Bedfordshire, Luton and Milton Keynes Health and Care Partnership

BLMK Medication Safety Group Newsletter

Edition 4

Medicines Safety Group (MSG)—taking a systemwide approach

The MSG have been collaborating across the system to identify and mitigate against risks as patients move across the interface.

The following three key themes were identified:

- **Clarity of documentation**

Shared cases indicated that where detail was excluded this increased risk of errors—key examples included omitting the indication for a medication or the rationale for a change in dose, which led to error through lack of clarity of the intended plan.

- **DOACs & anticoagulation**

Evidence suggests that incorrectly dosed DOACs can lead to significant harm—with 2 fold increased risk of major bleeding when overdosed. Patients were also over twice as likely to die (ORBIT AF-II) when underdosed vs patients on the correct dose. DOACs are a high risk medicine, with factors such as multiple medicines in class, with multiple indications contributing to the complexity. In addition, doses must be altered for variables including weight, age and renal function, therefore close monitoring is important. The ICB are working with ECLIPSE and have now launched a DOAC dashboard to help identify patients who may be on the incorrect dose. ***For access to the Eclipse system please ensure you are using*** https://secure.nhspathways.org

- **Medicines reconciliation**

Thoroughly documented and high quality medicines reconciliation using a minimum of two independent sources is crucial for effectively gathering the latest list of medicines a patient is taking. The patient themselves are a core source of information, as many deviate from the prescribed instruction or may not be compliant with the medicine which may impact management. Risk of error was particularly high with patients who frequently attended multiple care settings, as each provider may make changes and communication of the plan may be lost or receipt delayed between care settings.

MHRA DSU April 2023: Nitrofurantoin: reminder of the risks of pulmonary and hepatic adverse drug reactions

Healthcare professionals prescribing nitrofurantoin should be alert to the risks of pulmonary and hepatic adverse drug reactions and advise patients to be vigilant for the signs and symptoms in need of further investigation.
Adverse reactions may occur with both short and long term use of nitrofurantoin.
Extra vigilance is required when prescribing for elderly patients or whose with a history of pulmonary or hepatic disease.

MHRA DSU April 2023—Isotretinoin (Roaccutane): new safety measures to be introduced in the coming months, including additional oversight on initiation of treatment for patients under 18 years.

- The DSU does not make any recommendations at present, however work is underway locally to locate patients who may be affected.
- A reminder to prescribers that isotretinoin is a hospital only medicine which must not be prescribed in primary care. Please refer any patients back to specialists to continue prescribing.

Lithium—sharing key points from the guidance

Following on from an incident shared by a partner, the below summarises the key considerations for prescribers when managing patients prescribed lithium.

- Lithium must be prescribed by brand as formulations are not bioequivalent
- Ensure that plasma lithium levels are checked every 3 months
- The blood level should be taken approximately 12 hours post dose. If a twice daily regime is prescribed, the patient should be advised to withhold morning dose until after the blood sample has been taken
- A level of less than 0.6 mmol / L is classed as sub therapeutic however a level as low as 0.4 mmol / L may be acceptable in certain patients
- Seek urgent advice from the Specialist team if the level is above 1.0 mmol/ L and withhold lithium treatment if the patient is showing signs of lithium toxicity
- Signs of toxicity include nausea, diarrhoea and/or vomiting, fine tremor, drowsiness, disorientation
- Clinical reports are available in SystmOne to assist with identification of patients who have not had a recent lithium level taken
- Community pharmacists are advised to verbally check that a patient has had a recent lithium level taken and confirm the patient is fully informed about their therapy
- The SCGs are currently under review with updates expected July 2023

To access current Shared Care Guidance click below:

Shared Care Guidance (Beds/Luton) Shared Care guidance (Milton Keynes)

Glycopyrronium—caution advised with differing sizes of ampoules

There have been a small number of administration errors with glycopyrronium ampoules, whereby a larger than intended dose was administered (whole 3mL ampoule given instead of 1mL, resulting in a 600 microgram dose instead of a 200 microgram dose). Caution is advised when selecting glycopyrronium for use in syringe drivers and when administering stat doses, as the larger ampoules (600micrograms in 3mL) may result in too higher volume being administered via subcutaneous route or a higher than intended dose being given.

Prescribers are advised to follow the BLMK end of life medication guidance and routinely prescribe glycopyrronium 200mcg/ml ampoules x 10 where possible: https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/categories/end-of-life-care-medicine-services/

If the higher volume ampoules are required, dispensing pharmacies are advised to consider highlighting this on the label to draw attention to this.

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