Community Pharmacy Patient Safety Group meeting – SUMMARY REPORT

Date	Wednesday 22 January 2020
Venue	Hamilton House, Mabledon Place, London WC1H 9BD
Chair	Janice Perkins
Time	10:30am – 3:30pm

Dr Andy Fox, Medicines for Children

Andy Fox introduced Medicines for Children (MfC). The group produces safe and pragmatic information, including leaflets and videos for parents. At present they have 220 leaflets which are drug and condition specific. The leaflets follow a standard format (max. 2 pages and written in basic language).

The development of leaflets involves an 8-stage process, which includes review by a group of parents/carers. Leaflets are subsequently reviewed every 3 years.

The MfC website is well visited. MfC are also developing an app to support parents scheduling and monitoring the provision of medicines to their children.

It was noted that MfC have struggled to engage with GPs and community pharmacists. PSG noted that they would be happy to share the work of MFC via social media, website and through MSO networks, and where possible via GP networks.

Mohammed Hussain and Paul Wright, NHS Digital

Summary Care Records

The Additional Information (AI) component of Summary Care Records (SCR), which could include information about a patient's communications preference, an end of life plan, or a record of immunisations, was highlighted. NHS Digital are actively encouraging the use of SCR AI.

Electronic Prescription Service: Controlled Drugs and other POMS

Mohammed Hussain (MH) thanked the group for providing their views on EPS, CDs and mixed prescriptions. NHS Digital intends to update specifications, (in line with NICE guidance) to split prescriptions for CDs and other POMs on EPS.

Electronic Prescription Service: Phase 4 roll out

The roll out of EPS Phase 4, which enables GP practices to use electronic prescribing for patients that do not have an EPS nomination, began in November 2019 for TPP SystemOne. The roll out of Phase 4 in EMIS will begin in February 2020, it is likely to take several months. The national roll-out schedule is available here.

Electronic Prescription Service: Regulation 28: prevention of future deaths report

The group discussed a Regulation 28 notice which involved EPS in the following circumstances:

- A woman was prescribed acute antibiotics electronically by a GP.
- The women did not have a nominated pharmacist.
- The GP nominated an appropriate pharmacy.
- The GP removed the nomination to stop future medication being automatically sent to said pharmacy.
- Unfortunately, the nomination was removed before the pharmacy had pulled down the prescription.
- This meant when the pharmacy pulled the prescription off the Spine, it did not appear.
- The GP did not tell the pharmacy. No-one from the family contacted the pharmacy or come to collect the prescription.
- This meant the pharmacy didn't know to look for the prescription, even though the activity could be seen on the EPS tracker.
- Had they known to look for it, it would have been possible to trace.

NHS Digital are now considering actions which to mitigate this happening again.

NHS Mail

NHS Digital provided an update with regards to NHS Mail. Changes will include:

- a new format for NHS mail addresses: NHSpharmacy.odscode@NHS.net.
- 10 emails addresses can now join shared inboxes for pharmacies (up from 3)
- Passwords now have to be changed once a year (instead of once every 90 days)

Updates

Pharmacy Quality Scheme

Members of the Patient Safety Group will be meeting NHS England/NHS Improvement in late January to discuss the Pharmacy Quality Scheme.

CPPE module on just culture

The CPPE module on Just Culture has been updated.

Controlled Drugs

CDAO meeting

An update from the most recent CDAO meeting was shared with the group.

- Changes to the NHS structure: the number of regions will reduce from 13 to 7, this will impact the CDAO areas.
- CPCS and supply of Controlled Drugs: it was emphasised (and reminded) that through CPCS
    - No schedule 1, 2 and 3 can be supplied.
    - Schedule 4 and 5 can only be given for a maximum of 5 days.
- Consistency: some areas are requesting root cause analysis for every incident. It was suggested that PSG draft a consistent tool for the whole network to use.

Hand out errors for methadone

The group discussed handout errors for methadone. If was suggested that the root cause is often familiarity. I.e. when a colleague knows a patient, they may not do all the appropriate checks. The group discussed how they could mitigate against such errors including request of:

- Photo ID-checks
- Address
- Date of birth check
- Volume of medication expected

Over the counter codeine

The group discussed the recent Horizon programme on the sale of OTC codeine. It was noted that although there is a voluntary agreement which restricts pack sizes to 32 and most pharmacies only sell one pack at a time, this is not legally binding and can be problematic.

Ruth Filik, University of Nottingham

Ruth Filik, an associate professor at Nottingham University, outlined a research opportunity, to investigate factors that influence mistake. The group provided feedback on feasibility and practicalities. The group also emphasised the need for more research on LASAs and actions to avoid LASAs errors.

PSG Conference

PSG members discussed possible workshops at the PSG conference which will take place in June 2020. Suggestions included: Safety by design (digital), design and architecture, human factors.

Lucie Mussett, NHS England/Improvement

Lucie provided an update of the development of the new Patient Safety Incident Management System (PSIMS). Progress has been slower than originally anticipated and the next phase will be public beta testing. A question and answer session followed.

Emollient

An update from the most recent emollient stakeholder meeting was provided to the group.

Share and Learn

Methotrexate

A situation in which a patient who had been receiving a methotrexate injection was moved to oral methotrexate was described. The patent was prescribed 4 x 10mg tablets by the GP, despite the fact

that the local formulary states that only 2.5 mg tablets should be prescribed. This was dispensed by their community pharmacy. Unfortunately, the patient took all 4 tablets at the same time. The patient did not come to any harm.

The root cause was the prescribing of 10mg tablets. Some members shared that they haven't stocked 10mg methotrexate for some time.

PSG members agreed they would like to see 10mg tablets phased out in the community sector.

Clozapine

A session at the Northern Irish Patient Safety Conference on Clozapine was discussed. It demonstrated low knowledge about the potential side effects of clozapine and how they may manifest in primary or secondary care. (Particularly in medical wards i.e. not mental health wards.)

Clozapine is the third line treatment for schizophrenia. Patients prescribed this are often older and the side effects they experience may be mistaken for symptoms of other, unrelated illnesses.

Pharmacists registered to provide a clozapine service are aware of the need for regular blood monitoring. However, the mortality rate due to GI side effects (specifically constipation) is greater than the mortality rate due to blood disorders.

Side effects of clozapine that could be the reason for admission or referral include:

- Constipation
- Hypotension
- Pneumonia
- Myocarditis. If clozapine is commenced in the community the first point of presentation will be A+E

People prescribed clozapine often smoke. Patients admitted to hospital will often have an enforced break from smoking. If their clozapine dose is not reviewed this can lead to toxicity. Doses are sometimes omitted when a patient is first admitted. Starting a patient back on the same dose can lead to harm.

Patients taking clozapine and their carers should be advised to inform their doctor or other HCP that they are taking clozapine if seeking advice for constipation or low blood pressure. If they cease smoking or are a smoker admitted to hospital, they should also inform their clinician.

Any other business

- Error statistics: Members agreed to collect incident data for 2019.
- Generic valproate resources: Generic valproate resources which have produced by MHRA and are available online here**,** were shared with the group.
- Future speaker: Graham Prestwich, from the Me and my medicines campaign, will attend the next PSG meeting.

Attendees

Alison Crompton (AC)	PCT Healthcare	Margaret Meehan (MM)	Boots
Binal Shah (BS)	Tesco	Martin Sadr-Kazemi (MSK)	Rowlands
Chris Kenny (CK)	Lincolnshire Co-op	Mary Gough (MG)	CCA
Emily James (EJ)	CCA	Nicola Goodberry (NG)	Weldricks
Jackie Giltrow (JG)	Paydens	Nisha Mistry (NM)	NPA
Jacqui Lee (JL)	Numark	Dr Caroline Parkhurst (CP)	Day Lewis
Janice Perkins (JP)	Well	Trevor Povey (TP)	Asda
Jasmine Shah (JS)	NPA	Victoria Steele (VS)	Lloyds
José Moss (JM)	Boots	Pete Horrocks (PH)	Norchem
Mark Donaghy (MD)	Kamsons	Qam Akhtar (QA))	Morrisons

Phil Day (PD)	Pharmacy2U

Apologies

Elaine Aldham	Dudley Taylor
Jasmine Shah	NPA
Sarah Simpson	Cohens Chemist
Peter Fulford	Morrisons
Ruby Munglah	Superdrug
Peter Glover	Day Lewis
Elaine Hand-Griffiths	Well

Guests

Dr Andy Fox	University Hospital Southampton
Lucie Mussett	NHS England/Improvement
Mohammed Hussain	NHS Digital
Nicola Wake	NHS Specialist Pharmacy Service
Ruth Filik	University of Nottingham
Paul Wright	NHS Digital