Prescribing Tip No. Date: 330 26th August 2021

How to minimise the risks of medication errors with Rivastigmine patches

Rivastigmine patches are recommended by NICE as a treatment option for cognitive symptoms in mild-to-moderate dementia due to Alzheimer's disease, under the supervision of a dementia specialist.
Rivastigmine is rated Amber 0 with our local LSCMMG dementia guidelines

In 2010, an MHRA Drug Safety Update for rivastigmine (Exelon) patches reported medication errors and inappropriate use of rivastigmine transdermal patches, which resulted in overdose and hospital admission in some cases.
Despite the MHRA safety update, medication errors continued to be reported via the UK National Reporting and Learning system NRLS Reporting . Multiple patch application is the most reported patient safety incident.

These patient safety incidents may have been further compounded by of the number of different brands and strengths of patches available. Brands include Almuriva, Alzest. Erastig, Exelon, Prometag and Voleze in varying strengths of 4.6mg, 9.5mg and 13.3mg.

Type of error	Associated problems
Multiple patch application	Two or more patches applied to various areas of the body, often resulting in patient harm.
Omitted or delayed dosing	Delayed dosing has also occurred due to patches being replaced at the incorrect frequency, for example, 72 hours rather than 24 hours.
'Look-a-like' and 'sound-a-like' errors	Confusion between Rivastigmine and Rotigotine patches has occurred, mainly during the dispensing process, but errors during prescribing and administration were also noted.
Wrong strength	Incidents of the wrong strength of patches being prescribed or dispensed, resulting in adverse events have also occurred.

Advice on safer use of Rivastigmine patches –

Patients and caregivers should be:

- Provided with clear instructions on the frequency of patch removal and application, and appropriate areas for the patch.
- Encouraged to keep a record of when the patch was removed and when it was replaced.
- Encouraged to write the day of the week or date on the patch with a thin ball point pen.
- Advised that the patch should not be exposed to any external heat sources for long periods of time.

Healthcare providers (including hospitals, care homes and other adult social care settings) should have:

- A method for recording when and where a patch has been placed on the patient's body, and when the old patch has been removed. For example, on Medicines Administration Record (MAR) charts and patient 'body map' charts.
- Writing the date on patches that have been applied - this ensures that the date and patch is visible to all care staff, including if the patient is transferred to another setting.
- Care plans which include specific patch administration advice.

Pharmacists and Prescribers should have:

- Clear instructions on directions stating the frequency of patch application and removal. For example, **"Apply ONE patch every TWENTY-FOUR hours. Remove and discard the old patch before applying a new patch to a different area."**
- Safe prescribing systems, in particular electronic prescribing systems should be reviewed to minimise the risk of prescribing the wrong product or strength.
- Safe dispensing practices, in particular strategies to mitigate the risk of dispensing the wrong product (i.e. confusion between rivastigmine and rotigotine patches) or wrong strength should be considered.

Please check GP practice EMIS systems for suitable directions for Rivastigmine patches for your patients.

Robust systems are needed to ensure the safe prescribing, dispensing, and administration of rivastigmine patches.

How to minimise the risks of medication errors with rivastigmine patches – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Prescribing tip for actioning by practice

To contact the Medicines Optimisation Team please phone 01772 214302