BCHS Pharmacy Team Medicines Bulletin (April 23)

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NHS East London NHS Foundation Trust

Learning from BCHS Medication Incidents

In March we saw 21 medication incidents reported for BCHS, 6 were external medication errors (1 poor discharge). A thematic review of the internal incidents highlighted the following learning:

Insulin stock checking

A incident occurred where a nurse administered a lower dose of insulin than was prescribed as there was no further stock available in the patients home. This was escalated to the carers and more stock was collected. The GP was also informed and follow up visits were made to the patient. No harm came to the patient.

- Learning

Visiting staff to create a prompt and care plan to check stock levels of insulin weekly to ensure patient does not go without prescribed dose.

Syringe driver: Caution with cyclizine

This month we have seen 2 errors relating to cyclizine in a syringe driver. In one incident 10mg of cyclzine was administered for 3 days (prescribed dose 100mg). No harm came to the patient and they were asymptomatic.

Standard dosing is 100mg-150mg/24 hour subcutaneously. Please refer to the Bedfordshire Palliative Injectable Medicines Guidance.

Staffing Changes

Gaganjot Kaur, Band 5 pharmacy technician has left BCHS.

MHRA Drug Safety Update and ELFT Medication Safety Bulletin

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

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

Bulletin produced by Kelly Pritchard Specialist Clinical Pharmacist Bedfordshire Community Services 25/04/23

Good Practice Interventions

1. An external prescribing error was identified by a heart failure and diabetic nurse in an MDT. The patient was prescribed dapagliflozin for chronic heart failure by a cardiologist but this was contraindicated as the patient was a Type 1 diabetic. Once highlighted the prescriber stopped this medication and the patient was started on ramipril instead.

2. **Jacqueline White** (pharmacy technician) intervened when a patient who was on 20 different medication was incorrectly discharged from the acute without a dosette and sent with single boxes. The transfer of care team were not able to administer medication from the boxes without a MAR chart.

On phoning the chemist they were not aware the patient was in hospital and had been supplying and delivering dosette boxes for 6 weeks. Jacky produced a prompt sheet for the team to use and liaised with chemist so they could start supplying the new dosette boxes as soon as possible. A poor discharge alert was raised.

3. Congratulations to **Navreet Gill** (pharmacy technician) on being accepted on to the ELFT leadership program

Medication Shortages

Relevant shortages highlighted by the ELFT pharmacy procurement team are now located on the intranet: https://www.elft.nhs.uk/intranet/teams-support-me/pharmacy/medicines-shortages

New additions include:

-**Oxycodone 5mg/5ml Oral Solution-** anticipated resupply end June 2023 Further information linked here

-**Alfuzosin 10mg M/R tablets** – anticipated resupply May 2023

-**Microgynon ED tablets -a**nticipated resupply date is Jan 2024

-**Triptorelin acetate (Gonapeptyl Depot®) 3.75mg powder and solvent for suspension for injection prefilled syringes** are out of stock until late-April 2023, following a Class 2 Medicines Recall issued on 23rd March 2023.

-**Ketoconazole Shampoo**- anticipated resupply date of 29.12.2023

-Oxybutynin 5mg modified-release tablets -until w/c 1st May 2023

-**Canestan HC cream** - until early June 2023.

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