BCHS Pharmacy Team Medicines Bulletin (January 23)

We care
We respect
We are inclusive

NHS East London NHS Foundation Trust

Learning from BCHS Medication incidents

In December we saw a high level of external medication errors (14/22) including poor discharges from the acute. Please continue the good practice of reporting these medication errors and raising poor discharge alerts so that these can be fed back.

A thematic review of the internal incidents saw that there were errors in transcribing both insulin and tinzaparin. There was also an administration error with glycopyrronium which was similar to errors reported in the previous month. An in-depth learning bulletin regarding the glycopyrronium errors was shared with the teams. You can access it here:

Learning Bulletin

Learning/recommendations:

All staff should familiarise themselves with the **10R's** of safe administration of medicine

1.Right Patient	2.Right Consent	3.Right Time	4.Right Medicines
5.Right Dose	6.Right Route	7.Right Expiry	8.Right Documentation
	9.Right Effect	10.Right Education	

This is described in detail on page 19 of ELFT's Medicines Policy .

Staff should also familiarise themselves with the Policy for the Transcribing of Medication for the Purpose of Recording Administration in CHS 3.0

MHRA Drug Safety update and ELFT Medication Safety Bulletin

The MHRA drug safety update and the Trust's medicines safety bulletin for December are available here: https://www.elft.nhs.uk/intranet/teams-support-me/pharmacy/medicines-safety

Patient Safety Alert

Any questions or queries please contact the pharmacy team on **elft.pharmacybchs@nhs.net**

Good Practice Interventions

Navreet Gill -pharmacy technician, visited a referred patient in care home and found that there were discrepancies between the discharge letter and labelled medication from the acute hospital.

This had led to the patient missing doses of sando-K and uncertainty of the tinzaparin course length. An accurate medicines reconciliation and face to face visit enabled her to resolve this query and task the GP to undertake potassium monitoring following the error. A poor discharge alert was also raised.

Jacky White- pharmacy technician intervened when a care home patient's discharge letter was unclear on when to restart their edoxaban following a bleed. Additionally no edoxaban tablets had been sent home with the patient.
The G.P was tasked, and following a GP review, the edoxaban was restarted. A poor discharge alert was raised.

Jacky also received exceptional feedback from the wider ELFT pharmacy team for her CPD presentation on community health services. Well done Jacky!

Gaganjot Kaur –pharmacy technician intervened and clarified a care home patient's mirtazapine. Although listed on a recent discharge letter/sent with patient as current medication, there was confusion in the letter which stated it was with-held during hospital stay, stopped and required a GP review to consider restarting. The GP was tasked, and they clarified it was a mistake by the discharging hospital, to monitor drowsiness and that a GP review was required. A poor discharge alert was raised.

Medication Shortages

Relevant shortages highlighted by the ELFT pharmacy procurement team:

- **Clobetasone Butyrate (Eumovate) cream** and **ointment**. Estimated resupply date is end of January 2023 (not listed on the SPS website as an issue)
- **Chloramphenicol 0.5% eye drops.** Estimated resupply date is February 2023.(not listed on the SPS website as an issue)
- **Antibiotics for the treatment of Group b strep** supplies may be temporarily limited at certain wholesalers and pharmacies –update: supply is returning.

Any particular concerns regarding shortages, pharmacy have access to the Specialist Pharmacy Service (SPS) online medicines supply tool with up to date procurement issues. www.sps.nhs.uk

Bulletin produced by Kelly Pritchard Specialist Clinical Pharmacist Bedfordshire Community Services 17/01/23