# Medicine Matters

Clinical Commissioning Groups across Northumberland, Newcastle and North Tyneside

**Medicines information for care staff in a social setting**

**June2015**

*Issue 35*

## What a Waste…..

Did you know the most expensive medicine is the one that is never taken? …..

NHS resources are limited and we are all tasked with spending money wisely. Careful planning and putting into place good systems can also help in our fight to reduce waste.
We have listed some "Top Tips" to help everyone in the day to day fight against medicines waste:

Top tips for care homes;

* Retain responsibility for ordering medicines from the GP practice. This should not be delegated to the supplying pharmacy
* Clearly mark the items which are required, only tick the repeat slip if an item is needed.
* Ensure that once the prescriptions are ready at the surgery, that you collect them/have them sent back to you rather than go straight to the dispensing pharmacy, in this way you can check what has been prescribed is correct.
* Where medication has been prescribed but has not been requested/needed anymore then inform the pharmacy in writing (attach
* a note or agree with the pharmacy how to transfer this information) and the item will not be dispensed. Let the surgery know that you did not need that item, otherwise they will assume it has been dispensed
* If "as required medication" has been placed in a monthly blister ask for it to be supplied in the original packaging. Blister packs last only 8-12 weeks, medication packed in the manufacturer's original packaging can last up to a few years
* "As required medication" left over from the previous month should not be sent back for destruction (if still prescribed and still in date). Instead the stock should be carried forward to be used the following month.

* Homes who's practices utilise electronic prescribing systems (EPS) must ensure that they continue to be actively involved in the ordering system and retain records of this process.

## Central Alerting Service (CAS) :how do you get your emails?

The Central Alerting System is a web-based cascading system for issuing patient safety alerts, important public health messages and other critical safety information and guidance to the NHS and others, including independent providers of health and social care.

Most recently there was a CAS alert about "Asphyxiation by ingestion of thickening powder"

https://www.cas.dh.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=102291

### Circumstances leading to the patient safety alert

An incident had occurred where a care home resident died following the accidental ingestion of the thickening powder that had been left within their reach. It appeared that the powder formed a solid mass and caused a fatal airway obstruction.

It was recommended based on this incident and a similar others, that appropriate storage and administration of thickening powders needed to embedded within the wider context of protocols, bedside documentation, training and expert advice when safely managing the care of patients with dysphagia.

**If your care home don't already receive these types of alert , you need to subscribe for email alerts by emailing safetyalerts@dh.gsi.gov.uk, advising that you would like to subscribe.**

## Eye drops and new technology

Many people need to use eye drops long term for conditions like glaucoma. Most conventional eye drops are prepared in sterile conditions and need a preservative to be added to them, which preserves the product for 28 days once opened, after which they must be discarded. It is the preservative in these drops which can lead to allergies when used long term. To tackle this problem, some manufacturers are now making eye drops with high tech delivery systems. These create an airless system, thus eliminating the need for preservatives, whilst maintaining sterility. Some systems can ensure sterility up to 6 months, others only 3 months.

**To this end, please check the expiry on each eye drop bottle as expiry dates vary considerably.**

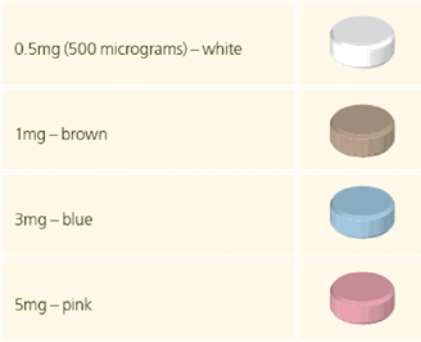
# Warfarin—A quick guide for care homes

## What is warfarin?

Warfarin is the most widely used anticoagulant. It works by stopping blood clots forming within the blood vessels by 'thinning' the blood. Blood clots can lead to strokes. Careful monitoring is required while taking warfarin. A blood test called an INR (International Normalised Ratio) is required to measure how long it takes for the patient's blood to begin to form clots. If the INR is too high the blood is too thin and this can lead to internal bleeding, if the INR is too low, the medication won't work properly, increasing the patient's risk of stroke. Consequently, the results of a patient's INR are very important and patients are tested regularly because warfarin levels can fluctuate. In particular, warfarin is subject to many drugs interactions and fluctuations in diet, which can cause the INRs to go up and down.

Warfarin is available in four different strengths of tablets, 500micrograms, 1mg, 3mg and 5mg (see below). Care must be taken to ensure the correct strength of tablet is chosen.

Regardless of the brand of warfarin used the colours of the tablets always remain the same. See below, e.g 5mg warfarin is always pink




In 2007, following a series of safety alerts around warfarin, the government under the auspices of "the National Patient Safety Alert– NPSA" set up the following support and guidance in relation to warfarin for use in care homes. The link provides more information http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59814

- When a patient starts warfarin they should be given a "yellow book" detailing information about warfarin , its interactions, benefits and risks.
- The "yellow book", details the INR range for that patient

**Cont:-**


- The yellow book has a space to record INRs and corresponding doses. Some local policies may not use a yellow book to record INRs instead they may provide printed results and corresponding doses. Using either method is fine as long as a consistent approach is taken
- The GP and pharmacist, should be shown the yellow book/ or equivalent and the INR entries before prescribing and dispensing, respectively.
- The Care Home should have a written protocol regarding warfarin
- Any dose changes to warfarin must be provided in writing.
- It is recommended that warfarin is provided in its original pack (not an MDS)

## Administration of warfarin

If the INR changes significantly, the dose of warfarin changes too. It is difficult to reflect these changes on a MAR chart, so to get round this the MAR chart can be annotated with " see attached additional anticoagulant chart or yellow book".

## MAR Chart; warfarin example

| | | | |
|---|---|---|---|
| date | 3 (medication name, form & strength) | | |
| qty | | | |
| by DB | Warfarin Tablets | | |
| SW | | | |
| date | dose & frequency | | route: |
| qty | See additional anticoagulant | | oral |
| by | chart | | |
| | special administration instructions | | |
| | | | |
| start | 10.1.09 | stop | |
| Signed: | D BROWNLEE | Countersigned: | S WHITE |

## Example of an anticoagulant record chart

| Date | Prescribed Dose (MG) and frequency | Time Given | Quantity of warfarin tablets administered | | | Administered By | | Yellow book available to check | | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1mg | 3mg | 5mg | | | yes | no | |
| 26.1.09 | 3mg daily | 6pm | | 1 | | | | | | |
| 27.1.09 | 3mg daily | | | | | | | | | |
| 28.1.09 | 3mg daily | | | | | | | | | |
| 29.1.09 | 3mg daily | | | | | | | | | |

**Future Issues:** If you have an idea for an article to be included in a future issue, please contact one of the Care Home Team on 0191 217 2858 or 217 2533 or email:

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