NHS

Prescribing Notes

July/August 2019

For Primary Care practitioners working in NHS Crawley and NHS Horsham and Mid-Sussex CCGs

The Electronic Prescription Service is changing. EPS Phase 4

Phase 4 of EPS allows prescriptions for patients without an EPS nomination to be signed, sent and processed electronically. NHS Digital has started Phase 4 pilot at a small number of GP practices across England in November 2018. The initial four practices were followed by four more in December and additional eleven practices in January 2019. Following a successful pilot, Phase 4 will be rolled out to all GP practices in England making EPS the default method for prescribing, dispensing and reimbursement of prescriptions in primary care in England. See LINK for more information.

When Patient Group Directions (PGDs) are not required.

This guidance is designed to assist organisations in identifying when a Patient Group Direction (PGD) should not be used. See LINK

Administration of medicines in schools and early years Settings

The administration of medicines in schools and early years settings, such as nurseries, has historically been a contentious area with confusion sometimes created between schools, parents and general practices. This bulletin provides clarity regarding the national legislation and good practice guidance in this area, so that children can receive their medication in a safe and timely manner and that staff can be supported to administer medicines within a clear framework. See LINK for more information

1. The Department of Education documents, 'Supporting Pupils at School with Medical Conditions' and 'Statutory Framework for the Early Years Foundation Stage' explain the legislative requirements and good practice guidance in this area.
2. POMs may not be administered in a school or early years setting unless they have been prescribed for a child by an 'Appropriate Practitioner', which includes a doctor, dentist, nurse or pharmacist.
3. However, **non-prescription OTC medicines do not need an Appropriate Practitioner's prescription, signature or authorisation in order for a school or early years setting to give them.**
4. Medicine (both prescription and non-prescription) must only be administered to a child under 16 where written permission for that particular medicine has been obtained from the child's parent or carer
5. From 1st October 2014, legislation on prescription only medicines changed **to allow schools to buy salbutamol inhalers, without a prescription, for use in emergencies**.
6. From 1st October 2017, legislation on prescription only medicines changed to **allow schools to buy adrenaline auto-injector (AAI) devices, without a prescription, for use in emergencies.**

Antimicrobial resistance (AMR) networks in England

A new tool is available on the SPS website, which will enable all AMR networks in England to find AMR networks regionally, at a STP and CCG level. It will also provide the opportunity for AMR networks to share work and resources within their area. SPS aims to provide a single point of reference online for AMR networks across England. The SPS website includes a comprehensive and dynamic map of antimicrobial resistance networks aligned to the various tiers of NHS geographies. See LINK

Class 4 Medicines Defect Information: Emerade 150, 300 and 500 microgram solution for injection in pre-filled syringe (MDR 55-06/18)
Pharmaswiss Česka republika s.r.o. (an affiliate of Bausch & Lomb UK Limited) has informed us of a risk of Emerade product failing to deliver a dose of adrenaline from the syringe due to blockage of the needle. See LINK for more information.
Action for healthcare professionals and patients
Healthcare Professionals should contact all patients, and their carers, who have been supplied with an Emerade device *to inform them of the potential defect and reinforce the advice to always carry two in-date adrenaline autoinjectors with them at all times.* This advice is provided in the approved patient information leaflet for Emerade, which should be provided to the patient or caregiver at dispensing. Patients experiencing any problem with Emerade failing to activate should report this via the MHRA's Yellow Card Scheme and keep the pen for further examination.

Direct-acting oral anticoagulants (DOACs): increased risk of recurrent thrombotic events in patients with antiphospholipid syndrome
A clinical trial has shown an increased risk of recurrent thrombotic events associated with rivaroxaban compared with warfarin, in patients with antiphospholipid syndrome and a history of thrombosis. Other direct-acting oral anticoagulants (DOACs) may be associated with a similarly increased risk. See LINK

Rivaroxaban (Xarelto▼): reminder that 15 mg and 20 mg tablets should be taken with food
MHRA has received a small number of reports suggesting lack of efficacy (thromboembolic events) in patients taking 15 mg or 20 mg rivaroxaban on an empty stomach; remind patients to take 15 mg or 20 mg rivaroxaban tablets with food. See LINK

GLP-1 receptor agonists: reports of diabetic ketoacidosis when concomitant insulin was rapidly reduced or discontinued
GLP-1 receptor agonists are not substitutes for insulin, and any reduction of insulin should be done in a stepwise manner with careful glucose self-monitoring. Abrupt discontinuation or reduction in insulin doses can lead to poor glycaemic control, with a risk of diabetic ketoacidosis. See LINK

Magnesium sulfate: risk of skeletal adverse effects in the neonate following prolonged or repeated use in pregnancy.
Maternal administration of magnesium sulfate for longer than 5–7 days in pregnancy has been associated with skeletal adverse effects and hypocalcaemia and hypermagnesemia in neonates. If use of magnesium sulfate in pregnancy is prolonged or repeated, consider monitoring of neonates for abnormal calcium and magnesium levels and skeletal adverse effects. See LINK

Febuxostat (Adenuric): increased risk of cardiovascular death and all-cause mortality in clinical trial in patients with a history of major cardiovascular disease
Avoid treatment with febuxostat in patients with pre-existing major cardiovascular disease (for example, myocardial infarction, stroke, or unstable angina), unless no other therapy options are appropriate. See LINK

Seven new additions to NHS England's list of treatments not to be prescribed in primary care
Following the results of a public consultation NHS England will newly restrict the prescribing of aliskiren, amiodarone & dronedarone (new patients), minocycline for acne, pen needles over £5 per 100, bath & shower additives and silk garments. The guidance on rubefacients (capsaicin) was aligned to NICE. Further local prescribing guidance will be shared when available. See LINK.

Shortages, Discontinuations and Patent Expiries. See LINK

Evidence-Based Interventions: patient leaflets
For each of the interventions in the Evidence-Based Interventions guidance NHS England have produced a patient leaflet that describes the condition relating to that intervention, the benefits and risks of treatment including what would happen if nothing was done and the alternative treatments available. See LINK