LEARNING MATTERS

MEDICATION

EDITION 23
SEPTEMBER 2022

IN THIS EDITION

Link below to previous Learning Matters:
Learning Matters Newsletters | HSC Public Health Agency (hscni.net)

Welcome to edition 23 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.

HSC Health and Social Care

QUALITY 2020

Know, Check, Ask

All medication errors are potentially avoidable and can therefore be greatly reduced or even prevented. Reducing medication errors is a priority for everyone, including healthcare professionals, service users and carers.

Medicines are the most commonly used medical intervention in Northern Ireland (NI), and at any one time 70% of our people take prescribed or over the counter medicines to treat or prevent ill health.

The Department of Health launched a medication safety campaign entitled **Know, Check, Ask (KCA)** which has been developed as part of the NI strategic plan "Transforming Medication Safety in NI" to support the World Health Organisation (WHO) 3rd Global Patient Safety Challenge Medication without Harm. The aim of the WHO challenge is to reduce severe avoidable harm by 50% globally over the next 5 years.

KCA was launched initially with messages tailored to the general public as part of the Living Well campaign in community pharmacies. Staff engaged with patients around their understanding of their medicines, and a 'My Medicines List' for people to record their medicines.

The campaign will encourage all healthcare professionals to use the same simple **KCA 3 step checking system** before you prescribe, supply or administer a medication.

- **KNOW** the medications you are prescribing, supplying or administering, what do they do, what benefits do they have and what are the side effects?
- **CHECK** that they are right for each individual patient, based on their health conditions and any other medications they are taking.
- **ASK** a colleague if you are unsure about, or don't understand anything, or think something is not quite right. Ask the patient if they understand and suggest that keeping a list of their medicines can help them.

Key Guidance

For further information see https://online.hscni.net/our-work/pharmacy-and-medicines-management/medication-safety/know-check-ask/

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Incorrect administration of Controlled Drugs Medication

Two Serious Adverse Incidents (SAIs) occurred recently relating to maladministration of medication in the hospital setting.

In the first case, a patient presented to the Emergency Department (ED) and was administered Oramorph® (morphine sulfate 10mg/5ml oral solution) via the intravenous route (IV), instead of via the oral route (PO) for pain relief. The patient was discharged the following day. Oramorph® is an oral medication and should not be administered intravenously.

In the second case, a patient was an inpatient in a surgical ward. Due to ongoing nausea, vomiting and abdominal pain, the patient was commenced on medication through a syringe driver. When the contents of the syringe driver were being reviewed 2 days later, an error was made, and one of the medications added to the syringe driver was incorrect. Instead of Oxycodone 55mgs being added to the syringe driver, Midazolam 55 mgs was added. The staff nurse on night duty later that night reported that an error had occurred, the syringe driver was stopped and held for a period of 4 hours. The doctor was informed and the patient was assessed, the syringe driver was then restarted with the correct prescribed medication.

KEY LEARNING

In relation to controlled drugs (CD) in Trusts, the standard operating procedure (SOP) for the management of controlled drugs for wards must be followed. Specifically, two practitioners, authorised to administer medicines should be present during the whole administration procedure and should witness the preparation of the CD, the CD being administered to the patient and the destruction of any surplus drug.

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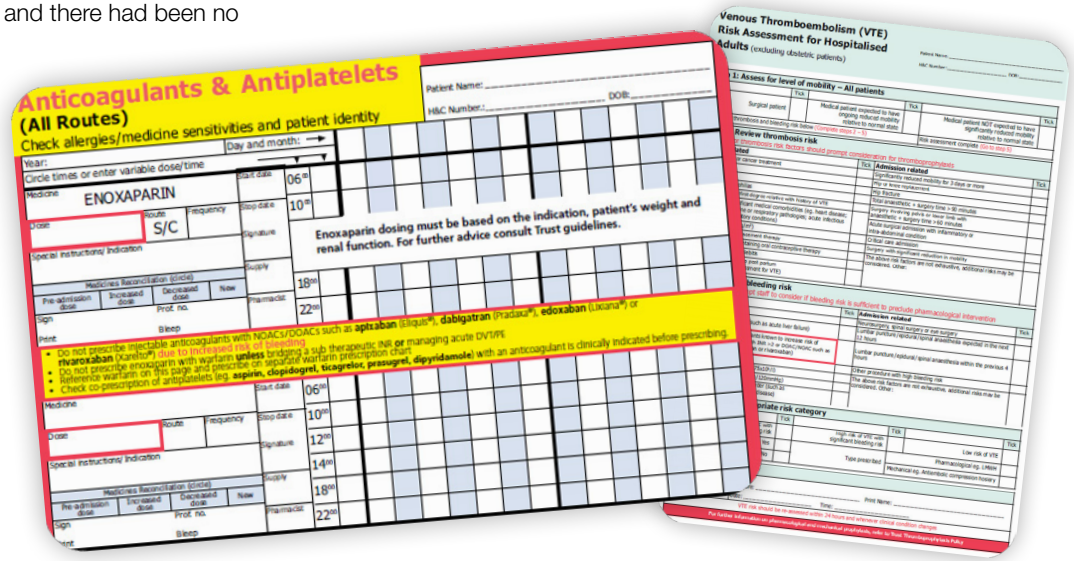
Assessing and Monitoring the Risk of Venous Thromboembolism (VTE)

A frail older patient with significant co-morbidities, advanced kidney disease, advanced dementia and Type 2 diabetes was admitted to the Emergency Department via the on call medical team, following an episode of weakness at home. An initial working diagnosis was made of Non-ST Elevation Myocardial Infarction (NSTEMI) and Acute Coronary Syndrome (ACS), due to an elevated Troponin T result. The patient was admitted to the Cardiology ward and prescribed 40mg Enoxaparin twice daily (treatment dose), until review by the Cardiologist. The Cardiologist concluded that this patient did not have a NSTEMI or ACS and therefore discontinued the Enoxaparin 40mg twice daily dose. This decision was based on the patient's history of renal dysfunction and high risk of falls. No prophylactic enoxaparin was prescribed. The patient was transferred to a Care of the Elderly (CoE) ward for ongoing medical treatment and social care input. On day 6 of admission the patient was found vomiting, pale and unwell. The patient rapidly deteriorated and a cardiac arrest call was made. CPR was commenced and during resuscitation blood was obtained for a D-dimer test to exclude a possible thrombus. The patient sadly passed away. The result of the D-Dimer was >8. During the patient's stay on the CoE ward no prophylactic dose of enoxaparin had been re-prescribed and there had been no re-review of the patient's VTE risk assessment, however the patient continued on background aspirin 75mg daily. The post mortem results showed a Pulmonary Embolus and Deep Vein Thrombosis.

KEY LEARNING

- A VTE risk assessment must be completed on ALL hospitalised adults.
- VTE risk should be re-assessed by medical staff within 24 hours of hospital admission and updated whenever clinical condition or diagnosis changes. Where indicated an appropriate dose of anticoagulation should be prescribed.
- When administering medicines, nursing staff must consider the patient's mobility status and the need for anticoagulation to be prescribed, unless contraindicated. If no anticoagulation has been prescribed, this must be escalated immediately to the prescriber for VTE risk assessment.
- Clinical pharmacists should check VTE risk assessment when undertaking medicine reconciliation on admission/ review and escalate any issues to medical staff.



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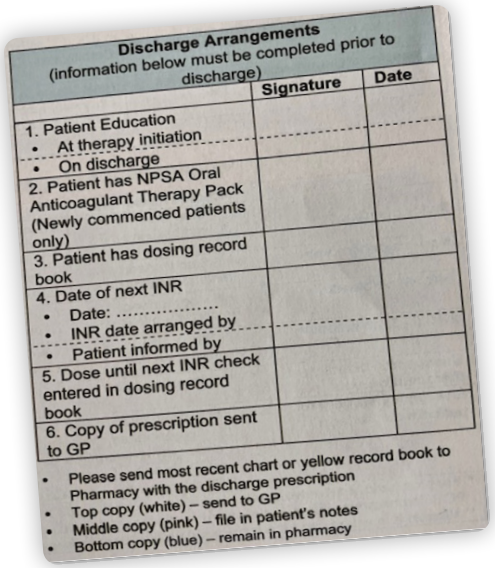
Safe Warfarin Discharge

Patient A was an inpatient on an acute medical ward and planned for discharge. The discharge letter was written in advance and medicines had been dispensed and stored in the bedside locker. One of Patient A's medications was warfarin. The dispensing label for warfarin will not specify a particular dose as it is subject to change according to the international normalised ratio (INR). The label would have referred the patient to the dose in the updated warfarin anticoagulant yellow book. The post discharge doses of warfarin had not been prescribed for the discharge date, as the INR result was still pending. Pending the INR result, patient was discharged from the ward:

- without a copy of the discharge letter and warfarin chart (for GP or anticoagulant clinic).
- without an updated warfarin anticoagulant yellow book that includes daily warfarin dose.
- without a referral for an INR blood test to be rechecked post discharge.

Patient A decided to take their pre-admission warfarin dose and was re-admitted to hospital 14 days later with melaena, high INR of 7.4 and weakness.



Discharge Arrangements (information below must be completed prior to discharge)	Signature	Date
1. Patient Education • At therapy initiation • On discharge		
2. Patient has NPSA Oral Anticoagulant Therapy Pack (Newly commenced patients only)		
3. Patient has dosing record book		
4. Date of next INR • Date: ..... • INR date arranged by • Patient informed by		
5. Dose until next INR check entered in dosing record book		
6. Copy of prescription sent to GP		

- Please send most recent chart or yellow record book to Pharmacy with the discharge prescription
- Top copy (white) – send to GP
- Middle copy (pink) – file in patient's notes
- Bottom copy (blue) – remain in pharmacy

KEY LEARNING

- An INR level should be taken and reviewed prior to patient discharge to ensure appropriate warfarin dosing plan is prescribed and communicated to the patient and GP.
- The warfarin discharge checklist must be completed before discharge – this can be found on the warfarin prescription or in some Trusts on the discharge prescription. Completion of this improves safe discharge for patients taking warfarin.
  - Patient is educated about warfarin and the dose of warfarin to take.
  - Patient receives an anticoagulant therapy pack.
  - They have a yellow record book and doses are documented up to their next INR test.
  - A date for their next INR is arranged.
  - A copy is sent to the GP.
- The staff handover process at the beginning and end of each shift must highlight all outstanding tasks to be completed for each patient.
- Induction training for all staff should include warfarin and how to safely discharge patients who take warfarin.
- Please consult your local Trust policy for specific guidance on the discharge of patients on warfarin.

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Prescription Writing – When a Quick Fix is Not Enough

Patient A was admitted to hospital with abdominal pain.

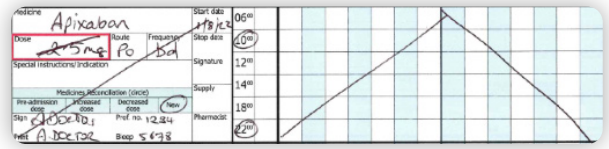
Fourteen days later whilst continuing to receive treatment, the patient required their medicine kardex to be rewritten. This was undertaken by a doctor and when rewriting the medicine kardex an error was made when prescribing Aspirin 75mgs. The doctor recognised their error; however, instead of re-writing the full prescription, which is the correct procedure, they amended the prescription. The amended prescription was not clear to nursing staff, nor was it queried; as a result the patient missed their daily dose of Aspirin 75mgs for 4 consecutive days.

KEY LEARNING

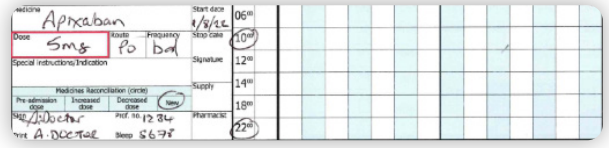
- When a correction is required to an existing prescription, no amendments should be made. Instead, the original prescription and remainder of the administration section should be scored out (see illustration). A new prescription for the medicine should be written so that the prescription is clear to read.
- Medicine kardexes should be written/ rewritten in a quiet area with no interruptions and with sufficient given to completing the task.
- All rewritten medicine kardexes should be double checked and countersigned by two members of staff.
- Medical staff should verbally communicate with nursing staff any change to prescription medication for all patients and ensure any changes are appropriately recorded on the kardex.
- Nursing staff must query all unclear, ambiguous medication prescriptions with medical colleagues.
- Patient's medicine kardex should be actively reviewed by the doctor leading the daily ward round.

The images below illustrate how a medication was initially written up as 2.5mg before realising that the intended dose was 5mg.

- If an error is made during prescribing, or a correction is required to an existing prescription, no amendments to the prescription should be made.



Instead, the original prescription and remainder of the administration section should be scored out as shown above. A new prescription for the medicine should be written, as shown below.



- All prescriptions must be clear, accurate and legible.

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Outpatient Treatment Advice Notes – Think Patient Not Paperwork

Two cases have highlighted the need for care when recommending, prescribing or dispensing medications following outpatient appointments. In both cases a check of the medication against the patient should have spotted the error.

Case 1: Bisoprolol for a constipated child

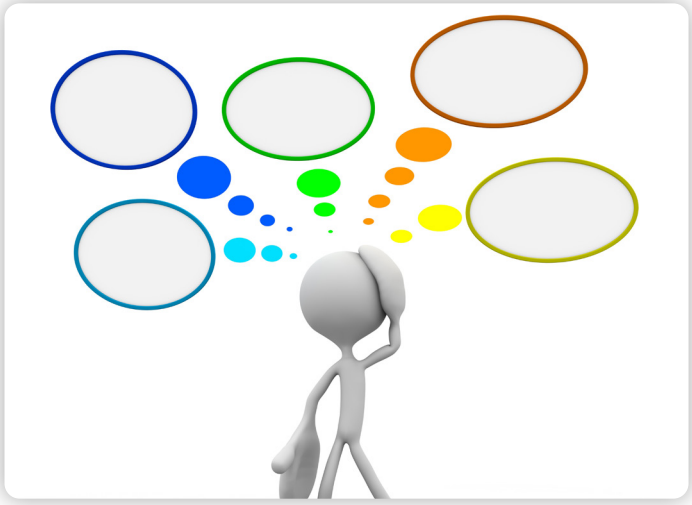
A GP pharmacist read a poorly handwritten outpatient advice note as bisoprolol 5mg tablets instead of bisacodyl 5mg tablets and produced a prescription. A GP signed the prescription and it was dispensed by a community pharmacy. The error was noticed by reception staff when a repeat prescription was ordered some weeks later.

Case 2: Lorazepam ten-fold dosing error

A consultant psychiatrist handwrote an outpatient advice note as lorazepam 10mg BD instead of 1mg. A GP issued a prescription for the same, which a community pharmacy dispensed and residential care staff administered later that evening. The patient became very agitated and not as responsive as usual. The error was detected the next morning on contact with psychiatry. The patient attended the ED for observation.

KEY LEARNING

- **Outpatient clinics** should use an electronic format for advice notes whenever possible.
- If you are a **GP pharmacist** keep the advice note with the prescription until it is signed.
- If you are the **signing GP / prescriber** check the final prescription against the original advice note.
- If you are a **Community Pharmacist** pay particular attention to to newly prescribed medication as part of the clinical check.
- **Everyone:** step back and think- does this medication make sense for this patient?



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Right Device but Wrong Insulin

A patient had been prescribed Novomix 30 Flexpen® 'by their GP'. The pharmacy generated a correct label for Novomix 30 FlexPen® but the wrong insulin Novorapid FlexPen® was dispensed. The medication was delivered by a delivery driver. There was no check with the patient to confirm that they had received their normal insulin. It is normal procedure for the pharmacy staff (when insulin is dispensed) to confirm with the patient that it is their usual insulin. This check however only occurs if the patient or carer collects their medication at the pharmacy.
If insulin is delivered to the patient's home this check does not occur.

The patient noticed the insulin was different but continued to administer it, assuming the doctor had changed it. The patient was admitted to hospital with Diabetic Ketoacidosis. Staff sought advice and guidance on usual insulin regime. On arrival to the ward the patient informed staff that the insulin they were currently administering was Novorapid FlexPen®, however on NIECR record Novomix 30 FlexPen® was noted. Following this the error was discovered.

KEY LEARNING

For the community pharmacy:

- This is a known look-alike, sound alike error. Suggest inclusion of strategies to prevent miss selection e.g. separate fridge storage locations or use of shelf-edge labelling.
- Check that both the device and the type of insulin are correct before dispensing. Where possible a second member of staff should be involved in the checking process.
- The patient / carer should be asked to look at the insulin and confirm that it is the product that they are expecting.
- Delivery personnel for community pharmacies should be made aware of insulin deliveries and know to confirm the missing product with the patient / carer, where possible. Any queries should then be directed to community pharmacist.
- The use of clear bags by community pharmacy for dispensing insulin should be considered to facilitate the patient / carer check.

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Wrong Person or Wrong Address

A number of cases have occurred where patients' medications have been delivered to the wrong person by a community pharmacy delivery service.

Generally the patient or carer notices. However community pharmacy staff and homecare providers should be aware for the potential of error and ensure procedures to check correct patient / correct medication are adhered to.

CASE 1: A patient had an arrangement with a community pharmacy whereby his medication was delivered to his own home, a common arrangement. The delivery driver put medication through the letterbox at the patient's home. The medication delivered was not intended for that patient.

This resulted in the patient taking several naproxen tablets which were contraindicated for this patient as they had a history of peptic ulceration. They suffered a gastric bleed requiring hospital treatment.

CASE 2: A verbal arrangement had been made with a delivery driver to leave medications with a neighbour if not in. The medications in question included temazepam, diazepam and gabapentin. On the day in question the medications were apparently left with the neighbour's son. The medications went missing and were never recovered.

KEY LEARNING

- Ideally deliveries should be accepted by the patient/carer in person with a check made on correct name/correct address, however procedures should acknowledge this is not always possible.
- Delivery by 'letterbox drop' should only be in exceptional circumstances and covered by pharmacy procedures.
- Delivery to a neighbour should be with written consent and requires a particularly robust audit trail.
- Review your delivery set-up.
  - Could mobile technology be used to track delivery?
  - Does the delivery driver require physical resources such as a clipboard folder?

If you have any comments or questions related to this Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

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