The Dudley Group
NHS Foundation Trust

Medicines Management

Induction and Refresher Mandatory Training

For Community Nurses

March 2019

What is included in this self-directed learning pack?

- Key topics from the Medicines Management Policy
- Patient Safety Alerts and their implications for your practice
- Antimicrobial stewardship
- Learning from medication incidents
- Links to access resources e.g. videos and websites
- This pack **does not** replace reading the Medicines Management Policy

Learning Outcomes

On completion of this self directed learning pack you should be able to:

- Understand the contents of this pack
- Know how to access information about Medicines Management issues and obtain further information if required
- Understand that there are supporting policies and guidelines available on the Trust HUB, from the RCN and national safety alerts
- Understand that I have a responsibility to report medicines management incidents on the Trust incident reporting system (Datix®) in line with the Trust Policy

Why do we have a Medicines Management policy ?

- Think about some of the reasons why our Trust has a Medicines Management Policy.
- Now make a list below:
- _____
- _____
- _____
- _____

Why do we have a Medicines Management Policy?

Now review your list. How many of the following reasons did you identify?

- To define the standard(s) required
- To raise awareness of and minimise risks
- To ensure a safe and effective approach to medicines handling across the organisation
- To protect patients and staff

Where can I find information on Medicines Management?

- The NMC advises employees always check and follow their own Trust's guidance on safe and effective medicines handling
  - Our Medicines Management Policy can be accessed via the Hub: Procedural documents>Clinical Policies>Clinical Support
- The RCN has also worked with the Royal Pharmaceutical Society (RPS) and other stakeholders to produce guidance that you should be familiar with and highlighted sources of guidance for specific areas of practice

Patient Safety Alerts

- Patient safety alerts rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death.
- Alerts are currently issued via NHS Improvement and cascaded to our Trust via the Central Alerting System (CAS)
- The Never Events Policy and Framework incorporates key actions from previous NPSA alerts

The following slides highlight issues raised in patient safety alerts

Ensuring safer practice with high dose ampoules of diamorphine and morphine

"There have been a number of reports of deaths and harm due to the administration of high dose (30mg or greater) diamorphine or morphine injections to patients who had not previously received doses of opiates"

Major risks are:

- **Packaging of different strengths** of diamorphine and morphine **look the same** (5mg, 10mg, 15mg, 20mg and 30mg products all look similar)
- **Labelling** on outer carton and ampoule are **unclear**
- **Higher strength** (e.g. 30mg) **ampoules** of diamorphine and morphine **stored alongside lower strength products** (e.g. 10mg) in both primary and secondary care
- **Lack of awareness of risks and precautions** when prescribing, dispensing and administering higher doses of diamorphine and morphine injections

Ensuring safer practice with high dose ampoules of diamorphine and morphine

Think about how can you reduce these risks for your patients? Write your ideas below.

- _____
- _____
- _____
- _____
- _____

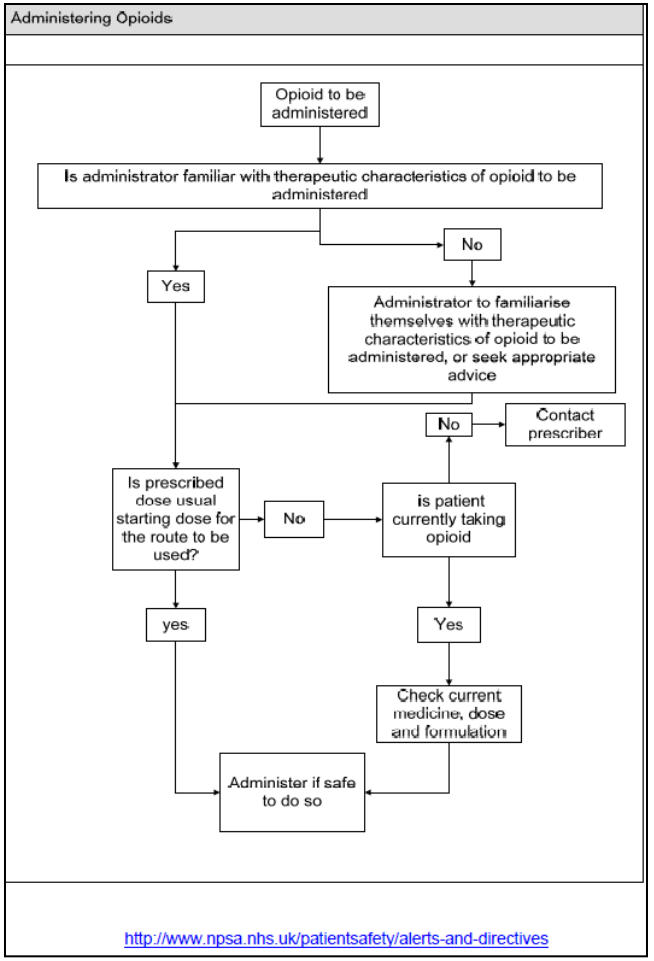
Ensuring safer practice with high dose ampoules of diamorphine and morphine

- Your list should have included the following:
  - Ensure that you are aware of appropriate starting doses and dose titration as well as safe systems for product selection, preparation, administration and monitoring
  - Where possible, the use of a second person should be used to provide an independent check to confirm the identity of the drug, strength, dose to be administered and expiry date of the diamorphine and morphine product is recommended to help minimise the risk of error. When you are working on your own consider other opportunities for a second check e.g. inviting patients and/or carers to carry out a second check or completing a check before the product is placed in a bag
  - Ensure ampoules are always kept in a well-labelled outer carton or box
  - Provide information to patient/carer on post administration side effects
  - Ensure that you know how to access a supply of naloxone injection, an antidote to opiate-induced respiratory depression
  - Advising patients/clients and/or their relatives or carers on security and safe storage of medicines to be administered at home

Reducing Dosing Errors with Opioid Medicines

"Opioid medicines are invaluable for the treatment of acute and chronic pain. There are risks if members of the healthcare team who prescribe, dispense or administer opioid medicines have insufficient knowledge of dosage and the requirements of the patient concerned. Every member of the team has responsibility to check that the intended dose is safe for the individual patient (e.g. for oral Morphine or Oxycodone in adult patients, not normally more than 50% higher than the previous dose)"

- The NPSA produced some possible algorithms which may be helpful for staff in reducing risks of dosing errors with opioid medicines. These are included in the Trust Controlled Drug Policy.



Risk of severe and fatal burns with paraffin-containing and paraffin-free emollients

- Click on the link to watch a video that has been produced for medical professionals and carers, which highlights the potential fire hazards associated with paraffin-based skin products
- As you watch the video think about how you can minimise the risk of harm

"Warnings about the risk of severe and fatal burns have been extended to all paraffin-based emollients regardless of paraffin concentration. Data suggest there is also a risk for paraffin-free emollients." MHRA, 2018

- Now read the latest MHRA advice for healthcare professionals https://www.gov.uk/drug-safety-update/emollients-new-information-about-risk-of-severe-and-fatal-burns-with-paraffin-containing-and-paraffin-free-emollients#review-of-new-evidence

The Safer Use of Insulin

"Errors in the administration of insulin by clinical staff are common. In certain cases they may be severe and can cause death. Two common errors have been identified:
• the inappropriate use of non-insulin (IV) syringes, which are marked in ml and not in insulin units;
• the use of abbreviations such as 'U' or 'IU' for units.
When abbreviations are added to the intended dose, the dose may be misread, e.g. 10U is read as 100.
Some of these errors have resulted from insufficient training in the use of insulin by healthcare professionals."

"Overdose of insulin due to abbreviations or incorrect device is a never event in all settings providing NHS Care
Overdose refers to when:
• a patient is given a 10-fold or greater overdose of insulin because the words 'unit' or 'international units' are abbreviated; such an overdose was given in a care setting with an electronic prescribing system
• a healthcare professional fails to use a specific insulin administration device – that is, an insulin syringe or pen is not used to measure the insulin
• a healthcare professional withdraws insulin from an insulin pen or pen refill and then administers this using a syringe and needle." (NHS Improvement, 2018)

- Check now to make sure that you have completed your Diabetes Management mandatory training
- If it is due/overdue you should complete this via the e-learning for Healthcare™ portal

Valproate contraindicated in women of childbearing potential unless there is a Pregnancy Prevention Programme

- Valproate-based medicines (sodium valproate, valproic acid, valproate semisodium) are effective medicines for treating epilepsy and bipolar disorder
- Valproate can cause serious harm to an unborn child when taken during pregnancy and should not be taken by women and girls unless nothing else works
- Valproate is not recommended for new initiations and where ever possible an alternative should be used first line.
- Women taking valproate should always use effective contraception to avoid an unplanned pregnancy
- Women prescribed valproate should not stop taking it unless advised by a doctor

What to do:

Watch this short video highlighting the latest safety information

- Be vigilant and ensure any women of child bearing potential on valproate have been counselled about the extra risk and are enrolled on the Pregnancy Prevention Programme
- Be vigilant for children who are stabilised on valproate but may soon be entering child bearing age and thus ensure the prescriber or a nurse has counselled them and their parents effectively.

Incident Reporting and Learning

- All healthcare professionals are responsible for reporting incidents/errors/near misses relating to the use of medicines using The Dudley Group NHS FT Incident Reporting System & Serious Incident Reporting Policy.
- The Trust incident reporting system (Datix®) and policies are available via the Hub.
- Examples of situations that should be reported as patient safety incidents are included in the Medicines Management Policy
- All medication incidents reported via Datix® are automatically sent to the pharmacy team and reviewed by the Medication Safety Officer (MSO). The Safe Medicines Practice Group will identify trends and ensure reported incidents are used to reduce the likelihood of recurrence and minimise the risk of patient harm.
- Changes in practice and lessons learnt are shared across the organisation through mandatory and ward based training, communication through medicines link nurses in each clinical area and through senior and junior medical communication channels, providing the opportunity for individual practitioners to review their practice, improving it in line with the outcome of incident reviews.

Test your Knowledge 

- The following questions are based on our Trust's Medicines Management Policy. You should attempt all questions before checking your answers on slides 20-21. If you are a unsure of any answers you can refer to the Policy on the Hub or discuss with your line manager.

Test your Knowledge

1. Community Nurses can collect patient's prescription medication from a community pharmacy? True/False
2. An oral/enteral syringes must be used to measure a 7.5mL dose of Sytron®oral solution. True/False
3. A running balance must be kept in the patient's record for all medications kept in the patient's home. True/False
4. You should return any schedule 2 controlled drugs to a community pharmacy if they are no longer required by the patient. True/False
5. Prescription pads can be stored in a locked car, when not they are not in use. True/False
6. All drug requisitions must travel to and from the pharmacy department in sealed tamper evident containers or by a person authorised by the registered nurse in charge. True/False

Test your Knowledge

7. Members of staff transporting medicines, including dressings, should carry them in a tamper evident container. True/False
8. Any member of nursing staff working on Trust property can request that the drug cupboards and/or their locks are replaced or new keys cut for drug cupboards following an incident. True/False
9. It is good practice at regular intervals for prescribers to note the prescription number issued to a patient in their notes. True/False
10. You accidentally drop a patient's bottle of sodium valproate liquid in their home. You should report this incident promptly to your cluster lead/ team leader and make an entry in the patients records. True/False

Answers

1. True - This should only be done in circumstances where it is essential for the patient/client's immediate treatment.
2. True - Where the administration of liquid preparations involves the use of volumes other than 5ml spoonful's, then only oral/ enteral syringes must be used.
3. False- A running balance should be kept for controlled drugs
4. False - These CDs can be destroyed by the healthcare professional using a destruction kit at the patient's home, and witnessed by the patient, their carer or representative or another member of staff.
5. False - When not in use they must be placed in a locked drawer/secure stationery cupboard.
6. True.

Answers

7. False. Members of staff should carry the medicines in such a manner as not to be obvious.
8. False. A senior manager must make a verbal request.
9. True. This information may be useful if a prescription or prescription pad is lost or stolen.
10. True. The record should include the date, time, quantity of stock damaged or broken, the signature of the member of staff who accidentally caused this and the signature of the member of staff or other person present who witnessed the incident.

Next steps…

- If you have a question or concern about any medicines management issue please contact you line manager or team leader
- Complete the declaration on the following slide that you have completed and understood the information provided in this self-directed learning package.

Medicines Management Induction and Refresher Mandatory Training For Community Nurses

Please print this page (File>Print>Custom range, then insert slide number). Complete the section below and return it to:

Learning and Development 2nd Floor Clinical Offices RHH

Community Nurses

Community Medicines Management Declaration

- I confirm that I have read the entire Community Medicines Management self-directed learning programme and understood its contents.
- I confirm that I know how and who to contact if I have issues regarding medicines management issues and obtain further information as required
- I understand that there are supporting policies and guidelines available on the Trust HUB and from the RCN and national safety alerts
- I understand that I have a responsibility to report medicines management incidents on the Trust incident reporting system (Datix®) in line with the Trust incident reporting procedure

Print full name	
Signature	
Date completed	
Position/Job Role	
Department/Directorate	