



PharmFax Safety



NPSA Guidance

Oral Bowel Cleansing Solutions

Following the death of a patient and 218 patient safety incidents relating to the use of oral bowel cleansing solutions, the NPSA issued a rapid response alert. This required healthcare organisations to review how [Oral Bowel Cleansing Solutions](#) are authorised and prescribed within their organisation to reduce the risk of harm to patients.

NHS Leeds in liaison with the Leeds Teaching Hospitals NHS Trust (LTHT) reviewed the use of Picolax®, Citrafleet® Fleet Phospho-Soda®, Klean-Prep®, Citramag® and Moviprep® in the primary care setting.

As a result the Medication Safety Alert No18 was produced by the LTHT Medicines Risk Management Team. This highlights the actions to be taken when authorising and administering oral bowel cleansing solutions. This has been circulated widely and is available from the [Medicines Management webpage](#).

Recent Methotrexate Incidents

We have had two reports where patients were prescribed, and dispensed, Methotrexate tablets with a **potentially fatal DAILY dose**, instead of the ONCE WEEKLY dose. We ask all healthcare staff to be vigilant and ensure that safe systems of work are in place to ensure the safety of Methotrexate patients. This will include checking the patients dose booklet prior to prescribing, dispensing and administering Methotrexate. Other safety suggestions include:

- Having flagged messages on computer systems which prompt and highlight the WEEKLY dose requirements,
- Having standard operating procedures for the supply of Methotrexate which contain actions to prevent the supply of incorrect dose regimes
- Shelf labels prompting dispensary staff to check the frequency of the dose.

Advice is available from the [NPSA](#) and the [Medicines Management webpage](#).



Safety Measures

Cold Chain DVD

The Medicines Management team have commissioned a DVD relating to the storage and handling of vaccines and refrigerated medicines. Copies of the DVD will be issued to key areas within NHS Leeds to promote 'best practice'. A limited amount of copies will also be available to borrow from the NHS Leeds Library Service.



Teams are reminded to request advice from the MMT for all vaccine fridges that show temperatures outside the recommended 2° to 8°C range.

Further advice can be obtained from the Medicines management Team on 0113 203 3402. An incident form should also be submitted.

Purple Pen Information

LTHT pharmacy team have implemented a new 'purple pen' system to highlight annotations made by pharmacists on prescription stationery (this will include discharge advice notes). This is to ensure annotations and alterations made to prescriptions can be clearly identified. This will clarify the prescribers intentions and provide useful information relating to drug administration and/or monitoring requirements. Trials have shown the purple ink to be visible when photocopied and faxed and will be an aid to improve patient safety and reduce harm to patients. This information is contained in the LTHT publication 'The Tablet' No 26 which is available from the [Medication Safety page](#) of the Medicines Management Webpage.





Liquid Preparation Errors

An acute hospital admission was necessary for a patient who suffered a serious reaction to their medication. Subsequent investigations highlighted two serious errors with this patients medication.

Amisulpride 100mg in 1ml liquid was prescribed where the intention was for the patient to receive a 0.5ml (50mg dose) in the morning and a 0.75ml (75mg) dose in the evening. Confusion with the strengths of available preparations resulted in the patient being prescribed and supplied with a dose of 2.5ml (250mg) in the morning and 3.75ml (375mg) in the evening. The Medicines Management Webpage contains information relating to the safe use of [Amisulpride liquid](#). Prescribers are requested to double check the dose and prescribe the appropriate volume of the licensed 100mg in 1ml preparation wherever possible.

Mirtazepine 15mg in 1ml liquid was prescribed with a dose of 1ml (15mg). A dispensing error occurred and the patient was instructed to take 5mls (75mg). As a result the pharmacy involved has reviewed its standard operating procedures paying particular attention to dispensing liquid preparations.

A reminder to all that small quantities of liquid should be administered via an oral syringe.



Special Liquid Preparation

Ketamine Injection. Prescribers are reminded that the licensed administration routes for Ketalar® (Ketamine) Injection are intravenous infusion, intravenous injection or intramuscular injection only. All other routes of administration are an unlicensed use of the preparation and the prescriber takes full responsibility for this action. Patients requiring Ketamine in an oral form should be prescribed the 'special' 50mg in 5ml liquid formulation. This is not listed in the BNF but is available to community pharmacies on request from the manufacturer.



Good Practice Identified

Controlled Drug (CD) Incident

Two patients were owed further supplies of CDs by a community pharmacy. Although both items were dispensed correctly an error occurred at the 'bagging up' stage resulting in one patient inadvertently receiving the other patients 'owing' item.

As a result the Community Pharmacy reviewed their checking procedures and now ensure when all CDs are checked they are bagged separately into a clear bag which allows the contents to be visible. This is sealed with the patients bag label. At hand out the CD is again checked against the prescription without breaking the seal. This simple, low cost method for improving patient and medication safety has been shared throughout NHS Leeds



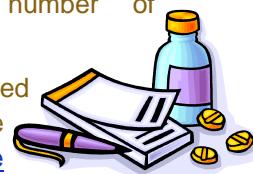
Flu and Methadone Supply

Pharmacists have the discretion to supply methadone to a patient's representative in exceptional circumstances. Being quarantined with Swine flu would be one such situation. We advise the patient should supply their representative with a note authorising them to collect on each occasion/day.

Pharmacists will use their judgement on whether or not to supply. This is against a background of how often the patient has sent a representative in the past and whether this has caused any problems. The representative would not be expected to attend for more than 5 consecutive days when the patient has suspected swine flu.

Where the supplying pharmacist is not comfortable to supply to a representative it may be necessary to contact the prescriber to adjust the patient's prescription to reduce the number of instalments.

Further information on Controlled Drugs can be obtained from the [Medicines Management webpage](#)



Pseudoephedrine Reminder

It is illegal to sell or supply:

- Any product that contains more than 720 mg pseudoephedrine or 180 mg ephedrine without a prescription
- A combination of products that between them add up to more than 720 mg pseudoephedrine or 180 mg ephedrine in one transaction
- A product that contains pseudoephedrine and a product that contains ephedrine in one transaction

How to contact us ☎ 0113 203 3402 or ✉ medicines@nhsleeds.nhs.uk