NHS
Hampshire and Isle of Wight

Prescribing and Medicines Optimisation Guidance

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Special Edition – Medicines Safety

#MedSafetyWeek 3 - 9 November 2025

2025 marks the 10th annual #MedSafetyWeek campaign, taking place 3 - 9 November. This year's theme is **'we can all help make medicines safer'**, and in the UK the focus is on the importance of reporting suspected adverse reactions to medicines, vaccines and medical devices to the Yellow Card Scheme.

How can practices support the campaign?

Talk to your colleagues and patients about suspected problems with medicines and devices and how to report them.

Share the MHRA digital resources and materials with colleagues and patients.

- Digital advert for patient waiting areas and TV screens
- A4 Poster
- Healthcare Professional Question Card

Share via social media, using **#MedSafetyWeek** and **#MHRAYellowCard**. Social media links can be found on the campaign page.

Educational resources for healthcare professionals

The Medicines and Healthcare products Regulatory Agency (MHRA), along with partner organisations have created e-learning modules specifically for healthcare professionals.

Learning for GPs, nurses, pharmacy teams can be found via the following LINK.

Reporting makes a big difference - anyone can report, and every report counts!

Adverse drug reactions (ADRs) and Allergies documentation

Drug allergies and adverse drug reactions can pose significant challenges in healthcare. Effective recording in GP practices is crucial for patient safety and involves clear documentation, coding, and good communication with patients and other healthcare settings.

Is it a drug allergy or an adverse drug reaction (ADR)?

Good question! It is often difficult to distinguish between intolerance and drug allergy, which can lead to inaccurate documentation, potentially compromising treatment outcomes. Adverse drug reactions are common, but not all reactions are allergic in nature.

- **Drug Allergy**: Any adverse drug reaction with an established immunological mechanism, or one that has clinical features consistent with a hypersensitivity reaction. (British Society for Allergy and Clinical Immunology (BSACI) definition).
- **ADR**: Non-immune, predictable reactions often listed as side effects in SPC or BNF.

Documentation Best Practices

- **Differentiate**: Only immunological reactions go in the allergy field; ADRs/intolerances should be recorded separately.
- **Use precise codes**: Avoid vague entries like "history of drug allergy."
- **Record allergy status for all patients**:
  - Drug allergy
  - No known drug allergies (KNDA)
  - Unable to ascertain
- **Include key details**:
  - Drug name
  - Reaction type and severity
  - Date of reaction
- **Engage patients**: Confirm allergy status regularly with patients or carers.

Guidance and Learning Resources

- NICE CG183 and QS97: Guidelines for safe allergy documentation.
- NICE CKS: Offers practical advice on ADR assessment and reporting.
- Medicines Learning Portal: Educational resource for understanding adverse reactions, useful for all healthcare professionals.

LFPSE (Learning from patient safety events) – GP Contract 2025/26 Reminder

All practices must register and maintain an account with LFPSE to:

- Record patient safety events related to their own service
- Log safety events occurring in other healthcare settings
- Allow individuals to download event records for appraisals and revalidation

This requirement supports the Primary Care Patient Safety strategy and contributes to a national NHS data source aimed at fostering learning, improvement, and a culture of safety.

- Primary care information on the national LFPSE service: LINK
- To register and/or record a patient safety incident via LFPSE: LINK

National safety alerts – GP Practice Requirements

- All GP practices must appoint a person to lead on MHRA alerts/Safety issues.
- Practices must be signed up to receive alerts system and have a procedure in place to manage them. To sign up for the alerts click here. LINK
- Compliance is monitored by the Care Quality Commission (CQC); guidance is available via GP Mythbuster 91 – Patient Safety alerts.

MHRA Communications

- **Drug Recalls & Safety Alerts**: MHRA issues various levels of recalls; details are outlined in their recall documentation. MHRA recall information
- **Drug Safety Updates:** Regular updates are provided to support prescribers, with summaries available online. Drug Safety Updates

Local updates and Medicines Safety Priorities

HIOW Medicines Safety Priorities – 2025/26 Updated focus areas

- Interface issues
- Propranolol
- Emollient & fire risk
- Valproate & Topiramate

All current workstreams and resources are available on the HIOW ICB website.

Recent Intervention Brief updates

Propranolol in young people
There has been growing concern over overdose risks, especially in young people and those with history of self-harm. Propranolol overdose is incredibly unpredictable and can lead to rapid deterioration. Practices are advised to identify and review at risk patients.
Propranolol_Intervention_Brief.pdf

Emollient and Fire Risk
Despite previous awareness efforts, incidents continue nationally. Practices should advise patients of the risks and refer high-risk individuals to the Hampshire and Isle of Wight Fire and Rescue Service for a Safe and Well visit.
Emollients_and_Fire_Risk_Intervention_Brief.pdf

Adrenaline auto-injectors in children
BNF now recommends a dose of 300microgram for children weighing ≥25kg (doses for Jext® are now aligned with Epipen®).
Adrenaline_Auto-Injectors_Intervention_Brief.pdf

Other updates

Methotrexate 10mg tablets – Important safety update

Please cascade to all clinicians.

Due to an incident raised nationally, we are reminding practices about the safety concerns with methotrexate 10mg tablets.

Due to its narrow therapeutic index and once weekly dosing regimen, methotrexate presents a high risk of accidental overdose. Inadvertent overdose, often linked to confusion or errors in dose or frequency can lead to severe and potentially fatal consequences.

The NPSA released a Patient Safety Alert in 2006, but despite this, 11 reports of serious toxicity associated with incorrect dosing were reported to the yellow card scheme between 1 Jan 2006 and 30 July 2020. A Drug Safety Update was also published in 2020.

Correct prescribing of methotrexate remains a key priority for the NHS and the overdose of methotrexate for non-cancer treatment is an established NHS England Never Event.

A significant contributing factor to methotrexate errors is the availability of both 2.5mg and 10mg tablets, which can be similar in appearance, increasing the risk of the patient receiving an incorrect dose.

To minimise the risks to patients, practices must take the following steps:

- Ensure all prescribers are aware of the risks associated with methotrexate.
- **Only prescribe** methotrexate doses in multiples of **2.5mg tablets**.
- **Do not prescribe** methotrexate **10mg tablets.**
- Ensure doses are clearly defined in both milligrams and the number of tablets, and the frequency as Once Weekly. For example: 10mg (FOUR tablets) ONCE a WEEK on the SAME DAY each week.
- Review all current prescriptions for 10mg tablets and change to 2.5mg tablets
- When changing the strength of tablets for patients, clearly explain the safety rationale to them as a patient, but also the wider risks posed to others by having 10mg tablets within the system.
- When changing between 10mg and 2.5mg tablets, a second check of the dose is advised to minimise transcribing errors.
- Any new requests for 10mg tablets should be queried prior to issuing a prescription.
- Prescriptions for doses greater than 30mg weekly should be queried.
- Dispensing practices should review the strengths stocked in their dispensary.

OptimiseRx messages have been enabled and Net Formulary entries updated to align with this advice. This message will also be communicated to Hospital Trusts and Community Pharmacies.

Recent Epact data for Hampshire and Isle of Wight shows that there have been 71 items for methotrexate 10mg tablets over the last 6 months, across 17 GP practices.

Please speak to a member of the Medicines Optimisation team if you need help in identifying methotrexate 10mg prescribing within your practice.

Nitrofurantoin: reminder of the risks of pulmonary and hepatic adverse drug reactions
LINK

We would like to remind practices of the potential for pulmonary and hepatic adverse drug reactions with nitrofurantoin.

Prescribers should be vigilant for new or worsening respiratory symptoms such as a persistent cough or respiratory infections while taking nitrofurantoin, especially in the elderly. Patients receiving long-term therapy, for example for recurrent urinary tract infections, should be closely monitored.

Pulmonary side effects such as pneumonitis can occur after short- or long-term treatment and nitrofurantoin should be discontinued if new or worsening symptoms occur.

Short-acting beta 2 agonists (SABA): reminder of the risks from overuse in asthma
LINK

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.

Local Respiratory guidance can be found on the HIOW ICB website Respiratory - Medicines Optimisation :: NHS Hampshire and Isle of Wight

Valproate prescribing report published LINK

The MHRA has published the first in a series of reports on trends in valproate prescribing as derived from the Clinical Practice Research Datalink (CPRD), in females and males in England.

This first report includes data from January 2018 to June 2024 and shows significant reductions in new and overall prescribing in both females and males aged 16-44, with notable shifts away from valproate as a first-line treatment. Going forward we plan to publish regular prescribing reports every 6 months.

Practices must continue to follow measures in place for prescribing and dispensing of valproate. Further information and resources can be found on our website. LINK

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Local medicines optimisation teams can be contacted via their generic team mailbox: See LINK

Previous bulletins can be found hosted on the ICS website here: LINK