Patient safety quarterly report (England): Quarter 3 (July – September) 2018

The NPA's Director of Pharmacy, Leyla Hannbeck, is the Medication Safety Officer (MSO) for all independent community pharmacies in England with fewer than 50 branches.

Dear Superintendent,

This is the NPA Medication Safety Officer's (MSO) patient safety report for Quarter 3 of 2018. It includes a summary of the most common dispensing errors reported to the NPA during the quarter along with top tips for minimising patient safety incidents.

Introduction

Although there was a slight reduction of patient safety incidents reported in Quarter 3 of 2018 compared to Quarter 2, the total number of reports remain consistently high. The month of July received the highest submission of reports compared to the months of August and September of 2018.

The updated **MSO Incident Reporting Platform** has been launched. This user-friendly platform will effective incident reporting, in a methodological order. There is an option for the form to be sent via email after completion to help reduce administrative time as the emailed form can be kept for pharmacy record requirements.

! An option has been created for selecting 'Look-alike sound-alike (LASA) errors' when an incorrect item has been dispensed

! Donot to include any personal data in the form, including that of the patient and team member

All MSO quarterly reports can be used to demonstrate evidence of sharing learning as part of the Quality Payment patient safety quality criteria.

IMPORTANT

- Please ensure that **all** reports submitted are complete reports
- Avoid selecting '*other*' when answering questions

NOTICEBOARD

Adrenaline auto-injectors (AAIs) – protocol

Following ongoing supply issues with EpiPen® and EpiPen® Junior AAIs, the Department of Health and Social Care (DHSC) and NHS England has issued an interim protocol, for dispensing **all brands of AAIs 150mcg.**

From Wednesday 17 October 2018, pharmacies/dispensing doctors receiving any prescription (NHS/private) for all brands of AAIs 150mcg must follow a 2-step validation process until further notice. Please ensure pharmacists and members of the pharmacy team are familiar with the interim protocol and FAQs document for further details.

The MHRA has also approved specified lot number of EpiPen® 300mcg and specified lot number of Jext 150mcg and 300mcg, to be used past their expiry date during this critical period of shortage.

Further guidance can be found on our NPA website with a dedicated webpage for all adrenaline-related news; this includes the latest adrenaline auto-injector stock update.

Valproate treatment – females of childbearing age

The Medicines and Healthcare products Regulatory Agency (MHRA) is continuing to receive reports that female patients taking valproate-containing medicines are still unaware of the serious

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risks in pregnancy and are still not receiving key safety information. An MHRA Central Alerting System alert has been issued for pharmacists to inform them of the issues not being addressed.

Community pharmacists and their teams are reminded:

- ! **Do not supply** valproate-containing medicines to females of child bearing age unless the Pregnancy Prevention Programme (PPP) is in place
  - Prescribers may opt a premenopausal female patient out of the PPP if there is a reason why there is no risk of pregnancy
- ! **Always supply** a relevant patient information leaflet – photocopy/print as appropriate
- ! **Dispense whole packs**, where possible
  - Attach warning labels/stickers to the medicine carton – available in the valproate information materials
- ! **Discuss risks** of valproate use in pregnancy with **all** females **each time** valproate-containing medicines are dispensed; ensure:
  - The patient has a Patient Guide – provided by GP
  - The patient has discussed their treatment and the need for contraception with their GP/specialist
- ! **Place valproate information materials** in a specified location so it is easily accessible to all pharmacy team members involved in dispensing
  - Dispose outdated materials related to valproate medicines

Pharmacy contractors are advised to ensure that dispensing standard operating procedures (SOPs) are updated to include the supply of valproate-containing medicines to childbearing females.

Quality Payments Scheme (QPS) – patient safety domain

Following the announcement of the second QPS for 2018/19, patient safety is a key domain with changes in its requirements. There are three sections with the potential to receive a total of 60 points (20 points each) as follows:

1. Complete a written patient safety report, identifying and managing risks at premises level associated with look-alike sound-alike (LASA) errors particularly focusing on five different drug combinations, and ensure it is uploaded on any electronic reporting system and/or the National Reporting and Learning Service (NRLS)
2. CPPE Risk Management training module to be completed by 80% of all registered pharmacy professionals and an example of a risk review to be available at premises level
3. Undertake a non-steroidal anti-inflammatory drug and gastro-protection audit for patients 65 years and over

NHS England still need to release their new guidance; the NPA will update QP resources to reflect the changes and assist pharmacy contractors meet the QPS requirements.

Yellow Card adverse drug reactions – awareness week

The MHRA will launch a third social media campaign to raise awareness about the importance of reporting suspected adverse drug reactions (side effects) to the Yellow Card Scheme, which takes place from 19-23 November 2018. The main emphasis of the campaign is that reporting helps the safe use of medicines to protect public health. This year, there is a focus on the safe use of medicines for babies, children, pregnant and breastfeeding women.

Healthcare professionals can show their support through the social media channel by following and retweeting MHRA (@MHRAgovuk) on Twitter, or directly posting animations/images (provided by MHRA) with your own message.

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Pregabalin and gabapentin – upcoming reclassification
The Home Office has announced that from April 2019, pregabalin and gabapentin will be reclassified to a class C Controlled Drug (CD), following a number of fatalities associated with them. This is to minimise misuse, ensure they do not fall into the incorrect hands, and patients do not accumulate stock. In addition, prescriptions for pregabalin and gabapentin will only be valid for 28 days. Currently, there is no guidance as to which CD Schedule they will be assigned to; however, as this is released, the NPA will update pharmacy contractors.

Frequent errors – common themes

Errors involving the NHS flu vaccination Advanced Service Patient Group Direction (PGD) 2018/19
A number of cases reported in Quarter 3 of 2018 involved errors with administering the flu vaccine:

- Fluad® was administered via the subcutaneous route instead of the intramuscular route – the pharmacist identified error after rechecking the product packaging and it's Summary of Product Characteristics (SPC), prior to administering the vaccine to another patient.
  ! Please note: Fluad® is **not** licensed for subcutaneous administration
- A flu vaccine was administered to a breastfeeding woman – this patient group is not eligible for the flu vaccine under the NHS PGD unless they fall into one of the eligible groups listed in the service specification

! Before offering the flu vaccine under the NHS flu PGD, pharmacists are **strongly reminded** to read and understand what is outlined in the NHS flu PGD and service specification 2018/19

The NPA has a suite of flu resources to support members in delivering both NHS and private influenza vaccination services, including guidance, standard operating procedures and FAQs.

Errors involving insulin aspart solution for injection 100units/ml 3ml cartridges
Several incidents involving generically written prescriptions for insulin aspart solution for injection 100units/ml 3ml cartridges have occurred. This is because Fiasp® Penfill and NovoRapid® Penfill®, both manufactured by Novo Nordisk Ltd, are two brand options that may be dispensed.

- There are key differences between the two products: Fiasp® Penfill has a more rapid onset of action, an increased post-meal glucose lowering effect, and a faster initial absorption rate compared to NovoRapid® Penfill®

! Before dispensing a generically written prescription for insulin aspart, or other insulin products containing 100units/ml or more of insulin (high-strength insulin), pharmacists and their teams **should check** the Insulin Passport (or safety card) to identify which specific brand the patient uses – if the patient has not been provided with one, contact their doctor/diabetic nurse, or purchase from the NPA Sales team on 01727 800 401

Hand out errors
Approximately 50% of hand out errors occurred in Quarter 3 of 2018. Some of the errors included:

- SOPs not being followed by new pharmacy team members, for example, not asking patient's date of birth for reaffirmation where patients have the same/similar sounding names
- Fridge items, especially insulin, handed over to the wrong patient – ensure correct bag labels are attached to all packages and check patient name on dispensing label against the prescription again, before handing out
- Picking the medication from the shelves by looking at the dispensing label rather than looking at the prescription itself
- Patients with similar sounding names – this should be highlighted during the labelling stage

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Other interesting errors – examples

Errors involving over-the-counter (OTC) sales

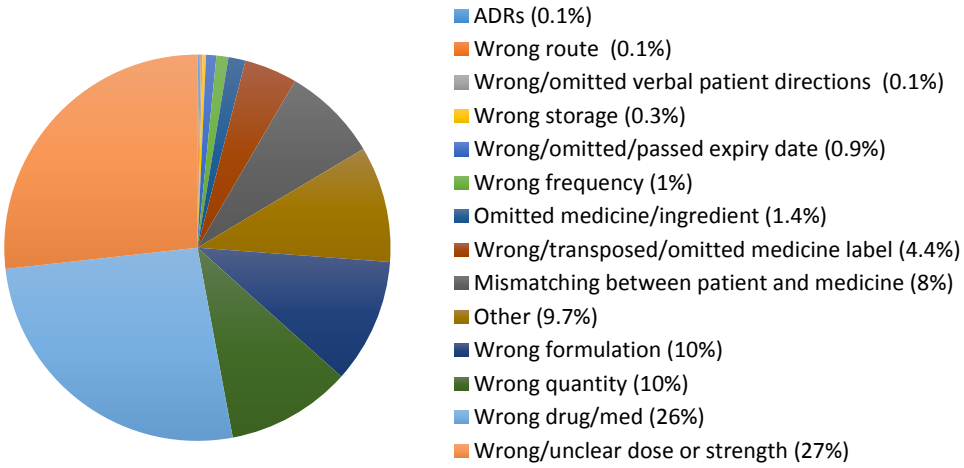
During an OTC consultation with a customer requesting co-codamol tablets 8/500mg, the pharmacist discovered that the shelf stocked co-codamol tablets 30/500mg, which is a prescription-only medicine (POM). After further investigation, it became apparent that at least six boxes had been sold that week as the counter assistant had put them on the shelf without identifying it as a POM. Trying to rectify the error, the pharmacy put a sign on the counter asking any patients who bought co-codamol tablets 30/500mg to return them back to the pharmacy as soon as possible.

In another OTC incident, a patient requested to buy treatment for scabies. Through questioning, the counter assistant recommended Derbac M liquid which the patient purchased. The next day, the patient came back to the pharmacy expressing that a dispensing/patient label was stuck to the bottle of the medication. It became apparent that Derbac M liquid was previously dispensed for a prescription but because the patient did not collect the medication in time, the product was put back on the shelf without removing the dispensing/patient label.

Key statistics and frequently appearing drugs

Medication error categories

Figure 1 illustrates the main medication error categories and incidence reported during Quarter 3 of 2018.



Key findings

- The two most common error categories reported continued to be dispensing a '**wrong/unclear dose or strength'** (27%) and dispensing the '**wrong drug/medicine'** (26%)
  - These percentages are very similar to Quarter 2 of 2018 figures with differences ranging from 1-3% for each category
- The most common LASA errors reported in the **'wrong drug/medicine'** category are listed in the table 1 below
  - These drug combinations have continuously been mentioned in previous quarterly reports
  - In one reported incident, a series of events occurred before the error was identified:
    - A patient prescribed nitrofurantoin capsules for a duration of one week, and after consuming a large quantity of alcoholic beverages over a weekend, felt unwell and slept for a few days, relating it to the 'heavy' weekend
    - After another blood test, the patient's results showed an abnormal liver function and the GP advised them to reduce alcohol consumption
    - The patient continued to feel unwell, was absent from work even after finishing the antibiotic course and a friend, who is a GP, questioned the patient and it transpired that metronidazole had been dispensed by the pharmacy instead of nitrofurantoin

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Table 1: common LASA errors

Commonly mistaken medicines	
Allopurinol	Atenolol
Amlodipine	Amitriptyline
Gabapentin	Pregabalin
NovoMix®	NovoRapid®
Pravastatin	Pantoprazole
Rosuvastatin	Rivaroxaban

- '**Mismatching between patient and medicine**' has also increased by 16.7% from Quarter 2 of 2018
  - Several errors involved prescriptions being processed for family members at the same address – double check patient names and date of birth as necessary, especially when multiple prescriptions are handed out

Contributing factors

Figure 2 illustrates the most commonly reported contributing factors to patient safety incidents during Quarter 3.

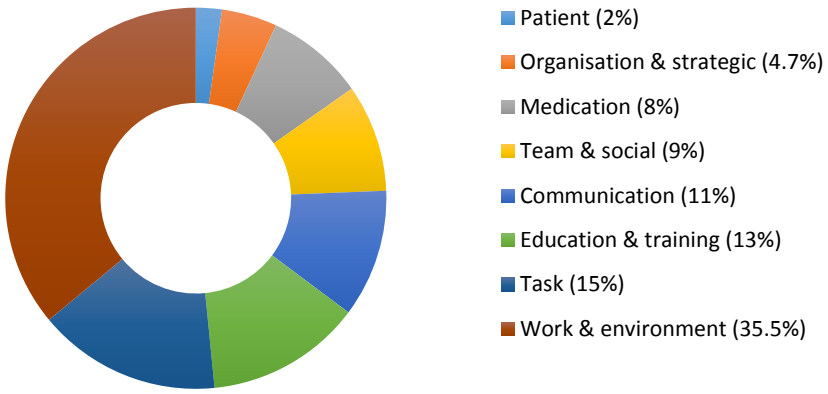

Figure 2. Contributing factors to errors reported in Quarter 3.

Key findings

- '**Work and environment factors**' (35.5%) continue to be the main contributing factor
- '**Task factors**' significantly increased by 13% compared to Quarter 2 of 2018, mainly involving:
  - Guidelines, policies and procedures
    - Not up-to-date/unclear; not monitored/reviewed; inappropriately targeted
  - Decision-making aids
    - Aids unavailable/not working
    - Difficulties in accessing senior/specialist advice
    - Lack of easy access to technical information, flow charts and diagrams
  - Procedural or task design
    - Poorly designed – too complex/difficult to remember
    - Too many tasks performed at the same time
    - Guidelines do not enable an individual to carry out the task in a timely manner
    - Misinterpretation of information

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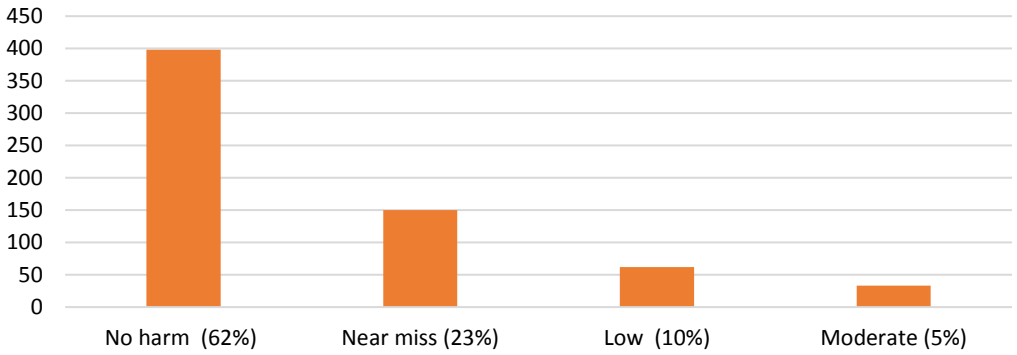
Degree of harm

Figure 3 illustrates the degree of harm caused to patients by incidents reported during Quarter 3 of 2018.



Key findings

- Errors resulting in '**no harm**' to the patient continue to be reported and these make up the majority of submissions (62%)
- '**Moderate harm**' stayed the same as Quarter 2 of 2018, which involved patients taking the incorrect medicine resulting in significant side effects but not causing permanent harm – this usually stemmed from:
  - Wrong medicines being dispensed to the patient – due to LASA errors
  - Wrong label, dose or strength dispensed to the patient
  - Incorrect assembly of monitored dosage systems

Top tips for minimising risk /general action points

LASA errors

Earlier this year, the MHRA sent a reminder to healthcare professionals (including pharmacy teams) to take extra care when prescribing LASA items. The following drug combination examples have resulted in serious harm and fatal outcomes:

- Atenolol and Amlodipine
- Clobazam and Clonazepam
- Propranolol and Prednisolone
- Risperidone and Ropinirole
- Sulfadiazine and Sulfasalazine

In order to avoid potential errors, pharmacy teams should:

- ✓ Be extra cautious when dispensing items with commonly confused drug names
- ✓ Check with the prescriber if there is any ambiguity or doubt over which item is intended to be dispensed for the patient
- ✓ Ensure SOPs, and guidance for dispensing, clinically and accuracy checking prescriptions, are followed
- ✓ "**The Five Rights**" of medication use should be considered
  - Right medicine
  - Right patient
  - Right dose
  - Right route
  - Right time
- ✓ Report incidents via the NPA Patient Safety Incident report form (for pharmacies in England and Scotland) and suspected adverse drug reactions via the Yellow Card Scheme

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As part of the QPS, one of the patient safety criterion requires pharmacy contractors to demonstrate actions that have been implemented to prevent LASA errors. Some examples of this could include:

- ✓ Physical segregation of stock
- ✓ Raise staff awareness – highlight importance of LASA during training sessions and internal communications/meetings
- ✓ Visual warnings – brightly coloured warning stickers on shelves/drawers, or incorporate warning flags into pharmacy computer systems
- ✓ Fatigue reduction strategies – focus on reducing stress and balancing heavy workloads
- ✓ Enhanced checking procedures – avoid self-checking; refer to the NPA "*Dispensing process – best practice*"
- ✓ Pharmacy simplification – reconsidering how the dispensary is laid out to minimise steps in selecting a product

The NPA has produced a new resource, "*Look-alike sound-alike items*", which lists common items (generic and brand) with similar names that have been highlighted by NRLS and previous patient safety reports.

For further information, advice and/or support on any patient safety or pharmacy topic/mater, please contact the NPA Pharmacy team on 01727 891800 or email at pharmacyservices@npa.co.uk.

Kind regards,

Leyla Hannbeck MSc, MRPharmS, MBA
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Medication Safety Officer