IMSN Medication Safety Bulletin

Edition 2. September 2022

IRISH MEDICATION SAFETY NETWORK

Improving patient safety with regard to the use of medicines.

2022 IMSN Conference– Save the date 25th November

The final touches are being added to the IMSN Conference "Collaborative Medication Safety" 2022 plans. This will be delivered virtually on the 25th Nov from 10am to 2pm and is lining up to be a very informative and enriching meeting.
A host of speakers include HIQA regarding their revised monitoring approach to medication safety in acute hospitals, an update from HSE Incident management, the latest news from Medicines Optimisation in Primary care (iSimpathy project), and a number of initiatives from Irish hospitals will be presented. ***Keep an eye on the website for the conference programme and registration details***

Have you been involved in a Irish hospital Medication Safety initiative? Share your experience with others by submitting an abstract to the IMSN conference to enquiries@imsn.ie *by 5pm on Friday September 9th 2022.* A selection of projects will be chosen for a brief oral presentation at the conference.

Hot topics near and far

WORLD PATIENT SAFETY DAY

As per the WHO, the theme for World Patient Day on the 17th Sept. 2022 is **Medication Safety!**

INJECTABLE MEDS

The EAHP have convened a SIG to examine and eliminate avoidable harm from injectable medicines including supply, preparation and administration. The IMSN have an active participant on this group.

OXYTOCIN

Safeguarding the use of oxytocin has been identified as a new Targeted Medication Safety Best Practices for Hospitals by ISMP USA. Improper use and administration of oxytocin has led to fetal hypoxia, maternal morbidity and, maternal, fetal and neonatal deaths. The International Medication Safety Network has developed a Oxytocin Safety SIG to further address the safe use of oxytocin **globally.** The IMSN have an active participant on this group.

WEBSITE: www.imsn.ie
EMAIL: enquiries@imsn.ie
TWITTER: @ IMSN_ie

Lithium Therapy
Patient Information Booklet

A National Patient Information Booklet for 'Lithium' has been developed. It has been reviewed and endorsed by St John of God's DTC, HSE Medication Safety Programme, IMSN, IPU, College of Psychiatrists and the ICGP. It has also been awarded the plain English Mark by NALA.

A National Print is being supported by HSE's National Quality and Patient Safety Directorate, and hardcopies will be distributed to Hospital and Community Pharmacies, and Community Mental Health Teams in September. An electronic version will be uploaded on IMSN website when available.

HEADS-UP

A recent MHRA alert has reinforced risks with Denosumab (*Prolia®*).

- An increased risk of multiple vertebral fractures have been reported in patients within 18mths of stopping or delaying ongoing denosumab treatment for osteoporosis, some within the first 9mths. Patients with previous vertebral fractures may be at highest risk.

- The current advice to patients is that the next injection **should not be delayed for more than four weeks**, as the benefits wear off quickly, which can cause a sudden drop in bone density and increases your risk of spinal fractures. Patients should not stop denosumab without specialist review.
- The optimal duration of denosumab has not been established, and ongoing treatment should be periodically re-evaluated, particularly after 5 or more years of use. Risks of long-term treatment with denosumab include rare cases of osteonecrosis of the jaw and atypical femoral fractures.

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. The IMSN endorse the use of ***Assess-ERR™*** Medication System Worksheets to help error report investigations, and to collect critical information after a medication error or near-miss occurs. https://www.ismp.org/resources/assess-err-worksheets

Dexamethasone SDU, 1 1-hourly for 3 days, then 2-hourly for 3 days, with increasing interval over a number of weeks post eye procedure. SDU represented single dose units (i.e. minims, eye drops)-unapproved/unrecognised abbreviation. Patient got dispensed Dexamethasone 2mg tablets and took according to instructions on label. Patient got admitted to hospital unwell with perforated ulcer and anaemia. Dexamethasone 2mg oral equivalent to approx. 12mg prednisolone.

Continuity of supply on discharge

Two different hospitals reported similar incidents relating to discharge of patients on Linezolid. Neither patient was provided with a high-tech prescription, community pharmacy did not stock in absence of same. Neither patient could access linezolid for 2-3 days post discharge. In one case, for treatment of a CNS infection, patient was readmitted to hospital with dizziness and collapse 3 days post discharge

Mix-ups with opioid release profiles

MST Continus® and Sevredol®

Patient prescribed morphine sulphate MR 80mg BD PO. Sevredol® administered instead of MST Continus® for 3 doses. Resulted in patient pain and requirement for breakthrough doses. Error detected because the meaning of 'MR' (Modified Release) was queried by a nurse to the pharmacist.

Palladone SR (slow-release)® and Palladone IR (immediate-release)®

Palladone® SR 2mg PRN prescribed rather than Palladone® IR 2.6 mg PRN. Patient received four doses over 24 hours. Error detected by pharmacist, patient required monitoring for opiate toxicity.