IMSN Medication Safety Bulletin

Edition 1. February 2022

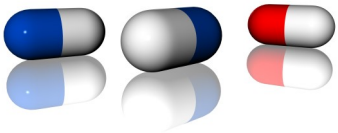
IRISH MEDICATION SAFETY NETWORK

Improving patient safety with regard to the use of medicines.

NEW YEAR, NEW ME, NEW BULLETIN

Welcome to the first edition of the IMSN Medication Safety Bulletin. The Irish Medication Safety Network (IMSN), established in 2007, is a voluntary, independent group of hospital pharmacy based specialists with an interest in medication safety.

Our principal aim is to improve patient safety with regard to the use of medicines.



We promote the exchange of information on medication safety and facilitate national and global initiatives to help minimize risks to patients. This includes development of best-practice guidelines and alerts, and convening an annual conference for education and networking. For more information on the activities of the IMSN and to check out supporting resources produced by the IMSN, visit www.imsn.ie or follow us on twitter @ IMSN_ie.

In our twice yearly bulletin (our New Year's resolution!), we will highlight items of interest regarding safe medication use in hospitals to Irish healthcare professionals.

2021 IMSN conference

The 2021 IMSN virtual conference took place on the 26th November and was attended by 381 delegates. The conference focused on innovation to support medication safety and we were privileged to have a host of excellent speakers providing the attendees with updates and examples of international, national and local innovative practice on:

- Outcomes of the International Medication Safety Network COVID-19 Vaccine Safety Interest Group
- Development and delivery of a mass vaccination programme for COVID-19 in Ireland through a Medication Safety lens
- Irish Hospital Medication Management Programme progress and vision
- Medicines Optimisation in Primary Care– iSimpathy Project
- Irish hospital initiatives to improve safe use of medicines (including antithrombotic stewardship, frailty intervention, and electronic options of ClearScribe and ePrescribing for Chemotherapy)

Check out www.imsn.ie for access to conference presentations.

SAVE THE DATE:
25th November
IMSN Conference
2022

WEBSITE:
www.imsn.ie

EMAIL:
enquiries@imsn.ie

TWITTER: @ IMSN_ie

WHAT DID I MISS?

New publications from IMSN (www.imsn.ie: Publications/Alerts)

eTRANSMISSION

IMSN Position Paper on electronic transmission of prescriptions from hospitals was published in November 2021. It considers barriers, & facilitators to implementing this change, highlighting risks and potential risk-reduction strategies.

DOACs

The Patient Information Booklet 'Anticoagulation in Atrial Fibrillation' has been updated. It can be accessed on the website (along with a Patient Information video) or ordered from your Bayer representative.

METHOTREXATE

Safety Alert for Once-Weekly Methotrexate was revised and updated in May 2021.

Top tips are included on how to reduce the risk of error in hospitals.

TO ERR IS HUMAN, TO LEARN IS DIVINE...

Utilising the Irish Medication Safety Network, the below section is intended to highlight some medication incidents reported in Irish hospitals to share learning with others.

- 79 year old patient admitted to ward post fall.
- Was on 15mg temazepam pre-admission, prescribed 50mg upon admission– unintentional dosing error.
- Administered by junior member of staff (staff shortages).
- Patient found to be very drowsy with unequal pupils and unreactive the following morning. Recovered after supportive care. Of note, zolpidem 10mg also prescribed (new addition, not prescribed prior to admission).

- Patient on dual antiplatelet therapy (aspirin and prasugrel) prior to admission.
- Aspirin and clopidogrel initially charted in the kardex before clopidogrel crossed out and prasugrel prescribed.
- Unintentional transcription error from kardex onto the discharge script – where aspirin and prasugrel and clopidogrel were co-prescribed.
- At point of dispensing in the community, the combination was queried with patient but dispensed.
- Patient developed significant epistaxis and multiple bruising / black marks under skin over the coming days. This resolved once clopidogrel was stopped.

- Tresiba® (insulin degludec) 200units/ml prescribed which was interpreted as the dose to be administered. Intended dose was 17 units but this was absent from the prescription.
- 200units was administered and error realised ~5 minutes later. Urgent call to Medical team.
- Patient was reviewed, put on glucose replacement and monitored in HDU. Patient remained stable, asymptomatic and made a good recovery attributed to the quick action of staff and the fact the insulin was not rapid-acting. The incident happened out-of-hours, at time of handover and was double checked by a person from night shift leaving the ward which were considered contributory factors.