

To: All Community Pharmacies

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27th February 2017

Dear Colleague,

Re: Learning from Serious Adverse Incident

You will be aware of the dispensing error which resulted in the tragic death of Mrs Ethna Walsh in 2014 in Antrim, following the mis-selection and dispensing of propranolol instead of prednisolone. On a personal and a professional level, pharmacists in Northern Ireland have been deeply affected and saddened by this incident.

Learning from this incident has been previously shared with community pharmacists and focused on:

- Reducing the risk of errors with beta-blockers
- Reducing the risk of errors where a medicine needs to be taken as multiple units to make up a dose e.g. more than 3 tablets or capsules
- Ensuring a second accuracy check in the dispensing process
- Discussing new medicines with the patient

Unfortunately, errors involving beta blockers continue to be reported to the HSCB and I am therefore writing to remind you of the advice and learning that was shared with community pharmacies following this incident (Appendix 1 and 2). I would ask that you continue to review your systems in line with this. I would also like to highlight the importance and value of reporting dispensing incidents, as without this there would be no learning.

The rolling programme of Community Pharmacy Assurance visits will provide an opportunity for pharmacists to discuss the steps that they have taken in response to the advice and learning and also to share with HSCB Pharmacy Advisers any additional learning points which could be shared with others to help reduce the risks of this type of error occurring. Discussions with pharmacists about adverse incidents during these visits have highlighted the impact that workload and stress levels can have on staff and their performance at work, and it is important to consider any steps that can be taken to reduce the risks associated with these factors.

Action required by all community pharmacists

- Discuss the advice and learning outlined both above and in Appendix 1 and 2 of this letter with all members of your pharmacy team and ensure that each of the steps recommended is considered in order to reduce the risks of incidents involving beta blockers.
- If you identify any further learning points, please share these with your Pharmacy Adviser so learning can be disseminated to all pharmacies.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Joe Brogan', written in a cursive style.

Joe Brogan
Assistant Director Integrated Care
Head of Pharmacy and Medicines Management

Appendix 1: Advice & Learning Shared with Community Pharmacists

Reducing the risk of incidents involving beta-blockers

1. Medicines Safety Matters August 2013¹ highlighted the risks associated with selection errors involving beta blockers which had resulted in serious harm to patients. The article provided the following advice:
 - *Use shelf-edge labels to highlight beta-blocker products on shelves and remember the need for extra care when selecting these*
 - *Use separators to segregate beta-blockers from other products with similar names, strengths and packaging*
 - *Keep dispensing areas clear and tidy*
 - *Review staffing levels throughout the day to ensure that, where possible, two members of staff are involved in the dispensing process.*
2. Following further dispensing incidents involving beta blockers, a specific Quality and Safety learning letter, “Dispensing Beta Blockers- selection errors” was issued in April 2014 by HSCB to all Community Pharmacies and HSC Trusts and this is appended to this letter for reference (Appendix 2). You will note that Community Pharmacies were asked to provide assurances to the HSCB that the learning letter had been shared with all relevant staff and that SOPs had been reviewed and updated if necessary.
3. HSCB correspondence ‘Further Dispensing Errors involving Beta Blockers’ in July 2015² again asked pharmacists to review processes within their pharmacy as another four beta-blocker incidents had been reported.

High Risk Medicines, and reducing the risk of incidents where three or more units of the same medication are required to make up the prescribed dose

The risk of patient harm as a result of a dispensing mix-up increases where the patient is required to take more than one unit of the medicine per dose e.g. tablets or capsules. In considering this specific serious adverse incident involving a short course of prednisolone, where up to eight tablets may be taken per dose, a mix up with ANY other medicine could potentially cause serious patient harm.

1. The 2014 Quality and Safety learning letter, “Dispensing Beta Blockers- selection errors” highlighted this risk.
2. The ‘More than 3’ rule was introduced to community pharmacists in the HSCB High Risk Medicines Poster³ which was issued in November 2015.

Additional advice to pharmacies in the High Risk Medicines poster included:

- *Identify high risk medicines in your pharmacy*

¹ <http://www.medicinesgovernance.hscni.net/primary-care/newsletters/medicines-safety-matters-community-pharmacists/>

² <http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-advice-letters/>

³ <http://www.medicinesgovernance.hscni.net/wpfb-file/high-risk-medicines-poster-cp-2015-pdf/>

- *Ensure they are stored safely*
- *Ensure there is a clinical check of all medicines before they are dispensed*
- *Ensure that patients know how to take or use their medicines safely*

Ensuring a second check in the dispensing process

1. The 2014 Quality and Safety learning letter, "Dispensing Beta Blockers- selection errors" advised that:
 - *Extra care should be taken to check prescriptions for high risk drugs.*
2. The 2015 'Further Dispensing Errors involving Beta Blockers' letter advised:
 - *Ensure there are two members of staff involved in the dispensing process where possible. Where this is not possible, the pharmacist should carry out a second check on the dispensed product.*

Discussing new medicines with the patient

1. The Quality and Safety learning letter, "Dispensing Beta Blockers - selection errors" advised that:
 - *As outlined in the Pharmaceutical Society of Northern Ireland's Professional Standards and Guidance for the Sale and Supply of Medicines, 'the pharmacist must ensure that the patient receives sufficient information and advice to enable the safe and effective use of the prescribed medicine'. It is therefore good practice that when pharmacists or dispensary staff are handing out medication to patients, they should check the patient's or carer's understanding of the medicine they are expecting to receive, where possible. This will help verify the accuracy of the prescription and dispensed medication. The name and appearance of the dispensed item should also be verified where possible.*