Vol 5. Issue 3: September 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.

Inside This Issue

MHRA Drug Safety Newsletters

Latest MHRA Drug Safety Newsletters:

- June 2024
- July 2024
- August 2024

Alerts, Notices & Shared Learning

Patient Safety: Removal of Epimax Original Cream, Epimax Parrafin Free Ointment and Epimax Ointment from the Grampian Area Formulary

Formulary Group has taken the decision to remove the following products from the Grampian Area Formulary:

- Epimax Original Cream
- Epimax Paraffin Free Ointment
- Epimax Ointment

Aspire Pharma issued Field Safety Notices on the above products and the advice has been shared by the MHRA in their July Drug Saftey Update.

In summary; due to a risk of eye related injuries when using the above products on the face/ near the eye changes were made to the product label. These changes and the background to the decision made by Formulary Group are detailed in this Patient Safety Notice. Actions for Prescribers, Primary Care and Community Pharmacies are also set out in the Patient Safety Notice.

HEPMA User Alert: Incorrect Selection of Penicillamine Allergen

The HEPMA Team are aware of some instances where PENICILLAMINE has been slected in error when trying to document a PENICLLIN allergy. Clinical staff using HEPMA are asked to be aware of the potential for mis-selection and to read the guidance in this HEPMA User Alert for information on avoiding this error and reviewing allergy status.

Look Alike, Sound Alike Medicines (LASAs)

Look Alike, Sound Alike (LASA) Medicines are a common cause of medication errors and occur when medicines have similar looking packaging (same size, shape or colour) or similar sounding names (the phonetics of their names), doses and/or strengths.

Like PENICILLIN and PENCILLIAMINE in the HEPMA User Alert above these similarities can lead to errors in prescribing, dispensing, supply or administration of medicines some of which may cause serious harm to the patient. The **level of harm** caused due to a LASA error will depend on the patient and the medicine administered but potential outcomes are:

- the patient receives wrong medicine
- overdosing
- underdosing

The following are some of the medicines reported to have been mixed up over the last 3 months within NHS Grampian. Some were near misses picked up prior to reaching the patient and thankfully none were reported to have caused harm, however, it demonstrates the risk of LASA errors at all stages of the medicines process.

Incorrectly recording **PENICILLIN** allergy as **PENICILLAMINE** in HEPMA

HUMALOG MIX 25 dispensed in error by community pharmacy instead of **HUMALOG MIX 25**

METOPROLOL prescribed in error instead of **METOCLOPRAMIDE**

FLUCONAZOLE sent in pharmacy order instead of **FLUOXETINE**

PROMAZINE prescribed in error instead of **PROMETHAZINE**

PROCYCLIDINE dispensed by community pharmacy in error instead of **PROCHLORPERAZINE**

LORMETAZEPAM prescribed to patient instead of **LORAZEPAM**

LONGTEC administered to patient in error instead of **SHORTEC**

HEPARIN administered to a patient instead of and **DALTEPARIN**

CALCIUM CHLORIDE added to an infusion instead of **CALCIUM GLUCONATE**

Examples of medicines with similar names

Click image to expand

What contributes to LASA Errors?

LASA errors can occur during prescribing, dispensing and administration of medicines as a result of:

- illegible handwriting
- verbal orders
- use of abbreviations
- mis-selection in computerised prescribing/dispensing systems

- similar appearance of medicines/packaging
- storage of LASA medicines close to one another

The Medicines and Healthcare products Regulatory Agency (MHRA) approves all packaging and labelling information of medicines sold in the UK and have produced best practice guidance for manufacturers. In addition to the packaging containing certain items of information vital for the safe use of the medicine and the format the information is presented, they identify "style" as an area for contributing to potential confusion when drug names and packaging is similar. While there is no legislative requirement for manufacturers to change the style of their packaging for different medicines they are receptive to feedback where the risk of confusion/mis-selection is high.

To reduce the likelihood of errors occurring with generic cephalosporins the MHRA along with the former National Patient Safety Agency (now NHS Improvement) agreed a labelling design mechanism which is required on the labelling of all medicines in this class; Tallman lettering or the use of different coloured text to highlight some unique aspect of the drug name; cefo**TAX**ime and cef**UROX**ime are examples of this.

Examples of similar packaging

Actions to Reduce LASA Errors

In their document Medication Safety for look-like, sound-alike medicines the World Health Organisation (WHO) suggests actions for healthcare professionals to reduce LASA errors. The MHRA also issued advice to healthcare professionals in their drug safety update Drug-name confusion: reminder to be vigilant for potential errors. Potential actions will have varying degrees of effectiveness or may only provide a temporary effect and staff will need to assess which ones, in isolation or in combination, will be most effective for their service or role. Examples include:

- Educating self and patients about LASA medicines that are prone to errors
- Be extra vigilant when prescribing and dispensing medicines with commonly confused drug names to ensure that the intended medicine is supplied
- Use generic names during prescribing (unless brand prescribing is a requirement e.g. insulins)

- Write legibly when prescribing (where written prescriptions are required)
- Clearly label storage areas and segregate storage of LASA medicines
- Take measures to avoid interruptions while prescribing, dispensing, preparing or administering medicines
- Avoid fatigue
- If there is any doubt about which medicine is intended, contact the prescriber before dispensing or administering the drug
- Follow local and professional guidance in relation to checking the right medicine has been dispensed to a patient
- Report suspected adverse drug reactions where harm has occurred as a result of a medication error via Yellow Card.

References/Useful Links:

World Health Organisation: Medication safety for look-alike, sound-alike medicines

Drug-name confusion: reminder to be vigilant for potential errors GOV.UK

Best Practice Guidance on the Labelling and Packaging of Medicine, MHRA December 2020

The problem of look-alike, sound alike name errors: Drivers and Solutions, Rachel Bryan, Jeffrey K Arsonson, Alison Williams, SueJordan, British Journal of Clinical Pharmacology March 2020

Contact

Lindsay Cameron

Medication Safety Advisor

lindsay.cameron2@nhs.scot