PostScriptPrimaryCare

NHS Greater Glasgow and Clyde

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Dose abbreviation in EMIS – Caution!

Taken from Cambridgeshire 'Prescribing Matters' September 2008

Prescribers should be aware of the following potentially serious "near miss" that occurred in a Cambridgeshire practice which has brought to light the possibility of dosage errors when using the EMIS system. When a prescriber enters a dose abbreviation, EMIS will check whether that abbreviation has been seen before. If not, it will ask what the dose description should be. The dose description will then be printed on the prescription and (for dispensing practices) on the label. There is no warning at this point to alert the prescriber to the fact that:

1. If the same abbreviation is used in future the same description will be printed.
2. The abbreviation is NOT specific to the user or to a particular drug but will be applied to any drug supplied in the same form (eg tablets).
3. What is shown on the screen when the prescription is reviewed is the dose abbreviation, NOT the description that will print.

Example:

· A prescriber wishes to prescribe prednisolone 5mg tablets, total daily dose 40mg. The dose "40mg daily" is entered. This is not recognised as a standard dose abbreviation so EMIS asks what the description should be and the prescriber enters "Take 8 tablets daily".

· From then on EMIS at that practice recognises "40mg daily" as an abbreviation for "Take 8 tablets daily".

· Subsequently a second prescriber at the practice wishes to prescribe gliclazide 80mg tablets, half a tablet to be taken daily.

The dose "40mg daily" is entered and the prescription and dispensing label print as "Take 8 tablets daily". EMIS have updated the system to improve the wording shown on screen when a new dosage is added but practices should ensure that:

·This issue is highlighted to all concerned

·**Non-standard doses are entered as the number of tablets required, NOT expressed as mg.**

·If you need information or training on how to review dose abbreviations currently stored in your practice system please contact EMIS.

EMIS have added a warning screen about this but despite this warning dosage errors have occurred in NHSGGC.

Paediatric Management of Infection Guidance

Infection Management Guidelines for Children have recently been approved by the ADTC Antimicrobials Utilisation Committee. These Guidelines are available on staffnet. The aim of the guideline is to provide a simple, best guess approach to the treatment of common indications; to promote the safe, effective and economic use of antibiotics and to minimise the emergence of bacterial resistance.

UTI Project

Last year, a study undertaken in a number of NHSGGC community pharmacies, in collaboration with NES and University of Strathclyde, identified both patient and pharmacist support for the availability of antibiotics without prescription for patients with urinary tract infections (UTIs). Antibiotic resistance was a concern for participating pharmacists but they welcomed the opportunity to supply antibiotics under controlled conditions.

A letter has been distributed to all NHSGGC community pharmacies inviting participation in the next phase of the study which will assess the implementation of a patient group direction for trimethoprim. Data will be collected over an 8 week period, February to April 2012, on female adult patients presenting with symptoms suggestive of a UTI. Patients will be invited to complete a short questionnaire on their symptoms and participate in a brief telephone interview with the study pharmacist, Jill Booth. For more information, please contact Jill on 0141 201 4464.

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Diabetes Guidance

The prevalence of type 2 diabetes is increasing rapidly in Scotland. The Scottish Diabetes Survey (2010) estimates a prevalence of 4.6%. This is reflected in an increase in prescribing volume of 4% with an increase in drug costs of £1million (9%) for GGC primary care over the last 12 months. This article considers recent safety concerns and waste associated with prescribing in diabetes.

Prescription Errors

Medication incidents continue to be a cause for concern within the NHS and those related to insulin can result in serious harm or death. Insulin is commonly listed in the worldwide top ten list of high risk drugs and has been identified as an important cause of hospital admissions, mainly as a consequence of hypoglycaemia. The recent NPSA safety alert indicated that of the 16,600 insulin related incidents reported between November 2003 to 2009, 14% (232) were attributed to patients being prescribed or dispensed the wrong insulin product. Everyone, including the patient, should take an active role to ensure that safety is improved within this large and growing healthcare population. There have been several recent local reports of both prescribing and dispensing errors which are summarised below.

Case 1: Written request for Insulin initiation for Humulin I® received by practice, diabetes specialist nurse (DSN) goes to initiate at home visit and checks prescription. A prescription for Humulin M3® 2x10 cartridge packs had been issued instead of Humulin I® pre-filled pens.

Learning Points

- DSN/Secondary Care to ensure product requested is emboldened on initiation request letter to highlight product and presentation with quantity specified. There are usually two or more presentations for each insulin type.

- Healthcare professional should cross reference to available information to confirm the correct identity of insulin products eg Prescriber to check against written request, community pharmacist to check with patient if new product being requested.

- Provide 1 pack for insulin initiation patients. Updated e-formulary now defaults to 1 pack for insulins. Less waste generated if product not tolerated.

- Similar principles apply to the addition of insulins to repeat prescription once patient stabilised and also communications when patients are transferred to/from hospital.

Case 2: Patient regularly prescribed NovoMix30® but dispensed NovoRapid® by community pharmacy. Use of wrong insulin resulted in significant hypoglycaemia associated with a fall and confusion. Patient found by relative and brought to hospital.

Learning points

- Healthcare professional should cross reference to available information to confirm the correct identity of insulin products. Community pharmacist should check with patient if new product being requested or to confirm the correct product is being supplied.

- There are many different types of insulin and some are known by two names (see below). Many of these names look and sound like one another. They also may have similar product packaging which will require consideration for storage and prescription checking within dispensaries.

- Patients should know the details of the insulin products that they use, this will include type of insulin, the presentation and any devices used in administration. Patients should be educated to ensure that they seek advice if the product they receive does not make sense or they are unclear over their insulin use.

Case 3: Patient being initiated on GLP-1 analogue (Liraglutide) by DSN, at consultation advised on cold chain issues. Two weeks elapse until prescription (1 pack of 3 prefilled pens) collected at community pharmacy by patient's wife. Correct item is collected from pharmacy and stored in cupboard awaiting DSN visit. At visit DSN identifies that the product has been outside the cold chain for five days. One pen can be used for 25 days, the remaining two are wasted at a cost of £78.51.

Learning Points

- Despite best efforts, effective cold chain communication remains a problem
- Cold chain principles should be reinforced to all parties who may be involved eg patient, relative, carers and delivery personnel
- Potential solutions include clear identification of cold chain items eg fridge stickers on outer bag and/or separate clear bag for fridge items
- Provision of smallest original pack available for initiation prescriptions to minimise waste Liraglutide is available in a 2 or 3 pen pack. A 2-pen pack is a month's supply and should be specified in any initiation communication. A change in pack size may be considered once the patient is stabilised.

Brand Name confusion

glulisine with glargine; Humalog®, Humalog Mix 25® or Humalog Mix 50®;

Humulin S®, Humulin I® or Humulin M3®; Humalog® with Humulin® products;

Hypurine products: Lantus with lente: Levemir® with Lantus® and NovoRapid® with NovoMix30®

For more information on errors with insulin please see Postscript Safety No.7: http://www.ggcprescribing.org.uk/media/uploads/ps_safety/ps_safety_07.pdf

Repeat prescribing

In addition to drug therapy patients with diabetes are prescribed many associated sundry items including needles, lancets, test strips etc. Within this area of repeat prescribing there is the likelihood of unnecessary prescribing and potential for waste. A level 1 diabetic medication review including sundry items will help to address these issues:

- By ensuring compatible products are being prescribed
- Obsolete items are discontinued where appropriate to prevent duplication and confusion.
- Items less suitable for repeats are added as acute prescriptions eg needle clippers, GlucoGel®.
- Quantities are reviewed in line with guidance from the Medicines Management Local Enhanced Service.
- Over ordering of rescue treatments such as GlucoGel® and under ordering of insulin are identified, prompting a check with the patient/carer and a clinical review with the nurse or GP.