

Library Current Awareness Bulletin: Pharmacy – June 2021

This is a current awareness bulletin from the Library & Knowledge Services team at Airedale. If you have any comments or queries please let us know. Our contact details can be found on the final page of this bulletin.

Please note: This bulletin contains a selection of material and is not intended to be comprehensive. Professional judgment should be exercised when appraising the material. The Library & Knowledge Services team takes no responsibility for the content and accuracy of the information supplied.

Section	Page(s)
Alerts, Guidance and Vaccine Information	1
News	2
Community Pharmacy	2-3
Education & Training	3
Hospital Pharmacy	4-7
Medicines Management	7-8

Articles can be accessed from the links provided. An OpenAthens account may be required to access some of the articles.

To create your free account, please go to <https://openathens.nice.org.uk/>



Alerts

Alerts and Recalls for Drugs and Medical Devices (GOV.UK)

[View the April and May Alerts](#)

Letters and drug alerts sent to health professionals (GOV.UK)

[View the April letters and alerts](#)

Guidance

[Designing pharmacy and radiopharmacy facilities \(HBN 14-01\)](#)

Department of Health, Updated May 2021

[NICE Guidance and Advice List – Latest Updates](#)

[Specialist Pharmacy Service – Latest Updates](#)

Vaccination Information

[COVID-19 vaccination programme](#)

NHS England

[Vaccination information from other organisations](#)

NHS England

News

[Achievements and developments during 2020/21 flu season](#)

NHS England

April 2021

[Letter from Professor Stephen Powis, to Chief Executives of all NHS trusts and foundation trusts, Chief Nursing Officers of all NHS trusts and foundation trusts, Medical Directors of all NHS trusts and foundation trusts, all GP practices and all community pharmacies.]

[BBC News articles on the pharmaceutical industry](#)

[Articles published by BBC News on the pharmaceutical industry are collected here.]

[GMC approves FPM's new speciality training curriculum](#)

Faculty of Pharmaceutical Medicine

May 2021

[It is anticipated that the new curriculum will be implemented in August 2021 and the final version of the curriculum and supporting guidance documents will be published soon.]

[Job security during the pandemic: working in community pharmacy as a kickstarter](#)

National Pharmacy Association

May 2021

[Since the government began its Kickstart Scheme back in September 2020 community pharmacies have been stepping up to fill as many work placements as they can.]

[Nearly one in five pharmacist roles vacant in parts of England, report finds](#)

The Pharmaceutical Journal

June 2021

[Nearly one in ten full-time equivalent (FTE) pharmacist positions in England were vacant as of July 2020, a survey by the Community Pharmacy Workforce Development Group (CPWDG) has found.]

[Optimising the use of Medication-Assisted Treatment](#)

Scottish Drug Death Taskforce

June 2021

[Based on the evidence that Medication Assisted Treatment (MAT) is protective against the risk of death, the Scottish Drug Deaths Taskforce and the Scottish Government has prioritised the implementation of MAT standards for people experiencing problems with their drug use.]

[World's first COVID-19 vaccine booster study begins administering jabs in Bradford](#)

The Pharmaceutical Journal

June 2021

[The trial is part of the COV-Boost study, which is funded by the National Institute for Health Research. It was announced by the Department of Health and Social Care in May 2021 as the first study, globally, to provide data on the impact of a third dose of COVID-19 vaccine on patients' immune responses.]

Community Pharmacy

[Provision of the progestogen-only pill by community pharmacies as bridging contraception for women receiving emergency contraception: the Bridge-it RCT.](#)

Cameron S.T., Glasier A., McDaid L., Radley A., Patterson S., Baraitser P., Stephenson J., Gilson R., Battison C. et al
Health Technology Assessment, vol. 25 (27) pp. 1-92

May 2021

[Introduction: Unless women start effective contraception after using emergency contraception, they remain at risk of unintended pregnancy. Most women in the UK obtain emergency contraception from community pharmacies that are unable to provide ongoing contraception (apart from barrier methods which have high failure rates). This means

that women need an appointment with a general practitioner or at a sexual and reproductive health clinic. We conducted a pragmatic cluster randomised cohort crossover trial to determine whether or not pharmacist provision of a bridging supply of a progestogen-only pill plus the invitation to attend a sexual and reproductive health clinic resulted in increased subsequent use of effective contraception (hormonal or intrauterine). **Methods:** Twenty-nine pharmacies in three UK cities recruited women receiving emergency contraception (levonorgestrel). In the intervention, women received a 3-month supply of the progestogen-only pill (75 µg of desogestrel) plus a card that provided rapid access to a local sexual and reproductive health clinic. In the control arm, pharmacists advised women to attend their usual contraceptive provider. The primary outcome was reported use of an effective contraception (hormonal and intrauterine methods) at 4 months. Process evaluation was also conducted to inform any future implementation. **Results:** The study took place December 2017 and June 2019 and recruited 636 women to the intervention (n = 316) and control groups (n = 320). There were no statistically significant differences in demographic characteristics between the groups. Four-month follow-up data were available for 406 participants: 63% (198/315) of the control group and 65% (208/318) of the intervention group. The proportion of participants reporting use of effective contraception was 20.1% greater (95% confidence interval 5.2% to 35.0%) in the intervention group (58.4%, 95% confidence interval 48.6% to 68.2%) than in the control group (40.5%, 95% confidence interval 29.7% to 51.3%) (adjusted for recruitment period, treatment arm and centre; p = 0.011). The proportion of women using effective contraception remained statistically significantly larger, when adjusted for age, current sexual relationship and history of past use of effective contraception, and was robust to the missing data. There were no serious adverse events. **Conclusion:** Provision of a bridging supply of the progestogen-only pill with emergency contraception from a pharmacist and the invitation to a sexual and reproductive health clinic resulted in a significant increase in self-reported subsequent use of effective contraception. This simple intervention has the potential to prevent more unintended pregnancies for women after emergency contraception.]

Education & Training

["Vital in today's time": Evaluation of a disaster table-top exercise for pharmacists and pharmacy staff.](#)

Watson, Kaitlyn E; Waddell, Jason J; McCourt, Elizabeth M

Research in Social & Administrative Pharmacy, vol. 17 (5) pp. 858-863

May 2021

[Background: While the importance of pharmacists' involvement in disaster management is becoming increasingly recognised in the literature, there remains little research on methods for preparing pharmacists and pharmacy staff for disasters. **Objective(s):** To investigate the use of a table-top disaster exercise to improve disaster awareness and preparedness for pharmacists and pharmacy staff attending The Society of Hospital Pharmacists of Australia (SHPA) Medicine Management conference 2019. **Methods:** A table-top disaster exercise was developed by the research team and presented as a workshop at the SHPA's annual conference in 2019. The workshop presented attendees with the hypothetical 'Cyclone Oma' that was tracking across the fictional state of 'New Cardiff'. Each workshop table was assigned a different hospital and was required to respond to Cyclone Oma as the scenario evolved. Workshop attendees were invited to complete a pre- and post-survey assessing their perceptions of disaster management and preparedness for pharmacists and pharmacy staff. **Results:** The pre- and post-workshop survey was completed by 41 out of the 47 attendees. Participants' assessments of their understanding of disaster management activities increased after attending the workshop (p < 0.001). Most participants felt the workshop improved their understanding of their role in a disaster (87.8%, 36/41) and allowed them to identify their strengths and weaknesses in disaster management (90.2%, 37/41). The workshop was well received with 92.7% (38/41) of participants stating they would like further continuing professional development opportunities in disaster management. **Conclusions:** This is the first disaster table-top exercise in Australia targeted specifically at the pharmacy workforce to be conducted and evaluated. The exercise improved understanding of disaster management and was well received by the participants. This research calls for further education and training opportunities in disaster management targeted at the pharmacy workforce.]

Hospital Pharmacy

[An investigation into prescribing errors made by independent pharmacist prescribers and medical prescribers at a large acute NHS hospital trust: A cross-sectional study](#)

Turner E., Barrowcliffe A., and Kennedy M-C.

European Journal of Hospital Pharmacy, vol. 28 (3) pp. 149-153

May 2021

[Introduction Pharmacists in the UK can register as independent pharmacist prescribers (IPPs) on completion of appropriate higher education training. IPPs have had the same prescribing privileges as medical doctors since 2009. Despite the years since their introduction, there are little data available to demonstrate the frequency and type of errors made by IPPs. Furthermore, there is no literature available comparing IPPs to doctors with regards to prescribing safety. This study aimed to start to fill this gap in the literature. Methods Pharmacists working in one National Health Service (NHS) Trust, in areas with a large proportion of prescribing undertaken by IPPs, were purposefully recruited to collect data over a 1-week period in May 2018. They collected data on all prescription items validated that were prescribed by IPPs and doctors. Errors that were identified were recorded in detail. Data collection forms and error definitions were taken from the EQUIP Study, a large study looking at prescribing errors by junior doctors in the hospital setting. Results 5840 prescriptions items were recorded; 1026 (17.6%) were prescribed by an IPP. 479 errors were recorded in total. Experienced IPPs, had a 1% error rate (seven errors); IPPs with less experience had a 0% error rate. Overall the error rate for pharmacists was 0.7% (95% CI 0.0% to 1.0%). In comparison, doctors made an average of 9.8% errors (95% CI 9.0% to 11.0%). Pharmacists made significantly less prescribing errors than doctors ($p < 0.01$). 85.7% of IPP errors were recorded as minor in significance, compared with an average of 31.7% for all doctor's prescribing errors. Actual patient harm occurred from 0.04% of all prescriptions. Conclusion In a single NHS Trust, pharmacists make significantly less prescribing errors than doctors. Embedding IPPs with more integrated roles in the multidisciplinary team is recommended. Further large trials are required to validate the results of this study.]

[Automatic dispensing cabinets and governance of controlled drugs: an exploratory study in an intensive care unit.](#)

Lichtner, Valentina; Prgomet, Mirela; Gates, Peter; Franklin, Bryony Dean

European Journal of Hospital Pharmacy, Online First

May 2021

Background: Governance of controlled drugs (CDs) in hospitals is resource intensive but important for patient safety and policy compliance. **Objectives:** To explore whether and how storing CDs in an automated dispensing cabinet (ADC) in a children's hospital intensive care unit (ICU) contributes to the effectiveness and efficiency of CD governance. **Methods:** We conducted a mixed-methods exploratory study, comprising observations, interviews and audits, 3 months after ADC implementation. We observed 54 hours of medications activities in the ICU medication room (with 42 hours of timed data); interviewed nurses ($n=19$), management ($n=1$) and pharmacy staff ($n=3$); reviewed 6 months of ICU incident reports pertaining to CD governance; audited 6 months of CD register data and extracted logs of all ADC transactions for the 3 months following implementation. Data analysis focused on four main CD governance activities: safekeeping/controlling access, documenting use, monitoring, and reporting/investigating. **Results:** Nurses and pharmacists perceived spending less time on CD governance tasks with the ADC. The ADC supported CD governance through automated documentation of CD transactions; 'blind counts'; automated count discrepancy checks; electronic alerts and reporting functionalities. It changed quality and distribution of governance tasks, such as removing the requirement for 'nurses with keys' to access CDs, and allowing pharmacists to generate reports remotely, rather than reviewing registers on the ward. For CDs in the ADC, auditing and monitoring appeared to be ongoing rather than periodic. Such changes appeared to create positive reinforcing loops. However, the ADC also created challenges for CD governance. Most importantly, it was not suitable for all CDs, leading to workarounds and parallel use of a safe plus paper registers. **Conclusions:** ADCs can significantly alter CDs governance in clinical areas. Effects of an ADC on efficiency and effectiveness of governance tasks appear to be complex, going beyond simple time savings or more stringent controls.]

[Critical analysis of drug related problems among inpatients in the psychiatry department of a tertiary care teaching hospital: A pharmacist led initiative](#)

Jayakumar A., Abraham A.S., Chand S., George S.M., Joel J.J., UP N., and Kumar S.

Clinical Epidemiology and Global Health, vol. 11

July 2021

[Introduction: Drug Related Problems (DRPs) frequently take place in modern medical practices, increasing the morbidity and mortality as well as the cost of patient care. **Objective(s):** The current study was undertaken to identify and evaluate various DRPs among the inpatients of the psychiatry department in a tertiary care teaching hospital using APS-Doc classification system and to identify the most recurrent drugs causing the DRPs. **Method(s):** A prospective observational study was conducted for duration of six months among 198 patients using APS-Doc classification system. The data was statistically analysed and tabulated. **Result(s):** A total of 205 DRPs were identified in 102 patients, among which 115 (56.1%) were potential drug-drug interactions (pDDI) and 62 (30.2%) were adverse drug reactions (ADRs). 21 (10.2%) DRPs belonged to the category of incorrect spelling of the trade name and 3 (1.5%) among them belonged to unintended prescription of the same drug. Two out of 205 DRPs (1%) belonged to the class of prescription of an incorrect dosage form or no dosage prescribed. One DRP each were categorised under wrong dosage form prescribed and inadequate generic substitution respectively. Out of the total of 314 drugs, risperidone (n = 43, 13.7%) was found to be the drug associated with the most number of DRPs followed by olanzapine (n = 38, 12.1%) and lorazepam (n = 32, 10.2%). **Conclusion(s):** The study revealed that more than half (51.5%) of the patients presented with DRPs and the most commonly identified DRPs were pDDIs and ADRs.]

[Description of pharmacists' reported interventions to prevent prescribing errors among in hospital inpatients: a cross sectional retrospective study.](#)

Alzahrani A.A., Alwhaibi M.M., Asiri Y.A., Kamal K.M., and Alhawassi T.M.

BMC Health Services Research, vol. 21 (1)

May 2021

[Background: Prescribing errors (PEs) are a common cause of morbidity and mortality, both in community practice and in hospitals. Pharmacists have an essential role in minimizing and preventing PEs, thus, there is a need to document the nature of pharmacists' interventions to prevent PEs. The purpose of this study was to describe reported interventions conducted by pharmacists to prevent or minimize PEs in a tertiary care hospital. **Methods:** A retrospective analysis of the electronic medical records data was conducted to identify pharmacists' interventions related to reported PEs. The PE-related data was extracted for a period of six-month (April to September 2017) and comprised of patient demographics, medication-related information, and the different interventions conducted by the pharmacists. The study was carried in a tertiary care hospital in Riyadh region. The study was ethically reviewed and approved by the hospital IRB committee. Descriptive analyses were appropriately conducted using the IBM SPSS Statistics. **Results:** A total of 2,564 pharmacists' interventions related to PEs were recorded. These interventions were reported in 1,565 patients. Wrong dose (54.3 %) and unauthorized prescription (21.9 %) were the most commonly encountered PEs. Anti-infectives for systemic use (49.2 %) and alimentary tract and metabolism medications (18.2 %) were the most common classes involved with PEs. The most commonly reported pharmacists' interventions were dose adjustments (44.0 %), restricted medication approvals (21.9 %), and therapeutic duplications (11 %). **Conclusions:** In this study, PEs occurred commonly and pharmacists' interventions were critical in preventing possible medication related harm to patients. Care coordination and prioritizing patient safety through quality improvement initiatives at all levels of the health care system can play a key role in this quality improvement drive. Future studies should evaluate the impact of pharmacists' interventions on patient outcomes.]

[Enhancement and evaluation of a prescription audit system for direct oral anticoagulants using a check sheet.](#)

Ishikawa N., Oshikiri H., Takasaki S., Kikuchi M., Obara T., Akasaka K., Matsuura M., Yamaguchi H., and Mano N.

Journal of Pharmaceutical Health Care and Sciences, vol. 7 (1)

June 2021

[Background: Renal function and use of concomitant medications should be carefully monitored in patients subjected to treatment with direct oral anticoagulants (DOACs); the dose should be individually designed for each patient. Owing to the complex therapeutic indications and dose reduction criteria, pharmacists exercise caution when determining the optimal dose for each patient. A DOAC check sheet has been developed that is automatically printed in the dispensing room at the same time as the prescription and can be used by pharmacists to dispense DOACs promptly and correctly. The purpose of this study was to evaluate the system for dispensing DOACs using a check sheet. **Methods:** The study was conducted at Tohoku University Hospital in Japan; prescriptions containing DOACs dispensed by the hospital pharmacists were evaluated. The DOAC check sheet described indications, dosage regimens, dose reduction criteria, and contraindications for each drug and included the patient's information. The check sheet was set to print automatically in the dispensing room at the same time as the prescription when an inpatient was prescribed DOACs. This check sheet was evaluated using a prescription survey and a questionnaire for pharmacists. **Results:** The usefulness of this check sheet for the correct use of DOACs was evaluated. There were

four inquiries out of 642 (0.6%) prescriptions from pharmacists to physicians regarding DOAC prescriptions, such as the dose introduced before DOAC check sheet utilization, and there were 21 out of 905 (2.3%) prescriptions when the DOAC check sheet was used it, showing a significant increase ($p = 0.0089$). After the introduction of this sheet, overdoses of DOACs were identified at the time of dispensing. Of the 52 pharmacists who responded to the questionnaire, 51 (98%) stated that the check sheet was useful. **Conclusion:** The use of the DOAC check sheet is likely to render safety to DOAC drug therapy for individual patients.]

[Evaluation of a Pharmacist-Led Penicillin Allergy Assessment Program and Allergy Delabeling in a Tertiary Care Hospital.](#)

Turner N.A., Wrenn R., Sarubbi C., Kleris R., Lugar P.L., Radojicic C., Moehring R.W., and Anderson D.J.
JAMA Network Open, vol. 4 (5)
May 2021

[Importance: Penicillin allergies are frequently mislabeled, which may contribute to use of less-preferred alternative antibiotics. **Objective:** To evaluate a pharmacist-led allergy assessment program's association with antimicrobial use and clinical outcomes. **Design, Setting, and Participants:** A pharmacist-led allergy assessment program was launched in 2 phases (June 1, 2015, and November 2, 2016) at a single-center tertiary referral hospital. The longitudinal cross-sectional study included all study period adult admissions; hospitalwide outcomes were assessed by segmented regression. Individual outcomes were assessed within an embedded propensity score-matched case-control study of inpatients undergoing comprehensive allergy assessment following self-report of penicillin allergy. Analysis occurred from March 1, 2020, to February 29, 2020. **Exposures**The longitudinal study analyzed hospital-level outcomes over 3 periods: preintervention (15 months), phase 1 (structured allergy history alone, 16 months), and phase 2 (comprehensive assessment including penicillin skin testing, 52 months). The case-control study defined cases as individuals undergoing comprehensive allergy assessment. **Main Outcomes and Measures:** Hospital-level outcomes included antibiotic days of therapy per 1000 patient-days and hospital-acquired *Clostridioides difficile* infection (CDI) incidence per 10 000 patient-days. Individual outcomes included antibiotic selection, overall survival, and CDI-free survival. **Results:** Longitudinal analysis spanned 2014-2020 (median admissions, 46 416 per year; interquartile range [IQR], 46 001-50 091 per year). Hospitalwide, allergy histories were temporally associated with decreased use of nonpenicillin alternative antibiotics (rate ratio, 0.87; 95% CI, 0.79-0.97) and high-CDI-risk antibiotics (rate ratio, 0.91; 95% CI, 0.85-0.98). Penicillin skin testing was temporally associated with lower hospital-acquired CDI rates (rate ratio, 0.61; 95% CI, 0.43-0.86). The embedded case-control study included 272 cases and 819 controls. Median age was 63 years (interquartile range, 51-73 years), 553 (50.7%) patients were women, and 229 (21.0%) patients were Black. Allergy-assessed patients were less likely to receive high-CDI-risk antibiotics at discharge (odds ratio, 0.66; 95% CI, 0.44-0.98). Estimated reductions in mortality (hazard ratio, 0.77; 95% CI, 0.55-1.07) and hospital-acquired CDI risk (hazard ratio, 0.53; 95% CI, 0.18-1.55) were not statistically significant. **Conclusions and Relevance:** Pharmacist-led allergy assessments may be associated with reduced high-CDI-risk antibiotic use at both hospitalwide and individual levels. Although individual reductions in mortality and CDI risk did not achieve significance, divergence of survival curves suggest longer-term benefits of allergy delabeling warrant future study.

[Implementation of a renal pharmacist consultant service - Information sharing in paper versus digital form.](#)

Seiberth S., Bauer D., Schönermarck U., Mannell H., Stief C., Hasford J., and Strobach D.
Journal of Clinical Pharmacy and Therapeutics, vol. 46 (3) p. 838-845
June 2021

[What is known and objective: Renal impairment (RI) and renal drug-related problems (rDRP) often remain unrecognized in the community setting. A "renal pharmacist consultant service" (RPCS) at hospital admission can support patient safety by detecting rDRP. However, the efficient information sharing from pharmacists to physicians is still discussed. The aim of the study was to test the implementation of a RPCS and its effectiveness on prescription changes and to evaluate two ways of written information sharing with physicians. **Methods:** Urological patients with eGFR non-indexed of 15-59 ml/min and ≥ 1 drug were reviewed for manifest and potential rDRP at admission by a pharmacist. Written recommendations for dose or drug adaptation were forwarded to physicians comparing two routes: July-September 2017 paper form in handwritten chart; November 2017-January 2018 digital PDF document in the electronic patient information system and e-mail alert. Prescription changes regarding manifest rDRP were evaluated and compared with a previous retrospective study without RPCS. **Results and discussion:** The RPCS detected rDRP in 63 of 234 (26.9%) patients and prepared written recommendations (median 1 rDRP (1-5) per patient) concerning 110 of 538 (20.5%) drugs at admission. For manifest rDRP, acceptance rates of recommendations were 62.5% (paper) vs 42.9% (digital) ($P = 0.16$). Compared with the retrospective study without

RPCS (prescription changes in 21/76 rDRP; 27.6%), correct prescribing concerning manifest rDRP significantly increased by 27.1%. **What is new and conclusion:** A RPCS identifies patients at risk for rDRP and significantly increases appropriate prescribing by physicians. In our hospital (no electronic order entry, electronic chart or ward pharmacists), consultations in paper form seem to be superior to a digital PDF document.]

[Validation of a hospital clinical pharmacy workforce calculator: A methodology for pharmacy?](#)

Bednall R., White S., Mills E., and Thomson, S.

International Journal of Clinical Practice, vol. 75 (5)

May 2021

[Background: The benefits of clinical pharmacy services are established within hospital practice but staff numbers required for service delivery are not well described and staffing levels vary. The need for a consistent, objective method of determining staffing levels was recognised at a UK University Hospital and a Clinical Pharmacy Workforce Calculator (CPWC) was developed. **Objective:** To develop the Activity Standard (AS) for pharmaceutical care and establish the reliability of the CPWC across acute hospital settings in UK. **Setting:** Acute hospital in-patient clinical pharmacy services on medical and surgical wards. **Method:** Using the World Health Organisation's Workload Indicators of Staffing Need (WISN) methodology, a two-round Delphi study was undertaken. This developed the Activity Standard for pharmaceutical care and identified the staff-time unavailable for clinical work. Consenting panel members then tested the CPWC, calculating the staff required for three scenarios to determine whether it could be reliably used by different operators. **Results:** Thirty-six participants consented to participate. Data were returned from 22 (61%) of whom 20 (56%) supplied analysable data. Consensus was achieved on the tasks required for pharmaceutical care delivery, the mean time each takes, how frequently they should be completed and the time unavailable for clinical work for each grade of staff. The CPWC calculates staffing requirements using these data. Eleven participants (55%) tested the CPWC and analysis of responses demonstrated that 30 of 33 (91%) calculations were accurately completed. **Discussion:** This study defined the WISN Activity Standard for UK pharmaceutical care delivery to hospital inpatients and showed content validity for the CPWC in acute medical and surgical hospital settings. Different operators used the CPWC reliably and applied it to local sites. **Conclusion:** The CPWC offers hospital pharmacy managers a useful tool to negotiate adequate staffing to deliver pharmaceutical care. Its development methodology could be applied widely in pharmacy practice.]

Medicines Management

[Effect of number of medications and use of potentially inappropriate medications on frailty among early-stage older outpatients](#)

Uragami Y.; Takikawa K.; Kareki H.; Kimura K.; Yamamoto K.; Iihara N.

Journal of Pharmaceutical Health Care and Sciences, vol. 7 (1)

May 2021

[Background: Frailty is an urgent concern among an aging population worldwide. However, the relationship between frailty and number and types of medications has not been studied in detail among early-stage older patients, and it is unclear what prescriptions may have a role in preventing frailty. This study aimed to clarify the effects of number of medications and use of potentially inappropriate medications (PIMs) on frailty among early-stage older outpatients in Japan. **Method(s):** A cross-sectional study was undertaken. Frailty scores and medications of outpatients aged 65-74 years who regularly visited community pharmacies were investigated. Frailty scores were classified as 0 (non-frailty), 1-2 (pre-frailty), and ≥ 3 (frailty). The association between frailty and number of medications was analyzed by age and compared between PIM use and non-use groups. The proportion of patients who used PIMs was also analyzed by frailty score. **Result(s):** Of 923 older outpatients, 49 (5.3%) and 318 (34.5%) patients had frailty and pre-frailty scores, respectively. The numbers of medications among patients with pre-frailty and frailty were significantly higher than among those with non-frailty ($p < 0.001$ for both). A similar increase was shown for PIM use groups aged 69-71 and 72-74 years, but not for the PIM use group aged 65-68 years and all groups without PIM use. An increasing linear trend was observed for the relationship between the proportion of patients who used any PIM, as well as some subcategories of PIMs (such as NSAIDs, benzodiazepines, loop diuretics and antithrombotic drugs) and frailty score. **Conclusion(s):** Unnecessary medication use among early-stage older outpatients, especially patients aged ≥ 69 years who use PIMs and many medications, seems to be associated with frailty, but further research is needed to confirm these findings.]

['I just take them because I know the people that give them to me': A theory-informed interview study of community-dwelling people with dementia and carers' perspectives of medicines management.](#)

Barry H.E., McGrattan M., Ryan C., Passmore P.A., Robinson L.A., Molloy G.J., Darcy C.M., Buchanan H. et al
International Journal of Geriatric Psychiatry, vol. 36(6) pp. 883-891

June 2021

Objective: Identify facilitators and barriers to successful medicines management for people with dementia (PwD) in primary care from the perspectives of community-dwelling PwD and carers. **Methods:** Semi-structured interviews conducted with PwD and carers in Northern Ireland. The 14-domain Theoretical Domains Framework guided data collection and analysis. Interviews explored participants' experiences and perceptions of medicines management. PwD also completed the Beliefs about Medicines Questionnaire indicating their level of agreement with statements about medicines. Qualitative data were analysed using the framework method and content analysis. Quantitative data were analysed descriptively. **Results:** Eighteen PwD and 15 carers were interviewed. PwD believed they were competent with medicines management ('beliefs about capabilities'). Most PwD reported having strategies to prompt them to take their medicines ('memory, attention and decision processes'). Carers played an important role in supporting PwD with medicines management ('social influences') and monitoring adherence ('behavioural regulation') and anticipated having to take on a greater role as patients' cognitive impairment worsened ('beliefs about consequences'). Participants highlighted assistance provided by community pharmacies with medicines acquisition and delivery ('environmental context and resources') and placed great trust in primary healthcare professionals ('social influences'). PwD had positive attitudes towards medication and believed strongly in the necessity of their medicines. **Conclusions:** This is the first study to use a theoretical approach to explore medicines management for community-dwelling PwD. The findings provide new insights into the critical role of carers in facilitating optimal medicines management and will inform future intervention development, in which carers' needs assessment and involvement will be key.]

[The problem with gentamicin: reducing administration and prescribing errors in neonates treated for early onset infection with gentamicin.](#)

Trivedi A., Lek E., Sharma S., Chellen S.

Archives of Disease in Childhood. Education and Practice Edition, vol. 106 (3) pp. 182-186

June 2021

[We describe a quality improvement (QI) project to reduce the number of administration and prescribing errors with gentamicin on a local neonatal unit in a district general hospital, from January 2017 to August 2019. Baseline data collected showed seven errors in the first 16 months of the project (from 1999 doses). The aim of this QI project was to have no low-level, moderate-level or severe level harm errors in the intervention period. A number of interventions were carried out including a change to local guidelines and teaching sessions for staff. All Datix reports for gentamicin were reviewed as well as data collected from the pharmacy team for a further 16 months. One low harm error was reported in this period (from 1938 doses). Education of the medical and nursing staff has been a key intervention in reducing our gentamicin errors as well as changing the way we prescribe gentamicin.]

Airedale NHS Library

 www.educationairedale.co.uk/library

 anhsft.library@nhs.net

 01535 294412

Airedale General Hospital – Location B11

This bulletin is available online from the library website and contains links to the listed articles.