Medicines management newsletter - June 2017

Welcome to our fourth newsletter

This edition includes:

- Antihistamines for nasal allergies
- How to minimise the risks of medication errors with Rivastigmine patches
- Focus on CDs—Buprenorphine patches
- Medication errors and incidents

Antihistamines are often used in the treatment of nasal allergies, particularly seasonal allergic rhinitis (hay fever). They reduce rhinorrhoea (runny nose) and sneezing but are usually less effective for nasal congestion. Antihistamines can be used orally but also topically in the eye, in the nose, and on the skin. (BNF no 72)

They can be divided in two groups:

First Generation (or sedating antihistamines) include chlorpheniramine (Piriton), promethazine and hydroxyzine (Atarax). Due to their side effects profile - sedation, and more frequent dosing, they are not usually the first preferred option.

Second Generation (or non-sedating antihistamines)
Include: loratadine, cetirizine, fexofenadine. They are potentially less sedating compared to the first generation drugs but are not free of side effects. The most common side effects of antihistamines include: headache, dry mouth, feeling sick and some degree of drowsiness.

The elderly are more susceptible to side-effects and when used for seasonal allergies antihistamines should be reviewed and discontinued when no longer required.

Top tips to minimise the medication risks with

Rivastigmine patches

UkMi (UK Medicines Information) state:

The following mitigation actions can be considered to support safe use of Rivastigmine patches and reduce the risk of further incidents occurring:

Correct and timely application

- Patients and caregivers should be given clear instructions on the frequency of patch removal and renewal, and appropriate areas for application. They should be encouraged to keep a record of when the patch was removed and when it was replaced, for example by using the manufacturer provided medication record dairies or writing the day of the week or date on the patch with a thin ball point pen.
- Robust systems should be in place in healthcare settings e.g. care homes and hospitals, to ensure correct application of patches at the scheduled time.
- Pharmacy dispensing labels should make the frequency of patch removal and renewal clear e.g. "*Apply ONE patch every TWENTY-FOUR hours. Remove and discard old patch before applying a new patch to a different location.*"

Rivastigmine patches are classed as a critical medicine as understood in the National Patient Safety Agency Rapid Response Report NPSA/2010/RRR009.

Available brands of Rivastigmine patches (March 2017)

Brand	Strength	Frequency
Alzest	4.6mg & 9.5mg	24 hours transdermal patches
Exelon	4.6mg. 9.5mg & 13.3mg	24 hours transdermal patches
Prometax	4.6mg & 9.5mg	24 hours transdermal patches
Voleze	4.6mg. 9.5mg & 13.3mg	24 hours transdermal patches
Erastig	4.6mg. 9.5mg & 13.3mg	24 hours transdermal patches

Further generic products may also be available in the UK. Details of these patches can be found in the British National Formulary, Electronic Medicines Compendium and the MHRA website. Patient information leaflets for the above products can be found via www.emc.medicines org.uk

Focus on Controlled drugs (CDs)
Buprenorphine patches

The following incidents have been identified and reported by care homes:

- Buprenorphine patches not always being correctly stored in the CD cupboard. Instead the patches were kept with other patient medications.
- A patient was supplied with two different strengths of buprenorphine patches by two different pharmacies as one was prescribed and dispensed out of hours and so the usual pharmacy wasn't used.
- Two patients in one home were using another patient's patches.

Learning points:

- Buprenorphine patches are Schedule 3 CDs that require secure storage.
- There are two different formulations of buprenorphine patches one needs to be changed every 4 days and one needs to be changed every 7 days, to avoid confusion it is recommended that buprenorphine patches are prescribed by <u>brand</u> and not generically.
- When applying patches the patient name and strength of patch should be confirmed by <u>two</u> members of staff at the point of patch application.

Medication errors and incidents

The National Patient Safety Agency defines a medication error as an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred. Errors may result in an incident or an adverse event or where averted they can be classified as a 'near miss'.

Examples of administration errors can include the following:

- Omissions – any prescribed dose not given
- Extra dose given
- Wrong dose interval
- Wrong dose administered, too much or too little
- Unprescribed medicine – the administration to a resident of any medicine not authorised for them

What actions should be taken after discovering an incident?

The priority is to ensure the resident is safe, this may require contacting the resident's GP or other healthcare professional. When you are satisfied the resident is safe you should (as appropriate) notify The Care Quality Commission (CQC), safeguarding and the local authority commissioner .

Safeguarding contact details: 0345 140 0845 (Sefton Call centre) in the first instance – please give basic details.

The secure email route is **adult.socialcare@sefton.gcsx.gov.uk**

For very urgent safeguarding matters telephone 0151-934-3737

To contact CQC—please notify using the correct notification form either via the provider portal or from the CQC website.

If you have any queries please contact the medicines management team on

0151 247 7146

Email us at: SSCCG.Carehomereferral@nhs.net