MedicinesUpdatePrimaryCare

NHS Greater Glasgow and Clyde

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Drugs issued from outwith the Practice

When patients are issued drugs from outside the practice, for example from hospital or addiction services, it is recommended by the Prescribing Team and Glasgow Local Medical Committee that these are added to the patient medication record. Although there is no contractual requirement to do this, it ensures the patient medication record and the Emergency Care Summary (ECS) are complete. This supports clinical decision making by flagging interactions etc and it improves medication reconciliation at the interface when an accurate ECS is available.

There is no recommended list of non-practice drugs which should be added to the patient medication record; this remains at the discretion of each individual practice. However, common examples include zolendronic acid, clozapine, HIV drugs and methadone.

Guidance on how to add drugs issued from outwith the practice is available for both EMIS and VISION on the GGC prescribing page. When adding these drugs onto either system the phrase **'HOSPITAL ISSUE ONLY – DO NOT DISPENSE'** should be added into the dosage field. This should act as a warning for community pharmacies if a prescription is inadvertently issued.

Although these actions minimise the risk of a patient being dispensed a medicine issued from outwith the practice, they are not infallible.

We recently had a report from a practice where all of the above safeguards were in place and despite this, a medicine from outwith the practice was issued to the patient and the error was not identified until the point of administration. This had arisen as EMIS warning messages had not been appropriately acknowledged, resulting in a prescription being issued. The prescription was then dispensed by a community pharmacy who assumed the issue to be correct and failed to query the message stating 'do not dispense'.

There were various points during this event where the error could have been prevented. It is important that all practice and pharmacy staff are fully aware of the importance of these warning messages to prevent these incidents from occurring in the future.

Synonyms update

The latest update of synonyms contains some new additions to the .PAED synonyms on EMIS.

The .PAED synonyms now incorporate synonyms to cover some of the standard formulations initiated at Yorkhill. It is hoped that prescribers can use these synonyms to ensure continuity in formulation when the prescribing is transferred to primary care. These synonyms have been entered into the file twice - as .PAED and also as .YORKHILL, as this may be more memorable for some prescribers.

Entries for .PAED and .YORKHILL will be developed further, including the addition of ACE inhibitor of choice for the next update. The new synonyms are highlighted on the synonyms update summary which is available on StaffNet.

For suggestions or comments on these or any other synonyms, please email **Prescribing@ggc.scot.nhs.uk**

Prescribing drugs with similar names

A prescribing error was recently reported to us where methylprednisolone (Depo-Medrone®) was selected instead of medroxyprogesterone (Depo-Provera®) in EMIS. Prescribers are advised to remain vigilant when selecting these medicines from drug lists in GP systems and others with similarly spelt names.

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Insulin Pen Needles and Lancets

Following a recent review of insulin pen needles and lancets, the following brands are now preferred list choices in the NHSGGC Formulary:

Preferred choices of lancets

1. Apollo Twist® Lancets
2. Omnican Lance® Soft Lancets

Device compatibility information is available here.

Preferred choices of insulin pen needles:

1. Omnican Fine® pen needles (4mm, 6mm)
2. GlucoRx Finepoint® pen needles (4mm, 5mm, 6mm)

Universal fit on all insulin pens – device compatibility charts are available for Omnican Fine® and GlucoRx Finepoint®.

Other needle lengths are available but use of shorter needles is considered national and international best practice to minimise the risk of intramuscular injection of insulin. 4mm, 5mm and 6mm needles are suitable for all people with diabetes regardless of BMI.

Currently only 60% of patients across NHS GGC who inject insulin are prescribed shorter (4mm, 5mm, 6mm) needles in line with recommendations; 30% of patients are using 8mm needles and 10% are still using 10mm or 12mm needles. Patients using longer needles should be identified and their needle length and injection technique reviewed, with a view to switching to a shorter needle.

Patients should be reminded that needles and lancets are single-use; a new lancet should be used for each finger prick blood sample, and a new pen needle should be used each time they inject insulin to minimise the risk of tissue damage, pain and inaccurate insulin dosing.

ScriptSwitch® messages will be active from the end of March to alert prescribers of the formulary choices, giving the opportunity to switch patients' needles and lancets when initiating a new acute or repeat prescription, or reauthorising a repeat. Community pharmacists have been notified of the changes to ensure that they carry stock of the appropriate products.

Adrenaline for anaphylaxis

Following the closure of the nursing home medical practice, prescribers are advised to consider the following when supplying adrenaline for anaphylaxis kits in nursing homes.

When administering adrenaline for anaphylaxis, appropriately trained healthcare professionals should administer adrenaline 1 in 1000 (1mg/ml) using the BNF doses shown in table 1.

Healthcare professionals should use adrenaline 1 in 1000 (1mg/ml) ampoules in preference to auto-injector devices e.g. Jext®, EpiPen® and Emerade® for the treatment of anaphylaxis to ensure the recommended dose of adrenaline is administered.

The use of auto-injector pens should be reserved for self-administration by patients or their carers only, and they should not be used routinely by healthcare professionals for the treatment of anaphylaxis.

Table 1: Dose of **intramuscular** injection of adrenaline (epinephrine) for the emergency treatment of anaphylaxis by healthcare professionals

Age	Dose	Volume of adrenaline **1 in 1000** (1 mg/mL)
Child under 6 years	150 micrograms	0.15 mL(1)
Child 6–12 years	300 micrograms	0.3 mL
Adult and child 12–18 years	500 micrograms	0.5 mL(2)
These doses may be repeated several times if necessary at 5-minute intervals according to blood pressure, pulse, and respiratory function.		
(1) Use suitable syringe for measuring small volume (2) 300 micrograms (0.3ml) if child is small or prepubertal		

Adrenaline 1 in 1000 (1mg/ml) is available in 0.5ml or 1ml ampoules. 1ml ampoules are the most cost-effective option and should be used in preference to 0.5ml ampoules.

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