IMSN Medication Safety Bulletin

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IRISH MEDICATION SAFETY NETWORK

Improving patient safety with regard to the use of medicines.

IMSN Conference 2023

The final touches are being made to the 2023 IMSN Conference which is taking place on Friday 24th Nov in University College Cork themed "*Smarter technology for a safer tomorrow*"

It is shaping up to be a great line-up with some of the highlights listed below:

- Introduction to the National Pharmacy eHealth Group
- Outcomes from IMSN Electronic Health Record (EHR) Medication Safety Working Group
- EHR Design/Delivery Manager for Children's Health Ireland
- Hospital Medicines Management System (HMMS) & Medication Safety
- National e-Prescribing Project progress
- Medicines optimisation for older community-dwelling people with multi-morbidity

Details of the full programme can be found at www.imsn.ie/conference.

In the event you have not received an Eventbrite invite but would like to attend please contact us at **conference@imsn.ie**

Presentations will be made available online at www.imsn.ie after the conference

Tribute to Sarah Fagan

The IMSN, and Pharmacy colleagues near and far, were deeply saddened to hear of the tragic loss of Sarah Fagan on 29th July 2023.

With over 20 years of experience, Sarah brought so much to the table. She was a highly esteemed, passionate and active member of the IMSN for a number of years. This included her role as membership secretary of the IMSN executive.

Her contributions to patient safety and medication safety for the Network have been significant and these were always undertaken with an effortless smile, a word of encouragement to teammates, a practicality and sensibility, an incredible work ethic, compassion and kindness, not to mention a witty sense of humour. It was an absolute pleasure and privilege to have her at our side, and we will miss her dearly.

We extend our sincere condolences, our thoughts and our prayers to her family, friends and loved ones at this difficult time. *Ar dheis Dé go raibh a hAnam.*

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CATCH THE PATCH

A number of incidents have been highlighted to the IMSN in relation to opioid patches. The incidents related to not removing an old patch when applying a new patch and subsequently finding multiple patches on patients that had been left on longer than prescribed resulting in harm.

Patient on examination had several transdermal patches on her abdomen – 2 x 25microgram Matrifen® patch applied as per medication chart as an inpatient but the patient already had a 50microgram patch present that had been applied by patient at home. This should have been removed when new patches were applied. Patient appeared drowsy on examination with signs of opiate toxicity. Anaesthetics were called to review the patient, opioid patches were removed and patient's condition stabilised.

Patient with deteriorating GCS was examined and found to have 2 Butrans® 5microgram patch - one on left shoulder and one on right shoulder.
Patient was prescribed 1x Butrans® 5 microgram patch weekly. The original patch had been applied at home but had not been removed when new patch was applied. Patient was given naloxone to address opiate toxicity.

Safe Practice Recommendations:

- A medication history should be collected from each patient upon admission and the presence of any transdermal patches at this time should be ascertained. The current location of the patch should be identified, information on what and when it was applied, and this should be documented clearly.

Fig 1 **Documentation of patch prescription and application in the drug chart**

- The patient's skin should always be checked prior to applying a new patch to ensure old patch is removed, noting that many are small in size and may either be clear or beige in colour. **'Off' and 'On'** should be documented in the administration section of the medication chart as standard practice.

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

Utilising the Irish Medication Safety Network, the below section highlights 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

- Elective patient prescribed 90mg of duloxetine on admission to hospital (determined by Doctor phone call to community pharmacist).
- Patient deteriorated during admission, loss of baseline mobility, confusion, muscle rigidity, temperature, bradycardic– subsequently identified as serotonin syndrome and duloxetine discontinued (>3 weeks of duloxetine).
- Root cause identified as incorrect dose of duloxetine communicated on admission. GP recently commenced patient on 60mg duloxetine then days later issued new Rx reducing to 30mg (due to patient renal impairment).
- Community pharmacy communicated to hospital that patient had recent 60mg Rx and 30mg Rx resulting in 90mg being prescribed on admission. Unintentional communication error. On questioning, patients relative also informed team the patient was not taking either dose regularly prior to admission, so patient was essentially initiated on 90mg on admission to hospital.

- Patient on HIV medications (from pre-admission) was discharged on new secondary prevention post MI, including ticagrelor and atorvastatin 80mg daily.
- Several months later the patient attended cardiac rehab and the pharmacist conducted medication review.
- Ticagrelor identified as contraindicated (increased bleeding risk) and high strength atorvastatin not recommended (risk of rhabdomyolysis)
- On questioning the patient reported waking up regularly to presence of blood in their mouth and also reported muscle pain. Suspected ADRs secondary to drug interactions. Corrective action taken, including review and change of ticagrelor and atorvastatin.
- Contributory factors: HIV meds dispensed (6mths supply) from specialist centre- community pharmacy were not aware the patient was on these medications. No clinical pharmacist review/interaction check prior to discharge.

Patient A admitted from nursing home. Accompanied by Patient B's list of medications which were sent in error. These were prescribed for Patient A who received one dose of each (including DOAC, levetiracetam, metformin). Error identified on ward transfer, when patient identified as drowsy which was investigated. Remedial and corrective action taken, including monitoring. No subsequent harm.