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## Voluntary ban on methotrexate 10mg tablets in Primary Care

For patient safety reasons, 1st April 2012 was the implementation date set for a "voluntary ban" on the use of methotrexate 10mg tablets by NHS GGC primary care. GP practices were requested to identify all patients prescribed 10mg tablets with a view to switching to the equivalent weekly dose using **only the 2.5 mg tablets**.

Despite the NPSA issuing alerts in 2004 and 2006 regarding the risks of prescribing different strengths of methotrexate tablets and a NHS GGC policy recommending a 2.5mg strength only policy, this was not reflected in practice. NHS GGC was one of the poorest performing health boards in Scotland. From the first communication regarding the "voluntary ban" in Nov 2011 through to July 2012, prescribing analysis shows NHS GGC has moved from 85% to **98.1%** of oral methotrexate as the 2.5mg tablet strength and is now one of the highest performing health boards.

Congratulations and thanks to all GPs, primary care support teams, hospital teams, community pharmacists and patient groups who have helped to achieve this prescribing change.

## Simvastatin Interactions

You will have received some communications recently about updated advice from the MHRA regarding prescribing of simvastatin, particularly concerning new drugs with which simvastatin is contraindicated or drugs which should have a revised recommended dose.

Key points are simvastatin is now contraindicated with ciclosporin, danazol and gemfibrozil. The maximum recommended dose for simvastatin in conjunction with amlodipine or diltiazem is 20 mg per day. Patients are being reviewed opportunistically at their next scheduled appointment within GP practices.

Whilst community pharmacists should be alert to the risks of prescribing simvastatin, particularly with diltiazem, amlodipine, verapamil or amiodarone, a refusal to dispense should be not be considered an option. Pharmacists are encouraged to discuss the prescription with the prescriber before taking any action or sending the patient back to the practice.

Further advice is available on the GGC prescribing website (<http://www.gccprescribing.org.uk/blog/postscript-71-september-2012/>) and MHRA, including a new patient information leaflet. (<http://www.mhra.gov.uk/Safetyinformation/Safetywarningsalertsandrecalls/Safetywarningsandmessagesformedicines/CON199556> )

## Fersamal® Tablets

Fersamal® tablets as a brand have now been discontinued. However, stock of ferrous fumarate is available from the same company (Mercury) as the generic ferrous fumarate 210mg, cost price for 84 is £1.44.

## Managed Medication Service delivered by Cordia in Glasgow City CHP - Green MAR charts

Community pharmacies requiring additional supplies of the green MAR charts can order these directly from the Admin team in the NW sector on 211 3877. Information sheets and guidance notes on the service are available from the local pharmacy champions; Garry Scott, Joan Miller and Alex McMillan.

## Specials/ Unlicensed Product Requests

Pharmacists and dispensary staff are reminded of the revised guidance that was issued in July relating to authorisation of Special/ unlicensed products. In summary, on receipt of a request for an unlicensed/ special product:

- Check Special Guidance for Primary Care document, Appendix 3 to see if a licensed product is available.
- Discuss with GP if there is a suitable alternative. If not, move to the next step.
- Check Appendix 4 to seek preferred supplier of the requested item.
- Contact CPDT for authorisation **for first supply only**. If the item is to be repeated, then authorisation is not required each time.

Place order for product from preferred supplier (if available) and endorse prescription accordingly.

In addition, all first prescription requests for the following should always be discussed with the GP:

- Omeprazole or Lansoprazole solution, all strengths. Losec Mups® and Zoton Fastabs® are suitable licensed alternatives (see note below)
- All dilution or mixing of steroids e.g. Canestan®/ Betnovate 50:50; Eumovate® in WSP is no longer recommended (See statement in September issue).
- Diltiazem 2% cream could be discussed with the prescriber with view to a possible change to licensed Rectogesic® (GTN ointment).
- Ranitidine 5mg/5ml as there is a licensed 75mg/5ml preparation available with a 1ml oral syringe shortly to be added to the Drug Tariff.

Pharmacists are reminded that these steps support an assessment of ongoing need for the medicine in line with the Board's polypharmacy guidance. Whether the patient takes other medicines in tablet or capsule form and the ability for patient/carers to administer various formulations should be made when asking prescribers to considering alternatives.

Tablet crushers are available from the wholesalers and NPA for patients to purchase. Further medicine specific information about suitability for crushing, how to administer etc available in NEWT guidelines and GGC guidance.

Suggested initial alternatives for Atorvastatin liquid: if the patient requires ongoing treatment, there is a new licensed Lipitor chewable tablets if patient has swallowing difficulties but can still manage to use chewable preparation. In addition, a licensed simvastatin liquid is available, though it is at a higher cost.

Magnesium Glycerophosphate: the most cost effective supplier for Magnesium Glycerophosphate 4mmol (97mg) tablets and 1mmol/1ml liquid appears to be Special Products Ltd as Maglyphos brand.

PPIs in children: Yorkhill have confirmed that their preferred PPI of choice in children is omeprazole (capsules orally if the child was old enough. For babies, omeprazole

MUPS which can be halved for a smaller dose).

For feeding tubes, they advise using the MUPS dissolved in water if the feeding tube is wider than 15 French gauge. In narrower feeding tubes, MUPS can clog up the tube; and so would use the granules from the opened omeprazole capsule dissolved in sodium bicarbonate 8.4% oral solution ("SodiBic" via AAH).

With regards to rantidine 5mg/5ml, Yorkhill have also advised that they provide the licensed 75mg/5ml strength for use with a 1ml oral syringe, with 0.1ml increments. The Board have now been told that 1ml oral syringes will be added to the Drug Tariff from December, in addition to the 5ml spoons and 5ml oral syringes already included.

## Computerised Smoking Cessation Programme

The electronic data capturing of the minimum dataset associated with the Pharmacy Smoking Cessation programme was introduced to the majority of Community Pharmacies in the North West sector of GGC in May and this has now been extended to Inverclyde, Renfrewshire and the North East. In total, 131 Pharmacies now have access to the new system and in general, it has proved to be very popular. At the time of going to press, we are still awaiting exact dates for rolling out to the remaining areas, but we are hopeful that we can continue this at the start of 2013.

### A Big Thank You

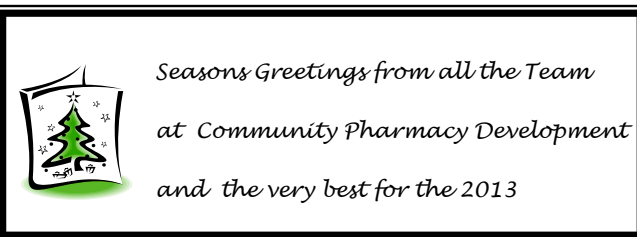
As you are now all aware, our Smokefree programme has since March, transferred away from using Nicorette® products, so a big thank you to everyone for their perseverance and ultimately the smooth transition to Niquitin®.

## Chloramphenicol PGD

All pharmacists are reminded that the above PGD is to be used to supply chloramphenicol after a MAS consultation to children aged 12 months and older. The OTC product is licensed for use in 2 years and older. Any child under 12 months presenting with signs of conjunctivitis should be referred to their optometrist or GP and medication to be supplied only on presentation of a GP10 form.

Supplies of this product to under 12 months are not legally supported using the PGD.

Please note that all patients presenting with red eye symptoms should be referred to an optometrists using the approved CPS/ Optometry Scotland form.



## Safe and Secure Handling of Medicines Within Primary Care

The NHS GGC Acute Safe and Secure Handling of Medicines policy was launched in April 2008. Since the implementation of the Acute policy, work has been underway to develop a complementary document for Primary Care healthcare service areas. After extensive consultation with staff (including medical, nursing and pharmacy staff) the finalised document has been approved. The key aims of the document are to –

- ensure staff comply with current legislation and best practice at all times in relation to the procurement, storage, security, transport, prescribing, dispensing, administration and destruction of medicines.
- protect both patients and staff from some of the risks associated with the use of medicines.

*The document is **policy** for all NHS GGC employees. It is recommended as a **guidance tool** for independent NHS GGC contractors, who are encouraged to adopt the principles in their own practice.*

The document is based on current legislation, good practice guidelines and common sense. It covers all non-clinical aspects of medicines use and is applicable to all staff who handle medicines. Much of the content is not new and is merely a description of current good practice. It is anticipated that the document will act as a stimulus for review and reflection on practice in each healthcare service area and, if necessary, review or development of standard operating procedures (SOPs).

The main chapter in the document includes explicit guidance on the legislative and / or good practice requirements necessary within all healthcare service areas to ensure safety and security in the handling of medicines in primary care environments. Detailed guidance is also provided on the transportation of medicines (including maintenance of the cold chain), with further smaller sections covering medication incidents, defective medicines and medicines for use in research and clinical trials.

The document is being promoted on a CH(C)P wide basis in a rolling programme across NHS GGC. The launch dates are being agreed with each CH(C)P / primary care structure and supporting publicity e-mails will be cascade through each area.

A dedicated e-mail address is available for questions or comments on the document (sshm@ggc.scot.nhs.uk).

The Primary Care document can be viewed on the NHS GGC Prescribing website via the link:  
[http://www.ggcprescribing.org.uk/media/uploads/policies/section\\_11/sshm\\_policy\\_-\\_1208.pdf](http://www.ggcprescribing.org.uk/media/uploads/policies/section_11/sshm_policy_-_1208.pdf)

## CMS – Care Planning Recording

Community pharmacists are reminded that any care issues should be recorded within the care plan section of the Pharmacy Care Record (PCR). The free text notes within the risk assessments act as a reminder for the pharmacists on the points that require a care action to be created but this section does **not** automatically transfer the information across as can be done within the High Risk Medicine and New Medicine Intervention Support Tools.

NES have also very recently launched a new educational resource to aid community pharmacists with care planning elements of CMS. The resource introduces a virtual family, The Cullen's, and concentrates on different diseases. The first one focuses on COPD and is designed to support pharmacists with the information gathering and recording on a mock PCR.

These virtual cases will allow users to question the patient and receive immediate verbal answers while completing on-line documentation similar to that used for CMS PCR. When the pharmacist has completed the record, he or she can compare this to a pre-prepared one for that patient, with an option to print either or both records for reference purposes. The patient will also provide a short verbal assessment of the pharmacist's consultation skills at the end of the scenario.

This e cases are available from the NES portal from mid-December 2012 and are also available from Keele University website:

<http://www.keelesop.co.uk/vpnes/copd/>

## Malaria Prophylaxis

The Scottish Malaria Advisory Group (SMAG) has updated advice on malaria chemoprophylaxis and risk areas in India <http://www.hps.scot.nhs.uk/ewr/article.aspx>. Due to problems with resistance, SMAG has opted to follow the WHO recommendation that prescription only anti-malarials should be recommended as first line choice for travelers to risk areas in India, as opposed to over-the-counter medication. It is recognized that other authorities may continue to recommend chloroquine plus proguanil.

This advice is available on the TRAVAX database for health professionals and the "fitfortravel" website for the general public

One of the key messages is that travellers should consult a health professional at least 6-8 weeks in advance of their trip in order to allow time for pre-travel preparations, including advice, chemoprophylaxis and any necessary vaccinations.

GPs in NHS GGC will be advised a private prescription will be required as malaria prophylaxis is not available under the NHS.

## Serial Prescriptions: Hints and Tips

The Board roll out of CMS serial prescriptions is continuing across NHS GGC. We have now issued invitations to participate to GPs in North West sector and East Dunbartonshire CHP with a healthy initial uptake.

It is planned that GP practices in the final two CHP areas will be invited to participate in March 2013, with training commencing after Easter. From there, the Board will continue to work alongside GP practices and community pharmacies to encourage uptake and the participation of more sites.

However, some common occurrences have emerged that community pharmacists should be aware and help to manage/ reduce any problems in dispensing serial prescriptions are:

### GP practices providing duplicate serial prescriptions

On occasions, some practices are re-issuing serial prescriptions, often in response to a patient who has forgotten or not realised that the pharmacy has a 6 month script for them. The duplicate script will actually replace the original prescription if scanned by the pharmacy. Dispensary staff should then complete the original prescription, send off any outstanding claims and submit the form to PSD.

### Incorrect "PRN" quantities

In order to prescribe a suitable quantity for PRN medications for a 24 or 28 week script, GPs need to calculate using their prescribing history for that item. We are working with practices to make them aware that they need to calculate PRN quantities for 24 or 48 weeks and adjust this accordingly. Pharmacists should be aware of this problem and discuss any items where the quantity cannot be dispensed in completed packs– the most common problem being with creams/ ointments, insulin devices and inhalers.

Related to this, is also the problem where there is a variable dose e.g. take 1 or 2 tablets up to four times a day. Again, GPs are being encouraged to look at the previous repeat prescribing history and amend the quantity.

Pharmacists should also be aware if a patient requests supplies of a PRN medication more frequently than expected, then this should be logged as a care issue on the PCR and discussed with the GP.

### Uncollected items/ Not Dispensed items

If a patient regularly refuses or declines a dispensing of a particular item, this should be recorded on the PCR as a care issue and discussed with the GP.

### Sending electronic claims

Dispensary staff should only send the electronic claim data to PSD for processing when the medication is transferred to the patient and not at the point of dispensing.

**Contractors should ensure that there is a process in place to check that a claim has been sent at the point of collection.** This claim message not only triggers

payment but also updates the GP clinical system and Emergency Care Summary data and therefore, needs to be as accurate as possible.

### CMS processes

Feedback from existing pharmacies has been that the actual dispensing of the serial prescription is relatively easy and straight forward. The difficulty appears to be in managing the process around planning when the patient will return to the pharmacy, storing the prescriptions prior to the next iteration and storing made up prescriptions within the pharmacy.

Some ideas and guidance are contained within the CMS toolkit and pharmacists must consider how to actually deal with the wider process of serial prescriptions in its complete sense, and not just as a dispensing process.

## Care Home Induction Guidance

Across NHSGGC approximately 8000 adults are cared for in the care home setting (ISD August 2012). The CHUMS study (DoH 2009) identified a high prevalence of errors in medication received by older residents of care homes. The main findings included that residents were taking an average of 8 medicines each and that on any one day 7/10 patients experienced at least one medication error. Both pharmacists and technicians have key roles in the management of this patient group:

- It is recognised that pharmacy staff should work closely with care home and GP practice staff to support delivery of pharmaceutical care for this vulnerable patient group
- It is recognised that pharmacists should regularly review residents' and their medication. They can also rationalise regimes to help home staff work more safely (CHUMS 2009).
- Although care home patients are currently exempt from CMS the underlying principles can be used to support medication review in this vulnerable patient group

The Royal Pharmaceutical Society Improving Pharmaceutical Care in Care Homes report (March 2012) identifies a number of priority issues that require action across Scotland. These include:

- Reducing inappropriate polypharmacy, psychoactive medication and high risk medicines.
- Improving falls and hip fracture prevention, pain management, dementia care, anticipatory care and palliative and end of life care, the management of "when required" medication, nutritional products and respite care.

To support pharmacists and technicians preparing to deliver pharmaceutical care activities within the care home setting, an NHSGGC care home induction guide has been developed aiming to provide signposts to relevant resources. It contains references to clinical and non clinical support materials including information on the legislative framework and regulatory guidance.

## Unscheduled Care Service



As we approach the busy Festive season, all pharmacists are reminded of the need to have signed the newly released Version 14 of the PGD that supports this service. Declarations must be signed by individual pharmacists and sent to the relevant Health Board(s) (see PGD for details).

Pharmacists must exercise their professional judgement when using the PGD. Patient access to their medication whilst the GP practices are closed must be considered and pharmacists should always consider the consequences of not making a supply of regular repeat medication to a patient.

Contractors are reminded that the national PGD for urgent supply of repeat medicines and appliances can be used for any patient that presents to a community pharmacy provided they are registered with a GP in Scotland. Evidence of previous supply can take a variety of forms e.g. patient's word, repeat slip or old packaging. Depending on the nature of the drug requested the patient's word can often be sufficient.

Contractors need to ensure all staff working in their pharmacy (including locums) know where the Unscheduled Care folder and CPUS forms are kept.

Access to medication should generally be resolved via the community pharmacist with the notable exceptions of Controlled Drugs or drugs for a clinical condition which has changed or if the patient is describing new symptoms.

Pharmacists will obviously have to exercise additional caution regarding drugs that are liable to abuse. Whilst we recognise the need to exercise caution, we would ask pharmacists to consider the clinical and other aspects surrounding requests for urgent supplies.

If the patient is available but is unsure what medication they are on, pharmacists can contact NHS 24 to seek clarification from the Emergency Care Summary. Please note that this is a verification of the patient's medication and should not be used as a means of seeking permission to supply.

If the pharmacist needs to speak to a doctor, please use the professional to professional numbers contained within the Unscheduled Care folder for the various GEMS OOH sites across the Board area. Please do not contact NHS 24.

The table below describes some common problems and the solutions to avoid these situations during the time where access to the pharmacy service is at its peak during the Festive closures.

<b>Problem/ barrier</b>	<b>Solutions/ possible actions or outcome</b>
Patients not on PMR in the Pharmacy	This is not a requirement for either Emergency Supply or PGD
Patient has no repeat slip or empty box	Again not a requirement as long as the pharmacist is satisfied that the patient is usually prescribed that medication
Locums	Locums need to sign up for the PGD in each of the Health Boards they work in and there is no requirement for the pharmacist to know the patient
Patient does not know what they take or the dose they take	Pharmacist can phone NHS 24 to get access to the ECS and confirm medication details
Pharmacist does not feel comfortable supplying a whole cycle on the PGD	Do not have to – can supply any amount under the PGD
Feel the patient is abusing this medication	Refer the patient to their own GP as OOH unlikely to supply
Do not have strength of tablet patient is currently on	Strength can be substituted as long as dose and dosage regime is equivalent.
Do not have liquid form only have capsules	In emergency or out of hours situation, as long as the patient can swallow the capsules, form may be substituted
Patient is recently discharged on new medication, not on repeat basis yet	Can still use the emergency supply route



## Glasgow Addiction Services Pharmacy update

Jennifer Torrens has commenced the role of 'Alcohol Pharmacist' within NHS Greater Glasgow and Clyde Addiction Services, in replacement of Leanne Blackwood. Jenny is responsible for the 'Disulfiram Service in Community Pharmacy' and the 'Community Pharmacy Alcohol Brief Intervention Scratch Card Initiative'. She can also be contacted for support and advice on alcohol related queries. Please find her details below along with the other members of the Addiction Services Pharmacy Team.

The Pharmacy Team will be recruiting for a new post shortly for a full time Advanced Pharmacist.

### Addiction Services

**Tel: 0141 277 7660**

Carole Hunter

Lead Pharmacist

Email: [Carole.Hunter@ggc.scot.nhs.uk](mailto:Carole.Hunter@ggc.scot.nhs.uk)

Tel: 07557012874

Mary Clare Madden

Senior Clinical Pharmacist (Independent Prescriber)

Email: [MaryClare.Madden@ggc.scot.nhs.uk](mailto:MaryClare.Madden@ggc.scot.nhs.uk)

Tel: 07557012877

Jennifer Kelly

Advanced Pharmacist (Independent Prescriber)

Email: [Jennifer.Kelly@ggc.scot.nhs.uk](mailto:Jennifer.Kelly@ggc.scot.nhs.uk)

Tel: 07557012875

Amanda Laird

Advanced Pharmacist (Naloxone Lead)

Email: [Amanda.McCulley@ggc.scot.nhs.uk](mailto:Amanda.McCulley@ggc.scot.nhs.uk)

Tel: 07557012879

Jennifer Torrens

Alcohol Pharmacist

Email: [Jennifer.Torrens@ggc.scot.nhs.uk](mailto:Jennifer.Torrens@ggc.scot.nhs.uk)

Tel: 07557012870

Aileen Cedervall

Clinical Pharmacist (Independent Prescriber)

Email: [Aileen.Cedervall@ggc.scot.nhs.uk](mailto:Aileen.Cedervall@ggc.scot.nhs.uk)

Tel: 07557012872

John Campbell

Improvement & Development Manager for IEP

Email: [John.Campbell@ggc.scot.nhs.uk](mailto:John.Campbell@ggc.scot.nhs.uk)

Tel: 07557012871

Deirdre Millar

Operational Manager Satellite Clinic, Gorbals

Email: [Deirdre.Millar@ggc.scot.nhs.uk](mailto:Deirdre.Millar@ggc.scot.nhs.uk)

Kirsteen Donnachie

Substance Misuse Services, Clyde

Email: [kirsteendonnachie@nhs.net](mailto:kirsteendonnachie@nhs.net)