PostScriptAcute

NHS Greater Glasgow and Clyde

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Information included is specific to the use of medicines in the **adult** setting.

Learning from incidents

Patient transfers and duplicate dosing

A patient was prescribed and administered two intravenous (IV) antibiotics on a receiving unit despite the fact that both drugs had already been administered one hour earlier in A&E. Duplicate dosing resulted in the patient receiving 2 g of amoxicillin and 680 mg of gentamicin within a two hour period.

Remember…

Staff receiving patients from A&E or other clinical areas **MUST** check **ALL** paperwork before prescribing or administering any medicines to avoid duplication

Key messages - general

- A&E departments will often prescribe and administer medicines before a Kardex is generated.
- A&E prescribing and administration paperwork must clearly document the medicines prescribed and, where applicable, administered.
- Best practice is to provide a verbal hand over when a patient is transferred to another clinical area. This should include details regarding the medicines administered and any *still to be* administered; this will help prevent both missed and duplicate doses.
- Staff likely to *receive* patients from A&E must be familiar with all A&E paperwork used for prescribing and administering medicines.

Key messages - gentamicin

- Treatment dose gentamicin should always be prescribed on the Kardex 'as per chart' and the 'GGC Gentamicin Prescription, Administration and Monitoring Chart' used to prescribe and administer individual doses (for further information on how to prescribe/administer gentamicin click here).
- If a Kardex has not yet been written, A&E staff should prescribe gentamicin 'as per chart' on the A&E record sheet and then use the separate GGC gentamicin chart to prescribe and administer individual doses for a patient.

Please note: It is important for staff *receiving* patients from A&E to continue to check ALL transfer paperwork (for evidence of doses prescribed and/or administered in A&E) before commencing gentamicin treatment.

IV iron and serious hypersensitivity reactions: new MHRA advice

Recent MHRA advice (August 2013), concerning safe prescribing and administration of intravenous (IV) iron, recommends strengthened measures to manage and minimise the risk of hypersensitivity reactions which may be life-threatening or fatal. Key points are outlined below: refer to MHRA advice for full details.

Prescribing

- An IV iron product should not be used in patients with known hypersensitivity to:
  - the active substance
  - the product itself
  - excipients in the product
  - other parenteral iron products
- The risk of hypersensitivity is increased in patients with:
  - known allergies (including drug allergies)
  - immune or inflammatory conditions (e.g. systemic lupus erythematosus, rheumatoid arthritis)
  - a history of severe asthma, eczema, or other atopic allergy

  In these patients, IV iron products should only be used if the benefits are clearly judged to outweigh the potential risks.
- IV iron should not be used during pregnancy unless clearly necessary and only under specialist advice. Treatment should be confined to the 2nd or 3rd trimesters, if the benefit is clearly judged to outweigh the potential risks for both mother and foetus.

Remember…

***Specific* product information for IV iron should always be consulted before use as information differs between individual products.**

Report any suspected adverse reactions via Yellow Card Scheme

Administration and monitoring

- IV iron should be administered in strict accordance with the product information for each individual product (advice varies between products).
- Caution is needed with **every** dose of intravenous iron that is given, even if previous administrations have been well tolerated.
- IV iron products should only be administered where there is immediate access to resuscitation facilities and staff trained to evaluate and manage anaphylactic or anaphylactoid reactions.
- Patients should be closely monitored for signs of hypersensitivity during, and for at least 30 minutes after **every** administration of an IV iron product.
- In the event of a hypersensitivity reaction, treatment should be stopped immediately and appropriate management initiated.

New advice regarding test dose

- Previously, an initial test dose has been recommended for some IV iron products before administration of the first dose to a new patient. However, there are no clear data that an initial test dose minimises risk: conversely, it may give false reassurance because hypersensitivity reactions have been reported in patients with a negative initial test dose.
- An initial test dose on first use of an IV iron product for a patient **is no longer recommended.** Individual product information will be updated to reflect this.
- Please note that the advice for administration of a product remains otherwise unchanged. For example, for iron dextran (Cosmofer®) a slower rate of administration for the first 25mg of iron is required for every dose.
- GGC protocols/guidelines for the use of IV iron should be reviewed in light of MHRA advice.

Informing patients

Healthcare professionals should inform patients of the risk and potential seriousness of a hypersensitivity reaction before **every** administration. Patients should be informed of the relevant symptoms and advised to tell their doctor or nurse straight away if any occur.

GGC Respiratory Inhaler Identification Guide

A new identification guide for respiratory inhalers is now available. It contains images of different inhaler preparations and spacer devices as an aid to identification. There is some limited dosage advice and examples of how inhalers should be prescribed on the Kardex. The main aim of the guide is to ensure patients receive the correct inhaler device during admission to hospital and reduce the wastage associated with the wrong inhalers being issued. The booklet will be introduced to all wards within GGC over the next couple of months.

Emergency Care Summary and medicines prescribed and supplied by specialist services

The Emergency Care Summary (ECS) is an important source of information for medicines reconciliation on admission to hospital. However, there are a number of drugs which are prescribed and supplied by hospital/specialist services and may not always be included in the GP prescribing record or the ECS.

There have been several cases of patient harm and near misses involving patients not receiving therapy, or being prescribed duplicate therapy or interacting medication, as a result of an "incomplete" prescribing record.

Case example:

Clozapine was omitted on admission to an acute hospital resulting in a worsening of mental state and subsequent admission to a mental health hospital. Restarting clozapine after missed doses without appropriate titration is also potentially dangerous (for further information see previous Postscript Acute bulletin).

There is no definitive list of such "specialist prescribed" drugs however the most common ones include:

- Addiction services: methadone, disulfiram
- Smoking cessation / community pharmacy: varenicline
- Mental health: clozapine, antipsychotic depot injections
- Sexual health/HIV: HIV drugs, contraception via Sandyford
- Rheumatology: etanercept, adalimumab
- Endocrinology: IV bisphosphonates, eg zoledronic acid
- Chemotherapy
- Homecare: darbepoetin, immunoglobulins

GPs are actively encouraged to add such medicines to their record. Historically however, there have been technological barriers related to their IT prescribing systems which have discouraged them from doing so. This has recently been addressed and GGC good practice guidance has been provided for GPs on how to record medicines that they are not prescribing or supplying. There are several benefits to this and a key advantage for those working in the acute sector is an improvement in accuracy of the ECS and subsequent medicines reconciliation. This issue has also been covered in the main Postscript bulletin.

Remember…

There may still be gaps in the ECS relating to medicines prescribed and supplied by specialist services. Two independent sources of information should always be used for medicines reconciliation.

New Vancomycin Prescription Chart Coming Soon………

A new vancomycin prescription chart is currently being piloted in several sites across GGC and is planned for rollout out early 2014.

Contra-indications to apixaban, dabigatran and rivaroxaban

Recent MHRA advice (October 2013), reminds prescribers of the major bleeding risk with apixaban dabigatran and rivaroxaban and highlights the clinical conditions where the drugs are contra-indicated.

Special care should be taken when prescribing these anticoagulant medicines to patients with other conditions, procedures, and concomitant treatments (eg, NSAIDs, antiplatelets), which may increase the risk of major bleeding. There is no specific antidote for any of the new oral anticoagulants. For advice on the management of bleeding complications or overdose, please consult the product information and local guidelines (dabigatran, rivaroxaban or apixaban).

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Guideline news

NHSGGC Acute Care Guidelines
Diagnosis and management of heparin induced thrombocytopenia
SIGN Clinical Guidelines
Management of epithelial ovarian cancer (SIGN 135)
NICE Clinical Guidelines
Myocardial infarction: secondary prevention (CG 172)
Neuropathic pain: pharmacological management (CG 173)

BNF LearnPro module

A LearnPro module on using the BNF has been developed for nursing staff. Although developed for nursing staff the module is appropriate for all staff who use the BNF in practice and is of relevance to newly qualified and experienced staff alike. The BNF is a core resource for information about medicines in daily use on every ward. This module covers the basic use of the BNF but will also give you some pointers to less well known BNF sections that are useful but underused. The module can be found here.

Seasons greetings to all our readers and best wishes for 2014!