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

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Recent regulator and statutory body activity

- NHS England - Harm from using Low Molecular Weight Heparins when contraindicated (Stage 1 warning)
  - Need to stop giving them when contra-indicated

- NHS England - Risk of death or serious harm from accidental ingestion of potassium permanganate preparations (Stage 1 warning)
  - Need to stop people swallowing the tablets
Recent regulator and statutory body activity

- MHRA - Medicines related to valproate: risk of abnormal pregnancy outcomes.
  - Tighter control in females of child-bearing age with supporting information for healthcare professionals and patients

- MHRA - Diclofenac tablets now only available as a prescription medicine
  - Supply now only via prescription or PGD, topical products not affected
Recent regulator and statutory body activity

- MHRA - Isotretinoin (Roaccutane): reminder of possible risk of psychiatric disorders—warn patients and family; monitor patients for signs of depression
  - Reinforcement of previous warnings- increased need to counsel patients/carers

- MHRA - Ivabradine (Procoralan) in the symptomatic treatment of angina: risk of cardiac side effects—new advice to minimise risk
  - Not to be used if resting heart rate < 70bpm or in conjunction with other drugs that cause bradycardia
Recent regulator and statutory body activity

• MHRA - Hydrogen peroxide: reminder of risk of gas embolism when used in surgery—
  – do not use in surgery, in closed body cavities or on deep or large wounds

• MHRA - Autopen insulin pen injection devices. Manufacturer: Owen Mumford
  – A mechanical fault in specific batches caused reversion to no dose being administered
Recent regulator and statutory body activity

- MHRA - All Accu-Chek Spirit Combo insulin infusion pumps. Manufactured by Roche Diagnostics Ltd.
  - shifts in basal rates possible after break in power supply

- MHRA - Veletri (epoprostenol) powder for solution for infusion: incompatibilities with some models of administration devices
  - need to check appropriateness of extension sets and pumps if using this drug
Recent regulator and statutory body activity

- **PHE** - Advice for GPs on pregnant women who are inadvertently vaccinated against measles, mumps, rubella, chicken pox (varicella) or human papilloma virus.
  - Details of a post-exposure monitoring scheme

- **MHRA** – New single reporting site for adverse effects to medicines, adverse incidents with devices, defective medicines or devices, concerns about fake medicine or device.
  - Simpler method of reporting issues to MHRA
Some more useful stuff to know

• Specialist Pharmacy Service/NPA - Community pharmacy NSAID safety audit 2014 – National data from PharmOutcomes
  – ~3000 out of 16,366 patients taking regular NSAIDs not on gastro-protection

• PSNC – Changes to way community pharmacists report to NRLS not to be introduced until decriminalisation of dispensing errors

• FDA - Dietary Supplements Containing Live Bacteria or Yeast in Immunocompromised Persons: Warning - Risk of Invasive Fungal Disease

• UKMI producing a Q&A to support implementation of naloxone alert
This months papers

- Dabigatran and Rivaroxaban Use in Atrial Fibrillation Patients on Hemodialysis – E-publication in Circulation 2015 (http://circ.ahajournals.org/content/early/2015/01/16/CIRCULATIONAHA.114.014113.abstract)


This months papers


This months papers


The effect of early in-hospital pharmacy-led medication review on health outcomes: a systematic review

- Methodology – comprehensive literature search, quality assessment, appropriate methods to combine data
- Results - included 7 controlled studies (one from N. Ireland) involving 3292 patients
The effect of early in-hospital pharmacy-led medication review on health outcomes: a systematic review

• Results
  – No significant effect on length of hospital admission [WMD (-) 0.04 days (-1.63 to +1.55)]
  – No significant effect on mortality [OR 1.09 (0.69 to 1.72)]
  – No significant effect on re-admissions [OR 1.15 (0.81 to 1.63)]
  – No significant effect on emergency department revisits [OR 0.6 (0.27 to 1.32)]
The effect of early in-hospital pharmacy-led medication review on health outcomes: a systematic review

- Potential Limitations
  - Small number trials of limited size and quality
  - Practicalities of testing value using controlled design methodologies
  - No assessment of impact on “process outcomes” e.g. prescribing errors, numbers of medicines, costs of medicines
  - Most studies involved frail elderly where potentially many confounding factors
  - 6/7 studies involved pharmacists who were not able to enact their recommendations
What are incident reports telling us? A comparative study at two Australian hospitals of medication errors identified at audit, detected by staff and reported to an incident system.

- Published in Int J Quality Health Care 2015: 1-9
- Findings comparing evidence of prescribing errors from an audit of 3291 patient records, direct observation of 180 nurses administering 7451 medicines and reported medication incident reports
What are incident reports telling us? A comparative study at two Australian hospitals of medication errors identified at audit, detected by staff and reported to an incident system.

- 12,567 prescribing errors identified at audit, of which clinical errors accounted for 31.1% and 539 (4.3%) were rated clinically important.
- During this timeframe 15 incidents were reported to incident systems – all had also been picked up in audit.
- This equates to a ratio of 1.2 incident reports per 1000 identified errors (increases to 13 reports per 1000 errors for clinically important errors).
- 21.9% of clinically important errors were detected by staff but only 6% of those detected were reported to incident systems.
What are incident reports telling us? A comparative study at two Australian hospitals of medication errors identified at audit, detected by staff and reported to an incident system.

- Direct observation of 7451 drug administrations yielded 10,955 administration errors
- One or more clinical errors occurred in 27.4% of drugs administered
- 10.2% of all drug administrations involved errors rated as clinically important
- None of these were reported to the hospital incident system.