Prescribing errors due to incorrect drugs, incorrect doses and prescriptions with incorrect patient details accounted for 50% of all incidents reported.

Most of these were near misses or had impact of ‘no harm’ i.e. the impact was either prevented from reaching the patient or the impact ran to completion without causing any harm.

3 of the incidents had minor impact on the patients. These were related to adverse reactions after drug administration: pain, palpitations & general urticaria.

There was no incident with moderate or major impact.

Our records on prescribing and dispensing safety are good compared with most hospitals.

The average total volume of prescription items across the Trust in a month is 31,000.

The dispensing error rate is estimated at 0.01%. This is lower than the dispensing error rate in hospitals of 0.02 – 2.7% of dispensed medicines.

The prescribing error rate is estimated at 0.05%. This is significantly lower than the cited prescribing error rate in hospitals of 7%.

The percentage of medication incidents from the total prescription items over this period is estimated at 0.09%.

Constant vigilance is required to prevent harm and maintain our medication safety records.
The use of systemic drugs in an ophthalmic hospital can be a big risk area if clinical staff are not up to date with the product characteristics and clinical specifications of the systemic drugs in question.

Moxifloxacin (Avelox®) is an antibiotic used to treat certain bacterial infections including bronchitis, pneumonia, sinus, skin and stomach infections in adults.

At Moorfields, it is prescribed for bacterial endophthalmitis; bleb-related endophthalmitis; penetrating eye injuries (A&E handbook)

Moxifloxacin is known to be associated with prolongation of QT interval, a risk of liver toxicity, seizures, serious bullous skin reactions and peripheral neuropathy.

An update from the MHRA in 2011 (http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON105760) advised that oral moxifloxacin should be used only when it is considered inappropriate to use commonly recommended antibacterial agents or when these have failed. This is because of evidence of an increased risk of life-threatening liver reactions and other serious risks (such as QT interval prolongation).

Since the serious incident in 2012 which was associated with liver failure in a patient treated with moxifloxacin for longer than the recommended duration, there has been no further harm to any patient given moxifloxacin at Moorfields. However, there have been 5 instances where pharmacists have identified errors in prescriptions received for oral moxifloxacin. These “near misses” were averted by pharmacists contacting the prescribing doctors and getting the prescription changed before dispensing.

All prescribers should prevent medication related incidents occurring with Moxifloxacin by taking appropriate drug history to minimise the risk of QT interval prolongation and ensuring that baseline liver function test and monitoring takes place. Also, the course length of Moxifloxacin should be limited to 10 days and the risk of interactions with concurrent medications should be considered.

Giving moxifloxacin for more than 10 days can cause severe harm or even death. Always do liver function tests in patients being prescribed moxifloxacin.