NORTHERN IRELAND
MEDICINES MANAGEMENT

HSC Health and Social Care Board

Safety Update: Propranolol / Prednisolone Incidents 2018

February 2019

Serious selection errors involving propranolol and prednisolone

HSCB have issued a number of communications to the Service in relation to the incorrect selection of beta blockers — see below:

- MSM newsletter with information on risks about incorrect selection of beta blockers (August 2013)
- Beta blocker learning letter re prescribing error (May 2014)
- Further dispensing errors involving beta blockers letter (July 2015)
- Learning from Serious Adverse Incident re dispensing error (February 2017)

The learning letter shared the learning from a serious adverse incident which resulted in the tragic death of a patient due to the mis-selection and dispensing of propranolol instead of prednisolone.

Learning from this incident has been previously shared with community pharmacists and focused on:

- **Reducing the risk of errors with beta-blockers**
- **Reducing the risk of errors where a medicine needs to be taken as multiple units to make up a dose, e.g. more than 3 tablets or capsules**
- **Ensuring a second accuracy check in the dispensing process**
- **Discussing new medicines with the patient**

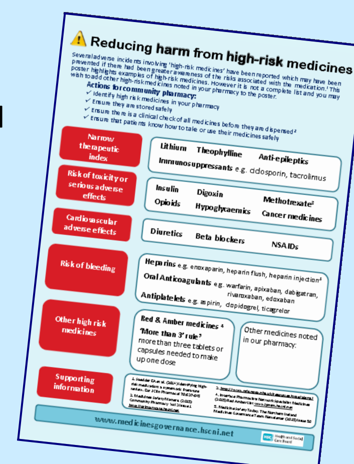
Unfortunately, since this letter was issued in 2017, there has been a further serious adverse incident reported to HSCB which involved mis-selection and dispensing of propranolol 40mg (8 per day) instead of prednisolone 5mg tablets (8 per day). Fortunately, the patient recovered after admission to hospital. For further information see: http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-advice-letters/

Important! - Final Accuracy Check

Community pharmacists have a key role in patient safety by ensuring that medicines are prescribed and administered safely. The final check of prescribed medicines is a crucial 'safety net' in preventing patient harm.

Action for Community Pharmacies:

- Ensure robust standard operating procedures (SOPs) are in place to cover the dispensing and supply of high risk drugs such as propranolol
- Ensure all staff follow the processes indicated in the pharmacy's accuracy checking SOPs
- Check the patient's understanding of their medication and, if you have any concerns, contact the prescribing GP
- Consider additional measures to highlight high risk drugs, e.g. separation of stock, shelf edging, computer alerts, HSCB High Risks drugs poster (available: http://www.medicinesgovernance.hscni.net/primary-care/high-risk-medicines/).



Drug Name Confusion — Look-Alike Sound-Alike (LASA) Drugs

Community pharmacists and prescribers are reminded to take particular care when prescribing and dispensing medicines with commonly confused names (see table below) to ensure the intended medicine is supplied. If pharmacists have any doubt which medicine is intended, contact the prescriber before dispensing the drug.

Double check:

- Right medicine
- Right patient
- Right dose
- Right route
- Right time

Medicines Names with Similar Sounds or Spelling	
Atenolol	Amlodipine
Clobazam	Clonazepam
Propranolol	Prednisolone
Risperidone	Ropinirole
Sulfadiazine	Sulfasalazine
Amlodipine	Nimodipine

For further information see MHRA Drug Safety Update and
NPA resources https://www.npa.co.uk/wp-content/uploads/2018/10/Look-alike-sound-alike-items.pdf

To support pharmacy teams in their safety huddle discussions around LASA drug errors, a series of one-pager resources have been developed, inspired and informed by the Boots UK 'Drug of the Month' posters, which were very kindly shared with the other medication safety officers (MSOs) on the Community Pharmacy Patient Safety Group. For further information and resources see: https://pharmacysafety.org/2019/02/04/lasa-medicines/ .

Action for Pharmacists

Pharmacists and all dispensary staff should be aware of LASA drugs. In light of the recent serious adverse incident, HSCB recommends:

- Reviewing pharmacy storage areas for propranolol and prednisolone to identify possible risks, e.g. on the same shelf, above or below one another, etc.
- Placing shelf edging warnings labels, regardless of whether they are stored separately or not.
- Talking to the patient / carer about their medicines as a way to identify potential errors. This gives the patient / carer the opportunity to say if it is the medication they are expecting or not.

Action for Prescribers

The potential consequences of a patient taking propranolol instead of prednisolone are serious and can be fatal.

The importance of a well-informed patient /carer in the safety chain, who can voice a concern that something is not right, can make all the difference.

In light of the recent serious adverse incident, HSCB recommends the following actions if propranolol or prednisolone are prescribed:

- Advise patients on the name of the medication in addition to the number of tablets to be taken each day.
- Advise patients to check that they have been given prednisolone before they leave the pharmacy.
- Advice patients to speak with a member of the pharmacy staff if there is any confusion or uncertainty.
- Consider adding a default warning to propranolol on GP clinical systems to be vigilant when issuing prescriptions.

This newsletter has been produced for GPs and pharmacists by the Regional Pharmacy and Medicines Management Team.
Every effort has been made to ensure that the information included in this newsletter is correct at the time of publication.
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