Medicines Safety Matters

Newsletter for Prescribers & Community Pharmacists

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HSCB Primary Care

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Inside this issue:

Introduction

Welcome to the first edition of the 'Medicines Safety Matters' newsletter. The newsletter will be produced quarterly with the aim of informing and guiding prescribers and community pharmacists in areas of medicines governance and prescribing safety.
We welcome your feedback and suggestions for articles that you would find useful. If you have any queries or require further information on the contents of this newsletter, please contact the Medicines Governance Adviser in your area (see team contacts).

The role of the Primary Care Medicines Governance Team is to:

- Promote safer systems for medicines management for prescribers, community pharmacists & their staff
- Promote the reporting of adverse incidents in primary care & share learning
- Co-ordinate regional medicines governance work in primary care e.g. actions related to NPSA Alerts
- Provide guidance on issues relating to Controlled Drugs legislation
- Develop guidance and procedures relating to governance issues e.g. prescription security
- Liaise closely with the secondary care Medicines Governance Team and support multi-professional initiatives to address governance issues at the interface between primary and secondary care

Errors with dropper & pump device formulations

Medication errors have occurred when prescribing and dispensing oral formulations using a dropper or pump device. Errors can arise from confusion about the dose that is delivered by the device or the dosing schedule, product changes or use of the device by the patient.
Examples of products where errors have occurred are memantine (Ebixa®) pump device and escitalopram (Cipralex®) oral drops.

Memantine (Ebixa®)

One activation of the pump delivers 0.5ml of solution, corresponding to 5mg of memantine.

The maximum daily dose is 4 pump activations = 20mg = equivalent to 40 drops delivered by the old dropper device (phased out February 2011).

Escitalopram (Cipralex®)

Escitalopram oral drops 10mg/ml formulation were discontinued at the end of March 2011. The 20mg/ml formulation is still available.

Patients currently taking the 10mg/ml product can be switched to the 20mg/ml product without any need for cross tapering by **halving the volume** administered.

Advice: Practices should be aware of these product changes and should check that prescribed doses and directions have been reviewed in order to ensure that they are accurate.

Please advise patients and their carers to carefully read the Patient Information Leaflet before using their oral solution delivered by a pump or dropper device.

New Monitoring Advised for Dronedarone (Multaq®)

Dronedarone is an anti-arrhythmic drug licensed for adults with past or non-permanent atrial fibrillation (AF), to prevent recurrence or to lower ventricular rate. Since dronedarone was licensed in 2009 there have been reports of liver injury, including 2 cases of liver failure. Some of the cases have occurred early after the start of treatment. The MHRA and Sanofi Aventis have advised healthcare professionals regarding new recommendations for monitoring liver function. There is also an additional warning advising of the risk of developing or worsening heart failure. Advice to prescribers was issued in January 2011 and by now, all patients taking dronedarone should have commenced their series of LFTs.

Advice: Practices should check that the necessary arrangements have been made & patients recalled as necessary.

Liver function tests for patients taking dronedarone:

- Prior to treatment
- Every month for the first 6 months
- At months 9 and 12

For further information on this topic, action to take if LFTs are raised and advice to be given to patients, see the MHRA website: http://www.mhra.gov.uk/home/groups/dsu/documents/publication/con108718.pdf

Take Care when Prescribing and Dispensing Controlled Drugs

Following a recent incident where standard release morphine was **prescribed** generically and subsequently **dispensed** as the modified release preparation, prescribers are asked to ensure that all prescriptions for oral morphine are written using the **brand name**.

Advice:

- All staff should be aware that certain CD preparations should be brand prescribed to ensure continuity of treatment e.g. sustained release preparations including opioid patches and morphine sulphate preparations. If a modified release medicine is written generically, the pharmacist should confirm the previous brand before dispensing
- Prescribers and pharmacists are advised that it is good practice for two members of staff to check CD stock supplied or dispensed, and for both individuals to initial the entry in the CD register. This will provide an additional check that the correct drug and strength, at the appropriate dose as recommended by the prescriber, has been supplied and that the accurate record is made in the correct section of the CD register
- Please ensure your processes for managing CDs are reviewed and updated, and staff trained, to ensure that the risk of supplying the wrong CD preparation is reduced

For further information on this topic, please see:

- *Medicines Safety Alert no 4 (web-link on back page)*
- *HSCB Guidance on 'Items Unsuitable for generic Prescribing'*
  Available online www.hscboard.hscni.net
  Look under 'News/Events' then 'Initiatives' and then 'medicines management' and 'prescribing guidance'


Items Unsuitable for Generic Prescribing

MHRA 'Drug Safety Update' Bulletin

The MHRA (Medicines & Healthcare Products Regulatory Agency) bulletin 'Drug Safety Update' is issued every month featuring the latest safety advice for medicines users. Recent topics include: monitoring atypical antipsychotics (April 2011), restriction to modafinil licence (March 2011) and cardiac risk with dextroproxyphene (Jan 2011). HSCB send the bulletin by email to all GP practices.
http://www.mhra.gov.uk/Safetyinformation/Healthcareproviders/Pharmacy/DrugSafetyUpdate/index.htm

Risk of confusion between medicines which 'sound-alike' or 'look-alike'

Adverse incidents continue to be reported involving drugs with similar names or packaging . These incidents have highlighted the importance of having robust processes in place for the prescribing, dispensing and administration of medicines.

Practices and community pharmacists are encouraged to take steps to minimise the risks associated with this.

Advice:

All staff should:

- Be aware of medicines which have similar names or packaging. See list for some common examples
- Be vigilant when selecting these medicines for prescribing, dispensing or administration
- Take care when transcribing from other information sources e.g. patient requests for prescriptions, hospital letters, telephone messages

Other steps to reduce risk may be considered as appropriate e.g. clinical system alerts, storage within clinical or dispensary areas, arrangement of stock in doctors' bags, shelf labels.

For further guidance, community pharmacists should refer to the HSCB Pharmacy Safety Alert No 1 December 2009 'Risk of confusion between medicines which have similar names'.

Medicines with similar names

Aminophylline	Amitriptyline
Atenolol	Amitriptyline
Amiloride	Amlodipine
Amlodipine	Amiodarone
Clarithromycin	Ciprofloxacin
Lamisil®	Lamictal®
Risperidone	Risedronate
Procyclidine	Prochlorperazine
Sulfasalazine	Sulfadiazine
Dopamine	Dobutamine
Celectol®	Celebrex®
Fluoxetine	Paroxetine
Hydralazine	Hydroxyzine
Carbamazepine	Carbimazole
Pregaday®	Pregababilin
Repavax®	Revaxis®
Mercaptamine	Mercaptopurine
Penicillin	Penicillamine

Clozapine — Did You Know?

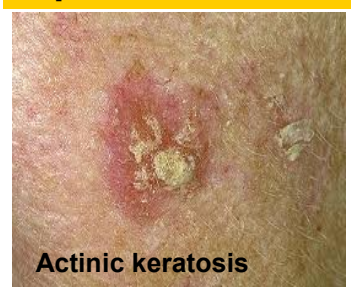
Clozapine is an atypical antipsychotic used to treat schizophrenia. It is classified as a Red List Specialist Medicine and therefore responsibility for **prescribing and supply remains with secondary care.** Clozapine can cause agranulocytosis and so it is mandatory that all patients undergo regular and timely blood monitoring which is arranged with the patient by secondary care. It is important that clozapine treatment is not stopped abruptly.

Please note:
Before a patient can receive clozapine, the patient, the prescriber and the pharmacy supplying the clozapine must be registered with a clozapine monitoring service. In Northern Ireland, most patients receiving clozapine receive the branded generic product: Zaponex®. In this case, registration must be with the Zaponex® monitoring service.

Advice:

- Ensure staff involved in prescribing and dispensing are aware of the highly specialist nature of clozapine and that responsibility for prescribing and supply remains with secondary care
- For patients receiving clozapine, this should be recorded on the repeat prescribing screen on the GP clinical system with a clear indication not to prescribe or dispense
- Patients presenting with potential symptoms of agranulocytosis (e.g. sore throat, fever), should be discussed urgently with the patient's GP who should consult with the patient's specialist
- All issues regarding clozapine treatment, including compliance issues, should be communicated immediately to the patient's specialist

Topical Diclofenac–different strengths



Actinic keratosis

Topical diclofenac sodium comes in two strengths. The **1%** strength is used to provide pain relief and is available as Voltarol Emulgel®. The **3%** strength is used to treat actinic keratosis and is available as Solaraze®.

Advice: In order to prevent the incorrect strength being selected from the computer system a warning can be added to alert the prescriber that the 3% strength should only be prescribed for actinic keratosis.

Avoiding Errors with Ranitidine Syrup for Children or Babies

There have been three adverse incidents in NI involving ranitidine syrup 75mg/5ml in children or babies in the past 6 months. Brief details are given below:

3 incidents reported in the last 6 months in Northern Ireland

1. Prescription for a baby stated 0.4ml three times a day. Ranitidine syrup was dispensed and labelled correctly but the pharmacist supplied a 5 ml syringe, which caused some confusion for the mother, who administered 4ml three times a day.
2. Prescription stated 10mg three times a day. The pharmacist labelled this as 5ml three times a day.
3. Prescription for a baby incorrectly stated 7.5**ml** three times a day but should have stated 7.5**mg** three times a day. Unfortunately the pharmacist didn't spot the error and the baby was given an overdose for several days.

In these three cases, the babies were given between **10 and 15 times** the intended dose of ranitidine but the errors were spotted before the babies came to any serious long term harm. Following the first of these incidents, the HSCB sent out an alert regarding risks when dispensing oral liquid medicines and oral syringes.

Advice: Community Pharmacists

- Double check the dose requirements when presented with a prescription for a baby or young child
- Check the script for accuracy and clinical appropriateness. Always consider the age of a patient when completing the clinical check on the appropriateness of the dose
- If a calculation is required which takes into consideration body weight, a second check should be carried out by another pharmacist if available. The calculation should be recorded in the patient medication record along with a record of the names of the pharmacists involved
- Ensure that the prescribed dose can be measured accurately when supplying an oral syringe
- Pharmacists should keep smaller sized oral syringes in stock for use in babies/children and for very small doses. (Local wholesalers can supply 1ml, 3ml and 5ml oral syringes)
- Ensure that patients or carers understand how to use the oral syringe provided and advise on the exact measurement to deliver the prescribed dose.

Advice: Prescribers

- Prescribers to double check any non-standard doses & have a calculator available at desk.
- Include **mg** and **ml** in dose instructions e.g. 7.5mg/0.5ml

Look ! Recent Medicines Safety Alerts

These have been developed by the Medicines Governance Team in response to reported adverse incidents. Copies of the HSCB 'Medicines Safety Alerts' are available online from the HSCB website:www.hscboard.hscni.net
Look under 'News/Events' then 'Initiatives' and then 'Medicines Management' or follow the link:
http://www.hscboard.hscni.net/medicinesmanagement/Medicine%20Safety%20Alerts/index.html#P-1_0

No 1	Mar 2010	Clinical risk assessment when issuing repeat & acute prescriptions
No 2	April 2010	Learning from adverse events—Heparin
No 3	July 2010	Risks when dispensing medicines into monitored dosage systems
No 4	Aug 2010	Prescribing & dispensing Controlled Drugs
No 5	Oct 2010	Prescribing and dispensing medicines with a range of strengths and preparations
No 6	Sept 2010	Risks when dispensing oral liquid medicines & oral syringes
No 7	May 2011	Change to the labelling of dexamethasone injection
No 8	Oct 2010	Issuing duplicate prescriptions