

The Palliative Care Toolkit

(The palliative care education sheet from Michael Sobell House, Mount Vernon Cancer Centre)

April 2006 - No 6

Welcome to the sixth edition of the 'PCKT' from Michael Sobell House. This bi monthly education sheet delivers to you palliative care information and tips that you can use in your day-to-day practice. This month we are looking at Safer Medication Practice in Palliative Care

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Education & Training Diary

April 2006

- 4th Journal Club
- 18th Journal Club
- 20th ICP Study Day 2
- 26th Volunteer Training
- 27th Out of Hours Training
- 27th Reflection on Practice Set
- 27th Principles of Palliative Care (Uni Herts)
- 28th Principles of Palliative Care (Uni Herts)
- 28th Symposia – Bereavement

May

- 2nd Journal Club
- 11th PICC & Hickman Line
- 12th MVCN Chemotherapy Study Day
- 16th Journal Club
- 18th Syringe Driver 1 & 2
- 19th Essential Communication Skills
- 19th Symposia – Day Care & Blood Products
- 23rd CNS Forum
- 24th Hot Topics in Palliative Care
- 25th Reflection on Practice Set
- 25th Principles of Palliative Care (Uni Herts)
- 26th Principles of Palliative Care (Uni Herts)
- 26th Junior Doctor Communication Skills
- 30th Journal Club

June

- 7th Cultural & Spiritual Issues in Palliative Care
- 8th Essential Communication Skills
- 8th Cancer Centre Visit
- 13th Journal Club
- 14th Volunteer Training
- 15th Bereavement & Loss Workshop
- 19th MVCN GI Study Day
- 21st TIPS for Clinicians
- 22nd TIPS for Clinicians
- 23rd Symposia – Palliative Care Emergencies
- 27th Journal Club
- 27th Principles of Palliative Care (Uni Herts)
- 28th Principles of Palliative Care (Uni Herts)
- 29th Reflection On Practice Set
- 30th Uni Herts Student Conference

*For enquires and booking forms contact Anni Hall
(Education Co-ordinator) on ext 4177*

Hot Topics in Palliative Care Generic and Brand Name Opioid Issues in Practice

Sarah Russell - Lecturer Practitioner in Palliative Care

In January 2006, the Royal Pharmaceutical Society of Great Britain (RPSGB) considered the issue of the prescribing of sustained release morphine preparations and opioid patches. The RPSGB agreed that sustained released morphine preparations and opioid patches should be prescribed by brand name. It was felt that there was a small but significant difference in release rates for the various sustained released morphine preparations which could affect the balance of individuals. The RPSGB was concerned that generic prescribing of sustained released opioids including opioid patches could potentially create confusion for the prescriber and patient – with generic prescribing there was no guarantee that the patient would receive the same brand each time. This issue had already been raised in 'Building a Safer NHS for patients – improving medication safety' (DH 2004) which recommended brand prescribing of oral sustained preparations. The RPSGB felt that with changing patches it was an even greater issue as patients became used to a specific patch – particularly with reference to fentanyl patches where there were both matrix and reservoir patches available. (RPSGB 13 Feb 2006 'Practice Committee considers opioid issues')

Safer Medication Practice

Adapted from David Cousins (2005) Head of Safe Medication Practice, National Patient Safety Agency

The National Patient Safety Agency (NPSA) is a Special Health Authority created to co-ordinate the efforts of all those involved in healthcare, and more importantly to learn from, patient safety incidents occurring in the NHS. Errors resulting from the use or misuse of medication are the most common threat to patient safety [1]. While medication errors are not new to healthcare practice, it is only recently that these errors have begun to be systematically analysed and investigated [2]. The NPSA defines a patient safety incident as 'any unintended or unexpected incident which could have or did lead to harm for one or more patients' [3]. Safe medication practice is therefore about minimising the risk of patient safety incidents involving medicines. Patient safety incidents involving medicines include *adverse drug events*, *adverse drug reactions* and *medication errors*. Bates et al have developed a model and a set of definitions for these terms (see [Table 1](#)) [4].

Have we got your contact address wrong? If so please contact Sarah Russell on 01923 844567 Thank you

Table 1: Definitions of patient safety incidents involving medicines [4]

Class Name of Category	Definition
Medication Error	Any error in the process of prescribing, dispensing, preparing, administering, monitoring drug therapy regardless of whether an injury occurred or the potential for an injury was present.
Adverse Drug Events	When injury occurs as a result of the drug therapy.
Preventable ADE	Where injury results due to an error taking place in some part of the medication process.
Non Preventable ADE (or Adverse Drug Reaction)	Where an injury occurred with no error having taken place in the medication process (For example, if the patient experiences a known side effect to a drug for the first time, and there was no way that the prescriber could have prospectively predicted or prevented the side effect from occurring).
Ameliorable ADE	Where the severity of the drug-induced injury can be substantially reduced if different actions are taken.
Potential ADE	An incident that possesses the potential for injury, but no harm takes place.
Potential ADE (Preventable)	Where an error occurs that has the potential to cause injury, but is intercepted by someone within the medication process (also referred to as a 'near miss').
Potential ADE (Non-intercepted)	Medication errors that have the potential to cause injury but fail to do so after the medication reached the patient.

1. Neale G, Woloshynowych M, Vincent C. Exploring the causes of adverse events in NHS hospital practice. *J R Soc Med* 2001; 94:322-30
2. Department of Health. Building a safer NHS for patients. Improving medication safety. A report by the Chief Medical Officer. London; 2004.
3. National Patient Safety Agency. Seven Steps to Patient Safety. London: National Patient Safety Agency, 2003.
4. Bates DW, Leape LL, Petrycki SJ. Incidence and preventability of adverse drug events in hospitalised adults. *Gen Intern Med* 1993;8:289-94.

Comment:

Symptom control in palliative care involves accurate holistic assessment, diagnosis, management, monitoring and reviewing in order to achieve optimum relief of symptoms. Drug prescription and administration is a key part of good symptom control and patient safety. In recent years there have been a variety of opioids available for prescription, dispensing and administration. Generic and brand names have been used interchangeably. Jansen Cilag has recently announced the the launch of the 12mcg Durogesic D Trans patch (Fentanyl) giving clinicians added dosing flexibility when prescribing. In line with the RPSGB and NPSA, brand name prescribing will be necessary when using the new 12mcg durogesic D Trans patch.

Interested more in safe opioid prescribing ?

**Come to our 'Hot Topics' study session on the 24th May 2006
1000 – 1230 in the Michael Sobell House Lecture Hall
Book via Anni Hall on ext 4177**

Journal Watch:

Zeppetella G; Ribeiro M (2006) Opioids for the management of breakthrough (episodic) pain in cancer patients, Cochrane database of systematic reviews (Online: Update Software); 2006 1 1;(1)

McDermott A; Toelle T; Rowbotham D; Schaefer C; Dukes E (2006) The burden of neuropathic pain: results from a cross-sectional survey, *European journal of pain* (London, England); 2006 Feb 1;10(2)

Moore C; Siu A; Maroney C; Fischberg D; Litke A; Silberzweig S; Morrison R (2006) Factors associated with reductions in patients' analgesia at hospital discharge, *Journal of palliative medicine*; 2006 Feb 1;9(1)

Hutt E; Pepper G; Vojir C; Fink R; Jones K (2006) Assessing the appropriateness of pain medication prescribing practices in nursing homes. *Journal of the American Geriatrics Society.*; 2006 Feb 1;54(2)

Useful Numbers:

Michael Sobell House (ward)	Ext 4281
Palliative Care Mac Nurse	Ext 4110/Bleep 547
Palliative Care Registrar	Ext 4281/Bleep 547
MSH Outreach Team	Ext 4596 -office hrs
MSH Lecturer Practitioner	Ext 4567 –office hrs

Garden House Hospice (Letchworth)	01462 679517
Harlington Day Hospice (Hayes)	0208 7590453
Peace Hospice (Watford)	01923 330330
Pasque Hospice (Luton)	01582 492330
St Francis Hospice (Berkhamstead)	01441 862960
St Lukes Hospice (Harrow)	0208 3828000
Berkhamstead Mac Nurses	01442 862960
Dacorum Mac Nurses	01442 240726
“	01923 330343
Hillingdon Mac Nurses	01895 279412
Ian Rennie Hospice at Home	01442 890222
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