Community Pharmacy Medication Adverse Events

Produced by Community Pharmacy Medication Adverse Events Group Pharmacy Department, The Royal Edinburgh Hospital

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This bulletin is produced by the Community Pharmacy Medication Adverse Event Group (secondary care) who meet on a quarterly basis. Community pharmacy medication adverse events identified within the hospital service, like any other type of adverse event, are automatically included in our medication adverse event review process. The aim of the group is to review processes and procedures to help identify why the adverse event occurred.

It is our intention to monitor all medication adverse events reported via our reporting system for common themes and using this bulletin we will disseminate anonymously any general learning points which might be useful to all pharmacies.

Lessons learned – good practice points

Listed below are some of the actions taken by community pharmacies as preventative action.

Compliance aids	Select stock before labelling so that a second check is carried out
Medication with similar names or packaging	Separate on shelf and attached warning label "Similar name/packaging: CHECK!"
Wrong strength dispensed	Separate on shelf and attach warning label "Double check strength before selecting"
Handing out prescriptions	Check the patients address and date of birth before handing out prescriptions
Check the label against the prescription before dispensing. Do not dispense from the label – it might not be correct!	

Substance Misuse Prescriptions – Designated Pharmacy

Prescriptions produced by NHS Lothian Substance Misuse Services and some GP prescriptions state a designated pharmacy for dispensing. Although a designated pharmacy is not a legally binding direction, pharmacists should check with the prescriber or nominated pharmacy before dispensing to ensure the patient does not already have a prescription running in another pharmacy.

It is necessary for several reasons for the prescriber/keyworker to have up-to-date information on the pharmacy their patient is using so if a decision is made to dispense a prescription designated for another pharmacy, please ensure they are aware of the change.

Avoiding selection errors: care required when reading medication names

The selection of incorrect medicines is a frequently reported error.

Selection errors can arise due to various reasons, e.g. because stock has been stored incorrectly, products have similar looking packaging and products may also have similar looking and sounding names.

The name, form, and strength of a selected product should always be carefully checked; however it is worth remembering that when reading labels and prescriptions, we frequently see what we expect to see.

See how easily your eyes and brain can be deceived by reading the following passage.

I cnduo't bvleiee taht I culod aulaclty uesdtannrd waht I was rdnaieg. Unisg the icndeblire pweor of the hmuan mnid, aocdcrnig to rseecrah at Cmabrigde Uinervtisy, it dseno't mttaer in waht oderr the lterets in a wrod are, the olny irpoamtnt tihng is taht the frsit and lsat ltteer be in the rhgit pclae. The rset can be a taotl mses and you can sitll raed it whoutit a pboerlm. Tihs is bucseae the huamn mnid deos not raed ervey ltteer by istlef, but the wrod as a wlohe. Aaznmig, huh? Yaeh and I awlyas tghhuot slelinpg was ipmorantt! See if yuor fdreins can raed tihs too.

Because we see what we want to see, checking is particularly difficult. Some methods have been suggested to try and address this, for example: reading the label backwards or out loud, or by going away and coming back and reading again as a double check.

Recent examples of where medication has been incorrectly selected and dispensed include:

Medication prescribed	Medication dispensed and issued
hydroxyzine 25mg	hydralazine 25mg
bisoprolol 5mg	bendrofluazine 5mg
amlodipine 10mg	amitriptyline 10mg
amitriptyline 25mg	atenolol 25mg
indapamide	imipramine
procycylidine	prochlorperazine
carvedilol 12.5mg	captopril 12.5mg

Medicine Supply Issues

When a medicine is required urgently for a patient and is out of stock with your wholesaler, what steps can be taken by the community pharmacy team to ensure continuity of supply for the patient? Remember, there is a difference between manufacturing issues and wholesaler out of stock situations.

- Does your wholesaler have a date for the medicine coming back into stock?
- Has the pip code of medicine changed due to a change in pack size?
- Is the supply issue due to a specific wholesaler out of stock or a national manufacturer cannot supply (MCS)?
- Can medicine be obtained from another wholesaler? Ask another pharmacy to order it for you if their wholesaler has it in stock and either borrow or direct patient there
- Does manufacturer have a supply available for urgent prescriptions? If so, order direct and charge through wholesaler – no need to open up an account, e.g. Janssen for Rapifen injection
- Does manufacturer have a date for release of new stock for MCS issues?
- When does the patient actually require the medicine? Medicine may come back into stock before they run out
- Is there a generic version of the medicine?
- Can GP prescribe an alternative licensed medicine if needed urgently?
- If no alternative licensed product available, is there an equivalent clinically appropriate unlicensed product available?
- Have you advised surgery of MCS issues and emailed the Scriptswitch team? scriptswitchteam@nhslothian.scot.nhs.uk
- For long term MCS issues, liaise with local GP sugeries. e.g. GSK steroid cream supply problems.

Taking the above steps should negate the need for patients having to visit numerous pharmacies trying to obtain an urgent medicine.

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When a locum is providing cover

There are a number of actions that can be taken by both the regular pharmacist and any locum pharmacist providing cover in a community pharmacy which can support best practise and provide help to reduce medication incidents.

Regular pharmacists:

- Provide an easily accessible locum information folder
- Provide site copies of relevant PGDs, located at the front of locum folder
- Make relevant service specifications and dispensary processes easily accessible
- Ensure that support staff are aware of and trained in all services provided by your pharmacy, e.g. PGD for supply of azithromycin for chlamydia
- Ensure that support staff are aware of and trained in relevant dispensary processes e.g. procurement and supply of specials
- Contact locum pharmacist providing cover before they start in the pharmacy to discuss any issues. Ensure they are aware of any specific services that your pharmacy offers.

Locum pharmacists:

- Ensure you are aware of any locally negotiated services (LNS) specific to that Health Board area. For NHS Lothian this information can be found at http://www.communitypharmacy.scot.nhs.uk/nhs_boards/NHS_Lothian/lothian_index.html
- Contact the pharmacy before arriving to discuss any specific issues that you may need to deal with during your time there
- On arrival at the pharmacy, locate the locum information folder if required
- Ensure you are aware of any LNS that the pharmacy offers, eg. Palliative care network pharmacy
- Sign any relevant PGDs if required to enable you to deliver the specific services
- Contact the pharmacist following your period of cover to discuss any specific issues that arose during your time in the pharmacy to ensure continuity of service delivery.

Multi-Compartment Compliance Aids [MCCAs]

The preparation and supply of MCCAs to patients is a complex issue and the potential for adverse events can occur at each stage of the process. It is important to ensure you have a robust SOP in place for the preparation and handling of MCCAs and it is useful to review it after three month's initial use and at least annually.

Use your Incident Log to note feedback or comments from locums and staff members. Locums or new staff members can provide useful input by reviewing the process with a fresh pair of eyes. It is useful to also review your SOP after errors or critical incidents to try to find out why they occurred and to prevent recurrence.

Staff should be aware of any known risks in relation to the preparation and supply of MCCAs to help minimise risk.

e.g.

- Filling MCCAs requires absolute concentration. Pressure of work, staff shortages, distractions, etc. can disrupt concentration while filling MCCAs. Don't multi-task!
- New members of staff may be unfamiliar with the system – supervise closely
- Hospital (or hospice) admissions or outpatient appointments may lead to medication changes. Ensure adequate communication framework
- Frequent changes of supplier result in frequently changing appearances of medicines leading to confusion in identifying contents of packs. Be aware and check with care.

The following learning points may help to reduce adverse events:

- When gathering up medicines required for dispensing these should be checked against the prescription by a second person before filling the MCCA
- Before the dispenser seals the pack, a second person should check the contents against the prescription and against the stock packs for accuracy to avoid any errors, omissions, and medicines added in duplicate, etc

- Set up a communication framework with relevant prescribers so that you are the first to know about medication changes. Check anything that is unclear with the prescriber and/ or the patient's GP before any further medicines are supplied. Consider how soon changes should be made: should they happen straight away or can it wait until the next dispensing? This will be a clinical decision and should be dealt with by the doctor/pharmacist
- Always tell patients/carers to return old MCCAs so that you can check on compliance. Look out for poor compliance and let GPs know about any problems. MCCAs don't solve all compliance problems!