Pharmacy Regional Newsletter

June 2024

Is the patient the correct one?

There has been a number of recent incidents reported where medicines have been handed out to the wrong person. In order to prevent these incidents occurring, community pharmacy staff should be made aware of the “Are you the right person?” check list. This should be followed when handing out medicines. Before handing over the medication the pharmacy staff should ask the patient or representative to state their name and address, this will confirm that the correct person receives the correct medicines. In some cases, where there is uncertainty the patient should be asked for their date of birth.

What if I know the person very well?
Somewhat counterintuitively, this can actually contribute to errors. We have had a number of incidents where the person collecting is very well known to the pharmacy staff, but staff have inadvertently lifted the wrong bag. A friendly chat distracts and makes it an unnatural conversation to check the collector’s name. Some of these involved monitored dosage system (MDS) and resulted in harm to the recipient. So always check the bag label corresponds to the patient as you make that hand over, as well as building in the checks on identity as above.

In this issue

Labelling error on gabapentin oral solution

Learning from a dispensing incident

Summary: Gabapentin 50mg/ml oral solution labelled in error with five times the prescribed dose.

What happened:

- A repeat prescription for gabapentin **50mg/ml** oral solution:"400mg (8ml) QID" was received by a community pharmacy for a nursing home patient. The prescription did not scan in the pharmacy and so was manually labelled by a member of the pharmacy team with the directions “**40mls four times a day**”
- This incorrect instruction **(five times the intended dose)** was added to the correct product
- The labelling error was not picked up as part of the pharmacist’s clinical or final accuracy check
- The patient’s family delivered the dispensed medication to the nursing home where the error was noticed by a nurse when checking the medication into the home

Contributory factors in this incident:

- Distraction or lack of concentration may have contributed to the labelling error
- The labelling error was not picked up through the pharmacist’s clinical or final accuracy check

Learning from this incident:

- All staff are urged to take extra care when dispensing liquids for high risk medicines, e.g. gabapentinoids (Schedule 3 controlled drugs):
  - ◊ Robust dispensing SOPs must be in place and followed, and all staff appropriately trained
  - ◊ Staff involved in dispensing and labelling should be trained on dose calculations, including converting milligrams (mg) to the equivalent number of millilitres (ml)
  - ◊ Prescription directions that require a calculation and/or interpretation should be flagged, for the benefit of the pharmacist when undertaking their final check
  - ◊ The pharmacist, when undertaking their final check, should be vigilant to prescriptions that have required a calculation/interpretation
  - ◊ Consider how the dispensary and workflow can be arranged to minimise noise and distractions.

Identifying salbutamol overprescribing
Maximise asthma control & minimise risk

Rates of hospital admissions and mortality for adult asthma in the UK are amongst the worst in Europe[1]. Overuse of short acting beta agonists (SABAs) and underuse of inhaled corticosteroids (ICS) are known to be contributing factors to poor asthma control. The *National Review of Asthma Deaths: Why asthma still kills (NRAD[2])*, published by the Royal College of Physicians in 2014, found that two thirds of asthma deaths were preventable. Unfortunately, a decade on we're seeing a rise in asthma deaths, not a reduction. In the last 3 years the number of asthma deaths in Northern Ireland has risen by 21%[3].

Identifying overuse of SABA inhalers

If an asthma patient is using their reliever inhaler three times a week or more, it's a sign of untreated inflammation in their airways. In theory, any patient using more than six puffs per week of a salbutamol inhaler is over-reliant – that is equal to about 300 puffs per year. As there are 200 puffs per inhaler, **only two inhalers per year should be needed if asthma is well controlled**. Research has shown that 26% of patients in Northern Ireland are prescribed 6 or more SABA inhalers per year.

The 5 things community pharmacists can do that will make a difference

- **Be aware of patients who may be overordering or overusing salbutamol** or other SABA inhalers:
  - ◊ When completing the clinical check, consider potential overuse by reviewing PMR records for previous SABA dispensing
  - ◊ Check with the patient if they are having to use their SABA more than 3 times per week or if they are experiencing symptoms of poor control
  - ◊ Check previous dispensing patterns if issuing an emergency supply of a SABA
- **Discuss asthma control and management**
  - ◊ Look for signs of poorly controlled or worsening asthma
- **Check that the patient is using their preventer inhaler.** Underuse of ICS will contribute to poor asthma control. Make sure the patient is taking their preventative inhaler regularly as prescribed
- **Ask the patient to demonstrate their inhaler technique** and support them if there are areas that can be improved
- **Signpost to useful resources.** There are great resources including self-help courses and inhaler technique videos available for patients from Asthma + Lung UK, Chest Heart & Stroke.

References:

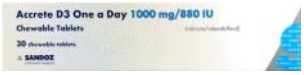
1. Global asthma report 2022, The Global Asthma Network (GAN). http://www.globalasthmareport.org/ (accessed 11 January 2024)
2. Royal College of Physicians. Why asthma still kills: the National Review of Asthma Deaths (NRAD) Confidential Enquiry report. London: RCP, 2014
3. 'Asthma care is in crisis'. Asthma + Lung UK Released on 24th April 2024

Medication errors involving calcium and colecalciferol containing products

Calcium and colecalciferol containing products come in a wide range of brands and formulations. Within brands, there can be a range of products such as oral tablets, chewable tablets, once daily chewable tablets and effervescent tablets or granules, which vary in composition and licensed dose.

Image by Racool_studio on Freepik

Dispensing incidents involving calcium and colecalciferol containing products have been reported to SPPG. The table below summarises some recent incidents and learning outcomes. Thankfully no harm came to the patients involved.

Intended product / dose	Product dispensed	Contributory Factors	Learning
Accrete D3® One a Day chewable tablets Each tablet contains: 1000mg of calcium and 880 units of colecalciferol. **Licensed dose:** 1 tablet daily 	**Accrete D3® Film coated tablets** Each tablet contains: 600mg of calcium and 400 units of colecalciferol **Licensed dose:** 1 tablet twice daily 	Same brand name 'Accrete D3®' leading to selection error. Mid-cycle monitored dosage system (MDS) changes.	Calcium salts should be prescribed by brand name to avoid confusion / aid product identification (as per HSC Items Unsuitable for Generic Prescribing list). Check both the brand AND formulation details during the checking process. Ensure the dose is appropriate for the product being dispensed as this could highlight a 'prescribing' error or a 'selection' error. Query any discrepancies with the prescriber. Report software issues and perform regular software updates. This particular issue was resolved on the McLernons system in May 2024. A limited variety of products may reduce the risk of selection errors. Choose from products on the NI Formulary.
Calcium carbonate 1.25g / colecalciferol 400 units (e.g. Calcichew D3 Forte®) Each tablet contains: 500mg of calcium and 400 units of colecalciferol.	Calcichew® 500mg chewable tablets Each tablet contains: 500mg of calcium	The prescription was written generically. A label was produced for the correct generic product but when printed off on the McLernons system it stated Calcichew® in brackets, not Calcichew D3 forte®.	
Adcal-D3 caplets Each caplet contains: 300mg of calcium and 200 units of colecalciferol. **Prescribed dose:** 1 caplet twice a day	**Adcal-D3 caplets** **Labelled dose:** 2 caplets twice a day	Prescribed dose differed from licensed dose. Non-adherence to SOP.	

New product Ceyesto® (Melatonin 1mg/ml oral solution sugar free)

NEW Melatonin 1mg/ml oral solution sugar free (licensed product)	Ceyesto® 1mg/ml oral solution (sugar free) Summary of Product Characteristics
Excipient(s) with known effect (EMA[1], NPPG and RCPCH)[2]:	Ceyesto® oral solution in the context of paediatrics contains: • Propylene glycol: 52 mg per 1 ml dose. • Benzyl alcohol: 6 mg per 1 ml dose. • Each 1 ml of oral solution contains 1 mg of sodium. Both ethanol and propylene glycol are substrates of alcohol dehydrogenase, and so there is the potential for accumulation when both are ingested concurrently or repeatedly, especially in young children with low or immature metabolic capacity. The NPPG Position statement 'Choosing an Oral Liquid Medicine for Children' advises on maximum content of propylene glycol and benzyl alcohol dependent on age and weight. Refer to NPPG and RCPCH [2] for details. The EMA advises not using products containing benzyl alcohol for more than a week in patients under 3 years of age, unless advised by the doctor or pharmacist (EMA 2017[1]).
Shelf-life	Ceyesto® oral solution: once opened must use within 1 month.
Consideration[3]	**When a prescription is presented in the pharmacy for melatonin 1mg/ml oral solution sugar free, the following needs to be considered prior to dispensing Ceyesto® against this prescription:** • **Ceyesto® is an option for children > 6 years**. Excipient content of Ceyesto® is **not** a clinical concern for **typical 6-year-old and older by weight.**

References:

1. Committee for Human Medicinal Products (CHMP), EMA. Questions and answers on benzyl alcohol used as an excipient in medicinal products for human use. EMA/CHMP/508188/2013. 9 Oct 2017. Questions and answers on benzyl alcohol used as an excipient in medicinal products for human use (europa.eu)
2. NPPG and RCPCH. Choosing an Oral Liquid Medicine for Children. Position statement 2020-01 Position-Statement-Liquid-Choice-V1-November-2020.pdf (nppg.org.uk)
3. Regional Drug and Therapeutics Centre Formulary Assessment Tool. Neonatal &Paediatric Pharmacy Group-Ceyesto melatonin Oral Solution. No 15 February 2024

New Patient Safety Standards

The Royal Pharmaceutical Society (RPS), the Association of Pharmacy Technicians UK (APTUK) and the Pharmacy Forum NI, have updated their joint professional standards that support pharmacists, pharmacy technicians and pharmacy teams responding to patient safety incidents. These can be viewed here.

Information on how to report incidents in NI can be found here.