BCHS Pharmacy Team Medicines Bulletin (October 23)

We care
We respect
We are inclusive

NHS East London NHS Foundation Trust

Learning from BCHS Medication Incidents

In September we saw 23 medication incidents reported for BCHS, 14 were external medication errors (9 of which were poor discharges). A thematic review of the internal incidents have highlighted the following learning:

Incident – Tinzaparin administration error

A patient was discharged into our care for tinzaparin administration. The discharge letter stated that the medication was due once a day in the evening. The tinzaparin was administered by our staff that evening. The next day the referral came through from the hospital and stated that the tinzaparin had already been administered in the morning before discharge. A double dose was therefore administered. No harm came to the patient as a result of the error.

Learning

Wait for the full referral from the hospital before administering any medication

Check when the last dose of medication was given if this is unclear

10 Rights of Medicines Administration

Refer to : Medicines Policy, the safe administration of LMWH in adults transferred to ELFT Community Health Services and the Policy for the transcribing of medication for the purpose of recording administration in CHS on the Trust intranet pages

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

Good Practice Interventions

Climate Champions: Supporting Greener Inhalers within care homes and domiciliary settings

Thank you to all the pharmacy team for supporting with this project over the past 5 months. The technicians were able to identify and task GPs when they identified patients that could be switched from Ventolin to Salamol, a greener inhaler choice. They were also able to highlight those who were overdue their annual asthma/COPD review or who had poor compliance. Well done team!

Clare Moody (pharmacy technician) This month Clare identified and raised 6 poor discharge forms when undertaking her medicines reconciliations. Examples of poor discharges she identified and helped solve included insulin sent home with patients without dates of opening and unclear directions for co-amoxiclav and eplerenone tablets. Great work Clare!

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

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) licensed in the management of Type 2 Diabetes Mellitus (T2DM). Supply is not expected to return to normal **until at least mid-2024.**

Hyoscine hydrobromide (Scopoderm®) 1.5mg patches are in limited supply until w/c 1st January 2024.

Methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets – supply disruptions likely to resolve between October and December 2023

Bumetanide 5mg tablets are out of stock until early March 2024 and **Bumetanide 1mg tablets** remain available until the end of October and will be out of stock until January 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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