BCHS Pharmacy Team Medicines Bulletin (May 24)

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We respect
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NHS East London NHS Foundation Trust

Learning from BCHS Medication Incidents

In April we saw 26 medication incidents reported for BCHS, 13 were external medication errors. A thematic review of the internal incidents have highlighted the following learning:

Controlled Drug (CD) Incidents

In April we had 3 incidents reported where CD's were missing from patient's homes. These occurred with different patients and different teams. On questioning in one incident it was thought that 2 missing oxycodone ampoules had been accidently thrown away by the patient/relative. In another incident a locked box was then implemented into the home.

Good Practice Points

If there is a discrepancy between the calculated stock figures and the actual stock, steps should be taken to establish what happened

- Check back through the entries for the controlled drug and ensure that there has not been a bookkeeping or numerical error.
- Check the MAR chart and any records of disposed medicines
- If the discrepancy cannot be explained or rectified, then the Team leader and Lead Pharmacist / CD Accountable Officer should be informed immediately, and an InPhase completed. The patient's medical records should also be updated.

Use a separate stock sheet for each Controlled drug	Patients and relatives should be encouraged to store in original dispensed labelled boxes
Keep different strengths physically separated to minimize risk	Patient's stock of controlled drugs should be checked, counted, reconciled and clearly recorded at the time of every administration
Undertake a risk assessment to support patient with managing storing their controlled drugs	Ensure that the patient information leaflet 'Safe Storage of Controlled Drug Medicines at Home' is left in the patient's home.

Please refer to the **Trust Policy 'Safe Management of Controlled Drugs in the Domiciliary Setting'** on the intranet

Good Practice Interventions

Navreet Gill (Pharmacy Technician) has successfully completed her Educational Supervisor Course. Well done Nav!

Kelly Pritchard (Clinical Pharmacist) has been delivering medicines safety training for the DN North as part of actions and learning from an incident.

Clare Moody (Lead Pharmacy technician) has been supporting with District Nursing North with their reflections in response to an incident action plan.

Clare also intervened when a patient was discharged without a supply of apixaban tablets. She confirmed that this was an error attributable to the acute trust and followed up to ensure that the patient managed to receive a supply.

ELFT Medication Safety Page

The Trust's monthly medicines safety page is available here: https://www.elft.nhs.uk/intranet/teams-support-me/pharmacy/medicines-safety

MHRA – Drug Safety Update

Patient Safety Alert

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

Naloxegol (Moventig®) 12.5mg are out of stock until early 21 June 2024.

Tegretol 100mg/ml liquid- no resupply date confirmed yet.

Flamazine® 1% cream- anticipated resupply date August 2024

Pabrinex® Intravenous (IV) injection –resupply date to be confirmed
Pabrinex® Intramuscular (IM) injection is being discontinued.

Daktacort® (hydrocortisone 1% / miconazole 2%) cream (30g, POM) has been discontinued with remaining supplies due to be exhausted by the end of May 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.

Bulletin produced on 22/5/24 by Kelly Pritchard Specialist Clinical Pharmacist Bedfordshire Community Services