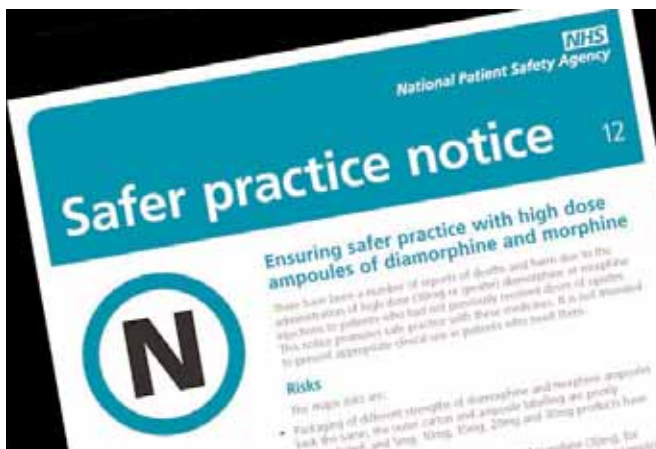


# Diamorphine advice issued by National Patient Safety Agency

NHS organisations in England and Wales have been advised to review and improve the way that high dose ampoules of morphine and diamorphine injections are prescribed, stored and administered.

The National Patient Safety Agency has issued a safer practice notice containing the following four action points to help protect patients from potentially fatal mistakes;

- Assess risk and have procedures for safely prescribing, labelling, supplying, storing, preparing and administering diamorphine and morphine injections
- Review therapeutic guidelines for the use of diamorphine and morphine injectable products for patients requiring acute care, including post-administration observation of patients who have not previously received opiates
- Update information concerning the safe use of diamorphine and morphine injectable products as part of an ongoing programme of



The safer practice notice was issued to all NHS organisations recently

- training for health care staff on medication practice
- Ensure that naloxone injection, an antidote to opiate-induced respiratory depression, is available in all clinical locations where diamorphine and morphine injections are stored or administered

The safer practice notice outlines the major risk areas associated with the high dose ampoules, including similar packaging for different strength products, storage of high

strength ampoules alongside lower strength products in clinical areas, and insufficient therapeutic training and understanding by health care staff of the risks involved.

The NPSA adds that implementing the recommendations will also help staff and organisations meet existing safe practice guidelines on the use of Controlled Drugs.

The safer practice notice and accompanying patient briefing can be accessed via *PJ Online* ([www.pjonline.com/links/hp](http://www.pjonline.com/links/hp)).

## brief

Information about pharmacist independent prescribing in the form of frequently asked questions is now available from the Department of Health. It can be accessed via *PJ Online* (at [www.pjonline.com/links/hp](http://www.pjonline.com/links/hp))

Advice to mental health trusts applying for NHS foundation trust status, highlighting both opportunities and risks, has been published by the Department of Health. It can be accessed via *PJ Online* ([www.pjonline.com/links/hp](http://www.pjonline.com/links/hp))

Scotland now has a pharmacist prescribing co-ordinator. The role of Annamarie McGregor is to identify good practice and use this to develop both supplementary and independent prescribing in all settings across Scotland.

All drug studies involving human testing should be registered, according to the World Health Organization. The WHO is in the process of setting up an internet search portal that will allow people to search all accessible trials that meet the requirements of its platform.

Postcode prescribing continues in the NHS because of failings in the way the National Institute for Health and Clinical Excellence interacts with the health care system, according to Richard Barker, director general of the Association of the British Pharmaceutical Industry. Mr Barker was speaking at a media event held last month.

### Correction

David Rosser is a consultant in intensive care medicine at University Hospital Birmingham NHS Foundation Trust, not Bristol as stated in a meeting report last month (2006;13:183).

## New guild president elected

Anthony Oxley, associate director of medicines management at Leicestershire Partnership NHS Trust, has been elected president of the Guild of Healthcare Pharmacists. He was elected by the guild national professional committee (known as the guild council) shortly before the GHP's joint conference with the United Kingdom Clinical Pharmacy Association, held in May.

Richard Cattell, director of South-West Medicines Information and Training NHS regional service, is the new vice president and organisation secretary. Also elected as officers were:

- Tony West, Guy's and St Thomas' NHS Foundation Trust, London, immediate past president and chair of the international committee
- Andrew Alldred, Harrogate and District Foundation Trust, chair of the practice committee
- David Miller, Sunderland Royal Hospital, chair of the terms and conditions committee
- Simon Mynes, Derriford Hospital, Plymouth, treasurer
- Vilma Gilis, Maidstone Hospital, communications officer
- Martin Pratt, Birmingham Heartlands Hospital, recruitment officer
- Tracey Boyce, Craigavon Area Hospital, secretary for Northern Ireland and regional member
- Robert McCartney, University Hospital of Wales, Cardiff, secretary for Wales and regional member
- Colin Rodden, Gartnavel General Hospital, Glasgow, secretary for Scotland and regional member

Details of other GHP officers are available at [www.ghp.org.uk](http://www.ghp.org.uk). A report of the GHP and UKCPA joint conference is on p218-20.

# Prescribing will increase pharmacists' role in the reporting of adverse drug reactions

**Pharmacists' roles** in reporting adverse drug reactions (ADRs) will become increasingly important as the part they play in prescribing grows, according to Vivienne Nathanson, head of ethics and science at the British Medical Association. She was speaking at the launch of a BMA report into ADRs.

The BMA report, "Reporting adverse drug reactions — a guide for health care professionals", warns that the increased availability of general sale list medicines may be making it harder to identify ADRs. Charles George, chairman of the BMA's board of

science, says in the foreword: "Increased private sector availability from sources such as newsagents, supermarkets and the internet can result in OTC medications, including herbal remedies, being purchased with little or no support or control from doctors or pharmacists."

Commenting on the report, Anthony Cox, pharmacovigilance pharmacist at the West Midlands Centre for Adverse Drug Reaction Reporting, said: "Following the admission of pharmacists to the yellow card scheme it is gratifying to see that the profession has performed admirably, now

accounting for about 18 per cent of reports."

Hemant Patel, President of the Royal Pharmaceutical Society, said that, as well as increasing the reporting of ADRs, more needs to be done to prevent them occurring in the first place. "Health care professionals, particularly in primary care, need to devote more efforts to identifying adverse drug reactions before they result in a patient being admitted to hospital," he said. Medicines use reviews allow pharmacists to identify ADRs before there is a serious risk to the health of the patient, he

added. "Patient safety could further be improved if pharmacists were able to access more information about a patient's condition."

In a separate development, researchers have found that the costs of non-compliance with medicines are about £8bn in England (*Journal of Medical Economics* 2006; 9: 27-44). Researchers found that 392,000 acute admissions in England resulted from ADRs, accounting for about 0.7 per cent of the Department of Health budget (based on 2004 figures). Wastage of medicines was estimated at 2.3 per cent of total medication costs.

## Computerised provider order entry reduces child chemotherapy errors

**Implementing** a computerised provider order entry (CPOE) system reduces the number of errors made when ordering paediatric chemotherapy, according to researchers at the Johns Hopkins Children's Center and Sidney Kimmel Comprehensive Cancer Center, Baltimore, US.

Audit data was collected for 241 days before CPOE was implemented and for 296 days after CPOE deployment. Analysis showed that, after CPOE was introduced, there were fewer incorrect dosage instructions on the order (0.06 per cent compared with 2.3 per cent) and fewer missing dose calculations (5.7 per cent compared with 18 per cent). The number of errors in treatment plans did not differ significantly



CPOE systems automate dose calculations and encourage complete data entry

before or after CPOE implementation.

CPOE was introduced as a result of a failure modes and effects analysis of the paediatric chemotherapy process. Features that the authors suspect reduce the likelihood of error are that it automates dose calculation, reduces hand-written orders, encourages prescribers to complete all data fields and

reduces the amount of information prescribers need to memorise.

The authors point out that the consequences of any errors made can be serious because of the narrow therapeutic profile and high potential for acute and cumulative toxicities of cancer drugs. The research appears in *Archives of Paediatric and Adolescent Medicine* (2006;160:495-8).

## Better clinical pharmacy studies needed

**Future studies** into the effect that clinical pharmacists have on patient outcomes should describe interventions in sufficient detail that they can be reproduced. They should also measure outcomes using validated instruments and, ideally, involve more than one centre. These are among the suggestions of US researchers, who carried out a literature review of clinical pharmacy papers, reported in the *Archives of Internal Medicine* (2006;166: 955-64).

From the 36 (out of almost 350) papers that satisfied their inclusion criteria, the authors conclude that the use of clinical pharmacists on hospital wards to improve the quality, safety and efficacy of care is supported.