Health and Social Care Board

Medicines Safety Matters

Newsletter for Prescribers & Community Pharmacists

Volume 3 Nov 2011

HSCB Primary Care

Medicines Governance Team:

Team Leader:

Brenda Bradley

Tel: 07917544301

Brenda.Bradley@hscni.net

Belfast Area:

Briegeen Girvin

Tel: 07748630415

Briegeen.Girvin@hscni.net

Northern Area:

Chris Blayney

Tel: 07825030616

Chris.Blayney@hscni.net

Southern Area:

Anne Marie Groom

Tel: 07817428869

Annemarie.Groom@hscni.net

South Eastern Area (Down, North Down & Ards, Lisburn)

Helen Bell

Tel: 07920187940

Helen.Bell@hscni.net

Western Area

Joanne McDermott

Tel: 07909757674

Joanne.McDermott@hscni.net

Inside this issue:

Double check the strength of Oramorph® oral solution

Oramorph® liquid is available in 2 strengths, one of which is ten times the concentration of the other:

- Oramorph® oral solution (which contains morphine sulphate **10mg**/5ml)
- Oramorph® concentrated oral solution (which contains morphine sulphate **100mg**/5ml)

Recently a patient was discharged on Oramorph® oral solution 10mg/5ml, the dose being 20mg (i.e. 10ml). A prescription for Oramorph® oral solution 10mg/5ml was issued in primary care. However, when issuing a further supply, the GP inadvertently prescribed Oramorph® concentrated oral solution 100mg/5ml, the dose being 10ml (i.e. 200mg). The community pharmacist noted the high strength and as it was a Saturday, contacted the Out of Hours GP who confirmed the strength and Oramorph® concentrated oral solution 100mg/5ml was dispensed.

The patient took the higher strength preparation and experienced nausea, agitation and shakiness. The patient subsequently reduced the dose themselves from 10ml to 5ml - although this was still 5 times the intended dose. The error was discovered and the GP practice has subsequently attached an alert to Oramorph® concentrated oral solution on their clinical system. It is also good practice to include both strength e.g. mg and ml on the dose instructions of liquid medicines.

Recommended action:

Healthcare professionals are reminded of the recommendations in the **NPSA Rapid Response Report on Reducing dosing errors with opioid medicines:** [1]

When opioid medicines are prescribed, dispensed or administered, in anything other than acute emergencies:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient e.g. by discussing with the patient or their representative, the prescriber or through medication records
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone, in adults, not normally more than 50% higher than the previous dose)
- Ensure you are familiar with the usual starting dose and standard dosing increments, frequency of administration, symptoms of overdose and common side effects of the medication

1. http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59888&p=2

Vaccine Mix-Up

Menitorix®
Contains:
Haemophilus type b
Meningococcal type c

An incident occurred recently in NI when vaccines were mixed up during a childhood immunisation clinic.

The two vaccines, Menitorix® and Menjugate® have similar names and similar blue packaging.

The NPSA have advised that there have been 12 other cases of this mix-up reported in the UK.

In 2005, NPSA also warned about vaccine mix-ups with Repevax® and Revaxis® due to similar names, packaging and labelling.

Staff are reminded to ensure that procedures exist to check that the correct vaccine is selected on each and every administration.

Menjugate Kit®
Contains:
Meningococcal type c

Prescribe medicines to treat epilepsy by brand name

The HSCB has received reports of cases where, failure to maintain patients with epilepsy on the same brand of antiepileptic medication, has led to a changed seizure and control pattern. The cases reported involved **lamotrigine and sodium valproate.**

Due to the potential for variation in bioavailability between brands, antiepileptic medication should be prescribed by brand name to ensure patients receive the same brand each time their medicine is dispensed; changing brands can affect epileptic control. Where bio-equivalence is not so significant e.g. use in pain relief, generic prescribing is appropriate.

Dec 2010 to May 2011 NI GP data:

15,000 Rx lamotrigine and **4,000 Rx** sodium valproate were prescribed by generic name

Generic Name (Not recommended)	Examples of Brand Name (Recommended)
Sodium Valproate	Epilim® Epilim Chrono ®
Phenytoin	Epanutin®
Carbamazepine	Tegretol®, Carbagen® Epimaz®
Lamotrigine	Lamictal®
Topiramate	Topamax®

Recommended Action:

- Prescribers should ensure antiepileptic medication is prescribed by brand name for the treatment of epilepsy; refer to the HSCB Generic Exceptions List (see links below)
- Pharmacists & practice staff should identify patients with epilepsy who are currently prescribed antiepileptic medication by generic name. Bring these patients to the attention of the prescriber so that arrangements can be made to ensure the appropriate brand is prescribed and patients advised accordingly.

http://primarycare.hscni.net/PharmMM_MedsMgt_Generics.htm
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html#P-1_0

Linezolid (Zyvox®) - Did you know?

Could This Happen To You?

An incident occurred recently where linezolid was prescribed by a GP practice and then dispensed by a community pharmacist. Neither the GP nor the pharmacist identified that linezolid was a red list medicine. In this case, the full supply had already been made from the hospital pharmacy.

- Linezolid is a red list drug initiated by secondary care on the advice of consultant microbiologists. It is not suitable for prescribing in primary care & supplies for patients must be arranged by the hospital.
- Linezolid (Zyvox®) is an antibiotic used for treating serious gram positive infections e.g. MRSA, VRE
- It has been associated with reversible myelosuppression, peripheral neuropathy and optic nerve neuropathy
- Weekly full blood counts are required for all patients
- The FDA in the USA has recently warned about serious interactions with serotonergic CNS medication e.g. SSRIs
- Linezolid costs £890 for 10 days oral-treatment

Learning Outcome: Promote awareness of the specialist medicines system including the Red Amber List and check this when an unfamiliar medicine is recommended or prescribed. Details can be found at: www.ipnsm.hscni.net

HSCB Medicines Safety Alert 'Responsibility for Prescribing and Dispensing Specialist Medicines' can be found at: http://www.hscboard.hscni.net/medicinesmanagement/index.html

Quinine – Risks when prescribing & dispensing

The MHRA has advised that quinine should not be used routinely for nocturnal leg cramps, except when:

- There is regular disruption of sleep
- Cramps are very painful or frequent
- Other treatable causes have been ruled out
- Non-pharmacological measures have not worked e.g. stretching exercises

Efficacy

Studies have shown that efficacy is modest, with around 20% fewer cramps (around one episode a week difference) when taking quinine compared with placebo. A reduction in leg cramps may take up to 4 weeks to become apparent. After an initial trial of 4 weeks, treatment should be stopped if there is no benefit. Treatment should be interrupted approximately every 3 months to reassess the benefit.

Side effects

Quinine is generally well tolerated at the doses used, however, adverse effects may include tinnitus, impaired hearing, head-ache, nausea, disturbed vision, confusion, flushing and abdominal pain.

Incidents have been reported when the wrong strength or salt of quinine has been prescribed or dispensed.

- There are two different salts of quinine: sulphate & bisulphate
- There are two strengths of quinine sulphate: 200mg & 300mg
- Quinine bisulphate 300mg is equivalent to quinine sulphate 200mg
- All three of the quinine preparations are used for treatment of leg cramps

Quinine Prescribing in NI
Six months (Dec 2010—May 2011)

Quinine salt	Number of Rx
Quinine sulphate 200mg	33,912
Quinine sulphate 300mg	28,185
Quinine bisulphate 300mg	3,339

Serious side effects

Patients should be warned not to take more than the recommended dose. Irreversible blindness and death may occur with overdose. Patients should be instructed to stop treatment and consult their GP if signs of thrombocytopenia occur, e.g. unexplained petechia, bruising or bleeding.

Recommended action:

- Review the need for quinine prescribing as per MHRA recommendations
- Review & rationalise the range of quinine salts & strengths prescribed
- Always state the quinine salt on all prescriptions
- Ensure that pharmacy stock is clearly differentiated on the shelf

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON085085

Ten Top Tips For Safer Prescribing

The National Prescribing Centre (NPC) has issued a new document which highlights a prescribing error rate of 7.5% and outlines strategies to make prescribing safer. It includes key suggestions to prevent error, together with points for safer prescribing and concludes with ten top tips for prescribers:

1. Keep up-to-date in therapeutic knowledge, especially for common conditions
2. Have all necessary patient information, including co-morbidities and allergies
3. Have all necessary drug information including side effects and interactions
4. Weigh the risks and benefits: consider if prescribing is necessary
5. Check computerised alerts for important interactions/drug allergies
6. Actively check for errors before signing
7. Involve patients in prescribing decisions and provide necessary patient information to achieve compliance, recognition of side effects and adequate monitoring and/or review
8. Have systems to ensure essential laboratory test monitoring and review
9. Build high levels of safety into your repeat prescribing system
10. Primary/secondary interface: have safe and effective ways of communicating medicines information and acting on suggested/initiated medication changes

http://www.npc.nhs.uk/evidence/resources/10_top_tips_for_gps.pdf

Caution–Peanut/Soya Allergy & Salmeterol MDI

The Royal Pharmaceutical Society has issued advice to pharmacists on the supply of salmeterol inhalers.

Two products are available:

- Serevent Evohaler® from GSK
- Neovent® from Neolab

Neovent® contains anhydrous ethanol and soya lecithin (E322), therefore it is contraindicated and should not be supplied to patients with allergies to peanuts and soya. Neovent® is only indicated for use in adults and adolescents over the age of 12 years.
Serevent® Evohaler is indicated for use in children aged 4-12 years and in adults.

Recommended Action:
Search for patients with documented peanut or soya allergy who are prescribed salmeterol MDI and ensure that Serevent Evohaler® is prescribed.

Pharmacists should carefully consider which brand would be suitable to supply if they are presented with a prescription written generically for salmeterol 25 micrograms metered dose inhaler.

The summary of product characteristics for Neovent® is not on the electronic medicines compendium (eMC) website, to obtain a copy, telephone Neolab 01256 704 110 or email info@neolab.co.uk

NPSA highlights incidents with Alfacalcidol

In September 2011, the NPSA highlighted the risks involved with the prescribing, dispensing, administration and monitoring of **alfacalcidol** preparations.

A search of incidents reported to the National Reporting and Learning System (NRLS) between Jan 2008 and Dec 2010 identified 341 medication incidents; two were associated with severe harm, two with moderate harm and the remainder with low or no harm.

Alfacalcidol is a vitamin D analogue used whenever there is a disturbance of calcium metabolism due to impaired hydroxylation of vitamin D e.g. in renal disease or parathyroid disease or in neonates.

A higher dose is given initially, usually 1-3 micrograms daily in adults, reducing to a maintenance dose of 250 nanograms - 1 microgram daily in adults.

Dosage frequency may be reduced to three times a week in renal patients.

Alfacalcidol has a number of presentations. There are three different strengths of oral tablets (available as generic and One-Alpha®), two strengths of injection and one strength of oral drops.

Alfacalcidol Prescribing in NI
Six months (Dec 2010—May 2011)

Alfacalcidol capsules	Number of Rx
Alfacalcidol 1 microgram	1528
Alfacalcidol 500 nanograms	1269
Alfacalcidol 250 nanograms	2789

Types of incidents reported:

- Monitoring: Failure to monitor calcium levels once or twice weekly initially, whenever nausea and vomiting occurs and every two to four weeks when stabilised
- Incorrect frequency of administration e.g. prescribed three times a week but instead, given three times daily
- Incorrect strength prescribed, dispensed or administered due to confusion over nanograms and micrograms e.g. 250 micrograms prescribed instead of 250 nanograms
- Incorrect product selection during dispensing and administration due to similar packaging
- Administering the wrong dose using oral drops due to confusion with the product strength e.g. 2 micrograms/ml; one drop contains 100 nanograms

Recommended action:

- Prescribers should check that plasma calcium monitoring is undertaken as per recommendations
- Micrograms and nanograms should not be abbreviated
- Avoid the use of decimals e.g. prescribe 250 nanograms rather than 0.25 micrograms
- Take care when selecting the correct alfacalcidol preparation from the GP clinical system, the pharmacy computer system and the shelf
- Pharmacists should ensure that stock is clearly differentiated on the shelf