

### My details

Heidi Taylor. 0114 3051129  
NHS Sheffield, 722 Prince of Wales Road,  
Darnall, Sheffield, S9 4EU  
heiditaylor@sheffieldpct.nhs.uk



### Concerta XL

We have received several reports of unresolved stock discrepancies involving Concerta XL (various strengths).

We have received various reasons why this may have arisen including:

- tablets remained in container trapped by desiccant and subsequently thrown away
- must have dispensed 28 when the prescription called for 30
- only 29 tablets in original pack

This issue has been raised with Janssen – Cilag to enquire if this is a problem that is being found in other areas.

They say that whilst unusual there have been occasions where there have been reported shortages in packs of Concerta XL. (Investigations into bottling miscounts revealed a low overall defect frequency of less than 0.0019%)

In light of this we would like to suggest that pharmacies take extra care when dispensing Concerta XL and may wish to consider the following suggestions:

- counting the contents of each container on receipt from wholesaler
- checking the contents before dispensing
- removing the desiccant from the bottle and checking no tablets remain before disposing of empty bottle

Any discrepancies in quantities in Concerta XL containers should be reported directly to the company (Telephone - 01491 567567.)

### Clarification

In the last clinical governance newsletter the shared learning article discussed possible methods for communicating with prescribers when issues arise on prescriptions. One of the examples of communication given was via e-mail. This requires clarification. Communication by email for the reporting of issues should be part of an agreed process between the pharmacy and practice; email communication that includes patient identifiable information should be encrypted, e.g. using an nhs.net account to nhs.net account. Most email incidents arise due to the inappropriate use of email by users and not through failures in the security of the system. The agreed process should include specifying the practice email address to be used to ensure it is one that is accessed regularly and that it will be accessed if a member of staff is on leave. The system should acknowledge receipt of emails. This is in line with information governance requirements. If you have any queries please contact Julie Eckford, Information Governance Officer:- Telephone –0114 3051096

### All change in CPDU

My time as clinical governance facilitator has come to an end as Steve Freedman (3051129) steps back into the role. Michelle Black (3051134) is back as Deputy Head of Medicines Management. We say a fond farewell and thank you to Sarah Wright who has returned to clinical practice. We also have Jo Tsoneva (3051274) who joined the team at the end of January as Improvement and Development Manager. The only remaining constant is Susie Coates, still to be found at 3051132. Thanks to all over the last year. Heidi.

## Shared Learning

### Learning point 1.

Prescription presented for Rifampicin 300mg capsules, Rifinah tablets were dispensed. (Rifinah contains rifampicin 300mg and isoniazid 150mg). This error was picked up during the medicine reconciliation process when the patient was in hospital.

The Rifinah tablets were a parallel import, the UK label attached stated RIFINAH 300mg TABLETS in large writing. In small print underneath it stated 'each sugar free tablet contains 300mg rifampicin and 150mg isoniazid'.

Consider:

- Double checking of parallel imports - ensuring the UK label is not covered by the dispensing label.
- Product knowledge and training of staff.
- Checking procedure - Clinical appropriateness of prescription, Correct product - in date, correct labels.

### Learning point 2.

Prescription presented for dexamethasone 2mg tablets, desmopressin 0.2mg tablets were dispensed. Patient took tablets for 6 days before realising. The dispensing label had no initials to indicate the dispenser or the checker.

Consider

- Ensure the SOP states a two tier dispensing and checking system is in place. This should be followed wherever possible. If self checking is needed a mental break should be taken between dispensing and checking the prescription.
- Both Dexamethasone and Desmopressin can come in 'little white pots'. Consider how they are stored on the dispensing selves. Could they be separated or shelves labelled with a warning?

These are just some ideas, discuss with your team ways of reducing the risks in your pharmacies.

## Warfarin

Warfarin continues to be of concern as evidence suggests that checks when dispensing prescriptions for warfarin are not happening uniformly across Sheffield. Early indications from the warfarin re-audit also supports this. The NPSA patient safety alert requires community pharmacists to:

- Before dispensing prescriptions for anticoagulant medication, check the patients INR is being monitored regularly and it is at a safe level to dispense the prescription.
- Check that if an interacting medication is prescribed to a patient on oral anticoagulants, the anticoagulation service is aware and extra INR blood tests are booked in.
- Ensure that patients on anticoagulant therapy have received appropriate verbal and written information at the start of their therapy, and when necessary throughout their treatment.

For clinical governance and audit purposes records should be kept of INR details on the patients PMR. Please refer to the full alert which can be found at [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

All patients / carers presenting prescriptions for warfarin should be subject to these checks, including all delivery and medidose patients.