Staffordshire Medicines Safety Network Newsletter

May 2019

Medicines Safety Network

Who are we and what we aim to do?

The Medicines Safety Officer Network is attended by MSO's from across healthcare organisations in Staffordshire. The Staffordshire network aims to look at the national and local medicines safety issues and provide a forum for sharing good practice, and discussing topical issues

Email: england.nmmedsreporting@nhs.net

Drugs and driving: the law

Prescription medication including opioid patches can impact on an individual's ability to drive. This is illegal.
Patients who drive should be encouraged to discuss with their prescriber if their medication has an impact on their ability to drive.

Transdermal Patches Body Maps

Repeated reports are received regarding the location of patient's transdermal patches.

This has included patients wearing multiple patches, missing patches or a patch in unusual location.

The use of body maps in some healthcare settings has helped to ensure it is clearly documented where the patch has been applied. Patches should be applied to a recommended site and rotated as appropriate.

Focus on Opioid Patches

Opioid patches have been the focus of discussions at the MSO Network in relation to patient safety. Numerous reports have been received regarding patients that have presented to healthcare professionals with multiple patches on them, and also those that have come to harm as a result of non-compliance with the manufacturer's instructions when wearing a patch. Reports have also been received in relation to fatalities linked to opioid patches.

Drug Safety Alert: Transdermal fentanyl patches: life-threatening and fatal opioid toxicity from accidental exposure.

In October 2018 a drug safety alert was issued in relation to transdermal fentanyl patches: life-threatening and fatal opioid toxicity from accidental exposure, particularly in children.

Nationally reports continue to be received relating to cases of preventable accidental transfer of fentanyl and other opioid patches.

All healthcare professionals, particularly those involved in the prescribing and dispensing of opioid patches are reminded that they should provide clear information to patients and caregivers regarding risk of accidental transfer and ingestion of patches, and the need for appropriate disposal of patches.

Advice for Healthcare Professionals

- Always fully inform patients and their caregivers about directions for safe use for opioid patches, including the importance of:
  - Not exceeding the prescribed dose
  - Following the correct frequency of patch application, avoiding touching the adhesive side of patches, and washing hands after application
  - Not cutting patches and avoiding exposure of patches to heat including via hot water (bath, shower)
  - Ensuring that old patches are removed before applying a new one
  - Following instructions for safe storage and properly disposing of used patches or those which are not needed

- Ensure that patients and caregivers are aware of the signs and symptoms of opioid overdose and advise them to seek medical attention immediately (by dialling 999 and requesting an ambulance) if overdose is suspected
- In patients who experience serious adverse events, remove patches immediately and monitor for up to 24 hours after patch removal
- Report any cases of accidental exposure where harm has occurred or suspected side effects via the Yellow Card Scheme

Transdermal Patches Transferral

The risks associated with transdermal opioid patches should be made clear to patients especially if they are co-sleeping with young children.
In June 2016 the death of a 15-month-old child was reported. The child had died from fentanyl toxicity after a patch warn by her mother became attached to her skin.
It is advisable that healthcare professionals tell patients who are prescribed medication in patches that co-sleeping with their children does hold a risk.

Latest Advice for Medicines Users - DECEMBER 2018 – MARCH 2019

- Fluoroquinolone antibiotics: new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible side effects
- Onivyde (irinotecan, liposomal formulations): reports of serious and fatal thromboembolic events
- Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed?
- Carbimazole: increased risk of congenital malformations; strengthened advice on contraception
- Carbimazole: risk of acute pancreatitis
- SGLT2 inhibitors: reports of Fournier's gangrene (necrotising fasciitis of the genitalia or perineum)
- Tapentadol (Palexia): risk of seizures and reports of serotonin syndrome when co-administered with other medicines
- Ipilimumab (Yervoy): reports of cytomegalovirus (CMV) gastrointestinal infection or reactivation
- Valproate medicines: are you acting in compliance with the pregnancy prevention measures?
- Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients
- Direct-acting antivirals for chronic hepatitis C: risk of hypoglycaemia in patients with diabetes
- Hydrocortisone muco-adhesive buccal tablets: should not be used off-label for adrenal insufficiency in children due to serious risks
- Oral lidocaine-containing products for infant teething: only to be available under the supervision of a pharmacist