Prescribing Newsletter

Making the most of medicines

May 2025

Contents

Can't find our documents??

All our guidelines are stored on the Medicines Optimisation section of the NHS Frimley website.

They may also be found on the relevant monograph of the Frimley Formulary.

New and updated documents on the NHS Frimley Medicines Optimisation Website

Paliperidone SABP shared care document has been updated to include the 6mthly prep. The guide to permitted adjustments to depot antipsychotic due dates has also been updated to include this preparation.

New BTS/ NICE/ SIGN guidelines for asthma were published in November 2024. These represent a change in the approach to the management of this condition. This has been summarised for NHS Frimley in this pictorial guide.

Update to Frimley Wound Care Formulary

On 1st April 2025 the new Frimley Wound Care Formulary was made live on the Convatec Complete Online Management System (CCOMS). This is for ordering dressings and is available to all nursing staff.

Working with our Tissue Viability Teams at BHFT and HCRG we are pleased to provide a single formulary for the whole of Frimley which provides a clear set of choices. Products and availability have been tailored to suit the type of nursing site. We encourage all GP practices to ensure as many dressing requests as possible are fulfilled using CCOMS via practice nurses. You may also notice that ScriptSwitch may guide you to CCOMs where it is the most appropriate route for a wound care product.

The updated formulary documents can be located as follows,

Wound Care Formulary- summary
Frimley Wound Care Formulary

If you have any questions on this please contact Ross Burton ross.burton@nhs.net or Simon Smith simon.smith22@nhs.net

Medicines Optimisation in Care Homes
Risks of secondary dispensing

Secondary dispensing medication occurs when medicines already dispensed by a pharmacy or dispensing doctor are re-packaged– often with the intention to make it easier for a patient to take (or remember to take).

Examples of secondary dispensing include:

- medicines removed from or cut-off a strip and placed into individual envelopes/ containers (perhaps for appointments or longer periods of time away from a care home or facility),
- medicines removed from the original containers and placed into daily/ weekly MDS boxes (by the resident, family member or care staff).

On a recent care home visit a MOSCCH pharmacy technician identified that medicines were being removed from dispensed packs and were not being labelled in line with the Medicines Act. Several residents had been unable to remove medicines from strips or felt unable to manage multiple boxes of medicines. To support them to self-administer staff had removed medication from their original strips and placed them into unlabelled envelopes or MDS boxes. Risk assessments were in place to ensure medicines were being taken appropriately however as the medicines were not labelled, there were no instructions on how/when they should be taken, no warning labels, and no additional advice.

With the support of the MOSCGG team the care home worked with the community pharmacy who were able to organise dispensing medicines for these residents into weekly blister packs.

Due to the increased the risk of medication errors **secondary dispensing is never recommended**. Please see the following links for further advice .

- RPS Professional Standards for optimising medicines for people in secure environments
- CQC - Administering medicines when a person is away from their usual care setting

Desmopressin 10 microgram/dose nasal spray– supply problems

We are aware of the ongoing shortage of desmopressin 10 microgram/dose nasal spray. The anticipated re-supply date is September 2025. When used for the treatment of arginine vasopressin deficiency (cranial diabetes insipidus), **desmopressin is a life-sustaining medication, and omission or delay in this patient group can result in severe harm or death.** Desmopressin tablets and sublingual tablets remain available and can support an increase in demand.

Actions

Where patients have insufficient supply until the resupply date, refer to the patients' parent endocrinology team (use advice and guidance). Whilst awaiting a response:

- Consider prescribing unlicensed imports of desmopressin 10 microgram/dose nasal spray*. Note, availability and lead times may vary.
- If the above cannot be sourced or is considered unsuitable, prescribe an equivalent dose of an oral desmopressin product, ensuring patients are counselled on the change in formulation and dosage.

Nasal Spray	Tablet	Sublingual
10 to 20 micrograms daily. Increased if necessary up to 40 micrograms in adults divided into 2 doses and to 20 micrograms in children and adolescents (<18 years) divided into 2 doses.	Starting dose in adults and children is 100 micrograms three times daily, adjusted in accordance with patient's response. For majority, maintenance dose is 100 to 200 micrograms three times daily	Starting dose in adults and children is 60 micrograms three times daily, adjusted in accordance with patient's response. For majority, maintenance dose is 60 to 120 micrograms three times daily.

Monitoring

Because patient response can vary considerably, patients should be monitored while their individual dose is titrated. The following monitoring is recommended:

When?	Monitoring
7 days after initiation / adjustment	Serum sodium (U&E)
Once stable, 1 month later	Serum sodium (U&E)

During the initiation / titration period, patients should be advised to monitor for symptoms of insufficient or excessive replacement. The following adjustments can be considered if the patient reports such symptoms.

Symptoms	Dose adjustment
Symptoms of insufficient replacement: dilute urine, passing high volumes of urine, polydipsia, fatigue.	Increase daily dose of tablets by 100 micrograms daily, or of sublingual by 60 micrograms daily
Symptoms of excess replacement: decreased thirst, decreased urination, headache, nausea, fatigue, confusion	Reduce daily dose of tablets by 100 micrograms daily, or of sublingual by 60 micrograms daily

***Prescribing unlicensed imports:**

Any decision to prescribe an unlicensed medicine must consider the relevant guidance and NHS Trust or local governance procedures. Unlicensed imports do not undergo any central quality assessment or suitability evaluation. Therefore, any import must be locally assessed in line with local unlicensed medicines processes.

Please see the links below for further information:

- The supply of unlicensed medicinal products, Medicines and Healthcare products Regulatory Agency (MHRA)
- Professional Guidance for the Procurement and Supply of Specials, Royal Pharmaceutical Society
- Prescribing unlicensed medicines, General Medical Council (GMC)

When prescribing a product that is not licensed in the UK due to a supply issue with the licensed alternative prescribers must indicate on the FP10 prescription that an unlicensed product is required. This can be done on electronic prescriptions by selecting *Desmopressin 10microgram/dose nasal spray (imported)*.

SmPC Desmopressin 10microgram/dose nasal spray SmPC Desmopressin 200microgram tablets BNF Desmopressin
SmPC Desmopressin oral lyophilisates SmPC Desmopressin sublingual tablets SmPC Desmopressin injection
SmPC Desmopressin 100microgram tablets Arginine Vasopressin Deficiency (Diabetes Insipidus) | Society for Endocrinology.

Thank you to FHFT for this article.

Large study ties early-life antibiotic exposure to higher risk of asthma, allergies & other conditions

A study using data on more than 1 million children using electronic health records data from the United Kingdom (1987-2020) published in the Journal of Infectious Diseases, found that antibiotic exposure before age 2 years was positively associated with asthma, food allergy, hay fever, and intellectual disability, with stronger associations observed following multiple antibiotic courses. Despite important benefits of antibiotics, this study contributes to mounting evidence for long-term harms from early-life antibiotic exposure, underscoring the need for judicious antibiotic use in infancy and early childhood.

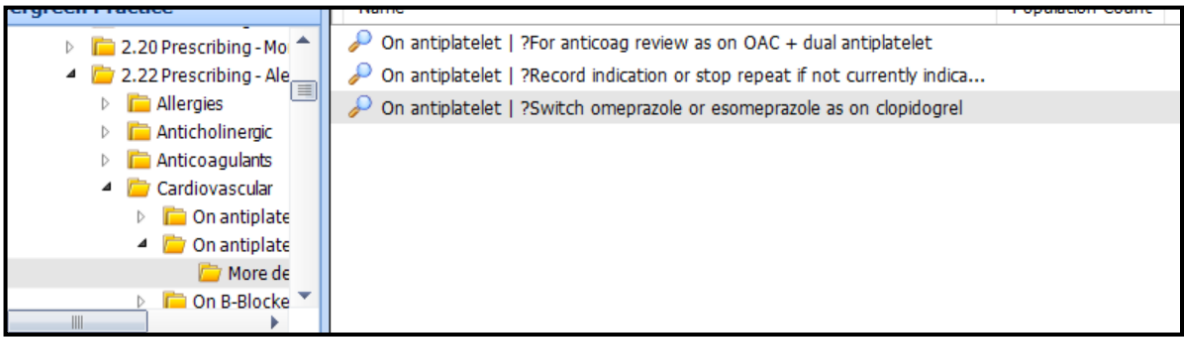
The Frimley Healthier Together website contains safety netting leaflets which, alongside parent counselling, support the "***no antibiotic***" and "***delayed antibiotic***" prescribing approach. Consider using this Gut Friendly leaflet to educate parents and patients about the importance of the gut microbiome. A summary table of common childhood infections and when to treat/ not treat with antibiotics is provided below.

Infection	When to treat/ not treat (taken from SCAN)
Sore throat	**Most young children presenting with tonsillitis have a viral aetiology.** No significant difference in pain score at day 3 in children treated with antibiotics compared to those treated with placebo. Antibiotic NNT greater than 4000 to prevent one case of quinsy. Optimise management of pain - regular paracetamol or ibuprofen for pain Base decision about antibiotic treatment on FeverPAIN score: Score 0-1: 13-18% likelihood of isolating streptococcus: use NO antibiotics Score 2-3: 34-40% likelihood of isolating streptococcus: use back up/delayed antibiotic OR NO antibiotic Score 4 or more: 62-65% likelihood of isolating streptococcus: use immediate antibiotic OR back-up antibiotic **Score validated in children 3 years and over - younger children are less likely to have a bacterial aetiology and are less likely to develop complications.**
Acute otitis media	**Generally antibiotics are not required**. Majority of cases resolve in 14-21 days without them (regardless of cause; bacterial or viral). Optimise analgesia: paracetamol or ibuprofen Consider eardrops containing an anaesthetic and an analgesic for pain (phenazone 40mg/g with lidocaine 10mg/g (Otigo)). Use only if all apply: • Immediate oral antibiotic is not given • No eardrum perforation • No otorrhoea **Children over 2 years: only consider starting oral antibiotics** if any of the following criteria are met in a child presenting with AOM (bulging ear drum or discharge): • Symptoms not improving after 3 days • Purulent discharge from ear canal (not due to otitis externa) (ottorhoea) • Systemically unwell • Has high risk of complications **Children aged 6 months-2 years**: start antibiotics if: • Bilateral AOM, or • Purulent discharge from ear canal (not due to otitis externa) (ottorhoea), or • Symptoms not improving after 3 days **Children under 6 months:** start antibiotics if a presumed AOM.
Acute rhinosinusitis	**Avoid antibiotics as 80% resolve in 14 days without, and they only offer marginal benefit after 7 days.** Use adequate analgesia. Consider treating with antibiotic if **most** of the following are present: • Symptoms for more than 10 days • Marked deterioration after an initial milder phase • Fever • Unremitting purulent nasal discharge • Severe localised unilateral pain (particularly pain over teeth and jaw)
Community acquired pneumonia	**Most lower respiratory tract infections are of viral aetiology - consider bacterial pneumonia if persistent / recurrent fever over preceding 24-48 hours with chest wall recession and tachypnoea.** Presence of generalised wheeze makes viral aetiology far more likely. Consider use of STARWAVe tool in children presenting with acute RTI and cough for prediction of hospitalisation in the following 30 days: **The 7 symptoms and signs are:** **S** - **Short** illness of 3 days or less **T** - parent-reported severe fever in the previous 24 h or a body **temperature** of 37·8°C or more at presentation **A** - **Age** less than 2 years **R** - clinician-reported intercostal or subcostal **recession** **W** - clinician-reported **wheeze** on auscultation **A** - Current diagnosis of **asthma** **V** - parent-reported moderate or severe **vomiting** in the previous 24 h If 0 or 1 characteristics, 3/1000 risk of hospitalisation in the following 30 days If 2 or 3 characteristics –1.5% risk of future hospitalisation in the following 30 days If 4 or more characteristics – 12% risk of future hospitalisation in the following 30 days: monitor closely and consider if antibiotic treatment is required and/or discussion with local paediatrician. **If mild severity** (child younger than 5 years with absence of persistent / recurrent fever over preceding 24-48 hours, no respiratory distress and no tachypnoea), antibiotics are **not** indicated. Provide verbal and written safety netting advice. **If moderate severity** (persistent / recurrent fever over preceding 24-48 hours, respiratory distress and/or tachypnoea) and presumed diagnosis of CAP (see differentials above), treat with oral antibiotics and provide verbal and written safety netting advice. **In severe disease:** Urgent review in hospital required.

Learning from Patient Safety Events (LFPSE) - Frimley ICB lessons and feedback

Clopidogrel and PPIs

There have been a number of incidents reported regarding the use of clopidogrel with inappropriate PPI cover, either where clopidogrel has been prescribed with omeprazole (manufacturer advises avoid) or where there has been confusion over which PPI to prescribe.
One report highlighted a patient who had been prescribed lansoprazole and omeprazole together for a number of months. This patient had been admitted into hospital, already taking omeprazole, and during the admission, was initiated on clopidogrel. The hospital team had changed the omeprazole to lansoprazole in line with interaction advice but this decision was not clearly documented in the discharge letter and the GP did not realise that the lansoprazole was a replacement for the omeprazole.
Another incident highlighted the importance of conducting regular safety searches to identify patients who need review. A patient prescribed clopidogrel and omeprazole was identified via a routine Ardens CQC search (found in Ardens folder 2.22). The omeprazole was changed to lansoprazole and the reasons for stopping were documented.



Please see the Specialist Pharmacy Service for guidance on this interaction.

Inappropriate dosing of modified release (MR) or immediate release (IR) preparations

Several reports have identified confusion with dosing frequencies of medicines when presented as immediate release (IR) or modified release (MR) formulations. Two examples of these reports are;

- Patient discharged from hospital with morphine sulphate m/r 10mg BD and subsequently prescribed morphine sulphate m/r 10mg QDS by the practice. Fortunately, the patient had continued to take it at the frequency prescribed by the hospital.
- Patient initiated on alfuzosin by the GP at the request of a urology specialist, who asked for a dose of 10mg OD. It was not specified as the m/r preparation (which is non formulary) and the GP prescribed 4 x 2.5mg alfuzosin tablets to be taken once a day. This was suboptimal for symptom control and the patient continued to experience LUTS symptoms. Please see the BNF monograph for alfuzosin which sets out doses and preparations per indication.

Sitagliptin dosing in renal impairment

A patient with an eGFR less than 30ml/min was prescribed sitagliptin 100mg OD. The BNF has the following advice for dosing in renal impairment:

- Reduce dose to 50 mg once daily if eGFR 30–45 mL/minute/1.73 m^2.
- Reduce dose to 25 mg once daily if eGFR less than 30 mL/minute/1.73 m^2.

This was noted by the PCN clinical pharmacist and brought to the attention of the prescriber; the dose was reduced to 25mg OD. The patient did not exhibit any immediate side effects and the HbA1c was measured.

Please see this link for further advice about dosing DPP-4 inhibitors in renal impairment.

*** Many thanks for your reports so far ***

Please continue to report events via this portal so we can share learning and feedback.

MHRA alerts

Fezolinetant ▲ (Veoza): risk of liver injury; new recommendations to minimise risk

Fezolinetant is indicated for the treatment of moderate to severe vasomotor symptoms associated with the menopause. It is non formulary. Fezolinetant treatment is associated with a risk of drug induced liver disease. New recommendations have been introduced to minimise this risk. Liver function should be monitored before and during treatment in all patients taking fezolinetant and it should be avoided in patients with known liver disease or perceived to be at a higher risk of liver disease.

See full alert here

Short-acting beta 2 agonists (SABA) (salbutamol and terbutaline): reminder of the risks from overuse in asthma and to be aware of changes in the SABA prescribing guidelines

Healthcare professionals and patients are reminded of the risk of severe asthma attacks and increased mortality associated with overuse of SABA with or without anti-inflammatory maintenance therapy in patients with asthma. Healthcare professionals should be aware of the change in guidance that no longer recommends prescribing SABA without an inhaled corticosteroid.

See full alert here

Please see the relevant guidelines and policies on the Frimley ICB MO website to support this practice.

- Primary care medicines optimisation of asthma in adults and children aged 12 years and over
- Medicines Optimisation position statement: Safe prescribing of salbutamol inhalers for asthma

Using potassium permanganate for skin conditions or wound care

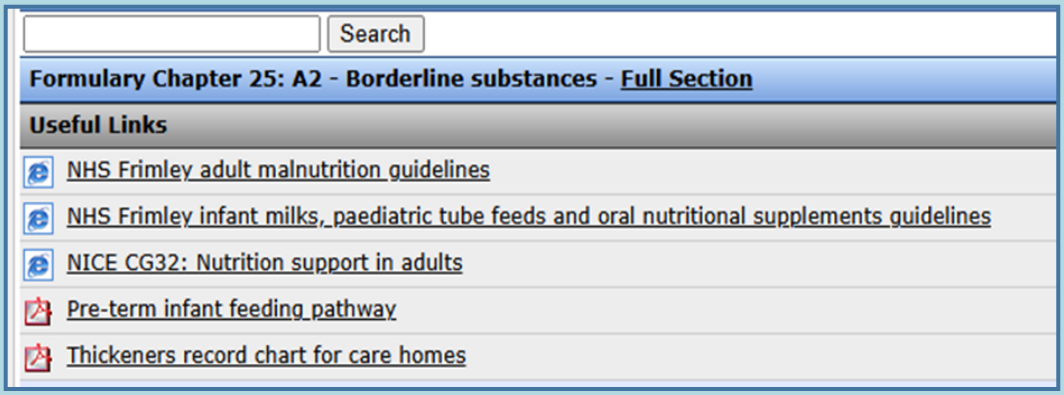
Please see this updated article from the Specialist Pharmacy Service which reviews the evidence for using potassium permanganate for skin conditions or wound care and highlights the risk of severe harm associated with its incorrect use. NHS England issued a National Patient Safety Alert on the inadvertent oral administration of potassium permanganate in April 2022. The alert highlights that serious medication errors continue to be reported. This is despite an NHS England alert in 2014 highlighting the risk of death or serious harm from accidental ingestion of potassium permanganate preparations.

NHS Frimley have previously provided a patient information leaflet and a risk assessment form to support the safe use of this preparation. Copies of these documents may also be found on the Frimley Formulary monograph and on DXS.

Nutrition corner

netFormulary Nutrition Update

The full list of NHS Frimley adult and paediatric oral nutritional supplements and tube feeds, plus supporting documents, has been updated and can be found at on our Medicines Optimisation pages here and also on the Frimley Formulary ('Chapter 25: A2 – Borderline Substances').



Any queries, please contact your NHS Frimley Prescribing Support Dietitian, Cathy Macqueen Catherine.macqueen@nhs.net or Ali Carr a.carr@nhs.net

NHS Frimley Medicines Optimisation team may be contacted on frimleyicb.prescribing@nhs.net

National Medicines Advice Service

Healthcare professionals in primary care across England may contact this service on 0300 770 8564 or asksps.nhs@sps.direct