Fire risk with Hedrin 4% cutaneous solution® and NYDA®

Hedrin 4% cutaneous solution® (4% dimeticone) and NYDA® (92% dimeticone) are two products available over the counter for the treatment of head lice.

An incident was reported to HSCB recently whereby a young patient suffered severe burns following application of Hedrin 4% cutaneous solution® and subsequent exposure to a flame.

Hedrin 4% cutaneous solution® and NYDA® are combustible when on the hair and in direct contact with an open flame or other source of ignition. Therefore, **during treatment, hair should be kept away from open flames or other sources of ignition.**

The PIL and packaging for Hedrin 4% cutaneous solution® states:

- Warning: Keep hair away from sources of ignition, especially naked flames and burning cigarettes, whilst being treated with Hedrin 4% cutaneous solution®. Treated hair can readily burn if ignited.

The PIL and packaging for NYDA® states:

- Warning: Because some of the ingredients are flammable, NYDA® must not be used near naked flames or heat sources, including hair dryers.
- Keep NYDA® away from sources of ignition and do not smoke during treatment.

Action:

- Patients / parents / carers should be made aware of the flammable nature of these products and the necessary precautions with their use.

NICPLD course: Learning from reported anonymous adverse incidents

HSCB and NICPLD have developed a short distance learning course on reporting adverse incidents anonymously to HSCB. As well as highlighting the new reporting system, the course guides pharmacists to where they can find advice relating to learning around incidents and other patient-safety resources. This course can be found on the NICPLD website: https://www.nicpld.org/.

Finally -Thank You! Thank you for all the reports sent in to date! We will continue to ensure that your tips and advice are published.

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:

Belfast Office: 028 9536 3926 South Eastern Office: 028 9536 1461 Southern Office: 028 9536 2104

Northern Office: 028 9536 2845 Western Office: 028 9536 1008

Past and current editions of the PRN can be found in the Newsletters section of the Northern Ireland Formulary website http://niformulary.hscni.net/PrescribingNewsletters/Pages/default.aspx.

Pharmacy Regional Newsletter

HSC Health and Social Care Board

Volume 4 Issue 1
January 2018

In This Issue

A focus on adverse incidents in the Pharmacy

This edition of the PRN newsletter focusses on adverse incidents in the pharmacy. Do you know how to go about reporting an adverse incident or a near miss? And what is done with the information you report? This edition of the newsletter seeks to provide answers to these questions, and to direct readers to sources of further information.

As you may be aware, it is anticipated that the Pharmacy (Preparation and dispensing Errors - Registered Pharmacies) Order will become law in the coming months. The order will amend the Medicines Act 1968 to provide new legal defences for preparation and dispensing errors for pharmacists, registered pharmacy technicians and staff supervised by them. Further details on this will be issued in due course. More information is available at: http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-advice-letters/ and http://www.legislation.gov.uk/ukdsi/2018/9780111161524/contents.

Reporting arrangements following an adverse incident?

In pharmacies, adverse incidents may relate to errors in prescribing, dispensing or administration of medicines or pharmacy services. Research has shown that the most effective way to improve patient safety across any discipline is to encourage reporting of adverse incidents and then disseminate the learning.

Please note, adverse incidents other than dispensing errors may also occur. Examples include:

- issue with collection and delivery services, e.g. delivery of prescription to the wrong address
- medicine(s) taken by a person other than the patient they were intended for
- issue with administration of medicine
- issue with loss of personal information, e.g. loss of prescription forms.

Reports of dispensing incidents and near misses fall into three categories:

1) Anonymous reports from pharmacists
2) Incidents reported by another body (e.g. patient, other HCP, Trust, RQIA) where the pharmacy has been named
3) Incidents involving controlled drugs (CDs)

1) Anonymous reports from pharmacists

Information from reports is reviewed to establish any trends and identify learning that can be shared across the profession. These reports are not are not followed up by HSCB, and information or contact details about who has submitted the report is unavailable to HSCB.

The Community Pharmacy Assurance process has highlighted that many pharmacies have internal processes in place to report incidents and disseminate learning both to staff in that

pharmacy and to other branches where this applies.
Community pharmacists in Northern Ireland are encouraged to report dispensing incidents and near misses anonymously to the Pharmacy & Medicines Management Team at HSCB so that learning and good practice advice can be shared across the region without any concerns for the reporting pharmacist.

Incidents can be reported anonymously using either the Anonymous Incident Reporting Form or the Online Anonymous Incident Reporting System.

Reports may be posted to HSCB or submitted via an **online anonymous reporting system** available at http://www.medicinesgovernance.hscni.net/.

Please note, as with the anonymous reporting form, there are no hidden identifiers in the online form and it is not possible for HSCB staff to identify where reports have come from.

Anonymous Reporting of Adverse Incidents by Community Pharmacies	Click here to anonymously report patient safety incidents and near misses occurring in

2) Incidents reported by another body (e.g. patient, other HCP, Trust, RQIA) where the pharmacy has been named

In this situation, HSCB has a governance responsibility to review the adverse incident with the pharmacy concerned. In most cases, this review will be completed by a pharmacy adviser. However, if the incident has resulted in serious harm to a patient, or if there were serious factors involved, then the incident may be discussed with the Department of Health and Pharmaceutical Society of Northern Ireland. The pharmacist will be asked to complete an AIF1 form by the pharmacy adviser, which must be returned within two weeks.

3) Incidents involving controlled drugs (CDs)

Review of a recent serious adverse incident highlighted that pharmacy staff were not aware of their obligation to report adverse incidents involving CDs. Any incident involving a **Schedule 2 or Schedule 3 CD** must be reported to the Pharmacy Inspector, HSCB, and the Accountable Officer. This includes all incidents involving temazepam and tramadol.

Pharmacy Inspector: canice.ward@health-ni.gov.uk, 028 9052 3703

HSCB: Contact your local pharmacy adviser via your local office (see page 4 of newsletter).

Recent example of an incident prevented by a community pharmacist — as reported anonymously

Bisoprolol / Bisacodyl mix-up

Just before closing time, a mother brought in a prescription for lactulose 500ml and bisoprolol 5mg/5ml oral solution 150ml, 5mg on alternate nights.
The pharmacist explained to the mother that the child's heart medicine would have to be specially ordered and could take up to five working days to come in.
The mother looked confused and then asked what the heart medicine was for as her son had no problems with his heart. She was asked what she was expecting from the doctor and replied "lactulose and some sort of suppository for constipation".

Pharmacist reported learning as:
Be aware of "odd" looking items on prescriptions especially on prescriptions for children.

Recent examples of adverse incidents

Tapentadol (Palexia®) formulation mix-up

A number of incidents have been reported involving the incorrect selection of the prescribed formulation of tapentadol.

Tapentadol (Palexia®) is a strong opioid used in the management of moderate to severe acute pain and the management of severe chronic pain. According to the Northern Ireland Formulary, tapentadol MR may be recommended as a sole agent for mixed (neuropathic /nociceptive) pain in a **specialist setting**. Despite this, it is widely prescribed. The immediate release formulation, Palexia® (a round tablet) is indicated for use in the treatment of acute pain, while the modified release formulation, Palexia® SR (an oblong tablet) is used in the management of severe chronic pain. The shape of the two formulations differs, but the packaging for both is very similar in appearance.

Regional learning from this incident:

- All staff involved in the dispensing process should be aware that the packaging for both the MR and IR formulations are similar
- A second person should check the formulation, quantity and strength of the CD being dispensed
- Staff must follow the processes indicated in the pharmacy's Accuracy Checking Standard Operating Procedure. Staff should be vigilant when a selected product does not match the expected licenced dose
- Order CDs via automatic ordering (instead of manual ordering) in order to reduce the risk of the incorrect formulation being ordered
- CD cabinets should be kept tidy, and stock separated to highlight different strengths + brands
- Pharmacists should maintain a running balance of stock in their register, and check that the CD register balances with the physical amount of stock after each transaction, and at regular intervals, to ensure irregularities are identified quickly. These checks should be initialled + dated
- Consider use of alerts/reminders on shelf edges, CD cabinet door and CD register to check that the correct formulation is selected during dispensing.

Returned Clexane® Re-dispensed

A patient was dispensed 3 boxes of Clexane® injections. The patient reported to the pharmacy that the third box contained what appeared to be used Clexane® injections. The patient realised this straight away and did not use any of the injections, nor did they have any injury from them as they had been placed back in original plastic packs.
The pharmacy's investigation of the incident later found that the main contributory factor was the patient return medication process: the unmarked returned box of Clexane® injections had been mistakenly placed into dispensary stock. The Clexane® injection had been returned to the pharmacy in the original box/packs, and not in a sharps bin. This was also identified as a contributory factor. The error was not detected by the pharmacist at the second check.

Regional learning from this incident:

- All staff must follow the processes indicated in the pharmacy's Accuracy Checking Standard Operating Procedure. A medicines safety newsletter on clinical checks can be found at: Medicines Safety Matters Community Pharmacy Vol 3 Issue 1
- All pharmacists are reminded of the importance of checking the contents of split and unsealed packs
- All pharmacies should have a robust process in place for handling medication returned by patients
- Do not leave returned medications on benches used for wholesaler stock-in or for dispensing, even for short periods of time
- GPs should be reminded to prescribe a sharps box for all injectable medications, not just for insulin.