Pharmacy Bulletin

NHS England and NHS Improvement - South West

Tuesday 9th July 2019

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Get Your Priorities Straight: Tips for Using Safety Huddles…

A huddle is a short, stand-up meeting — 10 minutes or less — that is typically used at the start of a day or shift to help teams anticipate and actively manage quality and safety issues

Huddles can be a great way to start a day, shift, or process by helping your team think critically about how to anticipate potential problems or ways to improve care.

Read more from the Institute for Healthcare Improvement (IHI) HERE, about the why, what's and how's of effective safety huddles.

Hydrocortisone 100mg/ml injections supplied in error (instead of the prescribed Hydroxocobalamin(B12) 1mg/1ml)…

We would like to make local community pharmacists aware that there have been several dispensing errors reported recently which have involved Hydrocortisone 100mg/ml injections being supplied in error instead of the prescribed Hydroxocobalamin(B12) 1mg/1ml.

The Hydrocortisone injections had also been incorrectly labelled as Hydroxocobalamin. These medications are both included in NPA resource on "look-alike sound-alike items" (LASA) items, which lists common items (generic and brand) with similar names.

https://www.npa.co.uk/wp-content/uploads/2018/10/Look-alike-sound-alike-items.pdf

Please be extra vigilant when dispensing medicines with commonly confused drug names to ensure that the intended medicine is supplied.

Resources on LASA ('Look Alike Sound Alike') Medicines…

The Community Pharmacy Patient Safety Group has published several resources to help pharmacy teams with discussions around look-alike sound-alike (LASA) errors.

The Resources include:

- a series of one-pager resources – contains informative LASA medicine dispensing and checking tips; and
- a poster – contains useful background information on LASA errors and summarises some of the Group's LASA work.

GET THE RESOURCES & FIND OUT MORE, HERE.

Preparation of Monitored Dosage Systems (MDS)…

We would like to make local pharmacy teams aware that there have been many dispensing errors reported recently which have involved medicines dispensed in Monitored Dosage Systems (MDS). We would like to share the learning.

Recently reported errors have included:

- Failed delivery of an MDS tray which left a patient without medication for 4 days.
- Two patients who have MDS packs delivered received each other's medication in error. One of the patients then took the incorrect medication and was sick immediately afterwards resulting in A&E attendance, see https://pharmacysafety.org/2017/05/24/safer-delivery-of-medicines/
- Saxagliptin being supplied in a patient's MDS for a further 2 weeks after it had been stopped by the patient's GP due to incompatibility with other prescribed medicine.
- A patient should have received Apixaban 2.5mg twice a day did not have this included in their MDS tray for 4 weeks, resulting in the patient being admitted to hospital, see https://psnc.org.uk/contract-it/pharmacy-regulation/dda/the-equality-act-2010-28-day-prescribing/
- An unknown tablet which hadn't been prescribed being found in a patient's MDS
- Bisoprolol incorrectly labelled as 5mg rather than 2.5mg.
- One 5mg Carbimazole tablet daily had been dispensed rather than the prescribed two tablets.
- Tamsulosin, which had been prescribed at night due to the risk of falls being dispensed in the morning slot of the MDS

Please be extra vigilant when dispensing medicines in Monitored Dosage Systems and ensure that the appropriate SOPs are followed at all times.

If you have any articles you would like us to include in SiPS, then please send to our generic mailbox - HERE.

In addition, if you know of any colleagues who would like to receive a copy of this bulletin, please send an e-mail with their name, place of work and e-mail address to our generic mailbox and we will add them to our distribution list.

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Please see our website "NHS England South West (South & North) Community pharmacy" for more information and any blank templates, forms and documents.

For reference available documents are, Contact Details (UPDATED MARCH 2019); Forms for requesting changes to Core or Supplementary hours; Blank unplanned closure form; links to the Pharmaceutical Needs Assessments (PNAs); links to LPCs; MUR guidance, MUR/NMS blank templates; Significant Incident reporting form; Serious Difficulty application form; and log for 100-hour pharmacies.

…NEWLY ADDED TO THE WEBSITE – Forged Prescription and Medicine Shortage Guidance…