May 2009

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from the NHS Leeds Primary Care Medicines Management Team

PharmFax Safety

NHS Leeds

Patient Safety Information

Protecting people with latex associated allergy

NHS Leeds nursing and medical staff must be aware of the theoretical risk of anaphylaxis for patients treated with medicines containing a latex bung or syringe cover.

The suggested actions are:

Where possible use an alternative product for patients with **known latex allergy**.
(Type I)

Where alternatives are not available, patients with **contact allergy (Type IV)** should be treated cautiously.

Cautious treatment would include ensuring:

- Adrenaline 1:1000 is readily accessible.
- Treatment is carried out in the presence of someone who is trained and confident (not just competent) in the treatment of anaphylaxis.
- There is access to a means to call for help and to call for an ambulance.
- Treatment is carried out in the presence of at least two members of staff.

Where patients have previously had an episode of anaphylaxis which is potentially due to exposure to latex, and no product is available that is latex free then the patient should not be treated in a community settings where there are no full and comprehensive "crash call" facilities.

The Regional Drug Information Service provide guidance on latex free medicines and in some cases contact the drug manufacturers to ascertain that the process involved is carried out in a totally latex free environment (Some have handling by operatives wearing latex gloves or other products containing latex)

Contact the Medicines Management Team on 0113 203 3402 for information.

The National Patient Safety Agency issued advice on this subject in May 2005. Available at http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety/allergy-latex/

Latex Allergy Definitions

The following definitions are taken from the Leeds Teaching Hospitals NHS Trust's Latex Policy

'Latex-free' is the term used to describe products that are not manufactured from natural rubber latex (NRL).

'Latex-safe' is the term used to describe an environment that minimises the risk of a reaction occurring in sensitised or allergic individuals. This is achieved by removing the NRL products that are most likely to cause a reaction.

Type I latex allergy is an immediate hypersensitivity reaction characterised by urticaria, conjunctivitis, rhinitis and occasionally life threatening anaphylaxis.

Type IV latex allergy is characterised by an eczematous rash often developing hours after exposure. It may be owing to latex proteins or chemical residues used in latex processing. This reaction predisposes individuals to developing Type I allergy.

Practitioners must assess patients who have a latex allergy against the definitions prior to treatment and follow the most appropriate course of action

For information, in addition to bungs and syringe covers, latex is also found in products such as:
Plasters
Surgical gloves
Catheters
Condoms
Blood pressure cuffs
Tubing
Rubber bands
Erasers
Some shoes and articles of clothing
This list is not exhaustive but is an aid to demonstrate the variety of products which may contain latex.

Tacrolimus Capsules

Prograf® and Advagraf® (Tacrolimus) potentially serious medication error reported in Leeds. This led to a no harm incident on this occasion but staff are asked to note the following safety information**.**

The MHRA/CHM issued advice in December 2008 stating it is important to note the correct use of these medicines.

Prograf® is an immediate release formulation that is taken twice a day, once in the morning and once in the evening.

Advagraf® is a prolonged release formulation that is taken once daily in the morning

The two are **NOT** interchangeable and switching between the two requires careful therapeutic monitoring.

Substitution should be made only under the close supervision of a transplant specialist.

Vaccine Storage Incident

As a result of a fridge fault the entire vaccine stock at a GP surgery had to be destroyed. This was normal practice as the stability of the stock could not be guaranteed.

Unfortunately the delivery of the replacement stock was inadvertently placed into the faulty fridge which had been switched off awaiting repair. This stock also had to be destroyed and the practice are currently reviewing their procedures to ensure all staff are aware of the correct procedure for handing vaccines.

PCT staff and contractors are reminded of the 'cold chain' requirements and the importance of regular fridge temperature monitoring.

Deliveries of vaccines must be placed in a temperature controlled fridge as soon as possible after receipt, and the temperature of the fridge must always be checked prior to stock being placed in the fridge.

Advice relating to fridge problems and the safe storage of vaccines can be obtained from the Medicines Management Team. Contact details as below

Reconciliation of Medicines

Communication of Medication Histories

A serious incident recently occurred in Leeds when a hospital pharmacist contacted a GP practice to obtain the medication history of a patient who had been admitted to hospital.

The medication history of a different patient was inadvertently given over the telephone and this was subsequently prescribed for the patient in hospital.

NHS Leeds advises practices to have a policy in place for the communication of patient medication histories to other healthcare professional to ensure sufficient information is provided for ongoing medical care.

When dealing with telephone requests we recommend that:

- the patients name and NHS number plus one other aspect of patient identifiable data, such as date of birth or address is checked to ensure the correct patients information has been selected.
- The name, position and contact details of the caller requesting the information is obtained and recorded in the patient record along with the information provided.
- verbal information provided is confirmed in writing e.g. by fax. (This must be to a secure fax number)

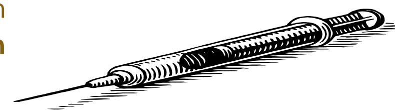
G-CSF Administration

G-CSF—Granulocyte colony stimulating factor such as Filgrastim®, Lenograstim® and Pegfilgrastim® should only be prescribed by those experienced in their use.

NHS Leeds staff recently reported an incident where G-CSF was prescribed as 'G-CSF 789 milligrams'

The intended drug and dose was subsequently confirmed as Lenograstim 789 **micrograms.** The patient was administered the correct drug and dose and no harm ensued.

This incident has been forwarded to the prescriber for information, asking for clarity when prescribing and staff are asked to note that treatment advice notes for these products may be written in **either** or **both** micrograms and units.



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