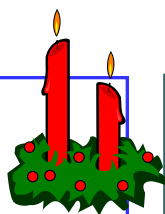


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Pseudoephedrine Controls—a success story

In April 2008, a number of restrictions governing the sale of ephedrine and pseudoephedrine containing products came into force. Accordingly, it became illegal to sell or supply any product that contains more than 720 mg pseudoephedrine or 180 mg ephedrine without a prescription. It also became illegal to sell or supply a combination of products that between them add up to more than 720 mg pseudoephedrine or 180 mg ephedrine without a prescription. Finally, it became illegal to sell or supply a product that contains pseudoephedrine and a product that contains ephedrine in one transaction

Furthermore, the Royal Pharmaceutical Society of Great Britain advised that the sale and supply of these products must be made by a pharmacist or suitably trained pharmacy staff under the supervision of a pharmacist.

Following a review of these measures the Commission on Human Medicines (CHM) has commended community pharmacy for their significant contribution to the control of these substances. The actions by the profession have been extremely effective, between July 2009 and July 2010, there have been no new reports of the misuse of these medicines (see [Pseudo-ephedrine and ephedrine: Managing the risk of misuse of medicines - July 2010 update](#)). However, the CHM recommended that the existing levels of monitoring, education, and awareness measures by pharmacists should be maintained.

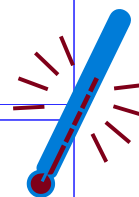
Cold-calls to patients

Following an alert raised by two pharmacies in Barnsley, Sheffield pharmacists are advised to report any suspicious, unauthorised approaches made to their patients. In Barnsley there have been three reports involving cold-calling patients seeking information regarding their health status, medicines, previous operations, etc. In one case the patient was told by the caller that they were taking too many medicines and is likely to be suffering unwanted side-effects. In another case the patient was offered a medication review over the phone by a company called 'Health Court'. All patients were elderly and hence likely to be vulnerable. In two of the three reported cases the patient was suspicious and no information was given but the third patient did give out personal details before saying that they would only take advice from their GP.

Calibration of fridge thermometers

Pharmacists have a responsibility to ensure that stock is handled and stored appropriately. The storage of vaccines and other preparations requiring refrigerated storage is of special concern and the following points should be noted, including the need to calibrate the thermometer:

- Fridge temperatures should be checked and recorded daily.
- Manufacturers' instructions for vaccine storage temperatures should be followed.
- Recorded temperatures should be between 2°C - 8°C, aim for 5°C giving a safety margin of +/- 3°C (Health Protection Agency 2008).
- If the temperature falls below or goes above the required temperature the pharmacist should ensure there are written procedures and systems in place to take appropriate action.
- The calibration of thermometers should be checked annually to ensure they are working correctly.

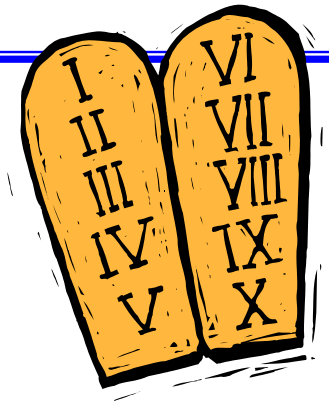


Safer compliance aids

Community pharmacists, GP practices and the pharmacies within Sheffield Teaching Hospitals are under increasing pressure to supply patient's medication in MDS packs, such as NOMAD systems. Compliance aids are intended to assist the patient, although in many cases they are requested for the convenience of carers and support workers.

There have been a number of patient safety incidents recently in Sheffield, which have involved Monitored Dosage Systems and therefore it is appropriate to raise some of the issues. The process of dispensing into such systems is not without risk and, for a number of particular preparations, may be pharmaceutically inappropriate. Furthermore, patients and their carers who administer from these packs must understand how to use the system properly and should have received the necessary training from a member of the pharmacy team. The patient's understanding should not be taken for granted and it would be good practice to assess the self medicating patient at least annually since their abilities may deteriorate with time.

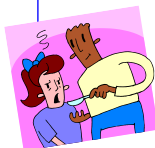
1. **Medication packed into a MDS tray has a limited shelf life.** In guidance issued by the RPSGB pharmacists are advised that "medicines must not be left in sealed monitored dosage systems for longer than eight weeks". There was a useful article, written by Claire Church and Jane Smith, published in the PJ "How stable are medicines moved from original packs into compliance aids?" (Pharmaceutical Journal, 21 January 2006 (Vol 276), p 75). I would recommend pharmacists to access this resource.
2. **Patients must not simply be supplied with the tray inserts;** the complete pack must be supplied sealed and including the product description, directions and warnings. Patients should also be supplied with patient leaflets. Ideally, the pharmacy will have sufficient stocks of the outer tray to ensure the supply of a complete pack. However, it may be acceptable for a competent member of the pharmacy team to deliver a tray and insert it into the outer case.
3. **It is poor practice to supply an MDS patient with four weeks worth of medication in weekly trays without good reason.** For example, it might be appropriate to supply four weeks to a patient going away on holiday. However, it is not unknown for carers and support workers to request for the whole month for their own convenience. Pharmacists should exercise their professional judgement in all cases and only make exceptions to good practice when it is considered appropriate. Where the pharmacist obtains weekly prescriptions then the packs must be supplied weekly. The pharmacist may decide whether to assemble all four weeks at one time or on a weekly basis. Whichever is the case, if there is a change in medicines during the month then there is an opportunity to adjust the contents of the packs.
4. **Requests for NOMAD, or similar systems, should only be met by the pharmacy following an assessment of the patient's needs,** which can be done as part of an MUR. We are currently working to adopt a suitable assessment toolkit which is intended to identify those patients who would benefit from a compliance aid. The toolkit will also identify other forms of support as an alternative to the supply of MDS.
5. **There should be good communication between the surgery and the pharmacy.** Pharmacists are often unaware that the patient has been admitted or discharged from hospital or intermediate care. With good lines of communication and if the surgery had a list of MDS patients associated with your pharmacy then perhaps they could be encouraged to keep the pharmacy informed as to patient movements. Work is being done to improve the interface between primary and secondary care but progress is often slow.
6. **Medication being delivered to the patient's home must not be left unattended.** There have been cases where the medicines have been left in the 'coal cupboard' or garden shed. This is not acceptable, especially with compliance packs. If there is no answer at the door then attempts must be made to speak to neighbours to understand whether the patient may have been admitted. The only alternative is to return the medication to the pharmacy pending further enquiries.
7. **Dispensing into MDS will result in an increase in the number of split packs on the dispensary shelves.** These must be clearly marked to avoid dispensing short quantities to other patients. Furthermore, snipped strips must not be put onto shelves. The batch number, expiry dates and product details is often lost from such strips. Neither should a box be filled with, say, odd bits of strips. The GPC Inspectors are alert to this issue and will look for such examples of poor practice.
8. **Variable dose medication, such as warfarin and prn drugs should not be put into MDS packs** as any change in regime or patient needs will be difficult to manage.
9. **Staff should be aware of the risks of handling certain medicines** which may be injurious e.g. cytotoxics and misoprostol. Gloves should be worn at all times and care taken not to inhale powder dust.
10. **The assembly of medication in MDS is an activity that requires a robust SOP that matches good practice and is adhered to by all relevant staff.** The SOP must identify who, where and how. In other words, which staff are trained and competent to assemble MDS, where the task should be performed (the dispensary bench may not always be appropriate) and how their task should be performed.



The Ten Commandments of MDS

- I. Thou shall remember that the 'Cup of NOMAD' is not blessed with eternal life beyond 56 days.
- II. Thou shall ensure thy patient is fully informed.
- III. Thou shall not overburden thy patient with a 'Cup of NOMAD' that runneth over. One week will suffice their needs.
- IV. Remember thou are commanded by the DDA to assess the wants of thy patient. It is they who shall benefit from the 'Cup of NOMAD' not the emissary from the council.
- V. Thine actions shall not be a mystery to the surgery. Let the sound of thy voice and deeds carry to the GP.
- VI. Ensure thy patient receives the prescribed goodness directly, leave not their medication outside their abode to be devoured by wolves or lost unto eternity.
- VII. Ensure all patients receive their full allocation of bounty. Let a sign be marked on the box that has given unto the 'Cup of NOMAD' so that all may see that it is not full.
- VIII. Let not thy patient drink too much from the 'Cup of NOMAD'. Their needs are finite, according to their issue, not the measure of the cup.
- IX. Let not thy servants suffer injury from the poisons within the medicine. Let them know of the dangers and give unto them the protection afforded by the shield of the rubber glove.
- X. Know thou the words of the holy SOP and be loyal to the wisdom contained therein.

DRUG SAFETY UPDATES



Codeine containing products

As a result of advice issued by the Commission on Human Medicines and its Paediatric Medicines Expert Advisory Group pharmacists and their staff are reminded that codeine-containing liquid over-the-counter medicines should not be used for cough under 18 years.

Manufacturers are currently updating the packaging and leaflets for OTC liquid cough medicines that contain codeine to include the updated advice. The new information will begin to appear in pharmacies from April 2011, and in the meantime existing packaged medicines will continue to be sold and pharmacists have been asked to consider the new advice when recommending cough medicines for children.

Pharmacists are also reminded that breastfed babies might very rarely develop side effects due to the presence of morphine in breast milk. (See November 2007 issue of [Drug Safety Update](#) *). However, this is a rare risk that applies to 1%-2% of the population who are ultra-rapid metabolisers of codeine to morphine.

RECENT DRUG SAFETY UPDATES

Isotretinoin: risk of serious skin reactions—[Drug Safety Update Sept 2010 Vol 4, Issue 2](#)

Serious skin reactions (erythema multiforme, Stevens Johnson syndrome, and toxic epidermal necrolysis) have been reported following treatment with isotretinoin, which may result in hospitalisation, disability, life-threatening events, or death. Treatment with Isotretinoin must be immediately discontinued and appropriate supportive care given if any serious skin reactions develop. Patients starting isotretinoin treatment should be made aware of the signs and symptoms of these serious skin eruptions and advised to stop treatment and contact their prescriber immediately if any of these arise.

Mercaptamine and mercaptopurine: confusion between drug names

([Drug Safety Update Oct 2010 vol 4, issue 3: S2](#))

In a medication error a 9-month-old was erroneously prescribed mercaptopurine by their GP rather than mercaptamine. This resulted in the child being admitted to hospital with pancytopenia. Prescribers were asked to remain vigilant with regards to the similarity of these two drug names but pharmacists should also be aware of the similarity between the two drug names.

Mercaptamine is used to treat nephropathic cystinosis whereas mercaptopurine is used in the treatment of acute leukaemia.

Tamoxifen Interactions—[Drug Safety Update Nov 2010 vol 4](#)

Pharmacists are advised of a possible interaction between tamoxifen and drugs which may be potent inhibitors of the CYP2D6 drug metabolising enzyme such as paroxetine, fluoxetine, bupropion, quinidine, and cinacalcet. Therefore, use of these drugs that inhibit this enzyme should be avoided whenever possible in patients treated with tamoxifen for breast cancer.

Memantine Pump Device—[Drug Safety Update Nov 2010 vol 4](#)

Several cases of administration error resulting in overdose with the new memantine pump device have been reported. The medication errors resulted from confusion between doses delivered by the new pump device and doses delivered by the previously marketed dropper. Four actuations of the pump device is equivalent to 40 drops delivered by the dropper device. Pharmacists should be aware of these differences in dose delivery and ensure that the patient or carer are aware of the change.

*** IMPORTANT NOTE *** There has already been a potential patient safety incident in Sheffield in which a memantine pump device was labelled "40 drops to be taken daily". Please can pharmacists check the device they are supplying and ensure that the label is appropriate.

Oral Bisphosphonates: Oesophageal Cancer Risk—[Drug Safety Update Nov 2010 vol 4](#)

It is known that the oral bisphosphonates used to treat osteoporosis, Paget's disease, and bone-related cancers can cause oesophageal irritation and reactions. There is also a suspicion that there may be a link with an increase in the incidence of oesophageal cancer although there is insufficient evidence to confirm this. However, Patients should be advised about the importance of adhering to dose instructions. Tablets should be swallowed whole with at least 200 mL water on an empty stomach immediately after getting up in the morning. Patients should stay fully upright for at least 30 minutes or 1 hour after taking the tablet and before taking any food, drink, or other medicine as outlined in the product information.

* <http://www.mhra.gov.uk/home/groups/pl-p/documents/publication/con2032917.pdf>

Alerts



21 October 2010

Drug Alert, Class 3, action within 5 days, Glaxosmithkline / Parallel Distributors, all presentations of Avandia and Avandamet.

Recall following recent recommendation by the European medicines agency to suspend the marketing authorisations of all products containing rosiglitazone.

28 October 2010

Drug Alert Class 4, caution in use, Novo Nordisk, Glucagen Hypokit 1mg.

In an extremely small number of cases the glass of the powder vial is cracked close to the base.

15 November 2010

Drug Alert Class 4, caution in use, Merck Serono Uk, Gonal F 450 Iu/0.75ml solution for injection in a pre-filled pen.

Error on the pen label.

17 November 2010

Drug Alert Class 2, action within 48 hours, Ebewe Pharma Ges.M.B.H.Nfg.Kg. Recall of several batches of fluorouracil 50mg/ml solution for injection 10ml and methotrexate 100mg/ml solution for injection 10ml.

Recall due to the risk of glass particles being present

18 November 2010

Two Class 2 Drug Alerts: EI (10)A/26, Janssen-Cilag Limited, Velcade 3.5mg powder for solution for injection.

Recall due to reports of visual particulates.

EI (10)A/27, Ucb Pharma Ltd, Ergocalciferol Injection Bp 300,000u.

Recall due to process deviation during manufacture which means that the usual sterility assurance level cannot be guaranteed.

19 November 2010

Uptake of the seasonal influenza vaccine 2010.

Public Health Campaigns

There are two more campaigns set to run for this year: -

Topic	Month	Links to National Campaigns	Contact
5 Vaccinations & Immunisations	10 January-21 January 2011	Childhood Vaccination Schedule	Bethan Plant
6 Stop Smoking Campaign	28 February-11 March 2011	National Stop Smoking Day	Claire Holden

The first, Vaccinations and Immunisations has three key campaign messages: -

1. **Dangers of measles and importance of MMR vaccination**
2. **HPV vaccination – awareness of cervical cancer, encourage parents/carers to ensure child has childhood vaccination and immunisation schedule and know where to go to access vaccinations.**
3. **Never to late to vaccinate!**



The second of these, the Stop Smoking Campaign, has the following key messages: -

1. **Smokers are more likely to quit with support from Stop Smoking Services**
2. **Stopping smoking will improve health and well-being**
3. **National No Smoking Day is a good day to try to stop smoking**

Full participation in these campaigns will produce real health benefits for Sheffield residents as well as help raise the profile of community pharmacy.

Community Pharmacy Development Unit

Highlights from community pharmacy update event 22 November 2010
Sexual Health Services and much more!

Key Presentations:

Information Governance – Julie Eckford, Information Governance Lead for NHS Sheffield, outlined the importance of information governance (IG) and the obligations of community pharmacies to ensure compliance. She also encouraged the use of the IG Toolkit available to ensure good practice procedures and respect for individuals' data. She highlighted the risks associated with non-compliance and the consequences of breaching the Data Protection Act 1998, including a £500,000 fine for a serious breach and the potential for up to a 2 year prison sentence for computer misuse – so think carefully about how you handle information – it says a lot about you and your business – let's make it positive! **(Post meeting note:- Two organisations have just been fined £60,000 and £100,000 respectively for the loss of personal data.)**

(Available resources from PSNC : - <http://www.psn.org.uk/pages/templates.html>)



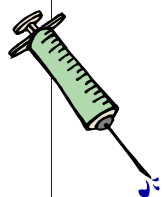
Contraceptive Services – Tracey Dibble (SCaSH) gave an informative presentation on the history of contraception, modern methods and the pharmacist's role in helping to reduce the high teenage pregnancy rates in Sheffield. It was noted that Long Acting Reversible Contraception is more cost-effective because it is less likely to fail and is longer lasting. Given that over 30% of pregnancies in the UK are unplanned... if only 8% of the population currently using the pill switched to a LARC method there could be a potential saving of £102 million per annum. Correct use of appropriate contraceptives **prevents** unplanned pregnancy. Adequate access to ALL forms of contraceptive will help reach Teenage

Pregnancy Targets (80% of decrease in USA's unplanned pregnancies attributed to improved access) & repeat abortion targets – let's make community pharmacy an easy access for this service.

Sexual Exploitation – Kerry Parkin, Outreach Manager for Sheffield Contraception and Sexual Health Service (SCaSH) emphasised that community pharmacies are uniquely placed to observe and recognise signs of sexual exploitation. She highlighted a list of common indicators of sexual exploitation and introduced a DVD entitled 'Dangerous Loverboy' which presented a harsh message of sexual exploitation.



Young Advisers – employed by Sheffield Futures, aged between 16-20 years, shared suggestions for community pharmacy about how best to engage with young people who are keen to utilise the services they offer. They highlighted the need to minimise jargon, be friendly but professional (ie not too friendly – they have enough friends!); to introduce themselves by using first names; to maintain eye contact; to ensure a confidential discussion is possible and to perhaps use a list of services available for young people to tick or refer to if seeking to avoid embarrassment.



CD Reporting – Dr Peter Magirr, Accountable Officer and Susan Rutherford, CD Governance Officer, from NHS Sheffield referred to the importance of CD incident reporting, not to apportion blame but to share learning in order to avoid recurrence. They outlined the types of incidents currently reported and demonstrated the need for community pharmacy to be particularly vigilant when dealing with CDs.

All presentations are available on the LPC website – www.sheffieldlpc.co.uk

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