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https:/www.npa.co.uk/services-and-support/patientsafety

PATIENT SAFETY UPDATE/ MEDICATION SAFETY OFFICER (MSO) REPORT

Q1 2019

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 my patient safety update / Medication Safety Officer's (MSO) report for Quarter 1 of 2019.

The report contains a summary of the most common types of dispensing errors reported to the NPA during the first quarter of 2019, along with my top tips for minimising patient safety incidents.

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Director of Pharmacy, NPA
Medication Safety Officer (MSO)
April 30, 2019

Noticeboard - important updates

Updated MHRA guidance for use of valproate containing medicines in pregnancy
The Medicines and Healthcare products Regulatory (MHRA) has published a drug safety update to help healthcare professionals, including pharmacists, to comply with the requirements of the valproate Pregnancy Prevention Programme (PPP), also known as "*prevent*", when supplying valproate medicines to females of child-bearing age.

A revised Annual Risk Acknowledgement Form has been developed which must be completed by the specialist when initiating treatment and during all future reviews; once complete, it must be countersigned by the patient/carer. This is intended to reduce and eliminate valproate exposure in pregnancy in view of its teratogenic effect. The Annual Risk Acknowledgement Form should be completed even if there are compelling reasons to demonstrate that there is no risk of pregnancy.

The NPA will shortly be launching a new patient safety template standard operating procedure (SOP) covering the supply of valproate in accordance with the requirements of the Pregnancy Prevention Programme (PPP).

Packaging changes for some buprenorphine patches
Butec and Transtec (buprenorphine) patches will now be supplied in child-resistant sachets, which means the sealed sachets must now be cut with scissors rather than being torn open as previously. The Patient Information Leaflet, and markings on the sachet have been updated to indicate the change.

! Pharmacists and pharmacy teams are advised to counsel patients on this change which will be effective in all new stock bearing serialisation codes

NPA patient safety Incident Reporting Platform (IRP) — user information

The **NPA IRP,** updated and launched end of October 2018, has proven to be user-friendly. The completed form can be sent via email helping to reduce administrative time as it can be kept for pharmacy record keeping requirements.

Key points for using the IRP

- **Patient identifiable information must not be included when completing the report — this is especially important since the implementation of the General Data Protection Regulation (GDPR) on 25 May 2018**
- An option has been created for selecting '**Look-alike sound-alike (LASA) errors**' when a '*wrong drug*' has been dispensed — please be aware if the '*wrong strength*' or '*wrong formulation*' has been selected, it is **not** considered a LASA error
- It is important that a **detailed** description of the patient safety incident in the '*describe what happened*' field is provided (think about the sequence of events and how the error was concluded) — simply writing a brief description, for example, '*wrong strength given'* is not enough as it does not provide sufficient information for us to conduct a full and complete data analysis which is a key part of the NPA's role as the MSO for all community pharmacies in England with fewer than 50 branches.
- Although the Quality Payments Scheme has ended, please continue to use the MSO quarterly reports to demonstrate **evidence of sharing and learning**

Examples of pharmacist's clinical check and vigilance preventing harm to patients

- In one incident the GP faxed a prescription for trimethoprim oral suspension 50mg/5ml at a dose of 10mls daily for an infant who had recently been discharged from hospital. The pharmacist queried the dose as it was very high for an infant based on their weight. The pharmacist spoke to the GP and confirmed the dose was transcribed exactly from the hospital discharge notes. The GP contacted the hospital pharmacy and confirmed an error had been made at the hospital and the dose should have been 1ml daily. The GP sent a new prescription with the correct dose.

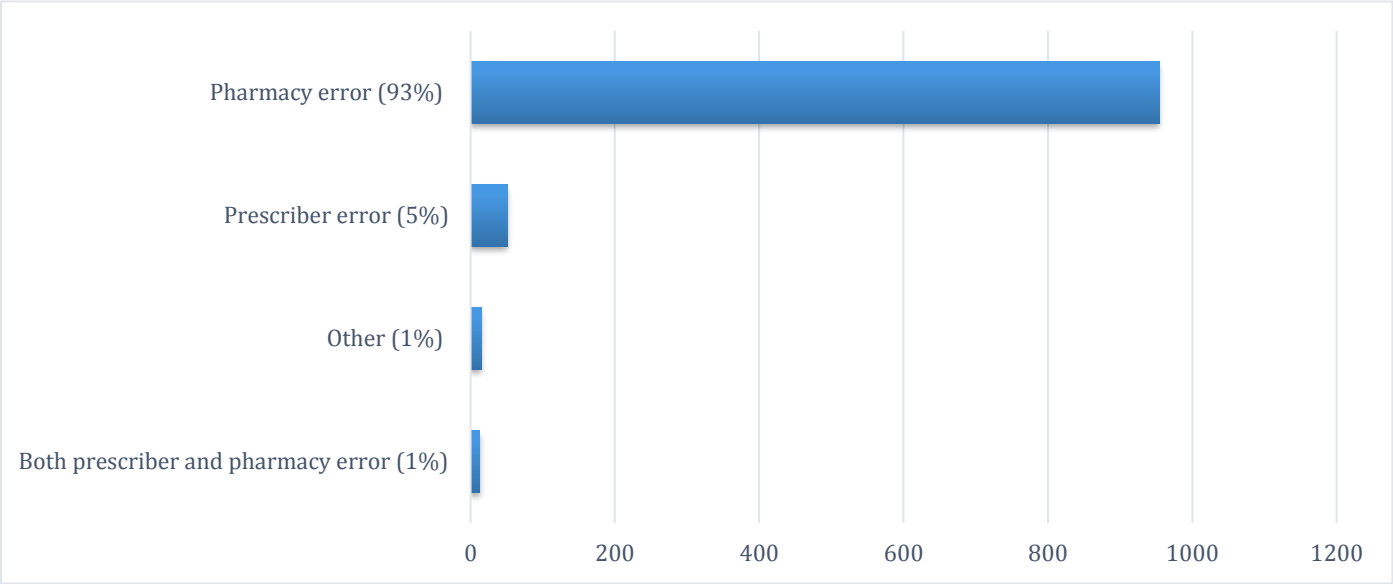
- A prescription for REVAXIS vaccine was received with a quantity of 3 pre-filled syringes. The pharmacist queried the quantity with the prescriber as this vaccine is normally administered as a single dose. The GP confirmed that the incorrect vaccine had been selected and the prescription was actually intended for Rabipur vaccine for pre-exposure prophylaxis against rabies. The prescription was immediately amended and sent back to the pharmacy.

MSO report Q1 2019

There was a 29% increase in patient safety incidents reported in Quarter 1 of 2019 compared to Quarter 4 of 2018. The submission rate of reports almost doubled in the month of February compared to the months of January and March. The Quality Payments Scheme may have contributed to this as a higher number of LASA incidents were reported in February.

KEY STATISTICS from patient safety incidents reported in Q1 2019

1. Origination of patient safety incidents during Quarter 1 of 2019



Key findings

- 93% of incidents originated from the pharmacy, mainly through dispensing errors
- 5% of incidents were due to prescribing errors (up from 3% during Q4 2918), most of which involved issues such as:
    - Incorrect nystatin dosages

- Increasing patients' current dose half way through their treatment and this change not being communicated to pharmacies
- Prescribing certain medicines knowing that patients are allergic to the active ingredients/excipients
- Not following prescription requests made by the pharmacy and/or patient directly

For example:

- Patient requested to order Betnovate cream but Betnovate scalp application was prescribed
- Amoxicillin was prescribed for a patient allergic to penicillin
- Patient was prescribed nystatin suspension with a dose of 4ml to be taken four times a day compared to the licensed dose of 1ml four times a day for oral candidiasis

Nystatin dose information changes

Please note the dose recommendations were previously changed for Nystan® oral suspension 100,000 iu/ml to follow some marketing authorisations in the European Union. However, due to the lack of robust data to support the dose changes, and following MHRA advice, the manufacturer, E. R. Squibb & Sons Ltd revised their doses back in March 2017 as stated in the Summary of Product Characteristics.

My advice regarding paediatric prescriptions

✓ Always double check calculations for paediatric doses

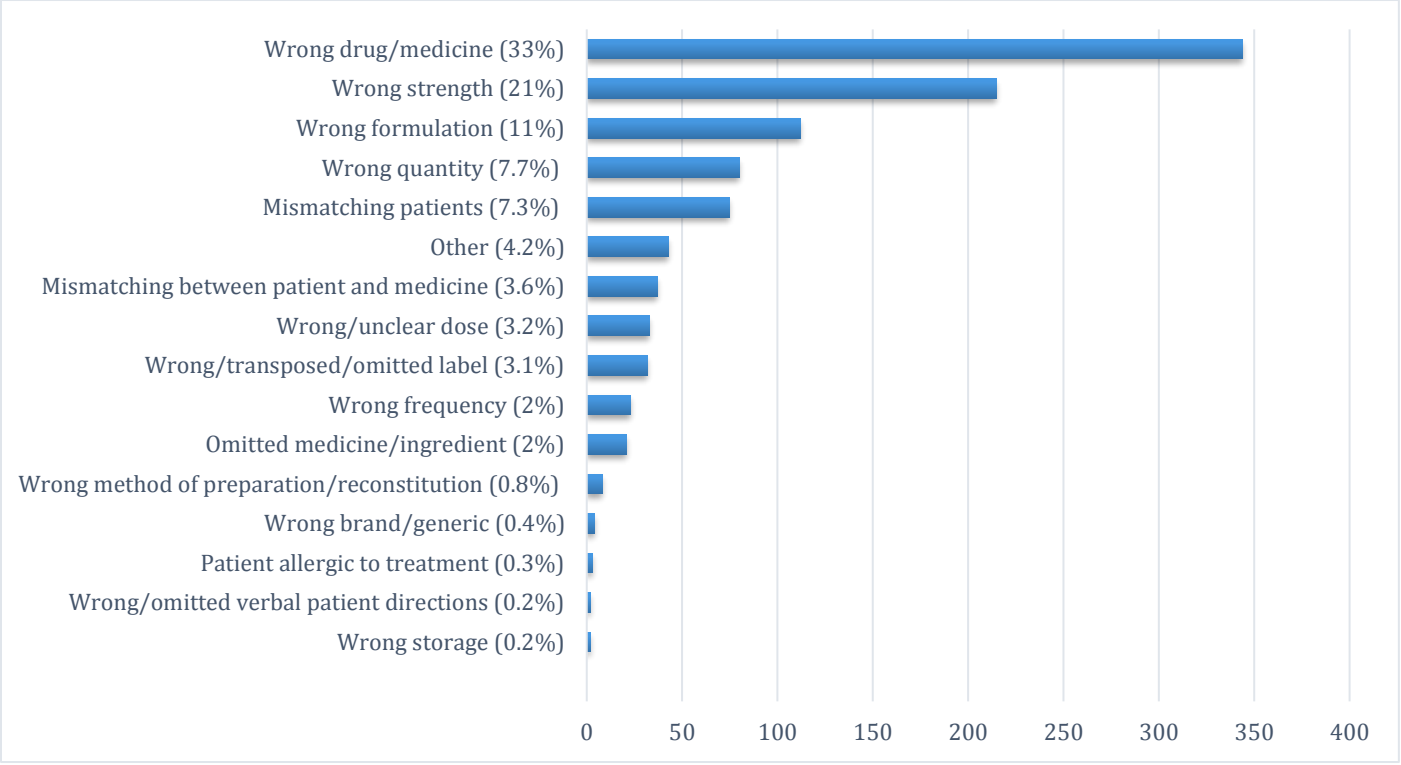
✓ Doses prescribed per weight should be confirmed with the patient/representative to ensure the correct dose has been prescribed

✓ Provide specific instructions on how to give each dose - avoid vague phrases such as "*take as directed*" or "*when required*"

✓ Encourage those administering the medicine to use oral syringes or other measuring devices to facilitate accurate dose administration of liquid formulations

! Calculations involving weight should not be based on ideal weight within the BNF, this can be used as a guide only – the accurate weight of the patient should be obtained

2. Medication error categories and incident reported during Quarter 1 of 2019



Key findings

The two most common error categories reported continued to be dispensing a '**wrong drug/medicine**' (33%) and dispensing the '**wrong strength**' (21%).

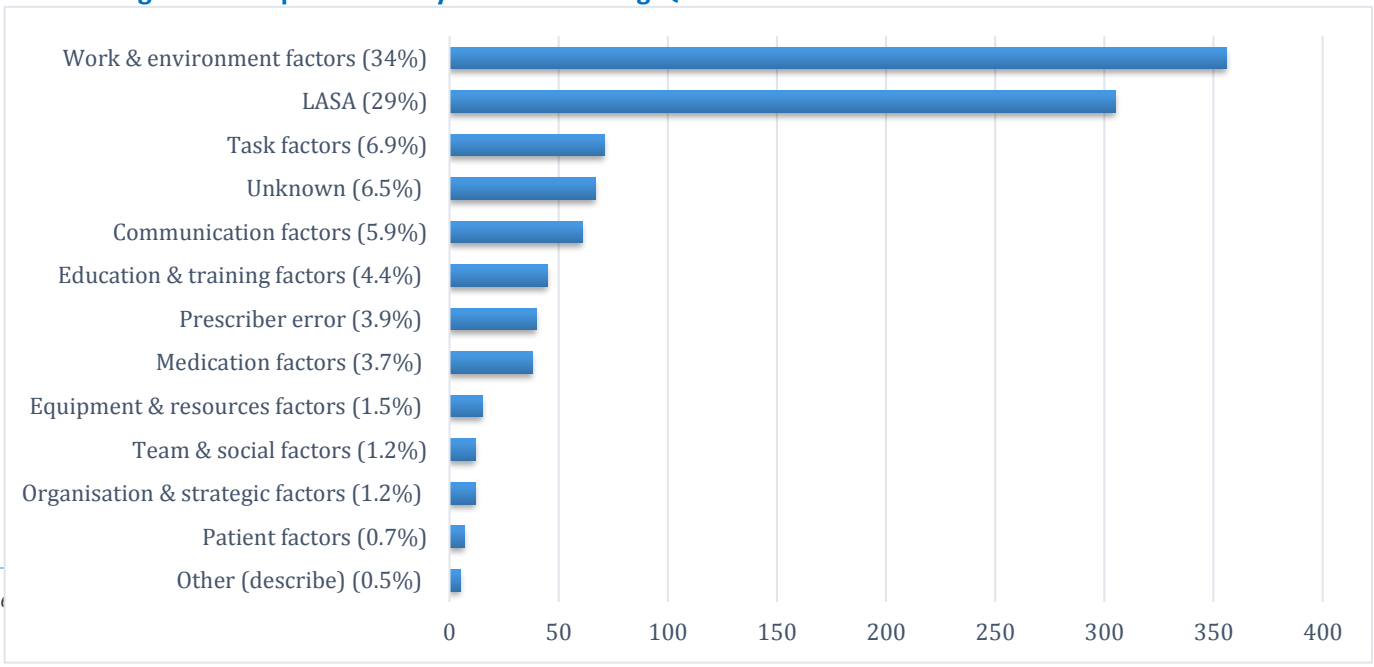
- '**Wrong strength**' incidents
  - Metformin tablets SR 500mg and 1000mg and metformin tablets 500mg and 850mg (11%)
  - Gabapentin capsules involving all strengths (10%)
    - In one incident, a patient received gabapentin capsules 600mg instead of 100mg. The patient took the wrong strength of capsules for 5 days, resulting in the patient to suffer from extreme drowsiness. The patient was referred to hospital for a full medical assessment to be performed
  - Citalopram tablets 10mg, 20mg and 40mg (10%)
    - Majority of the errors were due to similar packaging – this led the pharmacy to segregate their stock as part of their sharing and learning
- '**Wrong formulation**' incidents: majority involved inhaler preparations being dispensed incorrectly in place of dry powder, breath actuated and/or nasal spray, and vice versa such as:
  - Salbutamol inhaler/breath actuated/Accuhaler (7%)
  - Beclometasone inhaler/nasal spray (6%)
  - Fostair NEXThaler/Fostair inhaler (6%)

We have published an inhaler identification checker, which provides comprehensive tables to help pharmacy teams identify the correct inhaler/device to supply when presented with a generic prescription.

Example of wrong dose prescribing

An incident occurred where a patient received a double dose of methylphenidate prolonged release tablets due to **wrong dosage instructions** on the dispensing label. The prescription originally for Delmosart prolonged release tablets 18mg and 36mg at a dosage instruction of once daily was instead written as '*Take ONE tablet TWICE a day*.' This led the patient to experience hallucinations due to the long acting properties of Delmosart and the patient was taken to hospital for further medical assessment.

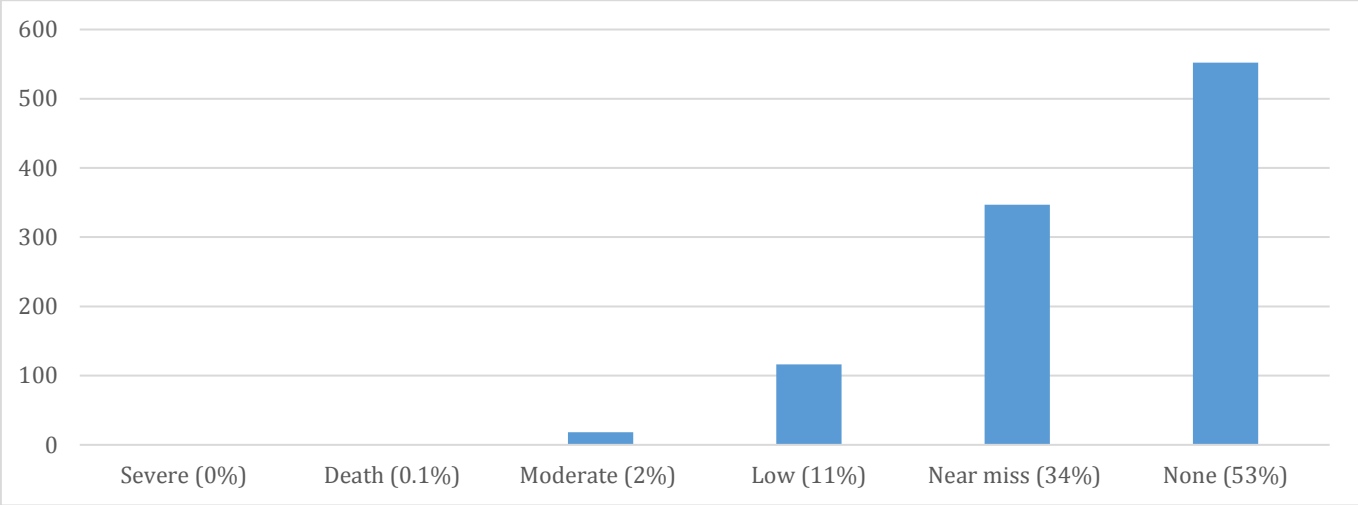
3. Contributing factors to patient safety incidents during Quarter 1 of 2019



Key findings

- '**Work and environment factors**' (34%) continue to be the main contributing factor mainly involving:
  - Time pressures – pharmacists and pharmacy teams 'rushing' to complete prescriptions and not paying full attention
  - Distractions – pharmacy teams interrupting pharmacists with other queries whilst checking prescriptions at the same time
  - Increased staff turnover – resulting in inappropriate skill mix and staff still undergoing training which ultimately led the pharmacist to self-check more prescriptions

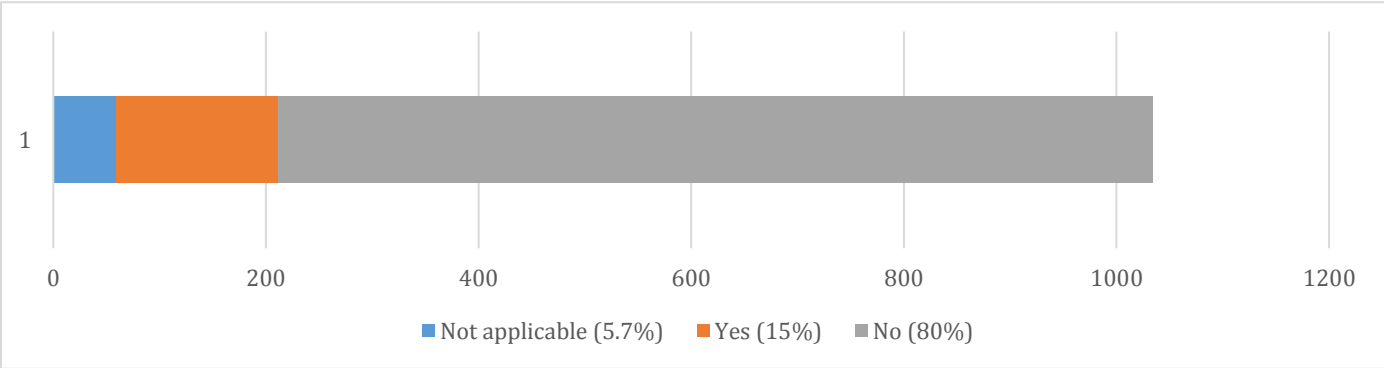
4. Degree of harm caused to patients by incidents reported during Quarter 1 of 2019



Key findings

- Errors resulting in '**none**' (53%) and '**near miss**' (34%) to the patient continue to be reported and these made up majority of reports
- Although the error rate reduced by 1% for '**moderate harm**' compared to Quarter 4 of 2018, all the incidents involved giving the **wrong drug** to patients who were then hospitalized:
  - A patient received pravastatin tablets, instead of paroxetine tablets, and took it for three weeks before being hospitalized due to feeling 'sick' for not taking the paroxetine tablets
  - A patient received amisulpride tablets 200mg instead of amiodarone tablets 200mg, and took it for four weeks resulting in hospitalization due to frequent arrhythmias

5. Self-checking during Quarter 1 of 2019



Key findings

- Majority of the errors reported did not involve a pharmacist; however, a number of pharmacists (15%) are still carrying out all steps in the dispensing process themselves, including the clinical and accuracy check of the assembled prescription
- Of the pharmacists who did 'self-check,' 24% of the errors stemmed from giving the '**wrong drug/medicine**' to the patient, specifically eye drops (8.3%) and inhalers (11%) such as:
  - DuoResp Spiromax inhalation powder – Duaklir Genuair inhalation powder
  - Spiriva Respimat inhalation solution – Spiolto Respimat inhalation solution
  - HYLO®-FORTE eye drops – HYLO®-TEAR eye drops
  - Dorzolamide eye drops – Dorzolamide/Timolol eye drops
- 23% of the errors also stemmed from giving the '**wrong strength**' of medication to the patient, of which 14% were due to gabapentin errors

Look-alike sound-alike (LASA) errors

The most common LASA errors reported in Quarter 1 of 2019 in the '**wrong drug/medicine**' category are listed in the table below.

Common LASA errors		Error rate
Amlodipine	Amitriptyline	4.5%
Gabapentin	Pregabalin	
Atenolol	Allopurinol	4%
Atorvastatin	Amlodipine	
Bisoprolol	Bendroflumethiazide	3.6%
Enalapril	Escitalopram	

The common groups of LASA error combinations were eye drops, external topical applications, Hormone Replacement Therapy (HRT) preparations and inhalers. Errors involving HRT preparations may have contributed due to the current medicine shortages as patients are being switched to alternative preparations in the interim.

- HRT preparation errors included: Elleste Solo/Elleste Duet, Femoston/ Femoston-conti and Kliofem®/Kliovance

Gabapentin and pregabalin errors have continually been reported as common LASA errors as per previous MSO Quarterly reports – we hope to see a reduction in error rate since the reclassification status of gabapentin and pregabalin.

- Please refer to the NPA poster designed to help pharmacy teams understand the legislative changes for gabapentin and pregabalin CD classification

Examples of LASA incidents

- A rare but serious LASA incident occurred where the patient was given clarithromycin tablets 500mg instead of ciprofloxacin tablets 500mg for a rescue pack. The patient took the rescue pack on a cruise holiday and started to feel very unwell after taking the medication for a couple of days. The patients' health had still not improved so saw the ships doctor on the cruise who gave them IV antibiotics, steroids and nebulised medication. It was after the treatment that the patient had noticed the wrong antibiotic was given initially. The incident is currently under investigation.
- Another LASA incident which resulted in the patient to experience ill effects was when paroxetine tablets 20mg was dispensed instead of pantoprazole tablets 20mg. The patient took the tablets for two weeks and suffered from

stomach issues due to not having the pantoprazole tablets. The patient even bought Gaviscon tablets to help control the acid reflux symptoms but did not work. The patient then read the patient information leaflet for paroxetine and realised the wrong medication had been dispensed. The patient informed both the pharmacist and GP of the error who was then closely monitored by the GP

My advice

- ✓ Use our 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

Examples of common error themes

Error type: posting medicines through the letterbox

The delivery driver went to deliver medication to a patient's home; however, the patient did not answer the door and the delivery driver posted the medication through the letterbox instead. When the patient returned home, she had discovered that her pet dog had eaten all her medication, prednisolone tablets 5mg – take six tablets daily for 7 days. The patient did not give any permission to post medicines through the letterbox and the delivery driver did not follow their delivery Standard Operating Procedures (SOPs). The dog was taken to the vet and kept under observation for 24 hours. The patient was very upset and distressed because not only did her infection worsen but the dog was also harmed.

My advice

- ✓ Pharmacists must have robust processes in place before starting a delivery service
- ✓ SOPs should be in place for the delivery of medicines, which includes the process for posting medicines through a letterbox
- ✓ Consent must be sought from the patient confirming they have authorised for their medicines to be posted through their letterbox and there are no pets, young children or vulnerable patients present at the property and understand potential risks associated with this type of delivery such as medicines could be delivered to an incorrect address leading to GDPR implications
- ✓ Check with your indemnity insurance provider to ensure your service would be covered
- ✓ The responsible pharmacist would be accountable for the patients journey until the medicine physically reaches the patient

Error type: Clinical Commissioning Group (CCG) Medicine Management switching insulin for patients

A number of incidents have occurred where the local CCG Medicine Management team has switched patients (both adults and children) who were previously stable on Lantus insulin to Abasaglar insulin due to cost saving measures. Although both of these brands contain insulin glargine and are biosimilar of each other, the patient resulted in unstable glucose levels because the patient was unaware of the change and became hypoglycaemic.

My advice

- ✓ Any insulin switches would require a managed approach with blood glucose monitoring, since dosage adjustments could theoretically be required
- ✓ All adult patients using high-strength, fixed combination or biosimilar insulin products should be issued with a patient booklet and Insulin Passport (or safety card) which carries a record of the patient's current insulin products and allows a safety check for administration, dispensing and prescribing
- ✓ Before dispensing a generically written prescription for any insulin products containing 100units/ml or more of insulin (high-strength), pharmacists and their teams should check the Insulin Passport (or safety card) to identify which specific brand of insulin the patient is using

- ✓ Refer to the NPA insulin SOP
- ✓ Insulin Passports are available to purchase via the NPA Sales team on 01727 800 401

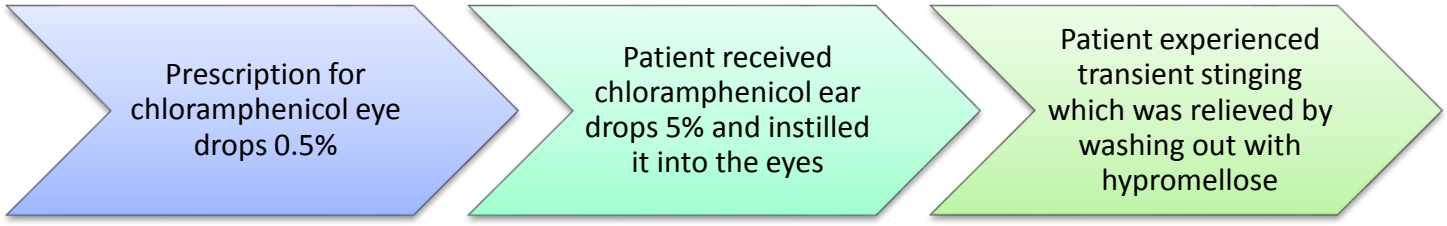
Error type: emergency supply on monitored dosage system

An emergency supply of a monitored dosage system was given to the patient's carer because the prescription had not been sent from the GP on time and the patient had run out of their medicines. The pharmacist was under pressure to give the supply of medicines to the carer due to time constraints and dispensed one weeks supply to the carer. The carer confirmed that there had been no changes to the patients' medicine and condition/situation. Later that afternoon the prescription was sent to the pharmacy and the pharmacist noticed that there were changes made to the patients' medicine. The patient had taken the medicines from the morning and afternoon slot but the patient was not harmed.

My advice

- ✓ A pharmacist should always use their professional judgement and clinical appropriateness when considering whether to make an emergency supply to a patient or not
- ✓ Even if a request comes from a carer, the pharmacist should attempt to interview the patient or consider an interview over the telephone to gather relevant information. Where a pharmacist is unable to speak directly to the patient, professional judgement should be used as other options (such as contacting the GP surgery) may need to be explored in such cases
- ✓ Refer to the NPA "*Emergency supply*" legal and practical guidance

Ear drop/eye drop error



My advice

- ✓ Exercise extreme caution and vigilance when dispensing chloramphenicol drops
- ✓ Ensure chloramphenicol ear and eye drops are stored separately in the fridge
- ✓ Place a warning note or label in the fridge to alert pharmacy teams to select the chloramphenicol preparation with care, because ear drops are not commonly prescribed/requested on prescriptions as eye drops
- ✓ Since most pharmacies would only keep limited stock of the ear drops, this could be placed into a clear bag in the fridge, which would mean it would have to be completely removed from the bag in order to label it
- ✓ Do not place dispensing labels over important information on the bottle
- ✓ Countersign the information on the product, label and prescription to indicate the right formulation has been selected

Safeguarding referrals

There have been many concerns raised regarding the lack of anonymity for pharmacy professionals who make safeguarding referrals.

Key points regarding safeguarding referrals:

- **Pharmacists have a professional duty to take action to safeguard adults and children who may be at risk**
  The GPhC Standards for pharmacy professionals requires pharmacists and pharmacy technicians to "*take action to safeguard people, particularly children and vulnerable adults*" and the standards must be met "*at all times, not only during working hours*"
- **Pharmacy contractors must provide pharmaceutical services in accordance with the professional standards**
  Under Paragraph 29 of Schedule 4 to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, contractors "*…must provide pharmaceutical services and exercise any professional judgement in connection with the provision of such services in conformity with the standards generally accepted in the pharmaceutical profession*"
- **When reporting a safeguarding issue, the pharmacist can request for their name to be kept confidential if it could compromise their safety or wellbeing**
  Authorities do not have to protect the person who reports a safeguarding issue, but may choose to do so dependent on local policies/procedures and/or if there were any concerns around the safety of the person reporting it. However, if a more formal enforcement action takes place, the pharmacist's name may be disclosed
- **HM Government guidance**
  Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers provides guidance on when and how to share information
- **Local Authority safeguarding teams**
  It is advisable for engage with and build up relationships with Local Authority safeguarding teams to develop a shared understanding of the challenges faced by both groups when raising a safeguarding issue
- **Threats or intimidation**
  It is unacceptable for you or any member of your team to be threatened or intimidated — contact the police if this happens

Contact

For further information, advice and/or support on any patient safety or pharmacy topic/matter, please contact the NPA Pharmacy Services team on:

- 01727 891800
- pharmacyservices@npa.co.uk

NPA Patient safety resources

- Concomitant use of alcohol with methadone: risks and FAQs
- Dispensing process: best practice
- Eye product identification checker
- Inhaler identification checker
- Insulin identification checker
- Lidocaine-containing products reclassification poster to help pharmacy teams
- Look-alike sound-alike items
- Medicines in pregnancy and patient safety
- Preventing dispensing incidents involving liquid preparations

The full range of the NPA patient safety resources can be accessed here.