BCHS Pharmacy Team Medicines Bulletin (November 24)

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NHS East London NHS Foundation Trust

Learning from BCHS Medication Incidents

In October 18 medication incidents reported for BCHS, 11 were external medication errors. This month the pharmacy team wanted to share the following learning;

Insulin Transcribing

In a recent incident, the patient's chart appeared to show that the patient had received both an old and new insulin dose that day. The dose had been increased from 30 to 32 units of Humalog Mix 50 insulin. The previous dose had been incompletely crossed off the chart, allowing the administration section to be signed in error. On further questioning , distractions had led to this documentation error and the patient did not receive an extra dose of the insulin.

Learning

- If the insulin dose changes then the whole insulin prescription should be crossed off and rewritten
- The MAR chart should be rewritten in full if it becomes unclear or ambiguous
- Re-transcribing onto the same chart for Insulin poses risk and inadvertent administration of incorrect doses or frequency of medication and should therefore be avoided.
- Where medication is to be continued, it should always be re-transcribed onto a new MAR chart.

Wrong Insulin Administration

The wrong insulin was administered to a care home patient. Lantus insulin a long acting insulin was administered instead of Insulatard insulin which is intermediate acting. The nurse had two patient's insulin on her and administered the wrong patient's insulin. The incident was escalated to seniors and the patients GP contacted. No harm came to the patient.

Learning

Please ensure you refer to and are following:

- 10 Rights of administration
- ELFT Policy for the Transcribing of Medication for the purpose of recording administration in CHS
- ELFT Policy for the Safe Use of Insulin.

Good Practice Interventions

Clare Moody (Lead Pharmacy Technician) A patient was discharged from the hospital with promethazine 25mg tablets, the dose was half a tablet (12.5mg) in the evening up to maximum 20mg in the day. Clare helped the care home in rectifying this prescribing error which caused confusion to the care home staff. Well done Clare for your continuous support and good clinical knowledge.

Well done **Priti Patel (Pharmacy Technician)** for the positive feedback from the care home manager and senior lead at Sharnbrook Lodge care home. They praised Priti for all the support and guidance she provided with medicine management in the difficult time when they lost their home manager in tragic circumstances.

Heidi Ratcliffe (Pharmacy Technician) A patient was prescribed paracetamol twice on the discharge summary in error. Well done Heidi for identifying this and feeding it back to the acute .

Medication Shortages

Relevant new shortages highlighted by the ELFT pharmacy procurement team and updates are now located on the intranet: https://www.elft.nhs.uk/intranet/teams-support-me/pharmacy/medicines-shortages

Kay-Cee-L ® (potassium chloride 5mmol/5ml) syrup will be out of stock from late September 2024. The anticipated resupply date is 31/12/25

Daktacort Cream Discontinued

Pabrinex® Intramuscular (IM) injection is being discontinued, with stock exhaustion expected from December 2024

Any particular concerns regarding shortages, pharmacy also have access to the Specialist Pharmacy Service (SPS) online medicines supply tool with up to date procurement issues. www.sps.nhs.uk

ELFT Medication Safety Page

The Trust's medicines safety page is available on the intranet: https://www.elft.nhs.uk/intranet/teams-support-me/pharmacy/medicines-safety

Patient Safety Alert

MHRA – Drug Safety Update

Any questions or queries please contact the pharmacy team on **elft.pharmacybchs@nhs.net** https://www.elft.nhs.uk/intranet/teams-support-me/pharmacy/pharmacy-community-health-services-chs.

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