LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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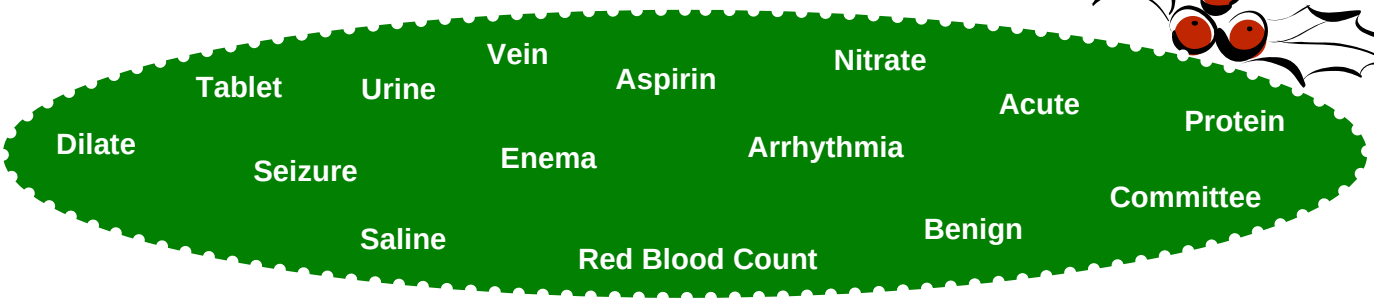
Holiday quiz

No prizes! (However, we thought you needed some education…)
Try to match up the words below with the definitions in the table.



To live long	Small table	In favour of young people
Conceited	What you are after you be eight	Having great ambitions
Dracula	Lower than a day rate	Where you go on your friend's boat
Roman Emperor	Unable to sing or play a musical instrument	Opposite of 'You're Out'
Not a friend	A body that keeps minutes and wastes hours	Opposite of an ugly

LJF update on smoking cessation – new flowchart

The smoking cessation section of the LJF (4.10j) has been updated with significant changes and will be available shortly at www.ljf.scot.nhs.uk. It is anticipated that the new guidance will result in better quality prescribing and more efficient use of resources.

The updated section also contains a link to a flowchart, which is designed to assist with product choice according to patient need.

Within the flowchart there is a further link to information about smoking cessation services within Lothian. **All patients should be considered for referral to these services, for which the success rate is good, to enable the recording of Lothian outcomes.** This will result in the capture of the necessary information for the national database on quit rates.

Thanks to James Higgins, Pharmacy Stop Smoking Service Co-ordinator, for contributing this article.

eLJF-GPASS v2009.1 upgrade

The latest version of eLJF-GPASS was emailed to practices in December 2009. Changes to the wound dressings section are included. EPASS-accredited CPD packs of eLJF-GPASS are available free of charge from the MMT or can be downloaded from the LJF website.

Reducing errors with opioid medicines

In July 2008, the National Patient Safety Agency (NPSA) released a Rapid Response Report on reducing dosage errors with opioid medicines.[1] It recommended that all healthcare professionals prescribing, dispensing or administering opioid medicines to patients, in anything other than acute emergencies, should:

* Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medical records.
* Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than previous dose).
* Ensure they are familiar with the following characteristics of the medicine: formulation, starting dose, frequency of administration, standard dosing increments, symptoms of overdose, and common side effects.

Oxycodone particularly, because of its many formulations, strengths and associated dosage regimens, has been associated with frequent prescribing, dispensing and administration errors. Care in selecting the correct formulation is essential, especially with the liquid preparation where the concentrate is **ten times stronger** than the normal liquid preparation. Selection of the wrong strength could be potentially fatal.

There have been instances where patients have been prescribed Oxycontin® **m/r tabs** three or four times a day and also on a 'when required' basis, which is clearly inappropriate for a modified release preparation. Additionally, there have been cases of oxybutynin m/r being confused with oxycodone m/r.

It is recommended that local medicines and prescribing policies, including Standard Operating Procedures, should be reviewed to reflect this guidance.

Key message:

Always double-check what formulation and strength is required when prescribing, dispensing or administering opioids to ensure that the patient receives the correct medication.

Formulation	Strength	Usual dose schedule
oxycodone capsules (OxyNorm®)	5mg, 10mg and 20mg	Every 4 to 6 hours
oxycodone m/r tablets (OxyContin®)	5mg, 10mg, 20mg, 40mg and 80mg	Every 12 hours
oxycodone liquid (= oral solution) (OxyNorm®)	5mg/5mL	Every 4 to 6 hours
oxycodone concentrate (= concentrated oral solution) (OxyNorm®)	10mg/mL	Every 4 to 6 hours
oxycodone injection (OxyNorm®)	10mg/mL, 50mg/mL	Every 4 hours or by infusion (see BNF 58)

Reference

1. Reducing dosing errors with opioid medicines. Rapid Response Report. NPSA/2008/RRR05. 4 July 2008. www.nrls.npsa.nhs.uk/resources/?entryid45=59888

Thanks to Judie Gilies, Lead Pharmacist, Controlled Drug Governance Team, for contributing this article.

The Controlled Drug Governance Team has moved to new premises.
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CORRECTION - The article entitled 'Are your CD prescriptions safe and legal?' in Issue 41 contained an error. It stated: The dose must be on the prescription and cannot be expressed as 'one to be taken as directed'. It should have read 'The dose on the prescription cannot be expressed as 'to be taken as directed or as required'. 'One to be taken as directed' is legally acceptable but the use of 'as directed' on any CD prescription is ambiguous and for safety and good practice reasons should be discouraged.

Monitoring requirements for DMARDs

The shared care protocols (SCPs) for eight disease-modifying anti-rheumatic drugs (DMARDs) used in rheumatology were recently reviewed and updated. The main changes relate to monitoring requirements, based on the British Society for Rheumatology guidelines.[1] For full details of all SCPs, please see the website www.ljf.scot.nhs.uk.

The only changes in monitoring for sodium aurothiomalate (Myocrisin®) and D-penicillamine are that ESR no longer requires routine monitoring. However, it should be noted that ESR is a useful parameter for decision-making in rheumatological conditions.

		Previous version	New version
azathioprine	FBC & LFTs	Fortnightly until dose stabilised; monthly thereafter.	Weekly for first six weeks then fortnightly until dose has been stable for six weeks then monthly until dose has been stable for six months then three monthly.
	U&Es including creatinine		Every six months.
	ESR	Fortnightly until dose stabilised; monthly thereafter.	
ciclosporin	FBC		Monthly until dose and trend has been stable for three months then three monthly.
	LFTs	Monthly.	
	U&Es including creatinine	Fortnightly for first three months then monthly. Return to two weekly testing if ciclosporin dose increased or NSAID co-prescribed.	Fortnightly until dose and trend stable for three months then three monthly. Return to two weekly testing if ciclosporin dose increased or NSAID co-prescribed.
	BP	Fortnightly for first three months then monthly.	At each visit.
	Fasting lipids		Every six months.
leflunomide	FBC & LFTs	Fortnightly for first six months: two monthly thereafter.	Monthly for first six months; if stable and not co-prescribed with another immunosuppressant or hepatotoxic drug, two monthly thereafter.
	ESR		
	BP		At each visit.
	weight		
methotrexate	FBC & LFTs	Fortnightly until the dose has been stable for two months; monthly thereafter.	Fortnightly until the dose and tests have been stable for six weeks. Then monthly until the dose and disease has been stable for one year. Thereafter, the frequency of monitoring may be reduced based on clinical judgement based on due consideration for risk factors including age, co-morbidity, renal impairment etc., when monthly monitoring is to continue.
	albumin		
	U&Es including creatinine		
	ESR	Fortnightly until the dose has been stable for two months; monthly thereafter.	
sulfasalazine	FBC & LFTs	Monthly until the dose has been stable for three months, then three monthly.	Monthly for first three months, three monthly for next nine months. If stable, reduce to six monthly for 2nd year, if stable after 2nd year then stop. One month after any increase in dose.
	ESR		

Reference

1. BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Dermatologists. Rheumatology 2008;*47(6)*:924.

Thanks to Carole Callaghan, Advanced Clinical Pharmacist, Rheumatology and Claire Stein, Primary Care Pharmacist for contributing this article.

Lean in Lothian repeat prescribing waste project

Medicines wastage continues to be a problem. According to the World Health Organisation, globally there is only 50% adherence to prescriptions for long-term conditions. Repeat prescriptions account for about 60 to 75% of all prescriptions written by GPs, and 80% of their prescribing cost. Lean is an improvement approach with the aim of minimising waste and being flexible and open to change. The Lean in Lothian Repeat Prescribing Waste Project was proposed in 2007 by the then Director of Finance, NHS Lothian. The project was overseen by a team of three, the NHS Lothian Modernisation Manager, the Associate Director for Contracted Community Pharmacy Services and CHP Development and the PCCO Head of Finance. The project team identified four pairings of Gpass GP practices, and community pharmacies where the pharmacy dispensed the majority of the prescriptions issued by the relevant surgery.

Through the application of Lean methodology the project determined a number of common improvement themes with the aim of minimising waste and identifying and removing any non added-value steps from the repeat prescribing process. Each practice/community pharmacy pairing worked to an agreed action plan. A number of tools and visual identification aids to support the repeat prescribing process were disseminated to practices to support staff and patients. Sixty-day follow up has been undertaken and the results collated.

Key improvement themes

Communication
Improve communication between GP practices, community pharmacies, patients, carers, and secondary care.

Patient/public awareness
Improve the public's understanding of repeat prescribing and the need to request only the medicines that they need through local and national campaigns.

Medication review
Revise, improve and disseminate training for GP practice staff on non-clinical (level 1) medication review and support implementation at practice level including synchronisation and alignment of repeat prescriptions.

GP Prescribing Management System IT Developments
(while liaising with national procurement representatives)
Develop 'future-proofed' repeat prescribing reporting database and 'dashboard' in partnership with Gpass team.
Commission format changes to the Gpass repeat request slip, differentiating those medicines that should be prescribed regularly from 'as required' items.

Potential benefits

The patient

- Improved patient safety by minimising unnecessary personal risks from unused/unwanted medicines
- Improved patient journey through simplifying the repeat prescription process
- Improved patient access to repeat prescription medicines.

The organisation (GP practice, Community Pharmacy and/or NHS Lothian)

- Simplification of the repeat prescribing process
- Reduced time from request to dispensing time
- Reduced unnecessary repeat prescribing
- Minimisation of the need for unused / unwanted medication disposal, thus reducing harm to the environment and costs
- Improved communication between GP practices and community pharmacies.

Next steps…

The next steps will involve disseminating the project findings to all GP practices and community pharmacies within Lothian along with the tools developed (crib sheets/practice system searches) and the key 'good practice' points. The key improvement themes will be embedded into the work plans of the Primary Care Pharmacy team. Additionally, project team members will continue to liaise with colleagues involved in the procurement of the national replacements for Gpass to ensure that the potential of IT developments is fully maximised.

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View the Lothian Joint Formulary at www.ljf.scot.nhs.uk