Health and Social Care Board

Medicines Safety Matters

Newsletter for Prescribers & Community Pharmacists

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Inside this issue:

Take care with immunosuppression & vaccines

During the influenza vaccination campaign 2012/13, the live attenuated intranasal vaccine Fluenz® was the vaccine of choice for children aged two years to <18 years of age. The vaccine is a live strain and therefore contraindicated in immuno-suppressed children.
Three incidents have been reported where the vaccine was administered to patients in this group.

Learning from these incidents has led to the following recommendations for GP practices and community pharmacists:

- Staff should be aware of immunosuppressant medication that patients may be taking (note that some of these examples must be prescribed by brand) see BNF chapter 8.2 and 6.3.2

  Tacrolimus
  Sirolimus
  Ciclosporin
  Mycophenolate
  Azathioprine
  Corticosteroids

- Community pharmacists should highlight potential risks to patients/ parents regarding vaccinations and immunosuppressant medication.

Additional advice to GP practices:

- Any immunosuppressant medications supplied by the hospital should be documented on the GP clinical system, not to be prescribed, but to give a complete medication history
- Patient Group Directions for the vaccines should be read and understood by all staff involved in the vaccination clinics. Contraindications for each vaccine must be noted.
- Patients who fall into the contraindicated categories should be identified prior to inviting them to attend a vaccination clinic
- A suitable questionnaire should be completed by patient/parent to highlight potential issues prior to vaccination.

Pregabalin overdoses lead to hospital admissions

Medicines Safety Alert

A number of incidents have occurred where patients have been admitted to hospital following an inadvertent overdose of pregabalin. The main contributory factors to the incidents were:

- Confusion between **pregabalin** and **gabapentin** which are in the same therapeutic drug class and have similar sounding names
- Lack of awareness of the maximum recommended dose of pregabalin (i.e. 600mg daily).

In January, the Board issued a Medicines Safety Alert to prescribers and community pharmacists which made recommendations to help reduce the risk of overdose and confusion between these products.

Please ensure all staff are aware of this alert
http://www.hscboard.hscni.net/medicinesmanagement/index.html

Alert

Oral anti-cancer medicines–NPSA advice

The NPSA report "Risks of incorrect dosing of oral anti-cancer medicines" states that " Doctors, nurses, pharmacists and their staff must be made aware that the prescribing, dispensing and administering of oral anti-cancer medicines should be carried out and monitored to the same standard as injected therapy". This can be addressed through the following action points:

Advice for GP practices:

- Treatment should be initiated by a specialist
- All oral anti-cancer medicines, regardless of indication, should be prescribed only in the context of a written protocol and treatment plan:
  - Red list by hospital
  - Amber list by hospital or GP if there is shared care
- Non-specialists who prescribe or administer these medicines should have ready access to protocols and treatment plans including guidance on monitoring and treatment of toxicity.

Advice for Community Pharmacists:

- Pharmacists dispensing oral anti-cancer medicines (amber list) should be able to confirm with the prescriber that the dose is appropriate for the patient.
- Have an SOP in place that covers the supply of oral anti-cancer medicines which should include; prescription receipt, pharmaceutical assessment, interventions and problem solving, assembly / labelling, accuracy checking & transfer to the patient.

Examples of oral anti-cancer medicines that are **RED LIST ONLY**

Busulfan (Myleran®)
Chlorambucil (Leukeran®)
Capecitabine (Xeloda®)
Imatinib (Glivec®)
Melphalan (Alkeran®)
Temozolomide (Temodal®)

Oral anti-cancer medicines can be used to treat other conditions e.g.

Rheumatoid arthritis, psoriasis, Crohn's disease, ulcerative colitis, systemic lupus erythematosus thrombocythaemia, sickle cell disease, inflammatory neuropathies

Examples of oral anti-cancer medicines that are **RED LIST** for cancer **AMBER LIST** for non-cancer

Cyclophosphamide
Hydroxycarbamide (Hydrea®)
Mercaptopurine (Puri-Nethol®)
Methotrexate

Shared Care Guidelines are available for non-cancer indications:
www.ipnsm.hscni.net

Eye eye, what's this ear?

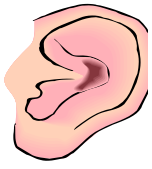
A patient experienced ocular pain when they were supplied with chloramphenicol 10% **ear** drops instead of chloramphenicol 0.5% **eye** drops on discharge from hospital.
The solution administered to the eye was twenty times stronger than intended.
There have been other reports of this mix-up occurring in primary care in the rest of the UK.

Advice for all staff:

Be aware of medicines that are available in a range of formulations for different routes of application.
Another example is aciclovir which is available as 3% eye ointment and 5% topical cream.

Chloramphenicol eye & ear products

0.5% drops
1% ointment



5% drops
10% drops

Recent prescribing and dispensing mix-ups

Dexamethasone/ Dexamfetamine

There have been two reports of mix-ups between the drugs dexamfetamine and dexamethasone.

In one incident, an 11 year old child was prescribed dexamethasone 500 microgram tablets at a daily dose of 2mg when the intended medication was dexamfetamine 5mg tablets.
The incorrect medication was dispensed and taken by the patient for 3 days.
This error was discovered by the parent before any serious harm was caused but could have led to serious consequences including symptoms of Cushing's syndrome which can have severe and persistent complications.

Wound Care Products

ActivHeal® Non adhesive foam	ActivHeal®Foam adhesive
Premierpore®	Premierpore VP®
Aquacel®	Aquacel Ag®
Activa® Leg Ulcer Hosiery kit 2 layers = **40mmHg used for leg ulcers** 	Activa® Leg Ulcer Liner pack 1 layer = **10mmHg used for light compression** 

Hillbilly Heroin–Abuse of oxycodone in Northern Ireland

The Drug and Alcohol Monitoring & Information Service (DAMIS) has alerted the Public Health Agency (PHA) to a number of reports of young people in Northern Ireland who are abusing oxycodone preparations, also known as 'oxys' or 'hillbilly heroin'.

It is vital that prescribers and community pharmacists are aware of the possibility of medication diversion for illegal use and should be vigilant for requests for oxycodone products or additional prescriptions for existing patients.

Reported sources of oxycodone in N.I. are:

* Internet supplies
* Diversion of prescribed medication
* Prescribed medication taken from the homes of terminally ill patients.

Routes of administration that have been reported are oral, nasal, intravenous and rectal.

The Department of Health in Northern Ireland, PHA and Department of Justice Northern Ireland (DOJNI) are monitoring this and request that anyone with additional information on this issue contacts DAMIS at DAMIS@hscni.net

In August 2011, illegal oxycodone worth £75,000 was recovered by the police in South Belfast and Comber.

Wrong vaccines issued by reception staff

Have you double checked?

A care home was given a supply of Prevenar 13® pneumococcal vaccines instead of the flu vaccines they were due to receive. Reception staff issued the vaccines without getting a second check to confirm that they were correct.

The incorrect vaccine was administered to a number of patients in the home.

Advice for GP practices:

All supplies of vaccines made from the surgery to outlying clinics, care homes, district nursing etc. for administration off-site must be made by a trained member of staff and double checked with a clinical member of staff.
Prior to administration, the identity of the vaccine must be checked to ensure the intended product is being used.

Legality of private prescriptions for controlled drugs

A number of queries and reports have been received regarding private prescriptions for CDs e.g. use of headed notepaper, prescribing for visitors from the USA, GPs not holding PCD1 forms.

Private prescriptions for CDs:

All private prescriptions for Schedule 1, 2 and 3 CDs for human use, and for presentation at a community pharmacy, must be written on a standard private prescription form i.e. PCD1.

If you prescribe CDs privately and require a supply of PCD1 forms, complete the registration form on the BSO website: http://www.hscbusiness.hscni.net/services/2272.htm

Issuing a private prescription for such a CD, other than on a PCD1, is a breach of the Misuse of Drugs Regulations (Northern Ireland) 2002 (The Regulations). **Dispensing** the drug against a private prescription other than a PCD1 (written, for example, on headed paper) is also a breach of the Regulations.

Legality:

All prescriptions for CDs (including private) must comply with legal requirements. The legality of the prescription should be checked by the community pharmacist before dispensing and the prescriber contacted where necessary.

Both HS21 and PCD1 prescription forms should be submitted to the BSO to enable monitoring of CD prescribing under the Accountable Officer Regulations.

In an emergency:

In an emergency when treatment is considered to be both immediately necessary and clinically appropriate for a patient who is not otherwise eligible to receive Health Service prescriptions, it is acceptable for Schedule 1, 2 or 3 CDs to be prescribed under Health Service arrangements on a standard Health Service prescription form (HS21) i.e. a private prescription is not necessary in these circumstances.

Further information:

Safer Management of Controlled Drugs – A Guide to Good Practice in Primary Care
http://www.dhsspsni.gov.uk/pas-guidance

HSCB Guidance for Prescribers on Developing a CD SOP
http://primarycare.hscni.net/PharmMM_Resources_Non%20Clinical%20Resources.htm

Sativex® Oromucosal Spray (*cannabis sativa* extract) is a red list drug in Northern Ireland.
Prescribing responsibility should remain with a specialist clinician.

Summary of recent safety advice from MHRA

www.mhra.gov.uk/drugsafetyupdate

Drug Safety Update

Dec 2012	Codeine Carbamazepine, Oxcarbazepine & Eslicarbazepine.	Safety review of codeine use in children Serious skin reactions
Jan 2013	Fingolimod Lenalidomide Roflumilast Tredaptive®	Bradycardia & heart block Serious hepatic reactions Suicidal behaviour Product withdrawn
Feb 2013	Denosumab Tissue Sealant Sprays	Atypical femoral fractures Updated safety advice
March 2013	Aqueous cream Dabigatran	Skin irritation Contraindicated in patients with prosthetic heart valves