Clinical Governance

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Room Specification for Local Enhanced Services and Infection Prevention and Control Guidance/Recommendations

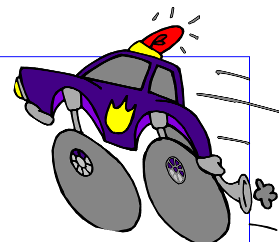
Rather than being prescriptive, the above document, which is to be released shortly, is intended to offer the latest guidance and recommendations. This will enable pharmacies that are considering improving their premises, such as through the installation of new consultation rooms, to "future proof" any development.
Since all Primary Care NHS providers are subject to the same infection prevention and control regulations as other parts of the Health Service, the specifications contained in the document are applicable to all independent contractors, pharmacies, GPs, dentists and optometrists.
As the range of services delivered from community pharmacy premises varies it is recognised that not all of this guidance will be relevant to all pharmacies. However, it offers detailed IPC guidance and recommendations in assuring clean, safe practice.
As well as guidance on premises, the above document also includes a section on standard infection control precautions. Pharmacies that offer patient testing or needle exchange facilities should have an infection control policy in place and the above guidance may be referred to within an over-arching SOP.

Methotrexate 10mg

NHS Sheffield and Sheffield Teaching Hospitals are keen to reduce the risk to patients being treated with methotrexate. For this reason patients should only be prescribed and supplied with the 2.5mg tablet. Unfortunately, since this is local rather than national guidance there is no ready solution to ensure that this is the only option on GP systems. As a result, prescriptions are still being issued for the 10mg tablet, partly at the request of some patients who prefer the reduced tablet load with the higher strength tablet.
In a recent incident a patient previously taking 4 X 2.5mg was prescribed the 10mg tablet and inadvertently took four tablets instead of one. Fortunately the patient realised their mistake and presented at A & E for subsequent blood tests.
To improve patient safety, please can the pharmacist query with the prescriber any prescriptions for the 10mg tablet.
Finally, can I remind pharmacists to be alert to the interaction between trimethoprim and methotrexate.

Disposal of Unwanted Medicines Service

The August edition of the Community Pharmacy News (PSNC) included an article highlighting some recent changes to the requirements for registration of the exemption from the waste management licensing regulations. One of the three major changes reported in the article noted that: "There is no longer a prohibition on accepting waste from a nursing home or GP surgery". However, there have been no changes to the service specification for Essential Service 3—Disposal of unwanted drugs.
Please note that NHS Sheffield has not agreed to fund any such extension to the waste collection from pharmacies that includes this waste.



Quickies

Service Level Agreements (SLAs)
Earlier this month an annual Service Level Agreement was issued* covering most of the enhanced services commissioned by NHS Sheffield (the PCT). In the agreement contractors are asked to complete details of the providing pharmacist(s) for those services where accreditation is a requirement. Where there have been any material changes, such as where an accredited pharmacist leaves or a new pharmacist is appointed to post, then NHS Sheffield must be informed within 10 days.
* These have been sent directly to some pharmacies although a number have been sent to the head offices of others, such as some multiples.

H-Pylori Training—a reminder
There are a limited number of places remaining for the next H-Pylori training which takes place here at NHS Sheffield on Thursday 14 October from 2.00pm—3.00pm. To reserve a seat please contact Jo Tsoneva (0114 305 1274), but hurry, they are going fast!

Xyrem (Sodium Oxybate) - Warning
There is a potential for a dosing error due to confusion between grams & millilitres with Xyrem (Sodium Oxybate). The measuring syringe supplied by the manufacturer is labelled in grams on one side and mls on the other. The recommended starting dose is 4.5g/day divided into 2 equal doses of 2.25g. The strength is 500mg/ml - so if it is labelled as 9ml per day, the patient could interpret this as 9g per day as that's the "9" on the syringe. Consequently the dispensing label should be absolutely clear for the patient who may otherwise be confused by the units. The dispensing pharmacy is strongly advised to examine the supplied syringe and clarify the dose with the patient/carer.

Quality Manager (Independent Contractors and Care Homes)
NHS Sheffield has appointed Lisa Falconer as the Quality Manager (Independent Contractors and Care Homes). Working within the Clinical Governance Team, Lisa's remit includes community pharmacy and she has expressed a wish to work with pharmacies to understand quality issues faced by contractors and to help resolve areas of concern. She is happy to be contacted on (0114) 305 1192.

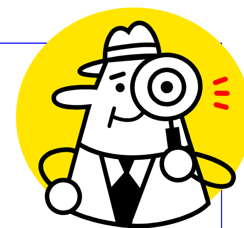
Recent Alerts
1) Contact Lens Solution. A product recall has been issued for AMO Complete® multi-purpose solution. This applies to the following packs, which should be returned to the supplier. Any patients that have suffered adverse effects should be reported to the Medicines Healthcare Regulatory Authority. (http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Devices/index.htm)

Complete® multi-purpose solution – affected lots in the UK			
Product code	**Bottle size**	**Lot number**	**Expiration date**
93505	360 ml	AH01072	April 2012
93515	240 ml	AH01225	April 2012

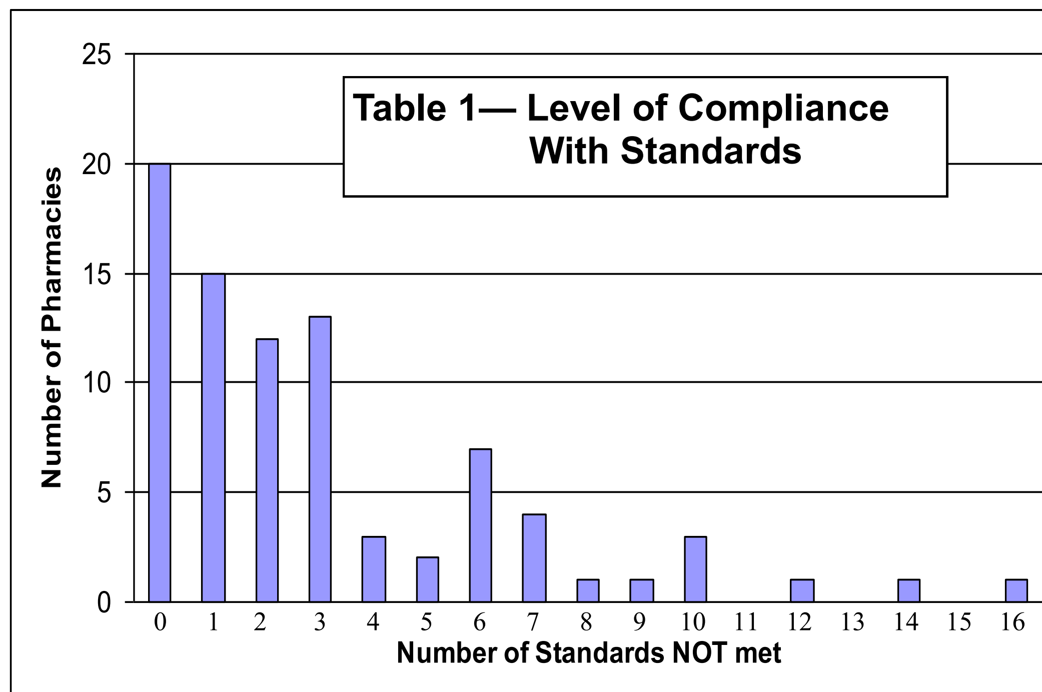
2) Window Cords. Looped cords and chains on window blinds can present a strangulation hazard to children and vulnerable adults. There have been a number of deaths associated with these types of blind cords throughout the UK. Risk assessments should be carried out on looped blind cords, primarily in healthcare environments where children and vulnerable adults are commonly present.

3) Faulty 'Durabrand' Microwave Appliance. In April 2009, the Fire Service attended an incident in a hospital ward involving a 'Durabrand' microwave oven, which had overheated and filled the room with smoke. The run-back timing mechanism appeared to have jammed, resulting in the oven being permanently 'on'. As a result ASDA has recalled all 'Durabrand' domestic microwave ovens (model XB2316) due to a fault with the timer mechanism. A product recall notice was posted in ASDA stores on 1st February, and press advertisements were run on 2nd February 2008 detailing the model implicated and action required. Any pharmacy that is equipped with this model microwave should return it to any ASDA store for a full refund (retail price £22.75). The original packaging and receipt are not required.

Community Pharmacy Contract Monitoring—an update



Between April 2008 and March 2010 a total of 84 contract monitoring visits were made by teams of assessors to community pharmacies. Generally, standards were found to be good with 60 pharmacies achieving at least 51 out of a possible 54 essential service standards. At the opposite end of the scale, 8 pharmacies failed to meet 8 or more standards. (Table 1— Level of Compliance with Standards).



Of the standards not met, Table 2 identifies the "Top 10". Internal Clinical Audit is giving cause for concern with 23 pharmacies failing to meet this standard. Keeping records of Signposting and Healthy Lifestyles are also areas of weakness. However, pharmacies have recently been sent template record sheets so hopefully this will help to improve compliance with this standard. Another area of concern is evidence of participation in CPD, 15 pharmacies unable to demonstrate compliance with this standard.

Essential Service	Standard	Pharmacies not meeting standard
ES8 Clinical Governance (Clinical Audit)	Internal Clinical Audit	23
ES5 Signposting	Records	20
ES4 Healthy Lifestyle	Records	20
ES5 Signposting	Written Referral	19
ES8 Clinical Governance (Education, Training & CPD)	Evidence of CPD	15
ES6 Support for Self Care	Provision of Leaflets	12
ES6 Support for Self Care	Records	12
ES8 Clinical Governance (Risk Management)	Equipment	12
ES4 Healthy Lifestyle	Records	12
ES8 Clinical Governance (Staffing & Staff Management)	Development Needs	11

Table 2— "Top 10" Standards not met

Dispensing Awareness—Picking Errors

Dispensing errors reported to the PCT are logged onto a system known as DATIX which enables a useful analysis of the data. From this data it was identified that 12% of errors were due to incorrect product selection. (See Table).

What was prescribed	What was dispensed
Ferrous Sulphate	Ferrous Fumarate
Diazepam	Temazepam
Atenolol	Amitriptyline
Oxycontin	Oxynorm
Paracetamol	Co-codamol
Mefenamic Acid	Metformin
Erythromycin	Penicillin
Subutex	Suboxone
Ramipril	Amlodipine
Class I Stockings	Class III Stockings
Frusemide	Fluoxetine
Hydralazine	Hydroxyzine

Table 1—Identified Picking Errors

The Royal Pharmaceutical Society has issued a Law and Ethics Bulletin entitled "Handling Medicinal Products with Similar Names" which is available on their website:- (http://www.rpsgb.org/pdfs/LEBhandmedprods.pdf)

The bulletin highlights the need to put stock to shelf correctly when unpacking orders. Pharmacists should consider separating stock with similar names, although this may lead to difficulties locating medicines. Importantly, stock should be correctly "faced" on the shelf, all packs neatly orientated, the name/strength clearly visible. Unfortunately, some generics manufacturers are guilty of poor pack design and colour choice, leading to an increased risk of error.

Referring to the near miss log would assist in identifying those medicines that are more likely to be picked in error. For this reason the log should provide an accurate record of near-misses to enable the contents of the log to be used as a tool to aid improvements in patient safety.

A robust checking process, which includes asking staff to check their own work before passing the prescription on for the final accuracy check will reduce the likelihood of dispensing errors. Although staff can develop their own checking process they should be encouraged to use a simple mnemonic, such as "HELP". This improves the check by making it more systematic.

HOW MANY
EXPIRY DATE
LABEL
PRODUCT

Returned Sharps

The pharmacy development unit have taken a number of calls recently asking for a collection of sharps which have been returned by patients. NHS Sheffield is unable to arrange for the collection of such clinical waste.

The recommended method of disposal of sharps by patients is, ideally, through the GP surgery or through the local authority, which has a duty to arrange safe disposal of sharps. A pharmacy is only able to accept waste medicines from households but this does not extend to other clinical wastes, for example needles and syringes, as they are not 'medicines'. The only exception to this is for the return of sharps under the needle exchange programme. However, patients must NOT be advised to take their sharps to pharmacies providing a needle exchange service, as this is funded by the Drug & Alcohol Action Team (DAAT).

Safer Lithium Therapy

Analysis of errors reported to the National Patient Safety Agency (NPSA) Reporting and Learning System suggests lithium therapy is an error-prone process. The analysis identified that the monitoring of lithium therapy is an area of concern leading to the issue of an alert in December 2009 by the NPSA .
As with the Warfarin alert, there is an onus on the dispensing pharmacy to confirm that the patient is being monitored, specifically in this case, their thyroid function and lithium levels . The pharmacy should also check that the results of the blood tests fall within an acceptable range. The lithium patient will have been supplied with a record book which must be presented with the prescription. This will highlight both the result and the range. Although the patients are told to present the record book each time they bring a prescription to the pharmacy there will be occasions when this is not the case. As a principle, however, therapy should not be withheld. Where it is not possible to assess monitoring, the pharmacist responsible for dispensing a prescription (or making an emergency supply), should communicate to the prescriber that lithium medication has been provided without blood test data being available. Of particular concern are those patients who are in residential care. Dispensing processes will need to reflect the need to contact the care home where a copy of the results should be held.
There are a number of resources available on the NPSA website, including a Standard Operating Procedure developed in conjunction with the National Pharmacy Association. This can be adapted for use in your pharmacy.

http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=65426&p=2

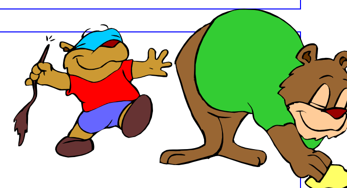
Specials Audit

You should have received a copy of the PCT led, multi-disciplinary audit for 2010-11 based on the supply of 'Specials'. Please note that the audit period is for the month of September only.
As highlighted in the letter accompanying the audit documentation, pharmacies are being paid £15 for each change from an unlicensed 'Special' to a licensed product. For this reason pharmacies should not submit claims under the Not Dispensed scheme for a 'Specials' product during the month of September as any such claims will not be accepted.

Pharmacy Declaration

Although the deadline was set for 23rd July, there are still a number of pharmacies yet to return the Contractual Framework Self-Declaration. Any outstanding declarations should be submitted to Rachel Brooks, Quality Standards Co-ordinator, at the PCT.

Tail-piece



Don't get caught out this year over the festive season! As Christmas day falls on a Saturday, Monday 27 December has been declared a Bank Holiday. Pharmacies are not required to open on either of these days in order to meet their requirement to be open for 40/100 hours. However, Boxing day (Sunday 26 December 2010) is not declared as a Bank Holiday so any pharmacy normally open on Sundays will need to apply for permission to close (where Sunday is included in core hours) or notify the PCT (where Sunday is classed as supplementary hours).
New Year's Day falls on Saturday 1 January 2011 and is not classed as a Bank Holiday. Pharmacies that are normally open on Saturdays will need to notify the PCT if they intend to close (where Saturday is classed as supplementary hours), or apply for permission to close (where Saturday is classed as score hours)
All applications to change hours must be made giving 90 days notice

No: 19 31/08/10

Drug Alert

Following the alert issued on Friday 27th August we can now confirm the death of a heroin user in Loughborough on Thursday evening was as a result of using heroin contaminated with Anthrax.

Please ensure your service users are aware of the following harm reduction messages:

There is no safe route for consuming heroin (or other drugs) that may be contaminated with anthrax as there is a potential serious risk from inhaling or smoking the anthrax, as well as from injecting it.

Anthrax can be cured with antibiotics, if the medical treatment is started early.

It is therefore important to know what sorts of symptoms and signs to look for, so that there are **no delays in obtaining the necessary treatment.**

The symptoms and signs include: severe swelling or redness around a wound site, which may be painless; pain at a site where you have previously injected; an open sore or wound; pus collecting under the skin; or a more generalised and severe flu-like illness (with muscle aches, headache, tiredness and high fever).

If you have used heroin and suspect that you have any or all of these symptoms, especially if the infection seems different to others you may have had in the past - **seek medical attention as a matter or urgency, either from your GP or local Accident & Emergency Department.**

Drug users currently in drug treatment, should stop using heroin altogether. Heroin users not in drug treatment should stop using heroin if possible and talk to a doctor or someone at a drug service about starting on a prescribed alternative drug (such as methadone or buprenorphine) and/or other treatment options.

Disclaimer
The purpose of the attached information is to ensure that all our partners are updated on current drug warnings, alerts or potential risks – as received by Leicestershire DAAT and Rutland DAAT.

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TACKLING DRUGS CHANGING LIVES