



Learning from BCCHS Medication Incidents

In April we saw 19 medication incidents reported for BCCHS, 13 were external medication errors (9 of which were poor discharges). A thematic review of the internal incidents highlighted the following learning:

Incident

Following an SOS call from the patient a nurse visited to administer tinzaparin. The nurse administered a dose from the patient's transcribed MAR chart but did not check the discharge letter for length of treatment. On return to the office and checking Sytm1 the nurse noted that medication had been stopped 2 days before following a clear scan.

Learning

Check Systm1 where possible before visiting

10 Rights of medication administration

Check discharge letter/prescription as well as transcribed chart

Document on the transcribed chart stop/review dates for medication

Consider asking the duty desk to check for any medication changes

Low molecular weight heparin – confirm treatment course length and indication prior to transcribing

Please refer to the [Policy for Transcribing Medication and the Procedure for administration of medicines by CHS staff](#)

Staffing Changes

Priti Patel will be joining the pharmacy team as a Band 5 Pharmacy Technician – start date to be confirmed

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

<https://www.elft.nhs.uk/intranet/teams-support-me/pharmacy/pharmacy-community-health-services-chs>.

Bulletin produced by Kelly Pritchard Specialist Clinical Pharmacist Bedfordshire Community Services 16/05/23

Good Practice Interventions



A member of the community nursing team identified an expired hydroxocobalamin (vitamin B12) injection dispensed in error by a community pharmacy. By undertaking correct checking procedures the expired medication was identified and therefore not administered. It was disposed of correctly and new medication was requested.

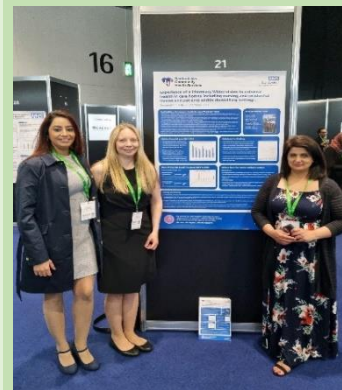
Navreet Gill (Pharmacy technician) identified that a patient had been discharged from the acute hospital with discrepancies on their discharge letter. The patient's long term dexamethasone eye drops had been omitted on admission and discharge from the acute. On clarifying this was unintentional, Nav liaised with the GP to ensure that this was rectified.

Jacky White (Pharmacy technician) has received great feedback from a patient and daughter for the help that she is providing them regarding the patient's medication management and adherence.

Clinical Pharmacy Congress

We are pleased to announce that the BCCHS Pharmacy team were selected to present a poster at the Clinical Pharmacy Congress on 13th May 2023.

The team were able to showcase our experience of enhancing healthcare within care homes and domiciliary settings.



Medication Shortages

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

No new additions highlighted by our procurement team since the previous bulletin.

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