PostScriptAcute

NHS Greater Glasgow and Clyde

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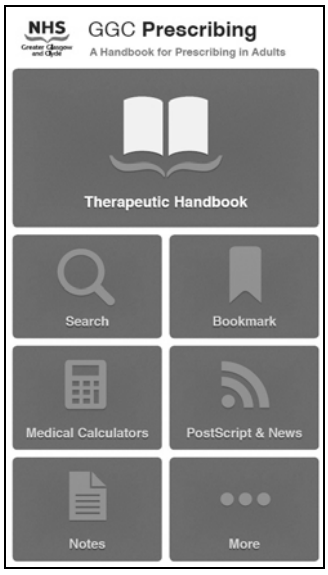
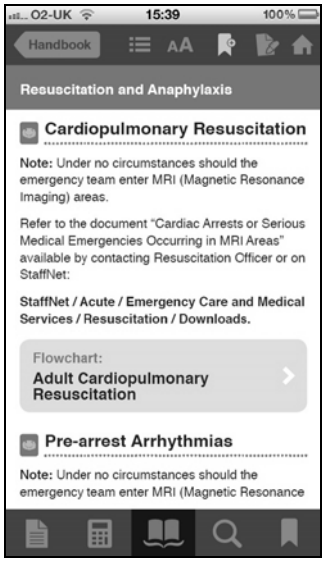
In this issue:

1. How to Access NHSGGC Prescribing Information

The NHSGGC Therapeutics Handbook and PostScript Acute bulletin are two key sources used for local prescribing information. Both can be accessed via StaffNet or the GGC prescribing website (www.ggcprescribing.org.uk).

A new NHSGGC Prescribing App is under development. This will be available to download from iTunes® and Google Play Store®. It will include all the contents of the Therapeutics Handbook in addition to links to all PostScript bulletins. The screen shots below give an insight into the overall design of the App. Watch StaffNet for more information on launch date!





To ensure that you are up to date with the latest prescribing advice, subscribe **now** to PostScript Acute and receive the latest edition emailed direct to your in-box. Some recent topics include: management of UTI in renal impairment, how to safely prescribe new oral anticoagulants and use of *electronic* Medicines Reconciliation.

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2. Errors with Concentrated Heparin Products

A recent incident with heparin has been reported. A concentrated unfractionated heparin product of 5000 units/mL (25000 units/5mL vial) was selected instead of a 1000 units/mL product (5000 units/5mL vial) which resulted in the administration of a **five-fold overdose**.

Good practice points

- Always double check ALL drug concentrations before administration.
- Refer to the GGC Therapeutics Handbook for advice on how to administer unfractionated heparin (1000 units/mL) and ensure robust checking procedures.
- Most clinical areas will NOT be required to keep the concentrated heparin product (25000 units/5mL vial). If it is required, ensure appropriate storage.
- Return the concentrated heparin product to pharmacy as soon as it is no longer required; quarantine in the drug cupboard if pharmacy is closed.

3. Summary of Major Changes to NHSGGC Therapeutics Handbook

The next edition of the NHSGGC Therapeutics Handbook will be circulated at the beginning of August to all acute sites and is valid until August 2014. An electronic version is available on StaffNet and on the Greater Glasgow and Clyde Prescribing website (www.ggcprescribing.org.uk). The 6th edition has been extensively revised since the publication of the 5th edition. Outlined below are some of the main changes, however, all members of nursing, medical and pharmacy staff are encouraged to familiarise themselves with guidelines relevant to their area of practice.

General Changes

- A new section has been added which provides guidance for 'Assessing medicines on admission for acute patients'.
- The paracetamol overdose guideline has been changed to reflect new guidance in the BNF and TOXBASE. Guidance has been divided into 3 sections; presentation < 8 hours after overdose, 8-24 hours and > 24 hours.
- Guidance for the preparation of omeprazole IV in the Management of Gastroduodenal Ulcers section has been changed. This is consistent with the information contained within the NHSGGC Adult IV Medicines Monographs.
- The Treatment of Venous Thromboembolism section now includes information on the use of rivaroxaban in **both** deep vein thrombosis and pulmonary embolism.
- The Antiplatelet Guideline and the Acute Coronary Syndrome flowchart now include guidance on the use of ticagrelor.
- Changes to the Stroke section include patient referral for thrombolysis if symptom onset < 4.5 hours.
- The treatment of choice for Night Sedation has changed. Zopiclone should be used first-line instead of temazepam.
- Infection section – major changes to this section are detailed under 'Infection section changes' on page 3.
- The Types of Antidiabetic Drugs section includes new information on safer insulin prescribing. This is described under 4 key headings:
  - Right Insulin
  - Right Time
  - Right Dose
  - Right Way
- The Malignant Ascites section within the Oncological Emergencies chapter has been updated.

3. Summary of Major Changes to NHSGGC Therapeutics Handbook (cont'd)

Infection section changes

General

- Several antifungals have been added to the list of alert antibiotics. Ceftaroline, fidaxomicin and temocillin have also been added. The permitted indications for some alert antibiotics have been revised.
- Warnings have been added to highlight antibiotics known to increase the risk of QT interval prolongation (e.g. macrolides, quinolones).
- Guidance on the management of *suspected* urinary tract infection (UTI)/lower respiratory tract infection (LRTI) has been added. This scenario should be managed in line with the individual UTI and LRTI guidelines. In the presence of sepsis, *suspected* LRTI/UTI should be managed following the guideline covering sepsis of unknown source.
- The gentamicin dosing guideline and the vancomycin dosing guideline have been updated and re-structured to improve clarity.

Severe sepsis (source unknown)

- The management of both healthcare and community-associated sepsis/severe sepsis is now the same. First-line treatment is benzylpenicillin + flucloxacillin + gentamicin.
- The dose of IV flucloxacillin for both sepsis/severe sepsis of unknown source and for *Staphylococcus aureus* bacteraemia has been changed from 2 grams every 4 hours to 2 grams every 4-6 hours.

Urinary tract infection

- Warnings to avoid trimethoprim (and co-trimoxazole) in patients with an eGFR <30 ml/min/1.73m^2 have been added and alternative management options are provided.

Community Acquired Pneumonia (CAP)

- For moderate CAP, doxycycline + amoxicillin is now recommended as an alternative to clarithromycin + amoxicillin.
- For severe CAP with a true penicillin/beta-lactam allergy, doxycycline + vancomycin has been added as an alternative to clarithromycin + vancomycin.
- Advice to consider clarithromycin first-line in patients with CAP associated with recent foreign travel has been added.

Hospital Acquired Pneumonia (HAP)

- Oral co-amoxiclav has been added as an alternative to doxycycline for those with late-onset HAP in the absence of sepsis and where CURB65 ≤2. If doxycycline is prescribed first-line and the patient fails to respond within 48 hours, contact microbiology for advice.
- True penicillin/ beta-lactam allergic patients, with late onset HAP where CURB65 ≥3 and/or sepsis is present, should now be treated with vancomycin + ciprofloxacin rather than vancomycin + gentamicin.

Central nervous system infections

- Advice on the recognition and investigation of suspected meningitis and viral encephalitis has been added.
- Patients with alcohol excess or liver disease have been added to the group in which listeria meningitis should be suspected.
- Chloramphenicol *plus* vancomycin is now recommended for bacterial meningitis in those with true penicillin/beta-lactam allergy and suspected listeria meningitis / age ≥ 50.

Feedback, both good and bad is welcomed by the Handbook Editorial Group and will be used to inform decisions about future editions.

Email any comments to
ggcprescribing@ggc.scot.nhs.uk

3. Summary of Major Changes to NHSGGC Therapeutics Handbook (cont'd)

Infection section changes

Intra-abdominal or hepatobiliary infections

- Amoxicillin + metronidazole + gentamicin should now only be used for the *initial* episode of either peritonitis or intra-abdominal sepsis. The management of any subsequent episodes should be discussed with microbiology.
- Where antibiotics are indicated for biliary tract infection and the patient is frail, elderly or has an eGFR<50ml/min/1.73m^2, piperacillin/tazobactam should replace the usual regimen of amoxicillin + metronidazole + gentamicin.
- A reminder has been added stating that antibiotics are NOT indicated for biliary colic in the absence of sepsis or for acute pancreatitis (unless there is co-existent cholangitis suggested by jaundice and sepsis).
- Antibiotics may be withheld at the discretion of the treating surgeon in cases of suspected appendicitis without sepsis and for those with mild diverticulitis (provided there is not evidence of perforation on a CT scan).
- A section on the management of sepsis post-laparotomy has been added and piperacillin/tazobactam is recommended first-line.
- Pulsed/tapered oral vancomycin is no longer recommended for patients with a second relapse of *Clostridium difficile* infection, such patients should be discussed with microbiology or infectious diseases.

MRSA Eradication Policy

- HiBi Scrub Plus® is now recommended for skin decolonisation in place of Clinisan Advance®

Bone and joint infections

- Rifampicin and sodium fusidate are no longer recommended first-line for all patients with a suspected prosthetic joint infection; empirical treatment is now dual therapy with vancomycin + initial gentamicin (maximum 3-4 days).
- A warning about the risk of peripheral neuropathy with a prolonged course of metronidazole has been added to the section on diabetic foot osteomyelitis; treatment options should be discussed with microbiology.

Skin and soft tissue infections

- The management of moderate and severe cellutitis/erysipelas has changed. Moderate infection should be managed with flucloxacillin alone and severe infection should be managed with flucloxacillin + gentamicin + clindamycin.
- Benzylpenicillin has been added to the management of both necrotising fasciitis and severe infections in parenteral drug users.

4. Guideline news

Guidelines approved since June 2013

NHSGGC Guidelines
Vitamin D: Measuring and Prescribing (*An additional guideline on the 'Management of possible vitamin D deficiency' is expected soon*)
Guidelines on the Management of Drug Misusers in GGC Acute Hospitals
Guidance for the Administration of IV Midazolam for conscious sedation in adults
SIGN Clinical Guidelines
Antithrombotics: indications and management (SIGN129 (Aug 2012) updated June 2013)
NICE Clinical Guidelines
Falls (CG161)
Stroke rehabilitation (CG162)
Idiopathic pulmonary fibrosis (CG163)

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