Pharmacy Regional Newsletter

Health and Social Care Board

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In This Issue

Don't Lose Your Bottle: Learning from a Paediatric Dispensing Error

Two incidents have recently been reported to the HSCB where children have been dispensed an incorrect liquid medication. In both cases the intended medication was a liquid antihistamine.

In one incident a child under one year had been prescribed chlorphenamine 2mg/5ml oral solution but received chlorpromazine 25mg/5ml oral syrup. The parents reported that the child had a glazed look and became physically limp.
A correct label was produced but the incorrect product was decanted from an original pack into an amber bottle. The original stock bottle was not kept along with the decanted medication and the selection error was not identified. The PIL issued was for chlorpromazine and this was also not spotted, however this somewhat fortuitously helped to inform staff in the Emergency Department.

In the second anonymously reported incident a child was dispensed bisacodyl instead of cetirizine 1mg/ml oral solution. One dose was administered to the child before the error was uncovered.

KEY LEARNING:

- **Keep the original container with the decanted bottles (or pack downs for tablets/capsules) for final check.**
- Secondary to the key learning: consider if co-locating adult and paediatric liquids at the same shelf location could be a risk in your pharmacy, and build a PIL check into your final check procedure.

'Out of Date Controlled Drugs Destroyed in Error' Learning from a Controlled Drugs Incident

A member of pharmacy staff destroyed 'out of date' Schedule 2 and 3 CD stock whilst undertaking destruction of CD 'patient returns'.

Why did this happen?
In line with their SOPs , the pharmacy had clearly marked and segregated 'out of date' CD stock and 'patient returns' in the bottom of the CD cabinet, however, when undertaking the destruction of CD 'patient returns' the staff member removed both from the CD cabinet and destroyed the 'out of date' CD stock in error. [cont.]

The pharmacy was very busy at the time and the staff member was frequently interrupted. Whilst destruction took place in the dispensary, with other staff present, the destruction of the 'patient returns' was not witnessed.

What has been learned?

1. **Destruction of CD 'patient returns' may be undertaken by a pharmacist or a competent member of staff with the destruction witnessed by another competent member of staff, at an appropriate time.**
   There is no requirement for 'patient-returned' Schedule 2 and 3 CDs to be destroyed in the presence of an authorised witness, but it is strongly recommended that pharmacists have this destruction witnessed by a competent member of staff (preferably a registered health care professional). A record should be made in a separate book set aside for patient returns when the pharmacy receives them and the date recorded when the destruction occurs. All controlled drugs (Schedule 2 to 5) should be rendered irretrievable (by denaturing) before placing in waste disposal bins. Further guidance is available here.

2. **Pharmacies should ensure safe storage and timely destruction of CD 'out of date' stock and 'patient returns'.**
   'Out of date' CD stock and CD 'patient returns' should be clearly marked and segregated from other CD stock to prevent them being issued in error to patients. Where possible, more frequent destruction of date-expired CD stock and CD 'patient returns' should occur to reduce volumes of CD stock held by the pharmacy.
   Due to the pandemic, pharmacies may have large quantities of 'out of date' CD stock. If so, pharmacies should contact the Medicines Regulatory Group at Department of Health (MRG) to arrange for witnessed destruction of Schedule 2 CDs at the earliest opportunity.

   MRG contact details:
   Sean Curley — Sean.Curley@health-ni.gov.uk
   Michelle Keatings – Michelle.Keatings@health-ni.gov.uk
   Aaron McKendry – Aaron.McKendry@health-ni.gov.uk

3. **Pharmacies must have an up -to-date SOP for maintaining a record of CDs returned by patients**
   Further guidance is available here.

Note: The HSCB accountable officer (AO) must be informed of all incidents involving any Schedule 2-5 CD. MRG inspectors should be informed of any incidents or discrepancies involving any controlled drugs, particularly if there is diversion or suspected diversion.

[1] Safer Management of Controlled Drugs A guide to good practice in primary care (Northern Ireland) May 2013

An Adverse Incident Case Study

A pharmacist took a call from a GP practice. The GP practice ordered a patient's normal medication: heparin 10units/ml 5ml amps (50units/5ml) and co-beneldopa 1 TID.
The GP practice told the pharmacist to hurry as the carer would collect the medication soon and that the co-beneldopa should be put into a medidose from now on.
The pharmacist tried to order heparin but it was out of stock from their usual wholesalers so they ordered it online from another, without consulting the PMR.

Dispensing

- The dispenser continued producing labels. The heparin label was also prepared and attached to the prescription, ready for the order due the next day. [cont.]

- The pharmacist filled and checked the medidose, which was then collected by the patient's relative.

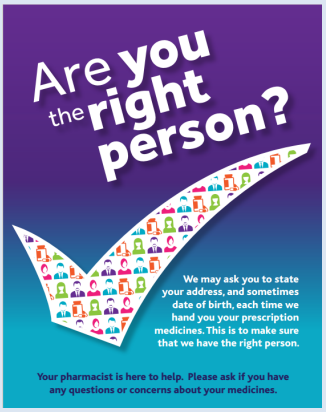
Administration

- The district nurse noticed the heparin box was different from normal when preparing to administer. The label said '50units/5ml' but the box said "heparin 5000units in 1ml".
- The medidose label stated "Co-beneldopa, take one three times day" but contained two tablets three times daily. The patient didn't think their dose was changed.
- When contacted, the pharmacist checked the prescription which had arrived from the practice and found the dose was 1 QID.

What issues do you think may have contributed to the errors?
(Answers on the back of the newsletter)

Note: heparin is a high risk medicine. Please refer to Medicines Safety Matters, May 2012, for further information on IV Heparin flushing solutions — avoid the risk of confusion with higher strength.

Continuing Increased Occurrence of Handout Errors



HSCB continues to note an increase in occurrences of hand-out errors. A Learning Letter first highlighted this in July 2020.
Changes in working practice and additional pressures as a result of the COVID-19 pandemic may have contributed to this. For example:

- Pharmacies are collecting a higher proportion of prescriptions from GP practices
- Higher volumes of dispensed medication awaiting collection
- The use of necessary protective measures such as social distancing, screens, personal protective equipment (PPE)
- More people collecting medication in the pharmacy on behalf of others and for multiple patients
- Dispensed medication awaiting collection stored in more than one location, e.g. store, fridge, CD cabinet
- Patients using a different pharmacy than before
- Staff shortage and rotation of staff.

Consideration should be given to the following:

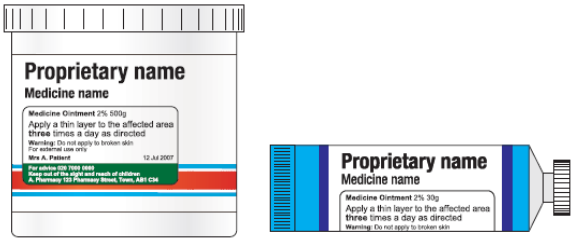
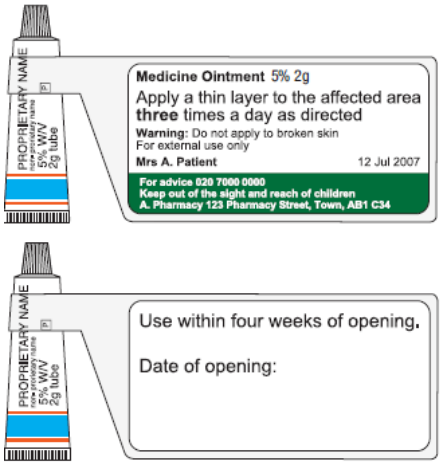
- Remind staff to ask the patient or representative to state their address back to them. This should be checked against the prescription and bag label for each patient
- Speak clearly and reinforce by writing if required
- Keep background noises to a minimum where possible
- Consider ways in which storage risks may be reduced, e.g. have a scheduled daily or weekly clear out
- Monitored dosage systems (MDS) are particularly high risk – consider adding a double check by a pharmacist, including opening bag, before handover
- Use of the "Right Person" poster.

ACTION:

- Community pharmacies are asked to review processes for handing out medication and discuss ways to reduce risk in their particular environment.

Labelling Creams and Inhalers When Dispensing

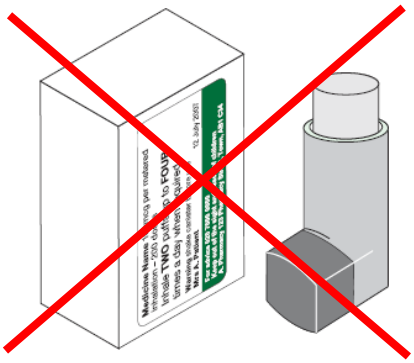
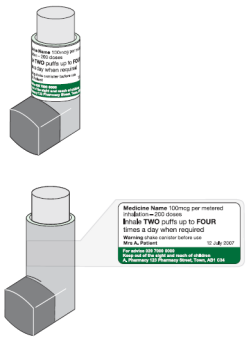
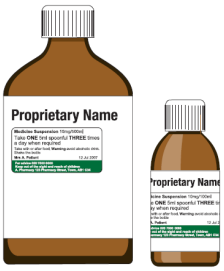
Feedback from Trusts indicates inhalers, liquids, creams and ointments are occasionally dispensed by some community pharmacies with the label attached to the outer box rather than the tube or inhaler. If the outer box is then discarded the label directions are not available for patients and for domiciliary care workers who need to match the product and directions to Medication Instruction Sheets.
The National Patient Safety Agency advised the following:

Product	Issues	Recommendations
Topical creams, ointments, etc.	1. Dispensing labels can cover essential information, including the proprietary and/or non-proprietary name.  2. If normal sized medicine tubes are labelled perpendicularly, the label will be obscured if the tube is rolled up during use.  3. Information on folded dispensing labels, for example on small tubes, is difficult to read. Labels can cover information that helps with accuracy checking and product selection when the medicine has been dispensed. Expiry date information will also be difficult to read. 	1. Label the tube or jar, not the box. 2. Do not place dispensing labels over important information such as 'For external use only' 3. Place the label longitudinally on the primary packaging (i.e. the tube or jar), on the front of the pack under the medicine name.  4. Use flags to label small tubes of creams/ ointments (if using flags for a patient who is a Braille reader, do NOT place the flag over Braille). The use of flags aids visibility of information and recognition of the product and allows clear display of expiry date information. The flag label is applied to the product and the normal dispensing labels are then placed on top of the flag. Flag labels are available from a number of suppliers. 

ACTION: Review dispensing SOPs to reflect these recommendations, including use of flagged labels where appropriate and train staff on the updates.

Reference — The National Patient Safety Agency. Design for patient safety: A guide to the design of dispensed medicines Edition 1 2007.

Labelling creams and inhalers when dispensing (cont.)

Product	Issues	Recommendations
Inhalers	• Important information on the dispensing label may be lost if the outer carton is discarded. This is particularly true if a child takes an inhaler to school. It may also be a significant problem where patients have more than one inhaler or in households where more than one person uses inhalers. If the label is discarded with the outer packaging, there may be no indication of the date of dispensing and dosage instructions that could be used by health professionals to assess usage of the inhaler. 	1. Place the label on the inhaler. This may require breaking the outer seal of the container. Explain this when counselling the patient about their medicine. 2. Flags can also be attached to inhalers where their shape means a conventional label cannot be attached, or where it is important that vital recognition symbols are not obscured. 3. It is important that the correct use and dose is reinforced by placing the dispensing label on the inhaler. 4. It is also important to have the dispensing date on the inhaler to help determine how long the patient has been using the individual inhaler. It is appreciated there may be issues if / when the patient washes the plastic shell. 
Product	**Issues**	**Recommendations**
Liquid medicines	1. Dispensing labels can cover essential information, including the proprietary and/or non-proprietary name 2. Label is placed on the box, which is then thrown away. 3. Label placed over safety information, such as 'For external use only 	1. Label the bottle, not the box: this allows for physical checks used as part of the checking process with the patient. 2. For example, is this liquid supposed to be clear or should it look opaque? 3. It also ensures patients do not throw away the label with the outer packaging. 4. Do not place dispensing labels over important information such as 'For external use only'. 

ACTION: Review dispensing SOPs to reflect these recommendations, including use of flagged labels where appropriate and train staff on the updates.

MDS Omission: Ensure Your Locums Know and Use Your SOPs

What happened?

A post-renal transplant patient, whose medication was dispensed into a weekly compliance aid, did not receive their immunosuppressant (prednisolone) for almost 2 weeks.

In agreement with the patient and GP practice, the community pharmacist requested prescriptions for all of the medications the patient required, however due to issues within the GP practice, the prednisolone prescription was not printed.

A locum pharmacist did not query the missing prednisolone and dispensed the weekly compliance aid based on the prescriptions provided by the GP practice. The error was picked up by the regular community pharmacist when dispensing a subsequent supply of the patient's medication.

Why did it happen?

The pharmacy's relevant dispensing Standard Operating Procedures (SOP) did have systems in place for receipting prescriptions including checking against PMR and the patient's monitored dosage system (MDS) file.

It appears that on this occasion the SOP was not followed as it should have been and this is thought to have been a contributory factor in this incident.

What is the learning?

The Responsible Pharmacist Regulations 2008 requires the responsible pharmacist to establish pharmacy procedures designed to ensure the safe and effective running of the pharmacy.

All locum community pharmacists must be aware of and adhere to the SOPs which are in place in the pharmacies where they work. The Responsible Pharmacist should ensure this is brought to the attention of all staff.

In particular with compliance aids managed by the pharmacy it is important to ensure SOPs have a system in place for detecting inadvertent omission which all staff understand and use.

In response to a National Patient Safety Alert (August 2020) a Steroid Emergency Card (SEC) for use in Northern Ireland has been developed. During clinical check processes pharmacists should consider if a patient is eligible for a SEC. Confirm with patient that they have a SEC and provide one if required.

For further details refer to: http://primarycare.hscni.net/wpfb-file/steroid-emergency-card-to-support-early-recognition-and-treatment-of-adrenal-crisis-in-adults-pdf/

Coding of Inhalers - Always Check Online Codebook

BSO Payment team routinely carry out validation checks as part of the monthly payment process. The most recent of the audits has detailed a number of issues in relation to the coding of inhalers.
From previous correspondence and discussion at BSO roadshows, contractors will be aware that some inhalers are coded over "BSO Unit of Measure" (which is number of inhalers) whilst others are coded over number of doses (dm+d measure). BSO are working to standardise the coding of all inhalers to the dm+d measure (doses) but this work is still in development.

ACTION:

- In order to ensure accurate payment, contractors must use the **online codebook** (http://www.hscbusiness.hscni.net/services/2046.htm) in order to make sure that items are coded correctly.
- Contractors should pay particular attention to the number of doses in an inhaler as there have been a number of changes to pack sizes by manufacturers recently.
- Contractors should not code from pharmacy labels or their pharmacy computer systems.

CDRF1: CD Stock Forms for Private or Non-Health Service Use

In Northern Ireland, the approved form to requisition Schedule 2 (S2) or Schedule 3 (S3) controlled drug (CD) stock for private or non-Health Service is the CDRF1.

Original completed CDRF1 forms (not copies) must be submitted to BSO as part of each prescription submission, for monitoring purposes (ideally at the end of the month received). This also applies to PCD1 forms and to all private forms for S2 and S3 CDs, from outside Northern Ireland.

The 'CDRF1 form' together with 'Guidance on Private Prescribing of Schedule 2 and 3 Controlled Drugs (Stock and Named Patients)' is hosted on Medicines Governance and primary care websites.

Buscopan® OTC Preparations: Stay Alert

Following reports of persons crushing and smoking Buscopan® (hyoscine butylbromide), the Department of Health and Health and Social Care Board issued a letter to raise awareness of this potential for misuse.

Buscopan® is available both as a prescription only medicine (POM) and as over the counter (OTC) preparations. There are 2 OTC versions of Buscopan® in different legal categories:

- Buscopan Cramps® (P)
- Buscopan IBS Relief® (GSL).

ACTION:

- Community pharmacists are asked to maintain their usual vigilance regarding sales of Buscopan® preparations and to remind staff of the legal and professional framework for sales of these products.
- If you become aware of requests for such preparations at your pharmacy which you regard as unusual or excessive, please contact a Pharmacy Inspector: Sean Curley (02890 528627) sean.curley@health-ni.gov.uk, Aaron McKendry (02890 528628) aaron.mckendry@health-ni.gov.uk or Michelle Keatings (02890 520230) michelle.keatings@health-ni.gov.uk).
- Consider moving Buscopan IBS Relief® from the GSL to the P section in your pharmacy.

Answers to Case Study

When errors happen in healthcare it is as the result of many interactions in a complex system and not just the often stated 'human error'.

There are many tools that can be applied to make sense of complex systems. One such tool is the Systems Engineering Initiative for Patient Safety (SEIPS) model.

NHS Scotland has developed a useful Worksheet based on SEIPs. Although designed for a wider system approach applying it to an error such as the case study can be a good starting point and allows us to see further than 'human error'.

To read further on this approach see Systems Approach Resources | Turas | Learn (nhs.scot)

Person:

- Pharmacist's attention on different issues.
- Concern for staff around COVID-19.
- Assuming ordered stock correct.
- Drug not often dispensed.

[Cont.]

Answers to Case Study (cont.)

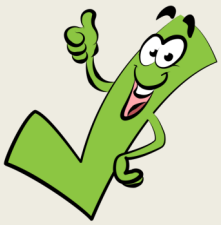
Technology and Tools:
- Handwriting: needs to be clearly legible when copying down information from phone calls.
- Consider patient PMR alerts identifying potential for confusion between strengths and sizes of high risk products.

Physical Environment:
- Need for regular cleaning.
- Wearing PPE.
- Noisy, busy pharmacy.

Organisation of Work:
- Medidoses prepared and checked by the same person without a break – have either two separate persons preparing and checking, or leave time for a mental break.
- Staff absences.
- Additional pressures and stress in dealing with circumstances with COVID-19 such as increased prescription volume.

External Influences:
- Rushing to prepare medidose box at request of surgery (if there is time, try to wait until the actual prescription has been received to start/change a medidose box).
- Practice cannot order a medidose for a patient.
- Stock issues adding pressure.
- Patient unaware of dose they were supposed to be on so unable to detect error in medidose box.

Tasks:
- Inadequate accuracy check.
- Ordering from new wholesaler - not using PMR.
- Would counselling of the patient / carers by the GP practice and pharmacy help?
- Prescription by telephone — it is good practice to note the name of the person calling.



This newsletter has been produced for community pharmacists and pharmacy staff by the Regional Pharmacy and Medicines Management Team. If you have any queries or require further information on the contents of this newsletter, please contact one of the Pharmacy Advisors in your local HSCB office:

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