pii/S155174111400103X)

- A Program Using Pharmacy Technicians to Collect Medication Histories in the Emergency Department
  [Link](http://europepmc.org/articles/PMC4296593;jsessionid=XmR68uDbMd2OzLQJQWuG.1)

- General practitioner views of an electronic high-risk medicine proforma to facilitate information transfer
  International Journal of Clinical Pharmacy Feb 2015;37(1):4-7
  [Link](http://rd.springer.com/article/10.1007/s11096-014-0033-8)
Omitted Medications: a continuing problem

• Clinical Medicine Feb 2014;15(1):12-14
• An audit of the administration of prescribed medications in acute medical wards in a district general hospital (Wrexham Maelor Hospital)
• Aim - to assess the frequency at which medications were omitted in the non-admitting medical wards, using two point-prevalence studies spaced one month apart.
• 200 patients in acute medical wards were included in the study
Omitted Medications: a continuing problem

- 73% of drug charts had at least one omitted medication
- 48% had two or more medications omitted
- 27% of charts showed full compliance
- The most common causes of omission were
  - Patients’ refusal (47.22%),
  - Patients’ inability to take the medicine (22.7%).
  - Medication unavailability (17.04%)
Medicines optimisation: identifying medicines associated with serious medication errors

Medicines optimisation: identifying medicines associated with serious medication errors

• The systematic review identified over 600 medication errors in just over 500 patients
• 47% of the serious medication errors were caused by 7 medicines or classes of medicines
  – methotrexate
  – warfarin
  – non-steroidal anti-inflammatory drugs (NSAIDs)
  – digoxin
  – opioids
  – aspirin
  – beta-blockers.
Medicines optimisation: identifying medicines associated with serious medication errors

• 10 medicines accounted for 73% of all medicines causing fatal events
• 20 accounted for 84% of all medicines causing non-fatal events
• In total 23 different medicines or classes of medicines were implicated
• These 23 medicines caused 82% of all serious medication errors.
The review highlights that there are a small number of well-known medicines or classes of medicines that are implicated in the majority of fatal events and medication errors. Though any medicine has the potential to cause harm it is important that health professionals recognise these potentially high risk medicines.
Exploring safety systems for dispensing in community pharmacies: Focusing on how staff relate to organizational components

- **Research in Social and Administrative Pharmacy 2015; 11(2): 216-227**

- Aim - to examine the activities that take place in community pharmacy dispensing, and to identify the ways in which organizational components either contribute to or reduce safety
Exploring safety systems for dispensing in community pharmacies: Focusing on how staff relate to organizational components

- Approximately 360 hours of observations and 38 interviews were conducted
- 52,500 words from 15 case studies and interview transcripts were analyzed
Exploring safety systems for dispensing in community pharmacies: Focusing on how staff relate to organizational components

• Four broad categories emerged which demonstrate the interdependency of unsafe acts and latent conditions
  – Dispensing with divided attention
  – Dispensing under pressure
  – Dispensing in restricted spaces
  – External influences