NORTHERN IRELAND MEDICINES MANAGEMENT
Newsletter
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#MedSafetyWeek 2025

'We can all help make medicines safer'

3rd-9th November 2025 marks the 10th annual **#MedSafetyWeek,** the theme, 'We can all help make medicines safer'. This aims to raise awareness about proper medicine use and reporting systems to safeguard patient health. **#MedSafetyWeek 2025** spotlights key campaigns for medication safety:

5 Moments for Medication Safety (see overleaf)
Highlighting key moments where action by the patient/carer can reduce the risk of avoidable harm associated with the use of medication (picture below).

Know Check Ask
Promotes awareness and education about the importance of using medication safely and encourages people to keep an up-to-date 'My Medicines List'.

Yellow Card reporting
Encourages reporting of suspected adverse reactions to medicines and vaccines, and problems with medical devices or healthcare products to MHRA Yellow Card scheme.

Help spread the 'We can all help make medicines safer' campaign by sharing #MedSafetyWeek materials on your social media channels.

Strengthen Your Safer Practice

Updated Medication Safety training has been launched as eLearnings on the NICPLD and MedicinesNI: eLearning websites to support pharmacists and GPs in safer practice.

Three refreshed eLearning modules are now available:
High-Risk Medicines: Opioids – Learn practical steps to support safer opioid use in patient care (CPD 2 hours).
High-Risk Medicines: Insulin – Learn about the actions you can take to promote safer use of insulin products whilst delivering healthcare services to patients (CPD 2 hours).
Medication Incidents (NICPLD only) – promotes the safer use of medicines in clinical practice through a better understanding of why medication incidents happen (CPD 3 hours).

These courses offer practical insights to help you **reduce risk** and **improve patient safety outcomes**.

In this Issue (Safety Focus)

NICE Guidance Recently published:

NICE TA 1091

Managed Entry decisions:

Ruxolitinib (Opzelura®)
Benralizumab (Fasenra®)
Guselkumab (Tremfya®)
Guselkumab (Tremfya®)
Idebenone (Raxone®)

5 Moments for Medication Safety

'5 Moments for Medication Safety' is a tool to enhance patient safety and reduce avoidable medication-related harm through specific actions at critical points in the medication use process. It was developed by the World Health Organization and has been adapted for use across NI through engagement with patients/carers. It outlines five critical moments where actions can improve medication safety:

1 Starting; ensuring the correct medication is initiated. Encouraging patients to ask questions about the medication, including its purpose, potential side effects, and interactions with other medications.

2 Taking; taking the medication properly, as prescribed. Encouraging patients to be aware of how and when to take their medications, including any specific instructions regarding food or other medications.

3 Adding; understanding the implications of adding new medications. Encouraging patients to consider other medicines they are taking, how these may interact and what they should do if they suspect an interaction.

4 Reviewing; regularly assessing the effectiveness and necessity of current medications. Encouraging patients to be aware for how long they should take each medicine and the review process for each.

5 Stopping; safely discontinuing medications when appropriate.
Encouraging patients to understand the process for discontinuing a medication, including any necessary follow-up or alternative treatments.

The HSC '5 Moments for Medication Safety' tool will be launched throughout Northern Ireland in autumn 2025. Healthcare staff will be able to refer patients and carers to the tool to promote conversations around their medicines and improve shared decision-making.

Tacrolimus Liquid Error: always confirm product and strength

An urgent prescription was requested for tacrolimus suspension for a child. The practice issued a prescription for '*tacrolimus 2.5mg/5ml oral suspension*', instead of the *'5mg/5ml strength*' previously prescribed and supplied by the Trust. The prescription was repeated at a later date. The patient receiving an under-dose due to a misunderstanding of the subsequent dose change. Although no significant harm occurred there was potential for more serious harm, if this incident had not been detected or if it had occurred in another patient, e.g. post-transplant.

Main Contributory Factors

- The Trust did not specify the strength of suspension
- The GP practice was not familiar with the HSC Agreed list of Paediatric liquid medicines

Actions

- Prescriptions for tacrolimus liquid (an unlicensed special) must have the manufacturer specified on the prescription, as patients should be maintained on exactly the same product.
- Prescribers must consult the HSC Agreed list of Paediatric liquid medicines when prescribing an unlicensed special liquid.
- If the hospital recommended product differs from the agreed formulation or strength, or it is not stated at all, the prescriber should check with the specialist before issuing the prescription. Where this is not possible the patient/carer may be a useful source.
- The patient/carer should be thoroughly counselled and understanding confirmed regarding dose and administration.