Walsall Joint Medicines Management Committee

Prescribing Update Newsletter

May/June 2018

Improving Health and Wellbeing for Walsall

MHRA Drug Safety Update

Valproate medicines (Epilim, Depakote) must no longer be used in women or girls of childbearing potential unless a Pregnancy Prevention Programme is in place

Esmya (ulipristal acetate) for uterine fibroids: do not initiate or re-start treatment; monitor liver function in current and recent users

Head lice eradication products: risk of serious burns if treated hair is exposed to open flames or other sources of ignition, e.g., cigarettes

Confidential prescribing and patient safety reports on key indicators now available free for GPs

JMMC/Formulary Update

Naltrexone-bupropion for managing overweight and obesity: not recommended as per NICE TA.

Blood Glucose Meter Formulary reviewed and updated April 2018: removal of Contour TS (has been discontinued) Contour meter replaces this, Glucomen Aero replaces the Caresens NPOP, Accu-Check Mobile should only be used in patients with dexterity issues/not able to handle sharps. There is also an advice section on the numbers of strips to prescribe.

https://walsallccg.nhs.uk/images/Blood_Glucose_Meters_Walsall_version_7_to_start_April_2018.pdf

Other Information: Discontinuation of Rewisca (Pregabalin brand) and Aviticol 800units by manufacturing companies

Guidelines Update (approved)

Malnutrition Guidelines (for Adults): https://walsallccg.nhs.uk/images/Meds_Management/Malnutrition_Guidelines_Adults_-_Identification_Treatment__Monitoring_April_2018.pdf

Malnutrition Guidelines Appendices: https://walsallccg.nhs.uk/images/Meds_Management/Malnutrition_Guidelines_Appendices.pdf

Key Tip #1

Before ordering a specials medication, check if the tablets can be crushed or dispersed (for normal release preps) with practice pharmacist

Key Tip #2

For children always specify dose in milligrams & millilitres to avoid errors

Key Tip #3

Brand prescribing now recommended for combination inhalers and insulin to prevent dispensing errors

Key Tip #4

Learning Disabilities patients should have an annual health check and medication review (review use of antipsychotics)

If you have any comments or suggestions about this or future editions please contact: walsall.medicines-management@nhs.net

NHS Walsall Clinical Commissioning Group

NUTILIS CLEAR—CHANGES

- Royal College of Speech & Language Therapists and British Dietetic Association have advocated use of new IDDSI framework for thickening fluids
- Walsall Acute transitioned to the new framework recently
- Scoops in tins of Nutilis Clear will be changing from purple 3g scoop to a green 1.25g scoop and directions for use on the labels will differ
- You may like to advise patients to seek advice from the managing healthcare professional, e.g. Speech & Language Therapist or Dietician
- Tins of Nutilis Clear with the new scoop & new 1.25g sachet will be available from mid-May 2018

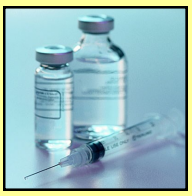
Please note: there may be a short period of time when existing tins and new tins will be available. The SLT team have advised they are sending a communication out with patients discharged from hospital on the new tin to keep their new green scoop and to follow the instructions they received in hospital if they receive an old tin with the purple scoop in community.

Number of level scoops required for thickening* (1 scoop = 1.25g)

IDDSI Framework	Level 1 Slightly thick	Level 2 Mildly thick	Level 3 Moderately thick	Level 4 Extremely thick
No. scoops per 200 ml	1	2	3	7

The new tins will be easily identifiable (red information sticker on tin lid). The new label will show four IDDSI levels instead of the existing three stages. The Nutilis Clear in the tin continues to remain the same. For queries contact Nutricia Patient & Carer Helpline: 08457 623653 or resourcecentre@nutricia.com

FOCUS ON: INSULIN PRESCRIBING



Right Person: insulin requirements vary with each individuals' lifestyle

Right Insulin: always prescribe by **BRAND** to avoid errors, be aware preparations differ in onset times

Right Dose: units must be written in full, errors can results from abbreviations, insulin was only available in 100units/ml, recently there are preparations available as 200units/ml and 300ml/units

Right Time: delayed/omitted doses can cause harm to patients, clear communication on when they should be taking their medication is vital

Right Device: Comes as vials for use with syringes & pumps, in cartridges for insulin pens and in prefilled pen devices. Insulin cartridges come in 2 different designs

Right Way: injected at 90° in abdomen, outer thigh or buttocks (rotate site to avoid fatty deposits)

OTHER INFORMATION

Medicines that require extra care when **switching between liquids and tablet/capsule** formulations: https://www.sps.nhs.uk/articles/which-medicines-require-extra-care-when-switching-between-liquid-and-tablet-capsule-formulations/

Controlled Drug Incident Reporting— this used to be sending emails to the Accountable Officer**,** however you **must now report this through the website:** www.cdreporting.co.uk **(select West Midlands region to register)**
Controlled Drug Accountable Officer: Chris Weiner

Medication Error Reporting — https://report.nrls.nhs.uk/GP_eForm (including near misses)