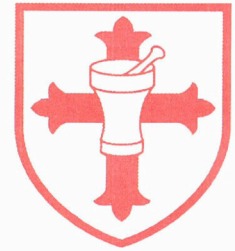




GHP

*Guild of
Healthcare
Pharmacists*



15th October 2010

Response Unit
Patient Safety
National Patient Safety Agency (NPSA)
4-8 Maple Street
London
W1T 5HD

Dear Sirs

Consultation on the Draft NPSA Rapid Response Report: Safer Loading Doses of Medicines

Response from the Guild of Healthcare Pharmacists

Thank you for the opportunity to respond to this consultation. The Guild of Healthcare Pharmacists represents UK wide around 4,000 pharmacists including the majority of hospital pharmacists, pharmacists employed by Primary Care Trusts (PCTs) and pharmacists employed by other public bodies such as the Commission for Social Care Inspection and the Healthcare Commission. The Guild is part of the health sector of the union Unite.

Question 1

Do you believe that there is a significant risk to patient safety from loading doses of medication?

Yes

Comments:

We believe that many patients suffer avoidable harm from the continuation or omission or inappropriate administration of loading doses and that many of these medicines are available as floor stock in most NHS Trusts. This is due to the urgency of the clinical situation and the absence of a sufficiently accessible 24/7 pharmaceutical support required to supply in a more restricted manner. However we

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believe that this is symptomatic of a wider issue and as a result the significant risk to patient safety is probably not just restricted to the area of loading /maintenance doses.

Question 2

Do you believe that guidance in the form of a Rapid Response Report (RRR) from the NPSA is an appropriate way to address these risks?

Yes, but with revisions

Comments:

We believe that the profile this RRR will give will be useful, but overall it must be realistic. We have concerns that the guidance as it stands will be impracticable to implement in many NHS Trusts. As a result, we believe that the RRR must be amended for it to deliver its objective. It is important that the key recommendation must be that a local risk assessment of the need for appropriate access to pharmaceutical support as this would improve patient safety in many areas including loading doses of drugs with narrow therapeutic indices.

Additionally the RRR does not cover the issue of the transfer of patients between organisations, between a patient having been giving a loading dose and achieving a stable maintenance dose, where significant risks exist.

Question 3

Do you believe that the recommendations outlined in the RRR will reduce the risks associated with loading doses?

Yes although as it stands will be impracticable to implement

Comments:

Point 3 of the RRR states ‘Develop systems to ensure pharmacists and nurses perform clinical checks of the loading and/or maintenance prescriptions before medicines are dispensed and administered, including checking whether the continuation of loading doses of critical medicines is intentional or in error. Information that supports appropriate clinical checks on the safe use of critical medicines should be available.’ We believe that while this would undoubtedly reduce the risks associated with loading doses and the subsequent maintenance doses, this will not be possible without continuous (24/7) clinical Pharmacy services at ward/department level.

Question 4

Do you believe that the recommendations outlined in the RRR are practical to implement?

No

Comments:

The key recommendation of local risk assessment of access to pharmacist clinical checks and individual supply of these high risk medicines is very feasible. However, loading doses of the identified examples digoxin, amiodarone (IV) and phenytoin for instance are usually given in an urgent situation (and hence the need to be given a loading dose). To facilitate this, these agents are usually stocked in areas that require them urgently. Without a continuous 24/7 clinical Pharmacy services, it will not be possible for a Pharmacist to check the prescription before dispensing loading or maintenance doses of these drugs and would mean restricted access to these often critical drugs. To restrict access by removing these drugs from stock would additionally compromise patient care. However, we can see the logic in this approach with warfarin and this will support what should have already been implemented following NPSA Patient Safety Alert No. 18. Although we would then have to accept that this may increase the time taken for

patients to stabilise to a maintenance dose of oral anticoagulant and the discontinuation of low molecular weight heparin.

While we understand the underlying message of the RRR, as the alert is currently worded, many of the identified medicines could be omitted pending a check by a pharmacist or individual supply . This would undoubtedly have to be balanced against the recent NPSA RRR 009 omitted and missed doses alert.

While we believe that NHS Trusts should have a continuous 24/7 clinical Pharmacy services at the patient's bedside, we have to accept that currently this is not the case or needs investment to be possible. Therefore we would support that for a defined (at national and local level) cohort of medicines, that present high risk, that the organisation produces comprehensive guides for each identified medicine. These guides would include information on how to prescribe and administer both loading doses and maintenance doses. These guides must be approved by the appropriate committees within the organisation and must have had Pharmacy input. The on-call Pharmacy service in most organisations would still be available to provide advice and support.

As there are a number of tools and guides available that may be of use, we would suggest that one work stream may be to evaluate existing resources to facilitate a national solution e.g. ensure that the Medusa guide has clear instruction and differentiation between loading and maintenance dosing. Additionally this information could be incorporated in order sets within electronic prescribing and medicine administration systems.

As a result we believe that point 3 must be amended to say 'Develop systems to ensure appropriately trained staff perform clinical checks of the loading and/or maintenance prescriptions before medicines are dispensed and administered, including checking whether the continuation of loading doses of critical medicines is intentional or in error. Information that supports appropriate clinical checks on the safe use of critical medicines should be available.'

Question 5

Do you think that a six month deadline is sufficient to complete the recommendations from the RRR?

No

Comments:

As previously stated, we believe that the profile this RRR will give will be very useful, but overall it does need to be realistic. As a result the timescale for RRR implementation needs extending to 12months to take into consideration our recommendations.

We hope these comments are of assistance

Our reply may be made freely available.

Yours faithfully

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Professional Secretary
Guild of Healthcare Pharmacists

Graeme Richardson
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Guild of Healthcare Pharmacists