Medicines Safety Bulletin

Issue 10 – February 2024

Welcome to the latest edition of our Medicines Safety Bulletin; a newsletter produced by your local Medication Safety Group. Our aim is to highlight to you medication incidents that have occurred both locally and nationally to promote and support safer practice.

Amiodarone monitoring

A recent audit by one of our cardiology teams found that 82% of patients on amiodarone had their LFTs monitored in the community, but only 54% of patients had their TFTs checked at regular intervals. Local shared care guidance (SCG) advises that both LFTs and TFTs are checked at least every 6 months:

York and Scarborough
Harrogate and District
North East and North Cumbria (NENC)

There are other monitoring requirements in addition to LFTs and TFTs, please see the respective SCG documents for further details. At each review please also check that your patients have an Amiodarone Patient Alert Card.

See: MHRA Drug Safety Update - Amiodarone (Cordarone X): reminder of risks of treatment and need for patient monitoring and supervision for further information.

Tramadol-Warfarin Interaction resulting in the death of a patient

A coroners court has attributed the death of a patient following a cerebral bleed to a generally unknown interaction between tramadol and warfarin. Susan Gladstone: Prevention of future deaths report - Courts and Tribunals Judiciary

Susan had been on warfarin for several years but had recently started on tramadol for low back pain. She was found to have an elevated INR of 11.6 two weeks after starting the tramadol.

Any interaction seems rare and it is unclear which patients are affected. It would therefore seem sensible to monitor warfarin patients more carefully if tramadol is started, being aware that a small proportion of patients may need a reduction in their anticoagulant dose. Consider using an alternative, non-interacting opioid such as codeine, if appropriate.

Tools & Resources to support medication adherence – really useful resources

SPS has put together a number of resources in one place (available here) which are really useful to assist in medication reviews for patients whose adherence may be affected by swallowing difficulties, manual dexterity, visual impairment or for those on complex regimens.

FOCUS ON INSULIN SAFETY

Patients on Insulin pumps

In the event of pump failure patients require immediate access to both long acting and short acting insulin as back up. Please make sure these patients have insulin pens or cartridges (plus a device) and needles on their repeat prescription templates. This is in addition to the insulin needed for their pump. At each review, please check that the patient has back up supplies at home and that it is all in date.

Near Misses with Tresiba – caution at all stages of the medicine journey

There has been a national shortage of Tresiba® (insulin degludec) FlexTouch® 100units/ml pre-filled pens since May 2023. As a result of this shortage some patients may have been switched to Tresiba® (insulin degludec) FlexTouch® 200units/ml pre-filled pens.

Both strengths of Tresiba® FlexTouch® pen delivery devices dial up the dose in unit increments rather than volume. However, a small number of patients have been incorrectly advised to administer half the number of units when changed to the double strength product.

Nationally there have been five reports of patients being incorrectly advised to reduce the number of units of insulin to be administered. These reports suggest that errors have occurred at the prescribing, dispensing and administration stages of the medicine journey. One case described a patient requiring treatment in hospital for diabetic ketoacidosis because of a reduced insulin dose. Further details may be found here: National Patient Safety Alert - potential for inappropriate dosing of insulin when switching insulin degludec

Reminder to never withdraw insulin from pen cartridges or prefilled pens using a syringe

In the event of a pen malfunction, those using a disposable prefilled pen should discard the faulty pen and use a new pen from their pack.

For those patients using a pen designed for use with cartridges it is good practice to prescribe a spare pen for use in case of damage, fault, or loss. Please see the NHSI Warning Alert on the Patient Safety Alert - Risk of severe harm and death due to withdrawing insulin from pen for more information.

Related advice from the Primary Care Diabetes Society can be found here

Exercise caution to avoid confusing the name of an insulin with the dose

Two recent incidents in a local Trust involved confusion between the insulin name and the dose the patient was on.

Several insulins have a number in their name e.g., NovoMix 30 and Humalog Mix 50. In one case Humalog insulin 50 units with meals was prescribed on admission to the Trust. The patient was known to the diabetic specialist nurse team who fortunately spotted the error. The correct insulin prescription for the patient was Humalog Mix 50 at a dose of 30 units with breakfast and lunch and 24 units with evening meal.

This bulletin has been produced by the North Yorkshire and York Medicines Management Team on behalf of the North Yorkshire and York Medicines Safety Group.
If you have any queries or feedback relating to the bulletin, we can be contacted using the Rxline mailbox: hnyicb-ny.rxline@nhs.net

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