



## Learning from BCBS Medication Incidents

In January we saw 32 medication incidents reported for BCBS, 18 were external medication errors. A thematic review of the internal incidents have highlighted the following learning:

### Incident : Missed Denosumab and Vitamin B12 injections

#### Good Practice

When recently assigned to her new caseloads, Band 6 Staff nurse Gemma Wright identified through good caseload management that a patient's vitamin B12 injection had been missed by a month and another patient's denosumab injection for osteoporosis had been missed.

#### What went wrong?

The previous case holder had identified that there was lack of medication in the houses but they did not request the medication from the surgery or advise the patient, relative or carer to request it. They had also relied on the relatives/carers to contact our services once medication had been obtained. Previous poor caseload management prevented the errors being identified in a timely manner.

#### Learning

- make sure medication is available and requested in advance.
- ensure a care plan is set up to follow up on the medication required and that the administration date is rescheduled.
- Caseload holding nurses should ensure that they are undertaking weekly caseload assurance checks (BCBS Community Nursing Standard Operational Procedure).

## 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](mailto: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 14/02/24

## Good Practice Interventions



**Clare Moody (lead pharmacy technician)** Clare identified a patient who had documented poor oral intake and swallow problems. The patient was discharged from the acute on solid dose medication which the patient could not swallow. She worked closely with the care team and GP to establish how the medicines could be given. The patient was also reviewed and found to have oral thrush which would have impacted swallowing. Clare discussed with care staff over the phone and sent information about what was available as liquid and what could be crushed to support the switching to more suitable formulations. Great work Clare!

**Priti Patel (pharmacy technician)** Intervened when information was missing on a discharge letter for a dose reduction of Betahistine. Priti liaised with the GP to resolve the issue. Great work Priti!

## 100 Medicine's Reconciliations

Well done to the pharmacy technicians for completing 100 medicines reconciliations in January. This is the most that the team have ever completed in a month and is a significant increase compared to a year ago. This shows the continuing hard work of the team and the expansion of our service.



## 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>

**Lantus® (insulin glargine) Solostar® 100units/ml solution for injection 3ml pre-filled pens** will be in limited supply from the end of January 2024 - resupply dates are to be confirmed.

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](http://www.sps.nhs.uk)