NHS
South East London
Clinical Commissioning Group

Learning from a serious incident involving an unlicensed special

A recent serious incident involving the prescribing and supply of the wrong concentration of a high-risk oral liquid medicine for a new-born child, has highlighted some areas of learning relating to safe prescribing and dispensing of unlicensed specials. Some key learning points for both prescribers and dispensers are outlined below:

- Not all unlicensed medicines are available to 'select' from digital prescribing systems, such as EMIS (used in South East London). This can result in incorrect products/strengths of medicines being prescribed.
- Handwritten prescriptions remain as a means to prescribe where an unusual / unlicensed medicine is not available on the digital prescribing system.
- Prescribers should take extra care to ensure they select the correct medicine, brand, concentration and volume when prescribing medicines, they are less familiar with, or for higher risk patients such as children, frail adults, multiple long term conditions or those with polypharmacy.
- Prescribers should ensure that when prescribing any medicine formulated as a liquid, that the dose is always expressed as both a quantity, as well as the equivalent volume.
- Dispensers should ensure that when dispensing any medicine formulated as a liquid, that the dose is always expressed as both a volume, as well as the equivalent quantity.
- Where prescriptions are unclear, or unusual, (and especially where the medicine is new / unlicensed / high-risk; or the patient is a high-risk individual due to being a child, frail, or with polypharmacy etc), dispensers should:
    - always check prescribing intention with the prescriber or specialist team as relevant, especially when involving high-risk medicines such as opioids, insulin, methotrexate etc.
    - always check with patients / carers / family / representative using open questioning to fully ascertain their understanding of what is anticipated, and for liquids (or other formulations that are not solid-dose oral formulations), that the dose, volume, and route of administration are very clearly understood.

- consider contacting the relevant specialist team for patients recently discharged from hospital or under specialist care as an outpatient (see details below).

The CCG is currently undertaking a project to ensure our formulary recommended unlicensed specials for children and young people are available to prescribe electronically via EPS, to minimise risk of unclear prescriptions being generated either by hand, or through the wrong product being selected on EPS.

The regional Medicines Information centre can be contacted at Guy's hospital using the following contact details: Guy's Hospital (020) 7188 8750, or (020) 7188 3849, or (020) 7188 3855. They can provide details of local services/centres in South East London.

For queries relating specifically to patients from the Evelina Children's Hospital, their 'Let's Talk Medicines' help line can be contacted Monday to Friday 9am to 5pm via: 0207188 3003 or letstalkmedicines@gstt.nhs.uk

Please continue to report any incidents involving medicines and prescribing via your local reporting mechanisms, so we can continue learning from near misses and incidents.

Other useful resources:

Prescribing Competency Framework:
https://www.rpharms.com/resources/frameworks/prescribers-competency-framework

BNF guidance on prescribing in children:
https://bnf.nice.org.uk/guidance/prescribing-in-children.html

BNF guidance on prescription writing: https://bnf.nice.org.uk/guidance/prescription-writing.html

Medicines Information services: https://bnf.nice.org.uk/about/medicines-information-services.html