National Medication Safety Network

Observatory
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National Medication Safety Network
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Observatory of recent safe medication bulletins, practice research, reports, and publications

Presented by Ben Rehman, b.rehman@nhs.net
Recent regulator and statutory body activity

NHS England

MHRA
Regulating Medicines and Medical Devices

European Medicines Agency
Science Medicines Health
NHS E Patient Safety Alert: Naloxone

- Stage One alert: warning
- Naloxone in patients where not indicated or dose given is too large
  - Opioid/opiate resp depression and sedation
  - Long-term opioid use & physical dependency
  - High risk of acute withdrawal syndrome
- There is NOT a one size fits all dose!
- Risks with too much in some patients groups, as much as giving too little in others
- BNF distinguishes doses, but…. read with care
MHRA drug recall
Zovirax 3% eye ointment

• Class II recall: metal particulars of high size
• Main use = herpes simplex keratitis sight-threatening condition
• Treatment alternatives
  – Cochrane: no significant differences in efficacy between topical aciclovir, topical ganciclovir, topical trifluridine and oral aciclovir
  – MHRA/UKMi summary recommends ganciclovir 0.15% eye gel or oral aciclovir as licensed alternative clinical options
MHRA Drug Safety Update

• Agomelatine (Valdoxan) and risk of liver toxicity
  – Checking liver transaminases & symptoms and signs of liver injury
  – Specialist mental health initiation (but some primary care patients?)

• Colobreathe and risk of capsule breakage
  – Some capsules shattered when pierced by inhaler device
  – Instructions for inhaler revised to reduce risk
  – Again, quite specialist use, but of relevance to CF clinics etc. to demonstrate + some shared care???
MHRA Drug Safety Update

• Boceprevir (Victrelis) and telaprevir (Incivo)
  – protease inhibitors for chronic hep C
  – European review identified changed factors for sepsis, worsening liver function, and mortality

• Ponatinib (Iclusig▼)
  – European Review now completed in CML
  – dose-dependent risk of blood vessel blockage; however, lower dose might not be effective
  – starting dose remains at 45 mg once a day; possible subsequent dose reduction
MHRA Drug Safety Update

• Chlorhexidine solutions
  – reminder of the risk of chemical burns in premature infants
  – use minimum amount of chlorhexidine solution; do not allow to pool; remove any excess
  – Monitor patients frequently to detect and manage cutaneous side effects at an early stage
EMA review of polymixin-based medicines

• Background
  – Because of side effects, limited use since 1960s
  – Activity retained for otherwise resistant bacteria
  – Concern: product information (pharmacokinetics and dosing) needs updating given increased use

• Review now complete with recommendations:
  – Dose expression: IU not mg
  – 9 million IU daily: 2 or 3 divided doses slow IV
  – critically ill: 9 million IU loading dose
  – renal impairment, reduce dose according to creatinine clearance
Relvar Ellipta update

• GSK’s **blue** steroid/LABA inhaler
• Potential safety in-use issue and concerted push back from NHS
  – Respiratory pharmacists
  – UKMi and other reviews
  – Safety pharmacists
  – APC uptake

• GSK have now confirmed that colour and product presentation to change: Jan 15
50 Years of Yellow Cards

- DTB editorial and recent event in London
- Remains one of the best adverse drug event reporting systems internationally
- Future developments likely to include better use of internet and social media in signalling
- But, ultimately, Yellow Cards still hugely important in PV
- Persuade patients and colleagues to use YC before posting ADRs on Facebook & Twitter!
This month’s papers

- Ruiz J. et al. Barriers to disclosure of medication errors. Archives of Disease in Childhood. 99 (pp A352-A353),
- Fernandez-Restrepo L. et al. The effects of increased awareness on medication error disclosures. Archives of Disease in Childhood. 99 (pp A352), 2014
This month’s papers


This month’s papers

- ED-based pharmacists make a big dent in medication errors. ED management: the monthly update on emergency department management. 26 (8) (pp 91-94), 2014.

- Bassett R.A. et al. Crushing medication error: Calcium channel blocker toxicity following administration of a crushed extended-release tablet of nifedipine. Clinical Toxicology 2014. 52 (7) (pp 803)

This month’s papers


• R Santucci et al. Medication adverse events: impact of pharmaceutical consultations during the hospitalization of patients. Annales Pharmaceutiques Francaises Nov 2014;72(6):440-450
This month’s papers

In detail


And something a bit lighter for Christmas!
Stress, strain, and self-reported errors in community pharmacy

- UK community pharmacy workload increasing - Rx item growth 2000 to 2010
- Other sectors:
  - Established relationship work-related stress and employee well being
  - Some data on links with job performance
  - Little for community pharmacy
- Stress could affect patient safety
  - Anecdote from community pharmacists: high workload ⇒ dispensing error

Study aimed to explore stress and its implications for pharmacists’ well-being and patient safety

Aimed to benchmark levels of occupational stress, and to investigate relationship between stress and self-reported dispensing errors and detection of prescribing errors.
Stress, strain, and self-reported errors in community pharmacy

- Postal survey method of random selection of community pharmacists
- Mailed to 2000, with expected 50% response rate
- Survey previously piloted and validated using various methods
  - ASSET organisational tool to assess the risk of stress at work
  - Validated tool to assess safety climate
Stress, strain, and self-reported errors in community pharmacy

• 48% usable response rate for data on stressors
• Demographics of sample similar to that of latest workforce consensus data
• Generally quite a stressed bunch compared with standard UK working population!
  – ↑ perceived overload ⇒ dispensing errors
  – ↑ resource and communication concerns ⇒ prescribing error detection
How does the UK media portray medication errors?

- Explore error types portrayal
- Newspaper reports on medication error over 5 years (2008-2013)
- 260 reports identified; 100 included
- Mainly news items (n = 87) not features etc
- Local (n = 89) and national papers
- 217 errors described
- Classified as neutral, negative, or sympathetic

2. Uddin I.; Franklin BD. How does the UK media portray medication errors? An analysis of newspaper reports. IJPP, 22 (Suppl 2), pp. 22-106
How does the UK media portray medication errors?

- 56/100 reports discussed errors that caused harm (31 did not cover whether harm or not)
- 60/100 specific drug or drug group; insulin most common
- Hospital and care homes most common settings
- Staff were commonly blamed! With main focuses on staff, training and workload NOT systems
How does the UK media portray medication errors?

- 51 reports considered to be neutral, 32 negative, 17 positive
- Staff were commonly blamed! With main focuses on staff, training and workload NOT systems
- Better use of pharmacists was often suggested