



LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues
in primary and secondary care



Issue No. 59

January 2013

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Stocking fillers

Zopiclone – LJJ hypnotic of choice

Non-pharmacological treatments are the recommended first-line interventions for sleep disorders. The hypnotic zopiclone is the LJJ second choice treatment. The price differential between zopiclone and temazepam continues to increase.

Psychotropic medication and QTc prolongation risk

Guidance has been prepared to provide an indication of the potential risks associated with the prolongation of QTc interval with psychotropic medicines. The guidance is available on the NHS Lothian intranet at [NHSLothian > Healthcare > A-Z > Medicines Management](#)

Discontinued skin products

Some frequently prescribed products have been discontinued by GSK, including Alphosyl HC[®] cream and the PanOxyl[®] Aquagel range. A date for resolution of manufacturing issues with PanOxyl[®] cream and Brevoxyl[®] cream is not yet available. Panoxyl[®] gel will be available again in September 2013.

5α-reductase inhibitors - LJJ first choice is finasteride

5α-reductase inhibitors are appropriate alternatives to alpha-blockers to treat symptoms caused by benign prostatic hypertrophy, when alpha blockers are ineffective, contraindicated or not tolerated. The LJJ first choice is finasteride. Dutasteride should be reserved for patients intolerant of finasteride. It is more expensive and its price is increasing significantly. Treatment with both medicines should be reviewed after 6 months.

Bicalutamide in prostate cancer – prescribe generically, not as Casodex[®]

Bicalutamide is available as a generic medicine and is 40 times cheaper than the branded product. Cost of 50mg x 28 tablets: Casodex[®] £128.00; generic bicalutamide £3.31.

Nitrofurantoin – keep it ordinary

Nitrofurantoin is the LJJ second choice for uncomplicated UTI. The modified release preparation should not be prescribed as it costs more than twice the standard release tablet, with no clinical advantage. The dose is 50mg four times daily for 3 days in women and 7 days in men.

‘Just in Case’ medicines for palliative care

A new information leaflet has been produced for patients to let them know about ‘just in case’ medicines. These medicines are used to relieve pain and other symptoms and prescribed for patients to be kept in their home ‘just in case’ they are needed at the end of life. The leaflet is available on the palliative care guidelines website at www.palliativecareguidelines.scot.nhs.uk/documents/Just_In_Case_Medicines_PatientLeaflet_NHSLothianOct12.pdf

Levomopromazine moved down to third line in palliative care

The palliative care guidelines www.palliativecareguidelines.scot.nhs.uk advise that levomopromazine is a third line agent in the management of intractable nausea and vomiting. Antiemetic choice should be based on the most likely cause of nausea and vomiting. There has been a tenfold increase in price for levomopromazine 6mg tablets (unlicensed).

Non medical prescribing conference workshop:

How can we reduce wasted medicines?

A workshop was held at the annual NHS Lothian non medical prescribing conference in April 2012, with the aim of reducing medicines waste. On display was a table laden with medicines returned to a Lothian pharmacy by a single patient (see photo). The value of the medicines was in excess of £1000.

The display stimulated discussion around potential reasons for items not having been used. Of concern was that the patient may not have understood how to use the medicines, which included several different types of inhaler, or perhaps was unable to comply with the complex medication regimen. There was discussion of effects on health outcomes, as not taking medicines as prescribed could have resulted in avoidable illness. Of further concern was the risk of stockpiled medicines to patients and their families, and risk to waterways of medicines disposed of down drains. In addition, the financial implications are especially significant in the current economic climate.

A report published in November 2010 explained that evaluation of medicines waste is almost impossible.¹ Not all of the waste is returned to community pharmacies for safe disposal and most other routes of disposal cannot be quantified. It is estimated that the proportion of the health service medicines bill wasted could be as much as 10 per cent (in Scotland £100 million annually). However, there are many reasons for medicines waste and a significant amount of prescribed drug wastage is inevitable - it is thought that less than half is preventable.

Small group discussion revealed several themes:

- Inadequate communication and patient education regarding medicines, leading to inappropriate or incorrect use of medicines, or poor compliance
- Therapies being stopped or changed because of ineffectiveness or side-effects, or when a patient's condition progresses, so that new treatments are needed
- Medication regimen not being reviewed comprehensively on a regular basis
- Patient deaths, which may involve drugs being changed or dispensed on a precautionary basis during the final stages of palliative care
- Repeat prescribing and dispensing processes that may cause excessive volumes of medicines to be supplied
- Medicines wasted on admission to or discharge from hospital.



Possible ways of minimising medicines waste were discussed:

- Improved patient education and more open communication, both between healthcare professionals and with patients, using the 'teach-back technique' to improve the effectiveness of discussions with patients about medicines
- Supporting high quality prescribing and encouraging use of the Lothian Joint Formulary
- Regular and thorough review of medication
- Providing support for isolated patients and other vulnerable people at increased risk of experiencing problems in taking medicines
- Improved prescribing and ordering systems and considering the use of 28-day supply where appropriate
- Improved use of patients' own drugs in hospital, including the 'Green Bag' system
- Improving awareness of the cost of medicines by staff, patients, carers and relatives.

The key message of the workshop was that minimising waste of all types is a desirable goal and that the focus should be on improving concordance in medicine taking and better medicines use.

Reference

1. Evaluation of the Scale, Causes and Costs of Waste Medicines. York Health Economics Consortium and The School of Pharmacy, University of London. Final Report. November 2010. <http://iris.ucl.ac.uk/iris/publication/418490/1>

Thanks to Anne Young, Primary Care Pharmacist, for contributing this article.

Lothian polypharmacy project

Polypharmacy, particularly in the frail population, presents significant patient safety risks. It is well documented that the prescribing of multiple medications to any given individual increases their risk of drug-related hospital admissions, adverse effects and interactions.

Systematic medication review addressing polypharmacy issues not only minimises the risk of medication-related problems but can improve condition management by optimising medicines, increasing patient compliance and improving patient/carer understanding and satisfaction. It also helps contribute to reducing medicines waste and supports evidence based, cost efficient prescribing practice. The Scottish Government has recently published guidance for clinicians, highlighting the risks of polypharmacy.¹

In January 2012, a team of clinical pharmacists from both primary and secondary care commenced a pilot project, undertaking polypharmacy medication reviews within care homes across NHS Lothian. Funding within the project also allowed for the review of patients living in the community, aged 75 years and over and taking 10 or more medicines. Linking in with the patients' Anticipatory Care Plans (ACPs) the pharmacist arranges a review of the patients' medication charts and clinical data and meets with care home staff ahead of a peer review meeting with the GP. At this meeting the pharmacist suggests changes to optimise patients' medications, whether this be stopping, starting, changing dose or monitoring. There has also been close working with the Medicine of the Elderly Consultants, who continue to support the pharmacists and GPs with any questions or challenging decisions they may have to make.

Examples of medicines targeted within the medication reviews included:

- ❑ **High risk medicines** which are the most common drug groups associated with admission to hospital due to an adverse drug reaction (ADR), for example the high risk combination of Non Steroidal Anti Inflammatory Drugs (NSAIDs), diuretics and an Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin-II receptor antagonist ('Triple Whammy')
- ❑ **Drugs poorly tolerated in frail adults** for example digoxin in doses of 250 micrograms or greater, antipsychotics, tricyclic antidepressants and anticholinergics
- ❑ **Medications without a valid or current indication** for example long term quinine or antibiotic use
- ❑ **Unlicensed 'specials'** to ascertain that it remains clinically appropriate for the patient, and if so, that an alternative licensed medicine would not meet the patient's clinical needs.

By November 2012 approximately 1,500 patient reviews had taken place across 59 of the 126 GP practices (47%). A detailed analysis of the data has been undertaken for 368 patient reviews and is shown in Table 1. Analysis continues on an ongoing basis for all other patients.

Table 1 – Agreed interventions

No. of patient reviews	Total medicines stopped	High risk medicines stopped	Average no. of medicines stopped per patient	Reduction in dose	Reduction in dose – high risk medicines	Total no. of interventions*	Average no. of interventions per patient
368	284	80	0.8	71	25	606	1.6

* Further interventions included medication started, medication switched and dose increases

GPs involved in the project have commented on the benefit of the joint review with the pharmacist and the opportunity it brought for discussion within the practice of issues pertaining to polypharmacy. Initial concerns regarding the data collection and time taking to complete this have been taken on board and the pharmacists are now assisting practices in completion of their datasheets where this has been possible.

If you have any questions regarding the polypharmacy project or would like more information please contact the Primary Care Pharmacy Co-ordinator Stephen.C.McBurney@nhslothian.scot.nhs.uk

Reference

1. Appropriate prescribing for patients and polypharmacy guidance for review of quality, safe and effective use of long-term medication. CEL 36 (2012). 1 November 2012. The Scottish Government. www.sehd.scot.nhs.uk/mels/CEL2012_36.pdf

Be vigilant - are you prescribing what you intended?

The days of illegibly scrawled handwritten prescriptions are surely behind us?
Pharmacists no longer have to decipher



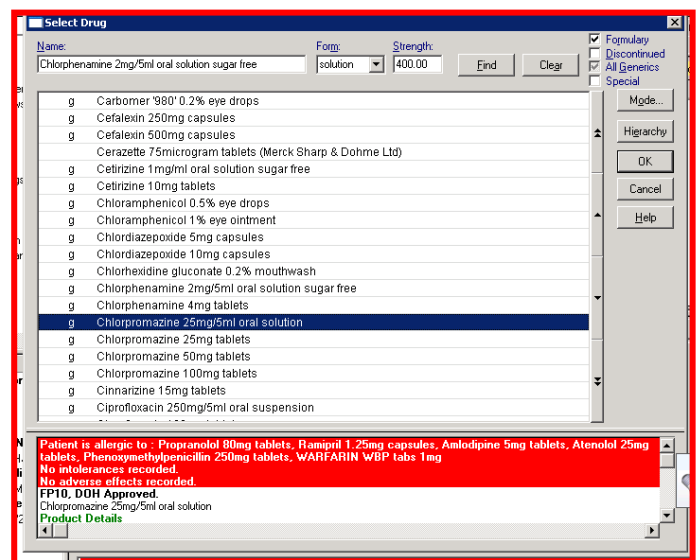
The introduction of electronic prescribing in primary and secondary care reduces overall prescription errors through improved legibility and reduction in incomplete, illegal and unclear orders.¹ This Australian study comparing prescribing errors on admission to hospital demonstrated that there was a reduction from 6.25 to 2.12 per admission following the introduction of electronic prescribing. However, whilst electronic prescribing does at least ensure prescriptions are legible, errors still occur, putting the patient at potential risk. A time of particular risk occurs with the introduction of new electronic prescribing systems, for example the switch from GPASS to INPS-Vision. Prescribers using the system should be appropriately trained and increased vigilance for errors should occur for all users.

The PRACTICE study² identified that 1 in 8 of patients are exposed to a prescribing error each year. 1 in 20 prescription items involved an error and 1 in 550 prescription items involved a severe error. Errors highlighted due to electronic prescribing mostly concerned the use of drop down menus and also included poor allergy data entry and repeat reviews of inadequate quality.

Key messages:

- Take additional care when selecting medicines from drop down menu
- Use eLJF-Clinical to minimise risk from drop down menus
- Record, share and learn from errors.

A potential prescribing error that can occur with the use of a drop down menu is with medicines of similar name. An often quoted example is penicillamine being prescribed instead of 'penicillin'. This is actually difficult to do as penicillamine is marked as a hazardous drug and as 'penicillin' is located by its approved name phenoxymethyl penicillin the two medicines are not adjacent in the drop down menu. A better example would be mistaking chlorpromazine for chlorphenamine – see screen illustration.



It is important that when such a prescribing error occurs that this is recorded on *Datix*, and/or a Significant Event Analysis (SEA) is undertaken. Prescribers should be vigilant when signing off a prescription; pharmacists should be vigilant when dispensing and patients should be vigilant when checking their medication.

References

- Westbrook JI et al. Effects of Two Commercial Electronic Prescribing Systems on Prescribing Error Rates in Hospital In-Patients: A Before and After Study. *PLoS Med* 2012;9(1): e1001164. doi:10.1371/journal.pmed.1001164 www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001164
- Investigating the prevalence and causes of prescribing errors in general practice: The PRACTICE study. A report for the General Medical Council. May 2012. www.gmc-uk.org

Supplement: Recent SMC and Lothian Formulary Committee Recommendations

The supplement can be accessed via the LJF website www.ljf.scot.nhs.uk in 'Prescribing Bulletins'.

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