



## Learning from BCHS Medication Incidents

In March we had 31 medication incidents reported for BCHS, 19 were external medication errors. This month the pharmacy team wanted to share the following learning;

### Incidents: Palliative Care Medication Errors

This month we have seen an increase in errors regarding the administration of palliative care medication.

In one incident midazolam 5mg was set up in a syringe driver in error instead of the 10mg prescribed. The error was quickly identified and rectified, and no harm came to the patient.

In a separate incident morphine was administered incorrectly as the syringe driver dose rather than the stat dose charted (10mg instead of 2.5-5mg). No harm came to the patient

### Learning

All staff should familiarise themselves with the **10R's** of safe administration of medicine

1.Right Patient

2.Right Consent

3.Right Time

4.Right  
Medicines

5.Right Dose

6.Right Route

7.Right Expiry

8.Right  
Documentation

9.Right Effect

10.Right  
Education

This is described in detail on page 19 of ELFT's [Medicines Policy](#).

## 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>

MHRA – [Drug Safety Update](#)



## Good Practice Interventions



**Pharmacy technicians:** The team have received positive feedback from Sarah Denmead (Deputy Lead Nurse-Unplanned Care) for the support they have been providing to the virtual ward patients. Well done team!

**Priti Patel (Pharmacy Technician)** intervened when there was confusion over daily administration of buccal midazolam to a patient in a care home. Priti liaised with the GP and this medication was then reviewed and their treatment optimised. Well done Priti!

**Jacky White (Lead Pharmacy Technician)** Thank you for your continued support, including delivering the new training to staff on the delegation of low weight molecular heparin (LMWH)

**Clare Moody (Lead Pharmacy Technician)** Thank you for your ongoing support. This month, Clare has made several clinically significant interventions, including identifying instances where medication was prescribed but not charted on care homes MAR charts, as well as cases where care staff had not been administering medication, despite it being charted.

## Medication Shortages

**Relevant new shortages highlighted by ELFT pharmacy procurement team:**

### Levofloxacin 250mg and 500mg tablets

Levofloxacin 250mg tablets are in limited supply until late April 2025 and Levofloxacin 500mg tablets are in limited supply until late May 2025.

### Estradiol (Estradot®) 25micrograms/24 hours and

**50micrograms/24 hours transdermal patches** will be out of stock until late April 2025.

### Estradiol (Estradot®) 75micrograms/24hours and

**100micrograms/24hours transdermal patches** limited supplied are available until late April 2025.

**Estradiol (Estradot®) 37.5micrograms/24 hours patches** will be out of stock from late-April until July 2025.

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](http://www.sps.nhs.uk)

Any questions or queries please contact the pharmacy team on [elft.pharmacybchs@nhs.net](mailto:elft.pharmacybchs@nhs.net)  
<https://www.elft.nhs.uk/intranet/teams-support-me/pharmacy/pharmacy-community-health-services-chs>.

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