Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.100 of 2022

Date of Notice: 26 September 2022

Addendum Witness Statement of: Dr Tracey Boyce

I, Dr Tracey Boyce, wish to make the following amendments to my existing response, dated 18th November 2022, to Section 21 Notice number 100 of 2022:

Minor Amendments

1. At paragraph 4.10 (WIT-87635) I have stated: "*This allowed me to assist Ms Gishkori, when necessary, with any Non-Executive Directors' questions about Acute Governance issues*."

   This should be amended to state: "*Attending the full meeting ~~This~~ allowed me to assist Ms Gishkori, when necessary, with any Non- Executive Directors' questions about Acute Governance issues."*

2. At paragraph Section 7.1 (c) (WIT-87639) I have stated: "*Four monthly audits of each wards' management.*"

   This should be amended to state: "*Four monthly audits of each wards' Controlled Drug management."*

3. At paragraph 10.2 (WIT-87642) I have stated: "*For financial control my* performance *in leading my team's delivery of the regionally set pharmaceutical savings targets were measured using the "MORE reports," (Attachment 14) in conjunction with the quarterly Medicines Optimisation Resource Efficiency regional accountability meetings with the Department of Health officers*."

   This should be amended to state: "*For financial control my performance in leading my team's delivery of the regionally set pharmaceutical savings targets were*

measured using the Medicines Optimisation Resource Efficiency ("MORE") reports (Attachment 14) in conjunction with the quarterly Medicines Optimisation Resource Efficiency regional accountability meetings with the Department of Health officers."

4. At paragraph 24.5 (WIT-87652) I have stated: "*Prescription of drugs: Not applicable. I had no responsibility or input into this in my role as the Trust's Director of Pharmacy apart from being responsible for the Trust's 'Medicines Code' (Attachment 19). The Code sets out the procedures and standards to be followed in the prescription of medicines within the Trust.*"

   This should be amended to state: "*Prescription of drugs: Not applicable. I had no responsibility or input into this in my role as the Trust's Director of Pharmacy apart from being responsible for the Trust's 'Medicines Code' (Attachment 19). The Code sets out the procedures and standards to be followed in the prescription of medicines within the Trust. There were no prescribing pharmacists working as part of the Urology team."*

5. At paragraph 27.4 (WIT-87655) I have stated: "*The pharmacist's concerns were that the dose of gentamicin being prescribed was subtherapeutic and that she could not find any record or sig that the patient was being treated for an infection."*

   This should be amended to state: "*The pharmacist's concerns were that the dose of gentamicin being prescribed was subtherapeutic and that she could not find any record or ~~sig~~ sign that the patient was being treated for an infection."*

6. At paragraph 34.2 (WIT-87663) I have stated: "*However, as I was not a Director, I only joined the meeting once the confidential section was complete and therefore I was not aware of the detail of those discussions or any discussions about recording it on the corporate risk register."*

   This should be amended to state: "*However, as I was not a Service Director, I only joined the meeting once the confidential section was complete and therefore I was*

not aware of the detail of those discussions or any discussions about recording it on the corporate risk register."

7. At paragraph 38.1 (WIT-87665) I have stated: "*I became aware of this when Mr Mark Haynes, AMD, asked me for Trust pharmacy help in auditing these prescription recommendations*."

   This should be amended to state: "*I became aware of this in September 2020 when Mr Mark Haynes, AMD, asked me for Trust pharmacy help in auditing these prescription recommendations."*

8. At Paragraph 41.3 (WIT-87669) I have stated: "*In relation to the Director of Acute Services think this failure was related to a lack of governance experience of the post holder at that time, Mrs. Gishkori*."

   This should be amended to state: "*In relation to the Director of Acute Services, I think this failure was related to a lack of governance experience of the post holder at that time, Mrs. Gishkori."*

9. At paragraph 42.1 (WIT-87670) I have stated: "*Once I was aware of the issues I escalated them in in a timely way to my line managers (the Director of Acute Service and the Medical Director) and I ensured that I undertook the actions that they asked of me. The governance arrangements at the time meant that I was not involved beyond escalating the concerns."*

   This should be amended to state: *"Once I was aware of the issues I escalated them in in a timely way to my line managers (the Director of Acute Service and the Medical Director) and I ensured that I undertook the actions that they asked of me. The governance arrangements to manage a concern about a doctor's practice, at the time, meant that I was not involved beyond escalating the concerns."*

10. At paragraph 43.1 (WIT-87671) I have stated: *"Overall, in my opinion, the governance arrangements in the Acute Directorate where not fit for purpose.*

This was because the Acute Governance team was chronically under resourced for the size of the tasks expected of them."

This should be amended to state: "Overall, in my opinion, the governance arrangements in the Acute Directorate ~~where~~ were not fit for purpose. This was because the Acute Governance team was chronically under resourced for the size of the tasks expected of them."

11. At paragraph 44.1 (WIT-87673) I have stated: "*I would like to add information about a telephone call that I inadvertently witnessed as it I think it may be evidence of some level of pressure on one of the Acute Services Directors who did not fully investigate Mr O'Brien's practice*."

This should be amended to state: "I would like to add information about a telephone call that I inadvertently witnessed as it I think it may be evidence of some level of pressure on one of the Acute Services Directors who did not fully address ~~investigate~~ Mr O'Brien's practice."

Major Amendments

12. At paragraphs 27.11 to 27.13 (WIT-87657 to WIT-87658) I have stated:

> "27.11 On 9th November 2016 one of the lead nurses who had been transferred into the Acute Governance team in 2014, Connie Connelly, gave me a letter of concern *(Attachment 24)* about an SAI that she had been working on *(Attachment 25).* The SAI review was considering the case of Patient 10. Ms Connolly was a panel member in the investigation which was being chaired by Mr Anthony Glackin, Consultant Urologist. The letter was unsigned.
>
> 27.12 The panel's concerns included:
>
> (a) That the root cause of the SAI was Mr O'Brien's lack of action in relation to the triage of Patient 10's referral letter from her GP.

(b) That there were 7 other patients' GP letters that were not triaged that week by Mr O'Brien.

(c) That the secretaries appeared to be aware that triage was not being completed and were putting patients onto the routine appointment list as a way of ensuring that they were kept in the system. They had kept a record of those patients which revealed that 318 letters had not been triaged by a Consultant Urologist.

(d) That some patients' notes were missing (despite being tracked to Mr O'Brien).

(e) That there appeared to be delays in the dictation of Mr O'Brien's letters.

27.13 That afternoon, I emailed Mrs Gishkori about the concern *(Attachment 26*) and I subsequently went to the Admin Floor to speak to her and Mr Ronan Carroll (AD for Surgery and Elective Care) about it."

This section, from paragraphs 27.11 to 27.13, should be amended to state:

"27.11 On 9th November 2016 one of the lead nurses who had been transferred into the Acute Governance team in 2014, Connie Conne~~o~~lly, spoke to me at my weekly meeting with the Governance team ~~gave me a letter of concern *(Attachment 24)*~~ about an SAI that she had been working on *(Attachment 25).* The SAI review was considering the case of Patient 10. Ms Connolly was a panel member in the investigation which was being chaired by Mr Anthony Glackin, Consultant Urologist. ~~The letter was unsigned.~~ I believe that Connie informed me that ~~27.12~~ the panel's concerns included:

(a) That the root cause of the SAI was Mr O'Brien's lack of action in relation to the triage of Patient 10's referral letter from her GP.

(b) That there were 7 other patients' GP letters that were not triaged that week by Mr O'Brien.

(c) That the secretaries appeared to be aware that triage was not being completed and were putting patients onto the routine appointment list as a way of ensuring that they were kept in the system. They had kept a record of those patients which revealed that 318 letters had not been triaged by a Consultant Urologist.

~~(d) That some patients' notes were missing (despite being tracked to Mr O'Brien).~~

~~(e) That there appeared to be delays in the dictation of Mr O'Brien's letters.~~

27.12~~3~~ Connie informed me that the SAI review was nearing completion and, because of the concern about the implications of the finding that Mr O'Brien had not triaged any of the eight urology referrals that had arrived during the relevant week in 2014, I asked Ms Connolly and Mrs Trudy Reid, Acute Governance Lead, to track the seven patients (other than Patient 10) from that week to ensure that they had not come to harm. That afternoon, I also emailed Mrs Gishkori ~~about~~ to escalate the concern and to advise her of the action I had taken (Attachment 26) ~~and I subsequently went to the Admin Floor to speak to her and Mr Ronan Carroll (AD for Surgery and Elective Care) about it~~.

27.13 On 16th December 2016 I returned to my office and found an envelope on my desk. Inside the envelope was a letter of concern dated 15th December 2016 (Appendix 24) about the Patient 10 SAI and the outcomes of the additional actions that I had requested in relation to the other seven patients who had not been triaged that week. The letter was unsigned (i.e. it lacked its third page, which has subsequently been located and provided to the Inquiry). I emailed a copy of the letter immediately to Esther Gishkori, Acute Director, and Ronan Carroll, Assistant Director responsible for Surgery, suggesting that we needed to meet urgently to discuss (which, I believe, we did the following week). A copy of this email has been supplied with my

addendum statement of 19 May 2023. I was given to understand by Connie Connolly around this time that it was she who had hand-delivered the letter to my desk. Therefore, I understood that it had come from one or more of the SAI Panel members.

Additional Documents

13. I would also like to attach additional documents in relation to the following areas:-

a. Email

Email from Tracey Boyce to Esther Gishkori and Ronan Carroll dated 16 December 2016 Concerns Raised by an SAI panel (*please see 1. 20161216 Concerns raised by an SAI panel Response from EG*).

b. Correspondence

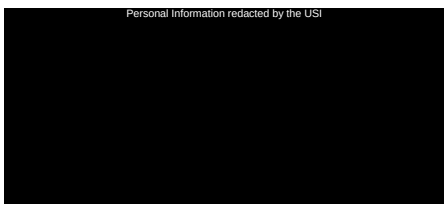
3-page letter from Mrs Connie Connolly, Lead Nurse Acute Governance dated 15 December 2016 – Letter of SAI Panel Concerns (*please see 2. 20161215 Letter of SAI Panel Concerns*).

c. Trust Board Report

Medicines Governance Reports from SMT Trust Board Governance Committee dated 15 August 2015 (*please see 3a.-3c. 20160815 Medicines Governance Reports for SMT TB Gov Committee, A1 and A2*).

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: 

Date: 19.05.2023

Section 21 Notice Number 10 of 2022 – Addendum

Witness: Dr Tracey Boyce

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1. 20161216 Concerns raised by an SAI panel Response from EG
2. 20161215 Letter of SAI Panel Concerns
3a. 20160815 Medicines Governance Reports for SMT TB Gov Committee
3b. 20160815 Medicines Governance Reports for SMT TB Gov Committee A1
3c. 20160815 Medicines Governance Reports for SMT TB Gov Committee A2

Stinson, Emma M

From: Gishkori, Esther [redacted]
Sent: 16 December 2016 16:45
To: Boyce, Tracey; Carroll, Ronan
Cc: Stinson, Emma M
Subject: RE: Concerns raised by an SAI panel

Yes Tracey,
I think we had better.
You may know that there had been an oversight committee established in relation to this Dr and it had been stood down as he was on sick leave.
I do however think we now need to inform the committee as things do seem to be fairly serious and potentially harmful for patients here.
We will try to meet on Tuesday. Perhaps before SMT?
E.
Thanks
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] Mobile [redacted]
Esther.Gishkori[redacted]

-----Original Message-----
From: Boyce, Tracey
Sent: 16 December 2016 16:34
To: Carroll, Ronan; Gishkori, Esther
Cc: Stinson, Emma M
Subject: Concerns raised by an SAI panel

Hi Ronan and Esther
Could we have chat about this next week - I am at a regional strategy day on Monday - perhaps we could get together on Tuesday?

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
[redacted]

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

-----Original Message-----
From: tracey.boyce@[redacted]
Sent: 16 December 2016 16:30
To: Boyce, Tracey
Subject: Scan from YSoft SafeQ

Scan for the user Tracey Boyce (tracey.boyce) from the device CAH - Pharmacy Corridor - C308

Southern Health and Social Care Trust

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to Patient 10 reference number Personal Information redacted by the USI is complete.

The remit of Patient 10 s Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as Patient 10 in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initials Patient 99) chart was not able to be found on Trust property at this time Patient 99 s chart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the Patient 99 s consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Discussed in Rosan Tracey Esther 20/12/16

Hand delivered to TB Friday 16/12/16

Issues and Themes of concern include:

- In May 2014, there was an informal process was implemented to monitor/manage Urology letters which had not been returned with management advice (not triaged). It appears that this process was created in an effort to limit risk of harm to the patient. The presence of this process implies that it was accepted that triage non-compliance was to be expected by a minority of consultants within the Urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved. In addition, this process has not been effective in addressing triage non-compliance. From 28 July 2015 until 5 October 2016, there are 318 patient letters which were not triaged. Currently the Trust cannot provide assurance that the Urology non-triaged patient cohort are not being exposed to harm while waiting 74 weeks for a Routine appointment or 37 weeks for an urgent appointment.

- During the manual look-back exercise on 14 November 2016, Patient 99 [redacted]s patient chart could not be found on Trust premises. Patient 99 [redacted]'s chart did appear in the Acute Governance office the week commencing 28 November 2016. After informal queries, it is understood that patient notes are not transported via Trust vehicles to or from Dr 6's outlying clinics (inc SWAH). This could compound efforts to establish any chart location or outstanding dictation. The Review panel acknowledge that processes should not be drafted to address one issue with one specialist team. On balance, the Review team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this Specialty does need urgently addressed.

- There is clear evidence that this patient Patient 99 [redacted]s letter was not triaged by week ending 30 October 2014. Patient 99 [redacted]was seen in SWAH by Dr 6 in January 2015. The outpatient letter was dictated 11 November 2016 and typed 15 November 2016. The Review panel have grave concerns that there are other Urology patient letters not being dictated in a timely manner. Upon further investigation, the Panel have found that the Trust does monitor the number charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed. This has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Dr 6.

If you have any further questions, do not hesitate to contact me directly.
Sincerely
Connie

Mrs Connie Connolly
Lead Nurse Acute Governance

Stinson, Emma M

From: Boyce, Tracey <Personal Information redacted by the USI>
Sent: 15 August 2016 16:17
To: Judt, Sandra; McCormick, Susan; Comac, Jennifer
Cc: Stinson, Emma M
Subject: Medicines governance reports
Attachments: Medicines Governance Report Aug 16.doc; MST 55.pdf

Hi all
For once I am getting myself organised in advance of my leave! Please find attached the medicines governance report and copy of safety newsletter for SMT and Trust Board Governance meetings.

I am on leave on the 8th September – so would you record my apologies for the Trust Board Governance meeting that day.
As we did last September, I am happy to take any questions in relation to the reports by email and I will answer them as soon as I return to work.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by the USI

Learn more about mental health medicines and conditions on the Choiceandmedication website http://www.choiceandmedication.org/hscni/

Southern Health and Social Care Trust

Medicines Governance Report

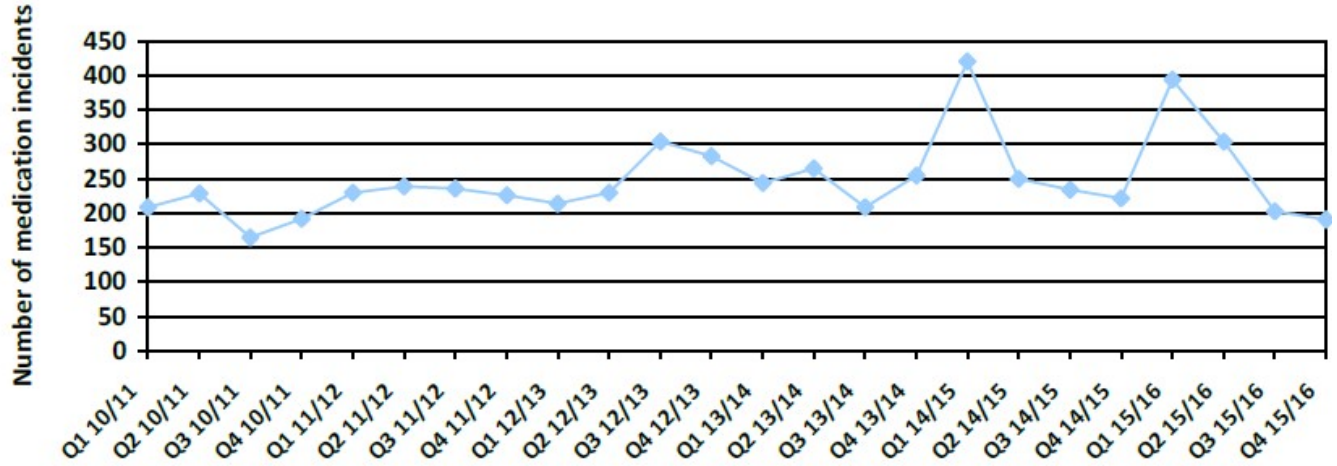
For Trust Governance Committee on 8th September 2016

Medication Incident reporting

During the final quarter of 2015/16 there were 191 medication incidents reported in the Southern HSC Trust. The average number of reported medication incidents each month was 64 per month, representing a small decrease from 68 per month in the previous quarter.

The medication incident report trend is shown below in figure 1.

Figure 1: Total number of medication incident reports per quarter



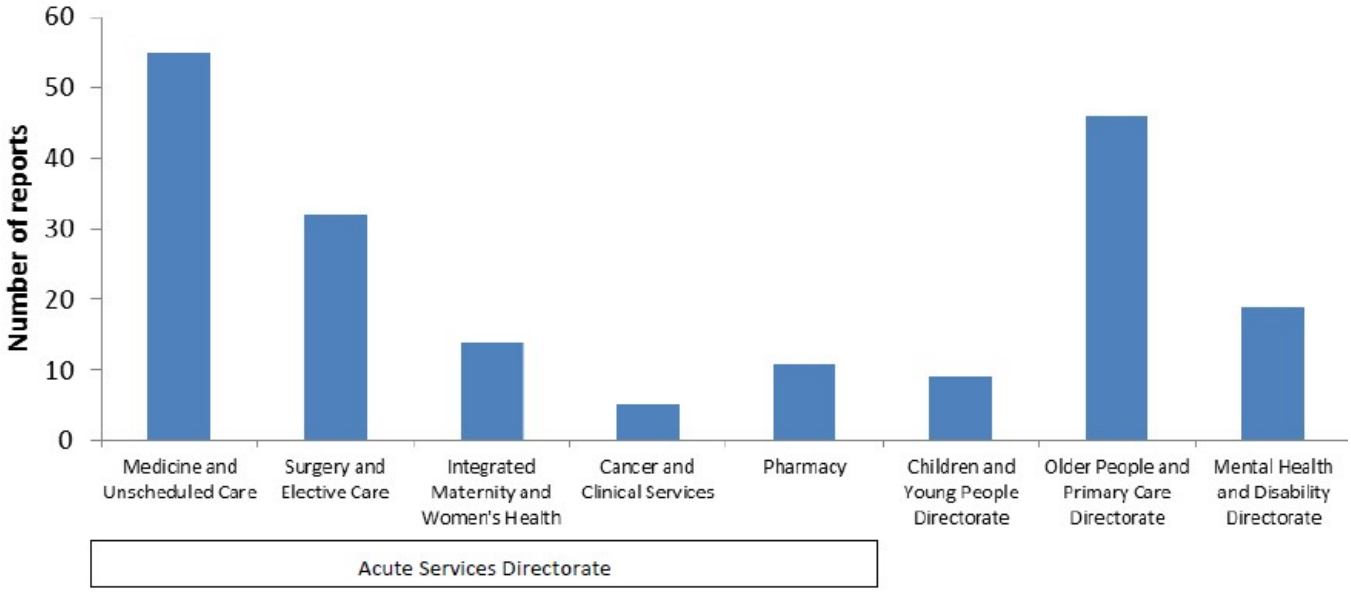
There were no trends of specific concern amongst the reports and the number of reported medication incidents is set against the figure of approximately 7,500 medication transactions, including prescribing, dispensing and administration, happening in the Trust every day.

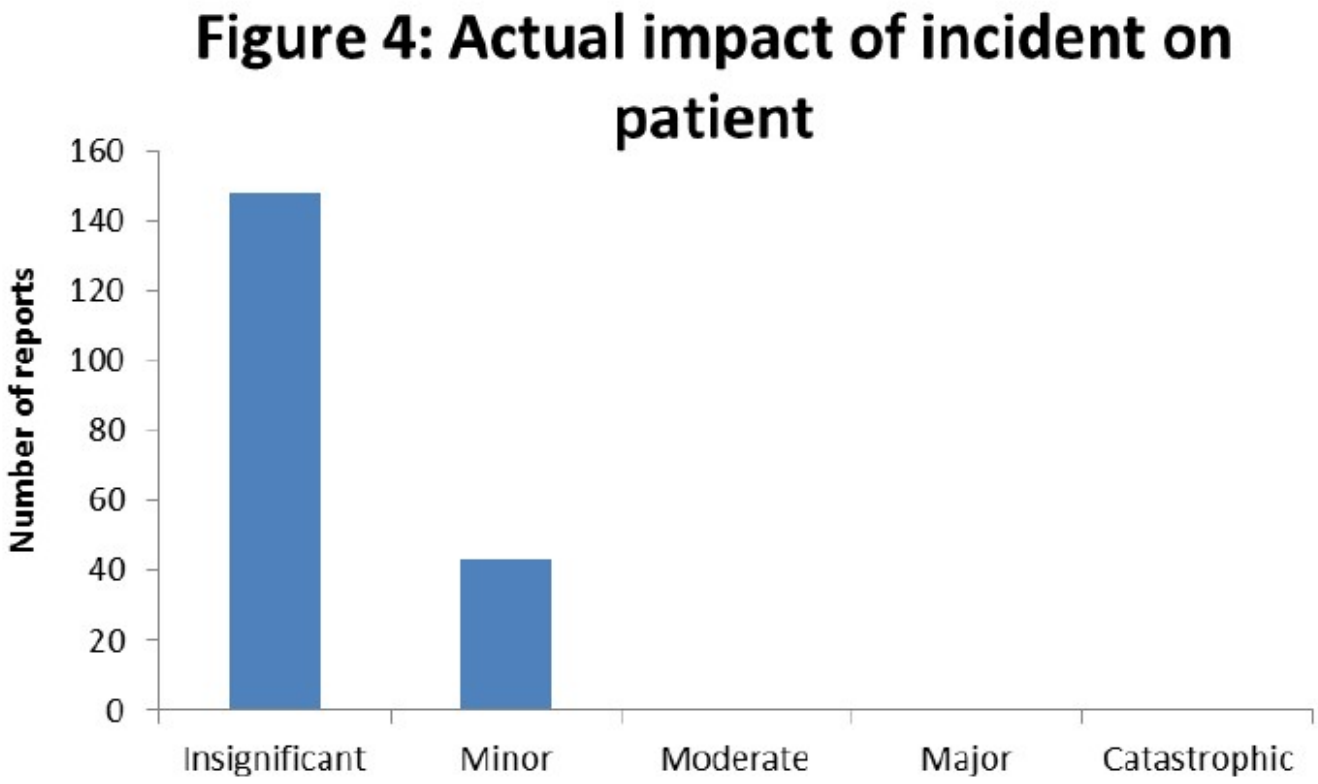
The monthly breakdown is given in Figure 2.

Figure 2: Number of reports

Most reports were received from the Acute Services Directorate (Figure 3).

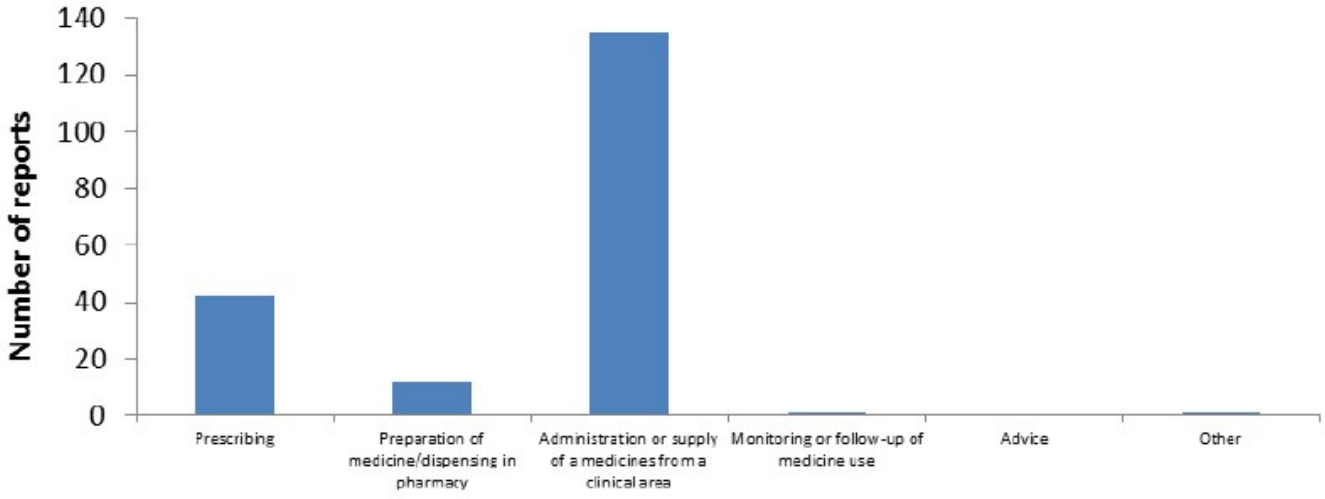
Figure 3: Reports by directorate





As can be seen in figure 4, most reported incidents were of insignificant or minor impact on patients. During the quarter there were no moderate, major or catastrophic incidents reported via Datix.

Incidents are categorised on the basis of the process involved: prescribing, preparation of medicines/dispensing in pharmacy, administration or supply of a medicine from a clinical area, monitoring or follow-up of medicine use and other (Figure 5).



- The most common prescribing incident in the Trust was 'Omitted/delayed medicine' which was the same as the regional top prescribing incident.
- The Trust's top administration incident was 'Omitted or delayed medicine' which was the same as the region's top administration incident.
- The Trusts most common dispensing incident was 'omitted medicine or ingredient' which was the same as the region's top dispensing incident.

Action resulting from Trust incident monitoring
The reported incidents have contributed to the following work in progress:

- Introduction of new infusion pumps and dosage charts for alteplase in stroke lysis treatment.
- Education and training of the safe use of insulin.

Other Trust medicines governance activities

Medication incident reporting, review and feedback
Since February 2008, medication incidents are received from the central reporting point. Various groups within the trust continue to review and feedback information on medication incidents. The Acute Medication Incident Review Group, which includes non-acute hospitals, meets on a monthly basis and prepares feedback for staff. Periodic review of medication incidents within OPPC and production of feedback to staff on a quarterly basis continues. The Pharmacy Medication Incident Review group meets on a quarterly basis. A medication incident review group within CYP meets on a bi-monthly basis. A new pilot of a medication incidents discussion group for MHD is underway.

Domiciliary and Day Care
Work continued with the Medicines Management Specialist Nurse on medicines management procedures. The project nurse has now moved to the next geographical area and continues to review clients in receipt of medication assistance to ensure arrangements were appropriate.

Medication Safety Today
Issue 55 of the newsletter was distributed in paper and electronic format.

Medicine Governance Education
Training continues to be provided as part of the Update on the Safe Administration of Medicines for nursing and midwifery staff and including bank staff.

Regional Kardex
Implementation of the new adult and paediatric Kardex are now complete. Work is on-going on the new regional long-stay, outpatient, paediatric and maternity Kardex. An editorial board has been set up to manage future versions of the Kardex and the Southern Trust Director of Pharmacy has been asked to chair this group.

Safe Use of Insulin
The safe use of insulin group now reviews all insulin related incident reports at its regular monthly meetings.

Drug and Therapeutics Committee Summary

During the quarter May to July 2016 the Drug and Therapeutics Committee activity was as follows:

- **Medicines Governance** – Jilly Redpath attended the Directorate Governance meetings to share and discuss actions required arising from the Quarterly Report, Medication incident report summary and the NPSA Alert summary reports. Progress updates on recommendations arising from regional incidents were also discussed at each meeting and included the use of Sodium chloride 0.9% for bladder irrigation and ensuring any Trust policies or protocols that include guidance on the use of oxytocin also highlight the BNF safety information.

- **Regional Kardex project update** – the new regional paediatric Kardex has now been implemented in the Southern Trust and the new regional Kardex editorial Board will begin to meet in autumn 2016.

- **New product requests –** four new product requests were considered:
  - Insulin glargine biosimilar 300 unit/ml (Toujeo®) – approved for use in the Trust.
  - Guanfacine hydrochloride tablets (Intuniv®) – approved for use in the Trust.
  - Lisdexamfetamine dismesylate (Elvanse Adult®) – approved for use in the Trust.
  - Single use portable negative pressure dressing (PICO l®) – approved for use in Orthopaedics in line with the patient selection protocol submitted by the clinical team.
  - Methoxyflurane inhalation vapour 3ml (Penthrox®) – decision deferred pending further discussions with Clinical Director for ED and anaesthetics.

- **Approval of clinical guidelines**
  The following guidelines were approved by committee members, prior to their addition to the Trust Clinical Guidelines internet site.
  - Dabigatran emergency surgery protocol
  - Dabigatran elective surgery protocol
  - AntiXa oral anticoagulant elective surgery protocol
  - AntiXa oral anticoagulant emergency surgery protocol
  - AntiXa oral anticoagulant haemorrhage protocol
  - AntiXa oral anticoagulant overdose protocol
  - Croup algorithm
  - Hypoglycaemia in neonates protocol
  - Paediatric sedation guidelines
  - Alcohol withdrawal guidelines

Dr Tracey Boyce
Director of Pharmacy
22nd August 2016

Medication Safety Today

Medicines Governance Team

Issue 55 The Northern Ireland Medicines Governance Team Newsletter May 2016

What's the time? It's insulin time!

Most hospitals have a separate prescription and administration chart for subcutaneous insulin so that insulin is prescribed on a daily basis. The prescription chart is combined with blood glucose monitoring. Medication incidents continue to occur where insulin has not been prescribed leading to delay and sometimes omission of insulin doses and hyperglycaemia. Unless a patient is very unstable, insulin should be prescribed each day for the next 24 hours. This should be done during the working day by the team looking after the patient and not left for night staff to do.

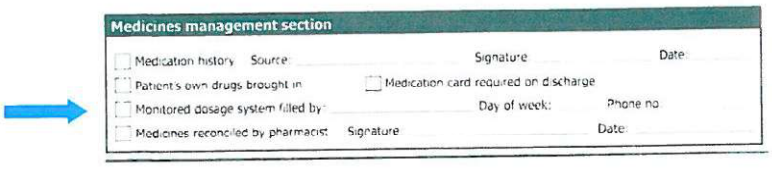
Safety tips:

- Have a set time each day when insulin doses are prescribed for the next 24 hours.
- Identify which patients are on insulin and ensure these are highlighted to medical staff.
- Where a patient's blood glucose control is unstable and you are unsure what insulin to prescribe, contact a member of the diabetes team for advice.

System alert

Some patients have their medicines dispensed in a Monitored Dosage System (MDS) at home. It is very important to identify this on admission to hospital to enable arrangements to be made for discharge medicines. Medication incidents have occurred where patients have been dispensed new medicines or new doses on discharge and have taken these in addition to their previous medication in the MDS.

There is a Medicines Management section on the front of the Kardex where this should be documented.


Medicines management section

Medication history Source: Signature Date:

Patient's own drugs brought in Medication card required on discharge

Monitored dosage system filled by: Day of week: Phone no

Medicines reconciled by pharmacist Signature Date:

Anticoagulant alert

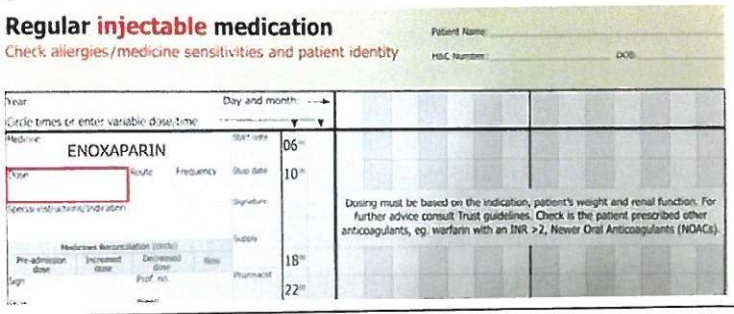
The non-Vitamin K antagonist oral anticoagulants (apixaban, dabigatran, edoxaban & rivaroxaban) or NOACs as they are commonly referred to, and warfarin are all licensed for the prevention and treatment of venous thromboembolism.

Care needs to be taken:

- when initiating these medicines due to the potential for interactions with other medicines and
- when admitting a patient to hospital to ensure enoxaparin is not co-prescribed in error. These combinations can increase the risk of bleeding.

To prevent these medication incidents:

- Complete the full VTE risk assessment before making a decision to prescribe enoxaparin. This and the enoxaparin entry in the injectable section has a prompt that warns prescribers about concurrent use of anticoagulants


Regular injectable medication

Check allergies/medicine sensitivities and patient identity

Patient Name:

HSC Number: DOB:

Year: Day and month:

Circle times or enter variable dose/time

Medicine: ENOXAPARIN

Dose Route Frequency Start date Stop date Signature Supply Pharmacist

06 10 18 22

Dosing must be based on the indication, patient's weight and renal function. For further advice consult Trust guidelines. Check is the patient prescribed other anticoagulants, eg. warfarin with an INR >2, Newer Oral Anticoagulants (NOACs).

Interactions: Statins and Clarithromycin

Clarithromycin inhibits the metabolism of some HMG-CoA reductase inhibitors, which results in increased plasma concentrations of these medicines. Rhabdomyolysis in association with increased plasma concentrations have in rare cases been reported in patients being treated with clarithromycin and simvastatin. Clarithromycin can produce a similar interaction with atorvastatin or pravastatin. When treatment with clarithromycin is indicated in patients receiving statin treatment, therapy with statins should be temporarily suspended during the course of clarithromycin.

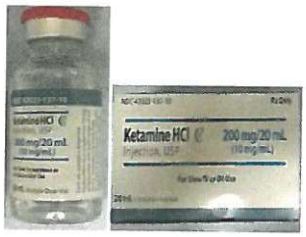
If you have any comments on this newsletter, please contact Jillian Redpath, Medicines Governance pharmacist on Ext: [redacted] at Craigavon Area Hospital or by e-mail at [redacted] Further copies of this newsletter and past editions can be viewed at www.medicinesgovernanceteam.hscni.net or on your Trust intranet.

Personal Information redacted by the USI

How strong am I?

Medication incidents have occurred when an incorrect dose has been administered to the patient due to confusion about the strength. Some reasons why this might happen include:

1. The usual strength stocked is no longer available, for example, ketamine 10mg/ml no longer available, 50mg/ml in stock. Intended dose was 30mg, however 150mg administered. Staff failed to read the strength and assumed the strength was the same as previously used.



2. Sometimes the strength per ml is the most prominent feature on the label and not the total quantity in the vial or ampoule. Staff may not realise that the vial or ampoule contains greater than 1ml and draw up the entire contents resulting in a higher than normal dose being administered.

Safety tips:

- Always check the strength of the medicine.
- Never assume that the strength is the same as the last time you administered the medicine.

Syringe Pump Checks

Syringe pumps continuously deliver medicines into the subcutaneous tissue of patients for whom oral medication is not suitable. Their use has greatly enhanced symptom management for palliative care patients in the latter and difficult stages of their illness. All medicines being delivered must be prescribed on the appropriate Trust prescription and administration chart. Checks should be conducted regularly during the infusion to confirm the pump is infusing as expected and there are no adverse effects. In a hospital setting once commenced the first check should take place after 30 minutes and then every 4 hours thereafter.
Observe for the following:

- ✓ Pain, swelling, redness, infection, bruising, oedema
- ✓ Blood in the infusion line
- ✓ Crystallisation
- ✓ Disconnection
- ✓ Infusion not progressing
- ✓ Infusion progressing too quickly

If any issues are identified STOP the pump and speak to the patient's consultant regarding their management. If the pump is suspected to be faulty replace with another pump and send defective pump for repair following trust procedure. It is also important to complete an incident form documenting the reason for return.

Desmopressin - unforgettable

Desmopressin is a synthetic form of antidiuretic hormone (ADH) used to treat cranial diabetes insipidus and is considered a life sustaining medication in this situation.

DON'T FORGET

In the treatment of cranial diabetes insipidus, it is most commonly given as an intranasal spray or oral tablets, but may also be given as an injection.

Omission of desmopressin has resulted in severe dehydration and death*. For this reason, desmopressin has been added to the list of Critical Medicines where timeliness of administration is crucial **

Please check that your ward has an updated list of critical medicines on display and where there is an omitted or delayed dose (>2hrs) of a critical medicine this should be reported as a medication incident using the Trust incident reporting system.

*DHSSPSNI Patient Safety Alert. PSA/2/2016 *Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus.*
**NPSA Rapid Response Report (NPSA/2010/RRR009) *Reducing harm from omitted and delayed medicines in hospital.*

AKI not OK

Medication incidents have been reported in patients, who have had Acute Kidney Injury (AKI) identified, but who have not had their medication reviewed appropriately. This issue has been highlighted in the GAIN Northern Ireland Guidelines for Acute Kidney Injury and other guidance.[1-3] These guidelines describe how medications may contribute to the development of AKI and may also, with a sudden reduction in kidney function, require dose modification to avoid hazardous side effects e.g. oral hypoglycaemic drugs have a much longer duration of action in kidney failure.

Once AKI has been identified it is important to review all medications, including the patients 'usual' drugs. The GAIN AKI guidelines highlight some of the medications to review although this is not an exhaustive list:

Drugs interfering with renal perfusion
ACE inhibitors and angiotensin receptor blockers
NSAIDs
All antihypertensives
Diuretics (loop and thiazide)
Nitrates
Nicorandil

Common drugs requiring dose reduction or cessation
Low molecular weight heparins
Opiates
Penicillin based antibiotics
Metformin (increased risk of lactic acidosis)
Sulphonylurea-based hypoglycaemic agents
Aciclovir

Drugs requiring close monitoring
Warfarin
Aminoglycosides

Drugs aggravating hyperkalaemia
Digoxin
Beta blockers
Trimethoprim
Potassium sparing diuretics e.g. spironolactone, amiloride

1 GAIN Northern Ireland Guidelines for Acute Kidney Injury 2014 http://www.gain-ni.org/images/GAIN_-_AKI_-_Northern_Ireland_Guidelines_for_Acute_Kidney_Injury_PDF.PDF [Accessed March 31, 2016]
2 https://www.thinkkidneys.nhs.uk/uklwp-content/uploads/sites/2/2016/03/Guidelines-for-Medicines-optimisation-in-patients-with-AKI-final.pdf
3 http://www.renalpharmacy.org.uk/