Vol.5: Issue 5 December 2024

MEDwatch *is the e-bulletin for all NHS Grampian Staff who are involved with patients and medicine management.*

Its aim is to improve the safety of medicines by sharing learning, and encouraging adverse event reporting from all staff groups.

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MHRA Drug Safety Newsletters

Latest MHRA Drug Safety Newsletters:

- September 2024
- October 2024
- November 2024

Alerts, Notices & Shared Learning

Community Pharmacy dispsening medication to a hopsital in-patient

Sharing Learning Points

LOCALLY

This shared learning describes an incident whereby a hospital in-patient presented at their Community Pharmacy to obtain their usual twice weekly dispensing of medication.

What happened?

A patient who receives twice weekly dispensing of medicines from a Community Pharmacy was admitted to a NHS Grampian ward one evening and prescribed and administered these medicines as appropriate.

The following morning the ward pharmacist contacted the patient's Community Pharmacy to inform them of the patient's admission.

Two days later, while still an in-patient, the patient left the ward temporarily and visited the Community Pharmacy to obtain their usual medication. The patient confirmed they had been discharged and the medication was dispensed by the Community Pharmacy. This resulted in the patient having had the medicines administered to them in hospital and dispensed to them by the Community Pharmacy. The patient then returned to the in-patient ward.

The issue was discovered the following day when the ward pharmacist contacted the Community Pharmacy prior to discharge to arrange recommencing twice weekly dispensing of medicines for the patient. At this point the ward pharmacist took appropriate measures to ensure the safety of the patient i.e. suspending prescriptions in HEPMA, informing the Drug and Alcohol Team and discussing the situation with the patient.

What went well?

- Communication between the ward pharmacist and the Community Pharmacy.
- Actions taken following discovery of incident.

What, if anything, could we improve?

When Community Pharmacies are notified that a patient has been admitted to hospital it is best practice to:

- clearly mark the current prescription as 'suspended' or move the prescription to a separate storage area from other prescriptions.
- record the date the communication was received on the prescription.

If patients who have recently been admitted to hospital present at a Community Pharmacy for routine dispensing of medicines, a process to confirm the patient:

- has been discharged from hospital care
- has not been administered the medication that day.

What have we learnt?

- Discharge communication is key
- A process to 'suspend' or segregate prescriptions in Community Pharmacies for patients who have been admitted to hospital may reduce the risk of this situation recurring.
- Community Pharmacies need to ascertain hospital in-patient status despite the patient presenting at the Community Pharmacy.

Risk Associated with Co-prescribing Warfarin and Tramadol

We wanted to share a reminder to prescribers following a recent MHRA Drug Safety Update.

The update advises prescribers to be alert to the risk of drug interactions when patients are prescribed warfarin and tramadol together. They warn that this combination can raise the International Normalised Ratio (INR), resulting in severe bruising and bleeding which can be fatal in some patients. The MHRA drug safety update shares an incident where a patient died from a bleed to the brain following concurrent treatment with warfarin and tramadol.

The update gives specific advice for healthcare professionals when co-prescribing warfarin with other drugs.

We would like to highlight the importance of undertaking an accurate medicines reconciliation with every patient and to remind prescribers to pay attention to alerts within prescribing systems.

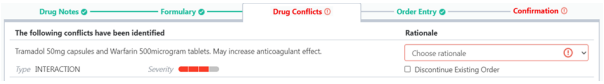
Alerts Within Prescribing Systems

Users of prescribing systems will know there are many alerts built into them. It is understandable that this can be frustrating and time consuming and it is tempting to close

them down without reading. However, they are intended to serve as a risk minimisation tool, forcing the user to pause and consider whether they do want to continue with prescribing/administering a certain medicine or combination of medicines.

Using HEPMA and, warfarin and tramadol as an example (image on the right), you can see the user is notified that this combination may increase anticoagulant effect.

With this in mind we are reminding prescribers and all users of electronic prescribing and administration systems to read the pop up alerts in these systems and consider the risk/severity before proceeding with prescribing or administering the medicine.



Access to Gentamicin and Vancomycin Calculators

Evidence

Antimicrobial Guidance

Following recent errors in prescribing gentamicin and vancomycin, the antimicrobial team would like to remind prescribers that Health Boards across Scotland use different dosing calculators for these medicines and it is essential that NHS Grampian calculators are used.

These can be accessed by the following methods:

- by clicking the 'Evidence' icon in TrakCare then 'antimicrobial guidance' icon
- via Hospital Portal 'References'
- via the 'Antimicrobial Guidance' desktop icon.

Prescribers can confirm they are in the correct calculator by double checking that NHS Grampian is shown in the URL.

Please **do not** search google to find the calculators as it may direct prescribers to a different health board's calculator.

Any incidences where incorrect calculators are used should be reported in Datix.

See this NHS Grampian news story for information.

For further information please contact the Antimicrobial Pharmacists: gram.antibioticpharmacists@nhs.scot

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