Medicines Safety Matters

Report Report Report!

Issue 15- May/June 2022

Welcome to the fifteenth edition of "Medicines Safety Matters"- a publication for all across Surrey Heartlands who are collaborating to promote medicines safety. It will highlight local medication safety incidents in order to share learning and promote a safety culture across all organisations. Research shows that organisations that **regularly report** more patient safety incidents usually have a stronger learning culture where patient safety is a high priority. For those working in general practice you can report medication errors using the LFPSE incident reporting e-form

Medicine Safety Committee (MSC) Updates

There will now be regular updates & reminders in this newsletter from the Surrey Heartlands Medicines Safety Committee (MSC).

To support the reporting of medicines-related safety incidents in Primary Care the MSC has updated the document Improving the Reporting of Medication Incidents Surrey Heartlands FINAL Feb 2022.pdf (res-systems.net) which is available on the PAD.

Two further documents have been produced by MSC to aid the sharing of intelligence across organisations, to support healthcare to learn from mistakes and to take action to keep patients safe: Community Pharmacy Incident Reporting Communications Process FINAL.pdf (res-systems.net) and Reporting medicines incidents involving social care FINAL.pdf (res-systems.net).

All non-GP prescribed medicines (hospital only, **RED** drugs, specialist drugs) should be recorded in the patient's medication record to ensure that records are complete and accurate. A local guide has been updated to support practice staff in adding non-GP prescribed drugs to the patient's record on the clinical system. Clinical system guides are included for EMIS Web, SystmOne and INPS Vision
Recording Non-GP prescribed medicines - Guide for Practices - Mar 2022.pdf (res-systems.net)

Action for HCPs:
Please contact Nikki Smith if you have any questions or concerns nikki.smith24@nhs.net

Mepivacaine -Safe Dosage

The maximum safe dosage (MSD) of **mepivacaine hydrochloride (Scandonest 3% Plain)** has been changed by the manufacturer. The summary of product characteristics sheet for this anaesthetic now lists the MSD as 4.4mg/kg. It was previously listed as 6mg/kg. The paediatric MSD has also now changed to 3mg/kg. Mepivacaine is indicated for local or loco-regional dental anaesthesia and chiropody procedures. The Royal College of Podiatry have information about the change on their website.

Action for HCPs: Please ensure you read the SPC before administering any products as they may be subject to change without warning from the manufacturer.

Penicillin Allergy Reporting

The National Institute for Health & Care Research alert have produced an article on "Are you sure you are allergic to penicillin?"

Fewer than 1 in 10 patients with a penicillin allergy listed in their notes are truly allergic as adverse reactions are sometimes mis-recorded as an allergy. This can lead to unnecessary use of less suitable antibiotic treatments which impacts the quality of patient care and can also contribute to antimicrobial resistance. Second choice antibiotics should be reserved for true allergic patients and where the specific sensitivity has been identified.

Action for HCPs:

In-line with NICE CG183: Drug allergy: diagnosis and management we wish to remind healthcare professionals to clearly document suspected drug allergies in a structured approach that includes:

- Generic and proprietary name of the drug or drugs suspected to have caused the reaction, including the strength and formulation
- Description of the reaction
- Indication for the drug being taken (if there is no clinical diagnosis, describe the illness)
- Date and time of the reaction
- Number of doses taken or number of days on the drug before onset of the reaction
- Route of administration
- Which drugs or drug classes to avoid in future

Also note:

- Care must be taken to record and code adverse drug reactions as "**adverse drug reactions"** and not as **"drug allergies"** and include their severity
- Information on drug allergies must be included in correspondence with other health professionals (e.g. GP referral letters)
- Ask the patient about drug allergies before prescribing medication (in addition to checking notes)
- If further information is provided on allergy status following a subsequent discharge, allergy status must be updated on the clinical system to ensure all healthcare professional have access to the most up-to-date information

Montelukast - Neuropsychotropic Side Effects

Prescribers should be alert for neuropsychiatric reactions in patients taking montelukast and carefully consider the benefits and risks of continuing treatment if they occur.

It has been known for some time that neuropsychiatric reactions may occur in association with montelukast treatment, and these reactions are listed as possible side effects in the product information. An EU review confirmed the known risks of neuropsychiatric reactions and found that the magnitude of risk was unchanged. However, the review identified some cases in which there had been a delay in neuropsychiatric reactions being recognised as a possible adverse drug reaction.

Action for HCPs:

- Advise patients and their caregivers to carefully read the list of neuropsychiatric reactions in the patient information leaflet and seek medical advice immediately should they occur
- Carefully evaluate the risks and benefits of continuing treatment if neuropsychiatric reactions occur
- Be aware of newly recognised neuropsychiatric reactions of speech impairment (stuttering) and obsessive–compulsive symptoms
- Report any suspected adverse drug reactions associated with montelukast to the Yellow Card Scheme

Hydroxychloroquine & Chloroquine with Macrolide Antibiotics

There is an increased risk of cardiovascular events when hydroxychloroquine & chloroquine are used with macrolide antibiotics.
A study has shown that co-administration of azithromycin with hydroxychloroquine in patients with rheumatoid arthritis is associated with an increased risk of cardiovascular events (including angina or chest pain or heart failure) and cardiovascular mortality.

Action for HCPs:

- Careful consideration of risks and benefits should be taken before prescribing systemic azithromycin or other systemic macrolide antibiotics (erythromycin or clarithromycin) to patients being treated with hydroxychloroquine or chloroquine
- Use caution in patients with risk factors for cardiac events and follow advice in the product information for each medicine
- Be vigilant for psychiatric reactions associated with these two drugs, especially in the first month of treatment; events have been reported in patients with no prior history of psychiatric disorders
- Report suspected adverse drug reactions on a Yellow Card
- Please refer to the drug safety update for further guidance

Pregabalin (Lyrica) and Risks During Pregnancy

A new study of more than 2,700 pregnancies that had been exposed to pregabalin showed use in the first trimester to be associated with a slightly increased risk of major congenital malformations compared with exposure to no antiepileptic drugs or to lamotrigine or to duloxetine.

Patients should avoid the use of pregabalin during pregnancy unless clearly necessary and only if the benefit to the patient clearly outweighs the potential risk to the foetus. It is important to ensure the patient has a full understanding of the benefits, risks, and alternatives, and is part of the decision-making process.

Full details of the study and the drug safety update can be found here.

The MSC are in the process of producing a risk assessment tool to support prescribers to safely prescribe in females of childbearing age.

Action for HCPs:

- Patients should use effective contraception during treatment and avoid use in pregnancy unless clearly necessary
- Advise patients planning a pregnancy or who become pregnant during treatment to make an appointment to discuss their health condition and any medicines they are taking as soon as possible.
- In cases where the benefit outweighs the risk, and it is clearly necessary that pregabalin should be used during pregnancy, it is recommended to use the lowest effective dose
- Provide counselling to patients using pregabalin on the potential risks to an unborn baby and direct them to the patient safety leaflet
- Report any suspected adverse drug reactions, including for the baby via the Yellow Card Scheme
- Be aware of UKTIS - the sole dedicated UK provider of evidence-based information on foetal risk following pharmacological and other potentially toxic pregnancy exposures.

Recording Allergies for “Co- Drugs”

A recent Coroner's report Regulation 30: Action To Prevent Future Deaths highlighted the risks of prescribing "co -drugs" when a person is allergic to one constituent.

In this case, a patient sadly died after suffering from Stevens-Johnson Syndrome/Toxic Epidermal Necrolysis - the likely aetiology being due to co-trimoxazole, an antibiotic with the constituent drug trimethoprim to which the patient had a known, recorded allergy.

There are numerous “co-drugs” and it is important that prescribers are aware of the individual constituents. EMIS have confirmed that as long as the allergy is coded correctly, then when adding a drug which has any medication linked to the allergy the system will create a warning advising patient has an Adverse Drug Reaction and gives the clinician the option to "Do Not Use Drug" or "Override".

Advice for HCPs: It is important to be aware of the individual constituents of “co-drugs” and to ensure that any allergy warnings flagged up are acted upon.

Potassium Permanganate

A Safety Alert has been issued around the inadvertent oral administration of potassium permanganate NaPSA-Inadvertent-oral-administration-of-potassium-permanganate-April-2022.pdf (england.nhs.uk)
Potassium permanganate is used in skin care because of its antiseptic and antimicrobial properties and may be prescribed in a concentrated form for external use only, usually as a 400 mg ‘tablet’ (Permitabs®, EN-Potab®) or occasionally as a 5% solution for dilution.

It is highly toxic when undiluted and incidents have been reported where is has been either inadvertently administered to patients orally or swallowed by patients when it is left unattended near the patient prior to use. We are aware of at least one local incident in recent years.

All practices have been asked to identify any patients that are currently being prescribed potassium permanganate and also to ensure that risk reduction measures are followed for any new initiations. A search to support this has already been circulated to our GP practices.
Detailed guidance has been produced by BAD and is available here Guidance-for-safe-use-of-potassium-permanganate-soaks-FINAL-for-website.pdf (bad.org.uk).

Packs contain 30 tablets and are not classed as a “special container” – therefore community pharmacists may have to split original packs which is a concern. The MSC have highlighted this to the MHRA as well as following up with the manufacturer around providing smaller pack sizes.

Advice for HCPs:
All sectors using potassium permanganate should review their own processes in line with the Safety Alert.
Provide all patients with the potassium permanganate patient information leaflet (PIL) updated by BAD (British Association of Dermatology) Potassium Permanganate Solution Soaks (bad.org.uk)
Please do not hesitate to get in touch with a member of your Medicines Optimisation team if you have any queries.

Sharing Information

Propofol is used for the induction and maintenance of anaesthesia but may also be misused, usually by healthcare professionals, due to its addictive properties. We are aware of a local incident where an HCP moved between jobs but the information that they had been involved in the theft of propofol was not passed on to their new employer.

It is important that information relating to individual's and patients' safety is shared and that people are free to speak up if they suspect any wrongdoing.

Advice for HCPs: Share information that may affect staff or patient safety and refer to your organisation's "Freedom to Speak Up Policy" where appropriate in order to keep colleagues and patients safe.

Prescribing Combinations of Drugs

The MHRA has previously reminded health care professionals that opioids co -prescribed with benzodiazepines and benzodiazepine like drugs can produce additive CNS depressant effects, thereby increasing the risk of sedation, respiratory depression, coma and death. Healthcare professionals are advised to only co prescribe if there is no alternative and, if necessary, the lowest possible doses should be given and for the shortest duration.
The new Opioid Prescribing Comparators dashboard produced by the NHSBSA includes "OP03 Opioids in combination with other medicines known to increase the risk of harm". The dashboard shows the number of patients with a prescription for Opioid pain medicines (excluding injectables and co-codamol and codydramol) in the latest 28-day period (by age and gender, and duration group as described in comparator OP02) who have also received one or more prescription in the latest 28-day period from either of the following groups: Antidepressants, Benzodiazepines, Gabapentinoids and Z-Drugs.
Organisations with direct clinical care for a patient who see information of concern, may request the underlying NHS Numbers for any comparators. In so doing they can compare records to clinical systems and conduct case review

Advice for HCPs: Register for the NHSBSA dashboards and use them to identify patients who are deemed to be at the greatest risk from harm to be prioritised for a structured medication review. Ensure patients or their carers understand the cumulative risk from their medicines.

Medicine Incidents

We regularly share learning about national incidents as well as local ones that have been recently uploaded to the Learn From Patient Safety Events (LFPSE) system and also reported to Surrey Heartlands CCG. We have attached a learning and sharing summary for incidents reported during quarter 4 2021-22.

Advice for Healthcare Professionals:
By reporting incidents via your local system everyone can learn, review, and change their own processes, if necessary, to avoid them happening again.
It is always helpful when reports include consideration of why the incident happened and what changes you have made. Reporting should not be seen as part of a blame culture but as a positive thing where everyone can share and learn.
If you think your incident would be good to share, whatever sector of healthcare you are in, or you are taking part in a medicines safety QI project, please get in touch with lis.stanford@nhs.net or nikki.smith24@nhs.net