BCHS Pharmacy Team Medicines Bulletin (July 23)

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NHS East London NHS Foundation Trust

Learning from BCHS Medication Incidents

In June we saw 20 medication incidents reported for BCHS, 9 were external medication errors (6 of which were poor discharges). A thematic review of the internal incidents and recent audits have highlighted the following learning:

Transcribing of Insulin

Following on from our transcribing audits we wanted to highlight the following requirements for transcribing insulin:

- On transfer confirm the insulin product and dose through medicines reconciliation with a minimum of **two** sources.
- Check if the patient has an insulin passport/card and update if appropriate.
- When transcribing ensure to stick to the following best practice principles:

Transcribe the exact Brand name e.g. Humalog, Novorapid	Transcribe the insulin device name e.g. 'Kwikpen', 'Flexpen'
Transcribe the strength of the insulin e.g. 100 **units** in 1ml	If an insulin dose changes, make sure the correct dose is transcribed

- A second transcription check must be obtained for each transcription. Although it is recognised that there are circumstances when this may not be possible at the point of transcribing e.g. in patients' homes. In this instance, it is advisable to have a short mental break between transcribing the chart and the final check for accuracy.
- A second check must be carried out within 24 hours of the transcription by an approved transcriber other than the original transcriber.

Please refer to:
Policy for the Transcribing of Medication for the Purpose of Recording Administration in CHS 3.0 and the
Policy for the Safe Use of Insulin 2.0

Good Practice Interventions

Navreet Gill (pharmacy technician)- through a thorough medicines reconciliation she identified that a patient in a care home was receiving an incorrect dose of Creon capsules and had not been sent sufficient amount on discharge . This was the result of an incorrect medicines reconciliation by the acute and a dispensing error on discharge. The incorrect prescription was clarified and amended. A poor discharge alert was raised and more supplies obtained.

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

Patient Safety Alert

Recruitment Update

Priti Patel pharmacy technician has now joined the team. She is based in Dunstable.

Medication Shortages

Relevant new 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

Diazepam 10mg/2.5ml rectal solution tubes- out of stock mid July until mid August 2023.

Fluticasone Propionate (Flixonase) Nasule 400 micrograms (1 mg/ml) Nasal Drops Suspension is being discontinued. Limited stock of Flixonase (fluticasone propionate) Nasule Drops will be available in wholesalers until December 2023

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) (Semaglutide, Dulagutide, Liraglutide and Exenatide) licensed in the management of Type 2 Diabetes Mellitus (T2DM). Supply is limited and intermittent **until at least mid-2024.**

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

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.

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