**GUIDANCE/EVIDENCE UPDATE**

- Patients requiring home oxygen
- Berkshire East Adult Palliative Care Guidelines

**SAFETY UPDATE**

- Resources to support the safety of girls and women who are being treated with valproate
- MHRA Safety Update March 2017

**FORMULARY UPDATE**

- Stoma Products - general tips
- Elvanse-lisdexamphetamine capsules

**Savings**

- SIP feeds

**SUPPLY ISSUES**

- Electronic Prescription Service
- Prescription Tacker - how to use
- Cancelling Electronic Prescriptions
- How to tell the difference between EPS1 prescription and EPS2 tokens

**SIGNIFICANT EVENT**

- Warfarin Drug Interaction

**CONTACT DETAILS FOR THE MEDICINES OPTIMISATION TEAM**

If you have a GP leaving or Non-Medical Prescriber (NMP) leaving or joining your practice please remember to fill in the relevant forms promptly to ensure prescribing costs are attributed correctly to your practice. Please complete and e-mail to Catriona Khetyar (catriona.khetyar@nhs.net) who is now the authorised signatory. She will sign off the changes and inform NHS Business Prescription Services. Here are the links.

http://www.nhsbsa.nhs.uk/PrescriptionServices/3973.aspx

http://www.nhsbsa.nhs.uk/PrescriptionServices/3974.aspx
GUIDANCE UPDATE

PATIENTS REQUIRING HOME OXYGEN

You may have received a communication about the new forms which are being introduced for the prescribing of oxygen. Please note that this is for information should a GP need to prescribe oxygen, GPs are not being asked to take over prescribing of oxygen.

The paperwork changes, for information:

- The Home Oxygen Order Form (HOOF) have been updated and there is a new Consent/ Initial Home Oxygen Risk Mitigation form (IHORM), which needs to be completed.

The change in the paperwork serves as useful reminder that the Home Oxygen Assessment and Review Service – (HOS-AR) looks after ALL patients on home oxygen in East Berkshire. This includes non-respiratory patients e.g. cluster headaches, cardiac failure and that prescribing of oxygen is done via this team, and not via the GP.

A reminder about the service:

Any patient being considered for home oxygen should be referred to the HOS-AR service, who will then assess the need clinically, assess the risk, give expert information to patients and carers and support throughout. Local incidents involving home oxygen include: two facial burns reported from patients smoking on oxygen, a fire after a patient put his dinner on to cook, fell asleep after too much alcohol and burnt down his flat and 2 frail patients falling on the tubing, which demonstrates the need for risk assessment prior to prescribing. The HOS-AR Service is best placed to complete the necessary paperwork.

How to refer?

1. Referral is via ICE – Referrals and Req N-Z/ Respiratory (on Left) /Adult Integrated Resp Ref/ Home oxygen and review
2. A paper referral may be available on the GPs desktops and can be faxed to 01753 636054.
3. In an emergency a GP can telephone and give verbal details and follow up with a referral later.

Who to refer?

Generally patients with resting saturations of <92% on room air or <94% if they have heart failure, polycythaemia or pulmonary hypertension or those that have a significant drop in saturation on exertion should be referred. Please note the HOS-AR service ask that on the referral oxygen saturations are a MUST-DO.

ACTION 1:

Do not prescribe home oxygen. For patients who require home oxygen refer to the HOS-AR Service, as above.
ACTION 2:

Generally patients at end of life may have been put on oxygen as it is felt there is nothing else for breathlessness, however the East Berkshire Palliative Care Guidelines are very clear that benzodiazepines, +/- morphine should be used first alongside fan therapy for those that are not hypoxic and oxygen therapy should only be considered for hypoxic patients at end of life. Follow the East Berkshire Guidelines, see below.

Berkshire East Adult Palliative Care Guidelines- attached
The guidelines contain pathways for symptom control, copied below is the breathlessness guidance; please refer to the attachment for other pathways.

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**SAFETY UPDATE**

**Resources to support the safety of girls and women who are being treated with valproate- MHRA Patient safety Alert April 2017**

It is vital where valproate is prescribed to girls and women of childbearing potential that they are made aware of the risks of taking the medication in pregnancy. The need for effective contraception planning must also be emphasised, along with the requirement for specialist oversight to safely change their medication if planning a pregnancy.

Previous MHRA alerts have resulted in a change of clinical practice in some organisations but evidence suggests a further concerted effort is needed to ensure professionals are informing all girls and women of childbearing age. A survey of women in April 2016 found of those taking valproate (n=624), <20% had received any of the educational materials.
MHRA (April 2017) says that “In girls and women of childbearing potential, valproate should be initiated and supervised by a specialist and only when other medications have not been tolerated or have been found to be ineffective”.

MHRA have updated the valproate toolkit, MHRA valproate toolkit. The toolkit provides a range of resources to support the safe use of valproate.

- Guidance on using the valproate toolkit for those prescribing and dispensing valproate
- Brochure for healthcare professionals
- Valproate guide for patients
- Prescriber Checklist
- Patient Card
- For use by GP practices: Template letter for women of childbearing age on valproate containing medicines

Practices are asked to achieve the following 3 points as soon as possible and at the latest by October 2017.

- Identify how the resources signposted in this alert can be used to support fully informed decisions* on the use of valproate by girls and women of childbearing age.
- Develop an action plan to ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care.
- Ensure relevant resources are embedded in clinical practice for current and future patients by revising local training, procedures and protocols.

*Ensure women and girls taking valproate medicines understand the risk of developmental disorders is up to 4 in 10 and the risk of birth defects is approximately 1 in 10.

The consultation checklist may be a useful document on which to base your own practice template imbedded into the patients notes as a record of the discussion.

**Action:** This alert asks all providers to undertake systematic identification of girls and women who are taking valproate, and to ensure the MHRA resources are used to support them to make informed choices.

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**MHRA Drug Safety Update - March 2017**


**Action:** Clinicians should be aware of the guidance and implement any necessary changes to practice.
FORMULARY UPDATE

Stoma Products- General Tips

- Colostomy bags are not drainable (However please be aware that, there may be exceptions to this as some patients with a colostomy prefer to wear a drainable pouch to enable them to be able to release a build-up of flatus)
- Ileostomy and urostomy bags are usually drainable and replaced every 1-3 days and patients should be advised to replace the night bag every 7 days. Some patients who are more susceptible to infections may be required to use a non-drainable night bag and renew daily. (This is the case for patients in nursing homes, to reduce the cross infection risk)
- Night bag quantities: 1 box of 10 every 2-3 months.
- A Flange is not usually changed at every bag change and 15 should be sufficient each month
- Flange extenders are used for extra security where hernia/skin creases may cause leakage and are changed when bag is changed.
- Belts, prescribe a maximum of 3 in 12 months: 1 to wear, 1 in wash and 1 spare if thought needed.
- Deodorants If correctly fitted, no odour should be apparent except during bag empty/change. Household air freshener should be sufficient in most cases.
- Barrier creams are not recommended as they reduce adhesiveness of bags and flanges (Specialist barrier creams are only recommended for specific peristomal skin complications and this would be after an assessment by a Stoma Nurse Specialist or Dermatologist.)

Elvanse®- lisdexamphetamine capsules

A reminder that this drug is RED for children.

**ACTION:**
Please ensure new requests in CHILDREN are declined. Prescribing to remain with CAMHs.

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SIP FEEDS

Here is a suggested practice Action-Plan to enable practices’ to achieve the defined LCS target and appropriately prescribe SIP feeds to patients at risk of malnutrition.

1. Encourage Food First for all patients where appropriate. Offer the 2 leaflets below (web links provided, for “Making the Most of What you Eat” and “How to Make a High Calorie Milkshake”) to help patients increase nutritional intake by dietary measures and food fortification.

file:///C:/Users/mc006/Downloads/9-nourishing-drinks-for-must-2.pdf


NHS Windsor, Ascot & Maidenhead Clinical Commissioning Group
NHS Bracknell & Ascot Clinical Commissioning Group
NHS Slough Clinical Commissioning Group
‘Thinking Locally, Working Together’
2. Only prescribe supplements to patients who meet ACBS criteria with a MUST score of 2 or more who have failed to improve after 4 weeks of Food First approach.
3. Prescribe on acute rather than repeat to ensure regular review.
4. Initiate Ensure Shake, first line, where a prescription is clinically appropriate and advise patient to continue with the dietary measures and food fortification, as above.
5. Review progress and MUST score every 4 weeks.

**ACTION:** Follow the suggested action plan above before prescribing a SIP feed. A 1 pg summary can be found using the web links below.


**Sip Feed Prices**

Abbott has dropped the price of their SIP products.

**ACTION:** Use Ensure products 1st line.

<table>
<thead>
<tr>
<th>Product</th>
<th>Price (April 2017)</th>
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<tbody>
<tr>
<td>Ensure Shake (7x57g)</td>
<td>£4.90 (70p per sachet)</td>
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<tr>
<td>Ensure Plus (220ml)</td>
<td>£1.12</td>
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<tr>
<td>Ensure Compact (4x125ml)</td>
<td>£5.40 (£1.35 per bottle)</td>
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**SUPPLY ISSUES**

**ELECTRONIC PRESCRIPTION SERVICE (EPS2)**

Patient demographics must be correct on PDS (the Spine) otherwise prescriptions cannot be sent electronically. **Any mismatches on PDS** (shown in red) e.g. spelling of name, address **must** be corrected.
PRESCRIPTION TRACKER - HOW TO USE

1. To use Prescription tracker you **must** be logged in with your smartcard

2. Save the link **https://portal2.national.ncrs.nhs.uk/prescriptionsadmin** on your ‘favourites’ toolbar

How to Find the Prescription ID (Barcode) for Electronic Prescriptions (EPS2) in EMIS Web

- In the medication screen, **Right click** on the name of the medication

- From the drop-down menu click on **Drug History**
  (this will list all issues)

- Click on ‘view’ (highlighted in blue)
  a new window will open to show EPS details eg pharmacy and barcode

- Click on the **arrow ’►’** to the **Left** of ‘medication issued’
  (it will show if EPS2 or printed prescription)

- The **Barcode** is at the top of the window, eg A12345-G80090-B30093 right click and **Copy**

- **Open** Prescription Tracker from favourites toolbar
  **https://portal2.national.ncrs.nhs.uk/prescriptionsadmin**
  (if a pop-up box shows ‘run’- click ok),

- **Paste** the barcode directly into the search box and click **Search**

- This will show you which **Pharmacy** it was sent to and where it is in the dispensing process.
How to find the Prescription ID

Right Click to “copy identifier”

Left click to view prescriptions

ACTION: If the prescription shows as EPS2 and has been sent to the pharmacy, any problems are the responsibility of the pharmacy who will need to download it (or contact their supplier if it gets ‘stuck’, which happens occasionally). **Do NOT re-issue as a paper prescription**

CANCELLING ELECTRONIC PRESCRIPTIONS

Prescriptions can be cancelled at any time until they have been dispensed, replacements can be sent electronically.

**ACTION: The practice should inform the pharmacy if a prescription is cancelled.**

FURTHER INFORMATION


HOW TO TELL THE DIFFERENCE BETWEEN EPS1 PRESCRIPTIONS AND EPS2 TOKENS

EPS1 prescriptions are printed paper prescriptions and have a longer barcode than EPS2 (electronic prescriptions)
LOCAL CASE STUDIES - SIGNIFICANT EVENT

Warfarin Interaction

A patient with mycosis fungoides and is under Oncology follow up. Pt had had PUVA treatment; comorbidities are hypertension and a past history of DVT for which the pt is on long term warfarin.
Repeat medication: warfarin, bendroflumethazine, amlodipine and candesartan. The hospital added bexarotene 150mg daily. This was initiated in the hospital nurse led clinic.

The pt was given a written treatment plan and a bexarotene diary and counselled on the importance of a low fat diet due to the risk of hyperlipidaemia and advice to avoid grapefruit juice because this can increase plasma levels. The patient was told to avoid vitamin A supplements and was made aware of the risk of photosensitivity. The pt was told to report any abdominal pain and seek medical attention.

The hospital prescribed bexarotene 150mg once daily. The GP was asked to prescribe fenofibrate 160mg daily and levothyroxine 25mcg once daily.

During the initiation phase the GP was asked to organise weekly fasting blood tests for and: FBC, UEs, LFT’s, full lipid profile, T4, TSH and CK and to fax the results through to the hospital. Bexarotene can cause central hypothyroidism and raised triglycerides and therefore regular T4 monitoring was required and fenofibrate co-prescribed.

Unfortunately the fact that the patient was on warfarin was not factored in and no INR was checked prior to starting treatment. The blood tests requested by hospital were entered onto our computer system and these were duly taken by the nurse on the 31 August 2016. These were received and faxed through on 1st September 2016.

On 7th September our patient attended their routine INR monitoring clinic, the INR was 8. A Venus sample was taken and sent to the lab which came back greater than 10. The patient described having black stools for the past three days and was advised to go to A&E where the pt received vitamin K.

The pt was seen in an urgent consultation on 8th September complaining of pain and stiffness in his right thigh, he had noticed huge spontaneous bruising over the weekend, his CK level also crept up to 408 iu/L. The fenofibrate 160mg was discontinued on 13th September due to the fact that his INR was greater than 10, a raised CK and cramping muscle pains.

This incident highlights the importance of a regular INR monitoring due to the possibilities of drug interactions, particularly when new medicines are started. It appears the major interaction was with the fenofibrate and the hospital should have requested INR monitoring together with the other routine blood test monitoring.

The patient suffered a potentially serious bleed as a result of this drug interaction which demonstrates the need to always be careful with warfarin. Since this incident the pt’s INR has remained stable.

**What went well?**

Once the INR was found to be significantly elevated, the warfarin was stopped, the pt was referred appropriately to A&E to receive vitamin K and a lab sample was sent.

**What could have been done better?**

The fact that the pt was on warfarin when the new drugs were started should have been apparent and an INR should have been requested at the outset and during initiation of the new drugs.

**What changes have been agreed?**

There is now an alert on his record so that if a medicine dose is changed, the INR should be done. And there is general awareness of the importance of drug interactions in patients on warfarin within the practice team.

**Medicines Optimisation Comment**

NHS Windsor, Ascot & Maidenhead Clinical Commissioning Group  
NHS Bracknell & Ascot Clinical Commissioning Group  
NHS Slough Clinical Commissioning Group  
‘Thinking Locally, Working Together’
• This significant event highlights the importance for INR checks whenever a new drug is started. As a guide, The British Society for Haematology recommends: All patients on warfarin who are prescribed a drug that may interact with it should have an INR performed after 3-5 days and the NPSA suggest 4-7 days. To help prevent future errors patients should be advised that they must inform their GP or anticoagulant practitioner if there are changes to taking medicines, supplements, complementary therapy or diet.
• Further information on warfarin safety, which although was published in 2007 by the NPSA is still valid. http://www.nrls.npsa.nhs.uk/resources/?EntryId45=61790
• In addition we would recommend feedback to the oncology consultant and nurse to alert the hospital of the need to advise/ remind GPs to check INRs when new medicines are started.

CONTACT DETAILS FOR THE MEDICINES OPTIMISATION TEAM

<table>
<thead>
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