BCHS Pharmacy Team Medicines Bulletin (September 23)

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NHS East London NHS Foundation Trust

Learning from BCHS Medication Incidents

In August we saw 23 medication incidents reported for BCHS, 9 were external medication errors (1 of which was a poor discharge). A thematic review of the internal incidents have highlighted the following learning:

Incorrect timings of LMWH injections

An incident occurred where tinzaparin dose timings were changed multiple times and on one incidence was administered 9 hours after dose was due. The GP was informed and no harm came to the patient. There are theoretical risks that if a LMWH treatment dose is given excessively early, a patient's risk of bleeding may increase or if a dose is delayed excessively, a VTE may extend or re-form.

Learning

When amending the dose-time for tinzaparin, the *"new"* dose time should be 24 hours after the first injection, plus or minus six hours. All subsequent doses should be given at the "new" time until tinzaparin is discontinued or the direction expires. Please note that amendments for enoxaparin and dalteparin are different.

Staff are reminded that in order to achieve an operationally achievable dose-time, please refer to the to the trust policy which can be found on the intranet: **"Guidelines for the Safe Administration of Low Molecular Weight Heparins (LMWH) in Adults Transferred to ELFT Community Health Services".**

Changes to the timings of LMWH injections to be clearly documented on MAR chart and SystmOne

Pre-existing transcriptions of LMWH on MAR chart should be voided and crossed out when timings have changed.

Please ensure changes to LMWH timings are verbally communicated with team during handovers

Staff to check the indication and duration of treatment with LMWH to ensure safety of future doses

Good Practice Interventions

Navreet Gill (pharmacy technician) well done to Nav for going above and beyond to help resolve the difficulties regarding dosette box provision within BCHS. When the local Lloyd community pharmacies were closing down this put significant pressure onto our nursing and therapy teams trying to review and source new dosette box provision . Nav was able to source a pharmacy that was able to accommodate extra patients for dosette box provision and liaised directly with them and the community teams. Nav also developed a procedure to enable the other technicians in the team to support this process. Well done Nav!

Jacqueline White (lead pharmacy technician) has received positive feedback from the nursing teams on her contribution to the Working Together Group MDT. Through excellent communication and joint working Jacky is working to support patients through this MDT, which is currently supporting 45 patients. In a recent case, Jacky was able to review medication compliance and improve the outcomes for a patient with dementia. Well done Jacky!

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

Katarzyna Muzyczka lead pharmacy technician for the mid joined the BCHS pharmacy team in September.

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

No new medication shortages since previous month

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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