Medicines Safety Bulletin

Issue 1 – March 2021

NHS North Yorkshire Clinical Commissioning Group

Welcome to the very first edition of our Medicines Safety Bulletin; a newsletter produced by your local CCG Medication Safety Group. Our aim is to highlight to you medication safety concerns that have been raised both locally and nationally, in order to promote and support safer practice.

Updated Primary Care Information Leaflet on Clozapine

TEWV have issued a new version of their GP information sheet on clozapine. It highlights the following key points:

- **Please ensure information regarding clozapine is added to the practice patient medical record** for each patient, to enhance patient safety and minimise the following potential risks:
  - Inadvertent co-prescribing of interacting medications
  - The potential to miss side effects or not attribute them to clozapine therapy
  - Clozapine being missed on admission if admitted to another Trust
- **Patients who develop signs of infection such as sore throat and raised temperature are advised to contact their GP or member of the mental health team**. GPs should check FBC and notify the mental health team
- **All patients on clozapine must be monitored and treated for constipation**. Clozapine-induced gastrointestinal hypomotility is probably less well recognised, but can progress to severe and fatal bowel obstruction. Visit https://www.tewv.nhs.uk/policy-type/pharmacy/ for the updated leaflet, found under the GP leaflet section.

Interactions between Medicines and Thickening Agents

Thickening agents can be starch or gum-based. Some drug interactions are specific to a particular type of thickener; some are common to all.

For example: Macrogol laxatives must not be mixed with starch-based thickening agents, as macrogol opposes the thickening effect of the starch, resulting in a thin liquid. This interaction has been implicated in a patient death. However, macrogol laxatives can be mixed with xanthan gum-based thickening agents.

The resources below give a useful overview of the points to consider:

https://www.sps.nhs.uk/articles/thickening-agents-and-thickened-fluids-do-they-interact-with-medicines/

https://www.sps.nhs.uk/articles/thickening-agents-what-to-consider-when-choosing-a-product/

https://www.sps.nhs.uk/articles/how-can-people-who-need-thickened-fluids-take-medicines/

Fentanyl Patch Safety

- The BNF now contraindicates fentanyl patches in opioid naïve patients
- Prescribing of half patches should be avoided wherever possible
- Following a review of recent MHRA alerts, a local acute Trust has agreed to stop discharging patients on fentanyl patches following surgery

https://www.gov.uk/drug-safety-update/transdermal-fentanyl-patches-for-non-cancer-pain-do-not-use-in-opioid-naive-patients

https://www.gov.uk/drug-safety-update/serious-and-fatal-overdose-of-fentanyl-patches

https://www.gov.uk/drug-safety-update/transdermal-fentanyl-patches-life-threatening-and-fatal-opioid-toxicity-from-accidental-exposure-particularly-in-children

Medicine Delivery SOPs – do yours need reviewing?

If your practice delivers medication to patients, have you reviewed your medication delivery SOP in the context of COVID-19? One of our local dispensing GP practices recently delivered two dosette boxes to the wrong patients, as their addresses were similar. Unfortunately, one of the patients took a dose of the other patient's morning medication before the error was discovered. Fortunately there was no harm to either patient. It is thought that a relaxation of identity verification during the pandemic situation may have been a factor in this case.

Check before administration of live vaccines to patients on immunosuppressants

Live vaccines should not be administered to individuals on immunosuppressive therapy including:

- those who are receiving, or have received in the past 6 months, immunosuppressive chemotherapy or radiotherapy for malignant disease or non-malignant disorders
- those who are receiving, or have received in the past 6 months, immunosuppressive therapy for a solid organ transplant (with exceptions, depending upon the type of transplant and the immune status of the patient)
- those who are receiving or have received in the past 12 months immunosuppressive biological therapy (e.g. anti-TNF therapy such as rituximab) unless otherwise directed by a specialist
- those who are receiving or have received in the past 3 months immunosuppressive therapy including:
    - adults and children on high-dose corticosteroids for more than 1 week
    - adults and children on lower dose corticosteroids for more than 14 days
    - adults on non-biological oral immune modulating drugs e.g. methotrexate >25mg per week
    - for children on non-biological oral immune modulating drugs (except those on low doses), specialist advice should be sought prior to vaccination

Further information can be found here:
https://www.gov.uk/government/publications/contraindications-and-special-considerations-the-green-book-chapter-6

Think Twice before prescribing Tramadol

1. Coroner warns about poor drug reviews after patient dies from tramadol overdose

A senior coroner has highlighted the case of an 84 year old man with dementia who died from an overdose of tramadol. The gentleman, who was found collapsed at his home by a neighbour, had amassed a large quantity of unused prescription medication at his house. One was tramadol, for which he had had a repeat prescription of 100 capsules a month over an extended period and on which he overdosed.
GMC guidance states, "When you issue repeat prescriptions or prescribe with repeats, you should make sure that procedures are in place to monitor whether the medicine is still safe and necessary for the patient. At each review, you should confirm that the patient is taking their medicines as directed and check that the medicines are still needed, effective and tolerated." For further information see: https://www.bmj.com/content/370/bmj.m3101

2. Association of tramadol with all-cause mortality, cardiovascular disease, venous thromboembolism and hip fractures among patients with osteoarthritis, a population-based study

Tramadol was associated with significantly higher all-cause mortality compared with nonsteroidal anti-inflammatory drugs (NSAIDs) among older patients with osteoarthritis (OA) in an observational study of more than 88,000 patients.

Read the full article here:
https://ard.bmj.com/content/79/Suppl_1/118.1?int_source=trendmd&int_medium=cpc&int_campaign=usage-042019

This bulletin has been produced by the North Yorkshire & Vale of York CCG Medicines Management Teams on behalf of the North Yorkshire & York Medicines Safety Group. If you have any queries or feedback relating to the bulletin we can be contacted using the Rxline mail box: nyccg.rxline@nhs.net

We also welcome any suggestions or ideas you may have for future editions.