LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

Issue No. 44

May 2010

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New Lothian policy now available

Safe Use of Medicines Policy and Procedures

Introduction

A small representative group was convened to produce a single medicines policy document for NHS Lothian. The main task was to amalgamate two documents, namely: the 'Safe Administration of All Medicines' (Primary and Community Division), and the 'Policies and Procedures for Medicines', (University Hospitals Division). The group also reviewed recent guidance and changes to legislation which would need to be incorporated in the new document.

Who is it for?

It is for all staff. The 'Safe Use of Medicines Policy and Procedures' will underpin the 'Respect for Medicines' campaign in Lothian which will be multidisciplinary, with patient involvement. This campaign aims to improve the safe and secure handling, storage and use of medicines and to improve accountability and cost-effective prescribing. Staff need to understand that they have a duty of care in relation to the safe and secure handling of medicines, as well as a requirement to keep up to date with changes to current NHS Lothian policies and procedures. In addition, they need to be aware that if these policies and procedures are not followed that they will be held accountable.

Audit

The Medicines Policies Committee is developing a rolling programme of self-audits to increase awareness amongst all staff who handle medicines of their own responsibilities, and to enable them to reflect on their areas of practice to ensure that proper arrangements are in place. Feedback is welcome, and the Committee would welcome your views on its use.

The document aims to reduce risk to patients, to staff, to the medicines themselves and to the budget through reducing waste. It contains a list of policy statements, backed up by a series of detailed procedures covering the following areas:

- Safe and secure handling of medicines at each stage of their journey
- Specific categories of medicines that require special handling arrangements, for example controlled drugs, cytotoxic chemotherapy, and unlicensed and off-label medicines
- Specific processes, for example, the use of patients' own medicines in hospital, self-administration schemes in hospital, and non-medical prescribing
- Preparation and administration of medicines by different routes.

References

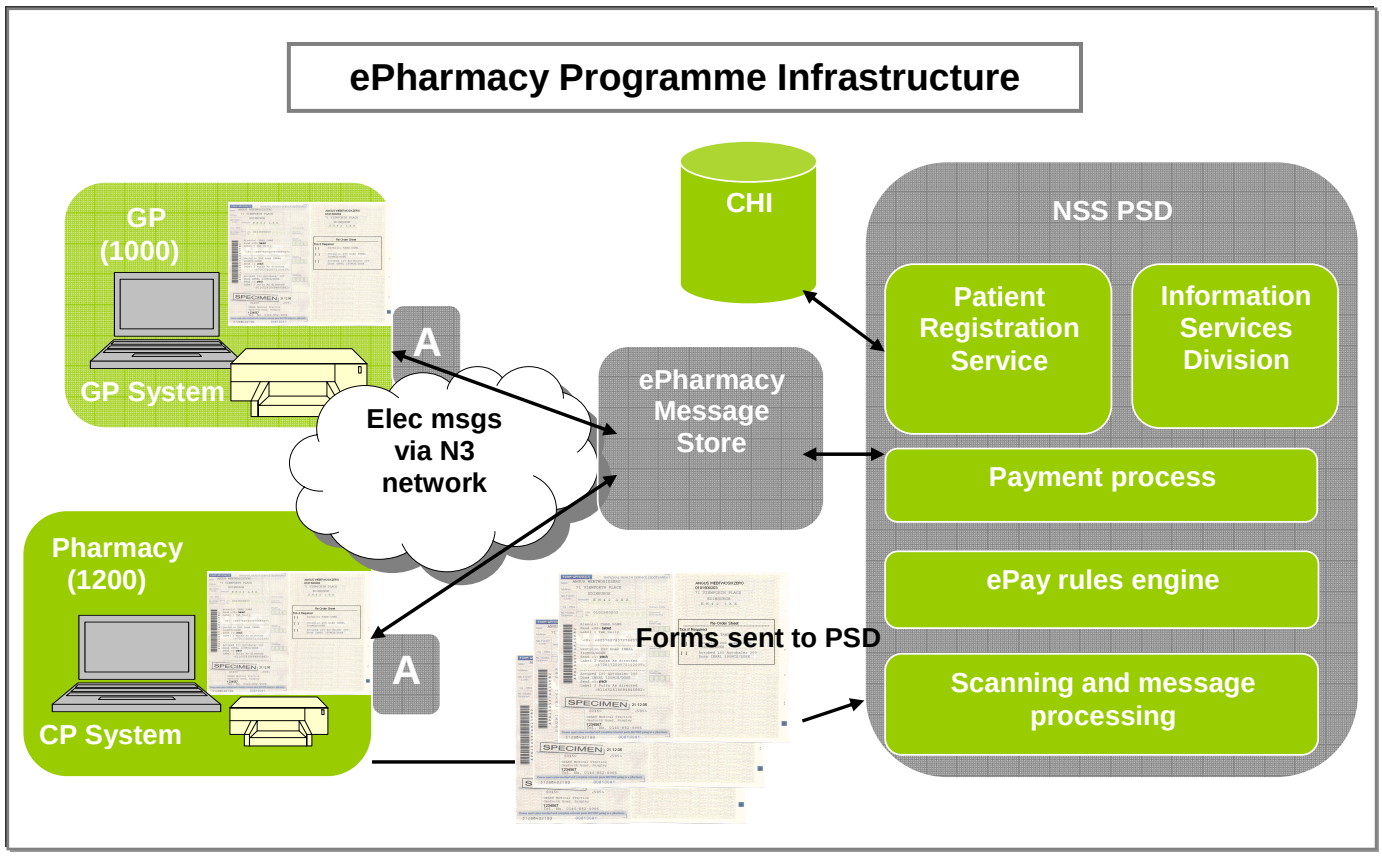
1. NHS Lothian 'Safe Use of Medicines Policy and Procedures'. December 2009. Available on the NHS Lothian intranet at http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGuidance/General/Safe%20Use%20of%20Medicines%20Policy%20%20Procedures%20-%20December%202009.pdf

Thanks to Dorothy Hughes, Associate Director of Pharmacy, Acute Services, for contributing this article.

It's ETP Jim – but not as we know it!

Electronic Transfer of Prescriptions (ETP) was incorporated into GP practice clinical systems across Scotland, including Lothian, from December 2007 as part of the Scottish Government's ePharmacy Programme. The installation of ETP functionality has been a key element in the successful implementation of the Acute Medication Service (AMS), the first of the ePharmacy services to be introduced into GP practices, as well as community pharmacies.

ETP in Scotland differs from that in England in that it is actually the generation and subsequent transmission of prescription information as an electronic message via a secure NHSnet/N3 connection to the ePharmacy Message Store (ePMS) rather than transmission of a prescription to a designated pharmacy. As a barcoded GP10 is printed in the GP surgery, a corresponding e-message is automatically generated by the GP system and transmitted to the ePMS. The e-message contains exactly the same information as the prescription.



When the GP10 is presented at a community pharmacy, the barcode is scanned and the associated prescription information is retrieved by the pharmacy system for dispensing. The e-message cannot be retrieved by the pharmacy unless the barcode on the paper GP10 form is scanned, or the Unique Prescription Number (UPN), which is printed alongside the barcode on the GP10, is entered into the pharmacy computer system. This ensures that the process remains patient-centred with the patient/carer continuing to have the choice of where to obtain their prescriptions.

Once the prescription has been dispensed, the community pharmacy sends an electronic 'dispensed' (or claim) message to the ePMS from where it is accessed by Practitioner Services Division (PSD) for payment purposes.

The Chronic Medication Service (CMS) will also use ETP, for instance when the GP produces a serial prescription. An electronic message will be transmitted by ETP to the ePMS. This electronic message is retrieved in the community pharmacy when the paper prescription form is scanned.

For more information, see the Scottish Government Health Department document, 'Establishing Effective Therapeutic Relationships' www.scotland.gov.uk/Publications/2010/01/07144120/16

Unallocated prescriptions - who's picking up the tab?

GP10 forms are now electronically processed for payment and scanned at Practitioner Services Division (PSD) with the aid of Intelligent Character Recognition (ICR). If a prescription cannot be successfully attributed to a particular prescriber within a GP practice via ICR it is termed 'unallocated', and the cost is divided across each CHP on a pro-rata basis. In NHS Lothian this financial year, the percentage of items that are unallocated is 0.8% (both in cost and volume) and this equates to around £1.07 million. Although this may appear to be a relatively low percentage considering primary care prescribing is estimated to cost £127 million this year, there are a number of additional considerations. Unallocated items can distort data at individual practice and CHP levels. If a practice does not report accurate prescribing figures through its prescriptions then the following may be affected:

- QOF points/analysis
- Prescribing Indicator attainment
- Lothian Joint Formulary adherence
- Prescribing trends
- Any historical element to the budget setting methodology.

A recent sample of unallocated prescriptions received from PSD indicated that the majority of issues arose at practice level. The following are the most common examples:

- Poor alignment of GP10 paper in printer
- Incorrect prescriber codes/practice details on prescription
- Prescriber signature outwith the correct box
- Printer problems including lack of ink.

Printer alignment appears to be the most common problem and this can be easily resolved by regularly checking each printer within the practice as part of general house keeping. Detailed guidance on the correct printing of AMS GP10 prescription forms is available on the Practitioner Services Division website at www.psd.scot.nhs.uk under Medical/Guidance. Additionally, an acetate template known as an ETP Prescription Overlay can be used to check for alignment and skew. This is available from the ePharmacy Helpdesk on 0131 275 6600.

Thanks to Zena Trendell, Prescribing Accountant Analyst, for contributing this article.

Shared care - subcutaneous methotrexate

The process for the prescribing and supply of subcutaneous methotrexate for self-administration by patients at home has changed, moving from secondary care centralisation to a shared care approach. This has resulted from the availability of a licensed product, Metoject®, a 50mg/mL formulation available in a variety of doses, providing the patient's exact dose for use at home. Prior to the launch of Metoject®, only unlicensed formulations of subcutaneous methotrexate were available. Patients eligible to receive methotrexate by this route, i.e. failure or intolerance by the oral route, will be assessed for their ability to self-manage and be taught by a specialist rheumatology practitioner. The initial three-month supply will be provided for all new patients by secondary care, to enable the patient to be stabilised on their target dose.

Following this, Metoject® prescribing will be undertaken by the patient's GP with dispensing by community pharmacy. A shared care protocol (SCP) has recently been approved and will shortly be available at www.ljf.scot.nhs.uk and on the NHS Lothian intranet. Monitoring requirements will be identical to those for methotrexate by the oral route. The SCP includes recommendations for the safe disposal of waste, including sharps. All patients currently established on this therapy will be transferred to the shared care approach over a period of two to three months. This is a significant step in improving the quality of care for patients on this therapy, as patients will no longer be required to visit the hospital on an eight-weekly basis.

Thanks to Carole Callaghan, Advanced Clinical Pharmacist, Rheumatology, for contributing this article.

Farewell to Dr Philip Rutledge

It was with regret that the LPB Editorial Team heard that Dr Philip Rutledge would be leaving the team, following retirement from his current post in medicines management. Philip has been a key member of the LPB team since its inception in the days of the 'Rx Bulletin' – remember the purple sheet - and has remained an enthusiastic contributor to the Bulletin. Many will remember Philip from the early days of medicines management in Lothian, and of course we all owe him a huge debt for leading on the development of the Lothian Joint Formulary, now recognised as an exemplar piece of work, used in other regions in Scotland and beyond. We all wish Philip the very best in his new (part-time) role as Consultant in Public Health, advising on the introduction of (non-drug) health technologies into NHS practice, and thank him for his contributions over the years - always done with consideration, objectivity, wit, humour and sometimes in a dodgy corduroy jacket.

Interaction - clopidogrel and proton pump inhibitors

Clopidogrel is indicated for the prevention of atherothrombotic events in patients with myocardial infarction, ischaemic stroke or peripheral arterial disease and for patients with acute coronary syndrome. In May 2009, the EU Committee for Medicinal Products for Human Use (CHMP) concluded that the concomitant use of proton pump inhibitors (PPIs) should be avoided whenever possible. The decision followed data indicating the possibility of an interaction between omeprazole and clopidogrel leading to a reduction in the cardioprotective benefits of clopidogrel. Data for other PPIs was less readily available but the decision was made to recommend a precautionary approach for all PPIs on the basis of some clinical outcome studies indicating reduction in cardioprotective benefits by other PPIs.[1]

Since the decision, further data has become available casting doubt over the clinical relevance of the interaction. Post-hoc analysis data from the PRINCIPLE-TIMI and TRITON-TIMI trials indicates that although the use of a range of PPIs reduced platelet function in patients receiving clopidogrel, no effect on clinical outcome was demonstrated.[2] In the COGENT study, patients were randomly allocated to clopidogrel, with or without omeprazole and no effect on cardiovascular outcome was found.[3] The trial was terminated early after 133 days.

The largest meta-analysis to date included 23 studies with 93,278 patients.[4] Overall, pooled estimates indicate that concomitant use of clopidogrel and PPI may be associated with adverse cardiovascular events and myocardial infarction but no effect on mortality was demonstrated. However, when considering cardiovascular outcomes alone, data was inconsistent. The analysis concluded that evidence available is inconsistent and conflicting with no evidence of effect on overall mortality. The risk of gastrointestinal bleeding must be carefully weighed before withdrawing a PPI in patients taking clopidogrel.

It can therefore be seen that the data available is still inconsistent. However, pharmokinetic, pharmacodynamic, and some clinical outcome data indicate a significant interaction for omeprazole with some data available for esomeprazole. Given recent evidence, the previous recommendation to avoid all PPIs unless truly indicated is no longer necessary. However, precaution in use of clopidogrel with omeprazole or esomeprazole is still recommended.

Advice for health professionals[5]

- Concomitant use of clopidogrel and omeprazole or esomeprazole is to be discouraged unless considered essential
- Doctors should check whether patients who are taking clopidogrel are also buying over-the-counter omeprazole and consider whether other gastrointestinal therapies would be more suitable
- Pharmacists should check whether patients buying omeprazole are also taking clopidogrel
- Consider PPIs other than omeprazole or esomeprazole in patients who are taking clopidogrel. Other gastrointestinal therapy such as H_2 blockers (except cimetidine) or antacids may be more suitable in some patients
- Discourage concomitant use of other known CYP2C19-inhibitiing medicines with clopidogrel because these are expected to have a similar effect to omeprazole and esomeprazole (CYP2C19 inhibitors include fluvoxamine, fluoxetine, moclobemide, voriconazole, fluconazole, ticlodipine, ciprofloxacin, cimetidine, carbamazepine, oxcarbazepine and chloramphenicol).

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Thanks to Marjory Neill, Cardiology Pharmacist, for contributing this article.

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