Community Pharmacy Newsletter – Jan 12

Note from the Editor

Welcome to the latest edition of the Tayside Community Pharmacy Newsletter.

Some articles included in this issue are:-

- Controlled Drugs Update
- New Medicines
- CMS Update
- Electronic Discharge Documentation – Improving Sharing of Information
- Pharmacy Technician Registration and CPD
- Palliative Care Educational Events
- Pharmacological Management of Hyperlipidaemia

It's your newsletter so be sure to feed back comments as well as any contributions or suggestions for future editions. Next issue will be April/May 2012.

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Diane Robertson, Principal Pharmacist
Community Pharmacy Development

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Controlled Drugs Update

Diamorphine Vials versus Ampoules

Concerns have been raised over the availability of diamorphine in a vial presentation and the potential for misuse of this presentation. The main issues are:-

- Possible diversion of part used vials
- The potential for inappropriate use of the vials for multiple doses.

The national Scottish hospital contract for diamorphine injection has been changed to accommodate these concerns and we would ask community pharmacies, where possible, to order diamorphine in ampoules rather than vials to reduce risk in the community.

Methadone Dispensing Errors

The CD Team has noticed an increase in the number of reported methadone dispensing errors and although this could simply be due to improved reporting, we thought it would be helpful to highlight this issue, particularly as taking the wrong dose can have serious consequences for the client.

Most errors have involved mistaken identity, resulting in the wrong client's dose being supplied. On occasion, more than one member of staff has been involved and mis-communication has been a contributory factor.

We would like to remind you all to be extra-vigilant in ensuring that the identity of each client and their prescribed dose is checked every time methadone is supplied. As an additional precaution, it is recommended that the client is asked what dose they normally take and confirm this is the same as the dispensed dose immediately prior to supply.

Should the wrong dose be given to a patient, every attempt must be made to contact them to inform them of the error and to ensure their safety. The prescriber must also be contacted and in most cases this will be Tayside Substance Misuse Services (TSMS). The service will offer help and advice regarding the error and will often have mobile telephone numbers for the patient to help facilitate contact. They will also often offer to see the patient on the day depending on the time of the incident and also the location. The service will also advise as to ongoing dispensing or prescribing arrangements.

TSMS contact details, Dundee 01382 424544, P&K 01738 474455, Angus 01241 435820.

All controlled drug incidents should be reported to the Accountable Officer via Lucy Burrow, Head of CD Governance on 01382 424016 or lucyburrow@nhs.net in addition to any internal reporting.

Stock Requisitions

On occasion, we have come across GPs who have ordered and been supplied with part-packs of injections. Pharmacies are reminded that when supplying medicines in response to stock requisitions this is classed as a wholesale transaction and only whole packs can be supplied.
(Ref. RPS MEP 35 Ed, Section 3.7.6)

A Date for the Diary for Pharmacy Technicians

There's still time for pharmacy technicians to apply for an NHS Education for Scotland Pharmacy session on CDs being held on 23rd February 2012 in Seminar Rooms A & B in Ninewells Hospital. This evening event is designed to update pharmacy technicians on controlled drug issues, with an emphasis on the implications for practice. Book your place through the NES Portal www.portal.scot.nhs.uk. For help in creating a Portal account and booking training you can phone NES Pharmacy on 0141 223 1603.

CD Team Contact: Carol Chalmers, PA to CD Team - E-mail: cdteam.tayside@nhs.net or Tel: (01382) 835153.

Lucy Burrow, Head of CD Governance
NHS Tayside

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New Medicines Update

Dabigatran (Pradaxa®▼)

Dabigatran is a new oral anticoagulant licensed for the treatment of non-valvular atrial fibrillation. Unlike warfarin, it does not require anti-coagulant monitoring.

Dabigatran is administered as the etexilate salt - a pro-drug which is rapidly converted to the active form (dabigatran) after oral administration. The bioavailability of dabigatran following oral administration is approximately 6.5 % and may be increased by 75 % when the pellets are taken without the hard capsule shell. Therefore, patients should be advised not to open the capsules and take the pellets alone (e.g. sprinkled over food or into beverages).

Dabigatran capsules must remain in the original packaging (blister foil or bottle) until a dose is required. Capsules must be removed from the blister by peeling off the backing foil and should not be pushed through the blister foil. If dabigatran is required in a monitored dosage system (MDS) (e.g. Venalink) the unopened blister must be included and the blister size may limit this. The stability of the capsules will be affected if these instructions are not followed, and this may also lead to an increase in bioavailability, gastric adverse effects and bleeding risk with dabigatran.

Local advice for dabigatran follows the national consensus and restricts use to patients with poor INR control on warfarin, or with allergy to or intolerable side effects from coumarin anticoagulants (click here for Tayside Area Formulary section 2.8 with further prescribing information). Anticoagulant clinics across NHS Tayside will identify eligible patients and make contact with relevant GPs – the clinical decision to transfer these patients to dabigatran will rest with the GP.

Key drug interactions include: systemic ketoconazole, ciclosporin, itraconazole and tacrolimus - which are contra-indicated. Caution should be exercised with other strong P-gp inhibitors (e.g. amiodarone, quinidine or verapamil) refer to SPC for further details. Renal function should be assessed in all patients before starting dabigatran and while on treatment, renal function should be assessed at least once a year in patients over 75 years of age and whenever a decline in renal function is suspected in any patient. Practices should therefore consider putting normal recall systems in place.

Adrenaline tartrate (Jext®)

Jext® is a new single-use intramuscular injection for self-administration of adrenaline for the emergency treatment of anaphylaxis. It is available in the 150microgram and 300microgram doses as with other intramuscular injections for self-administration (including Epipen®).

The advantages of Jext® include: reduced risk of inadvertent needle stick injury; and an extended shelf life of 24 months from date of manufacture. Jext® is the most cost-effective preparation based on the extended shelf life with current product costs. For these reasons Jext® is the preferred choice of intramuscular adrenaline for self-administration for new patients being prescribed adrenaline. Training of patients is required for those new to self-administered adrenaline and also for any patients who are switched between different brands of devices (switching is therefore not recommended without adequate training).

Jext® is bulkier and the release mechanism is different to Epipen®. For further information on Jext® and anaphylaxis which may be useful for patients, refer to http://www.jext.co.uk/. Patients can register for a service on the website to receive alerts to remind them when their device is about to expire. From the healthcare professional website http://www.jext.co.uk/healthcare/, resources can be ordered including training materials such as a patient DVD and simulator device.

Adrenaline for self-administration should always be prescribed by brand name to ensure the patient receives the device that they have been trained to use.

Citalopram and Escitalopram - QT interval prolongation

The potential for citalopram and escitalopram to cause QT interval prolongation has been known for some time and is reflected in the product information. However, recent data have further defined this risk and have clarified that their effects on the QT interval are dose dependent. Elderly patients have a higher exposure due to age-related decline in metabolism and elimination. The maximum dose of both medicines has therefore been restricted in patients older than 65 years.

For citalopram, new restrictions on the maximum daily doses now apply: 40 mg for adults; 20 mg for patients older than 65 years; and 20 mg for those with hepatic impairment. For escitalopram, the maximum daily dose for patients older than 65 years is now reduced to 10 mg/day; other doses remain unchanged.

The maximum dose of citalopram within the Tayside Area Formulary has been amended from 60mg to 40mg; and in elderly or patients with reduced hepatic function this has been amended from 40mg to 20mg. Escitalopram is non-formulary in NHS Tayside.

Patients who currently take doses higher than the new recommended daily maximum should have their treatment reviewed. For further information including updated advice on contra-indications, cautions, interactions and monitoring recommendations see MHRA Drug Safety Update, Volume 5, Issue 5, December 2011.

Claire James
Senior Pharmacist - Clinical Effectiveness
Medicines Information NHS Tayside

CMS Payment Changes

Circular PCA (P)(2011)11 covers the restructuring of payments for CMS. A summary of the key points is outlined below. Please click on the link below for full details: http://www.sehd.scot.nhs.uk/pca/PCA2011(P)11.pdf

Key Points

- The existing remuneration arrangements for transitional payments (TP), payment of shadow fees and allowances changed with effect from 1st October 2011.
- All other payments, e.g. MAS and PHS remain as before.
- Prescriptions from each contractor will be analysed to determine how many prescriptions were dispensed for residents of care homes and the transitional payment/shadow fees and allowances will then be split into two elements - one related to **patients in the community** and the other to **patients resident in care homes**.
- The community TP/shadow fees and allowances element will then be redeployed across three new payments as follows – a Quality and Efficiency Initiative Payment (QEI) (5%), a CMS Capitation Payment (15%) and a Community Migration Payment (80%).
- Payment of the QEI (5%) will be linked to performance against a target rate for submitting electronic claims for payment to PSD.
- Contractors will be able to claim £400 for completion of the e-learning module on electronic claims. The deadline for submission of this claim has now been extended to 6th February 2012.
- Each contractor will see 15% of their community TP shadow fees and allowances placed into a capitation pool. Each contractor will then be paid their share based on the number CMS registrations with associated PCR records which show that a priority has been assigned to that patient.
- To stabilise the introduction of this the CMS capitation payment will be subject to maximum and minimum tolerances of 10% different from what would have been due previously.
- The CMS capitation payments will be calculated on the numbers held centrally on the last day of the month.
- Community Pharmacy Scotland will work with Scottish Government to develop benchmark information for contractors on the level of registrations/PCR data that they are achieving.

Chronic Medication Service (CMS) Support Tools

To support pharmacists in the delivery of CMS, two new initiatives are being introduced in 2012. These initiatives will help encourage the dialogue between the patient and the pharmacist on the safe use of medicines.

The first of these initiatives is due to be introduced in January and the second proposed initiative will follow later in the year. A brief outline of both these initiatives is detailed below.

CMS High Risk Medicines Support Tool

The aim of this initiative is to bring into focus high risk medicines and formalise how pharmaceutical care is delivered to patients on these medications within CMS. Guidance and risk assessments for specific therapies will be available within the PCR.

The first two medications involved in this initiative will be Lithium and Methotrexate. A NES training event covering both drugs was run in November 2011 to update pharmacists before the launch of this important initiative.

This initiative will encourage pharmacists to focus on patients on those high risk drugs and allow outcomes to be recorded and evidence gathered around specific areas which will help give clear benefits to patients and show benefits of the service to other key stakeholders. This should provide evidence of how pharmacists can help improve patient safety surrounding medicines.

New Medicine Support Tool

As discussed at the various CMS training events, one of the main drivers behind CMS was that up to 50 % of newly prescribed medicine is not taken as prescribed.

The core objectives of this support tool are to:-

- Improve patient adherence with newly prescribed medicines to treat long term conditions through a series of structured interventions and support
- Improve patients' understanding of new medicines
- Enhance self-care and well being
- Reduce wastage of new medicines
- Underpin the pharmacists role in improving the management of long term conditions
- Document pharmaceutical care
- Facilitate effective therapeutic partnerships

Diane Robertson, Principal Pharmacist
Community Pharmacy Development

Improving sharing of information by implementation of an Electronic Discharge Document (EDD)

An Electronic Discharge Document (EDD) has been developed in Tayside to replace the paper Immediate Discharge Document and to help improve the quality of data transferred between different care settings. This is being implemented across Tayside hospitals. EDD brings a number of benefits over the existing system:-

- Prescriptions are clear and legible
- Rapidly transferred to pharmacy for dispensing
- Rapidly transferred to primary care on discharge
- Rapid access to historical information

Furthermore, it has been possible to embed some safety features during the development of EDD

- Warfarin prescriptions must contain essential information on the indication, duration, target INR, date, time and location of the next appointment before it can be signed off by the prescriber
- Medicines prescribed by the GP can be pulled into EDD to minimise transcription errors and improve medicines reconciliation

Currently 20% of all Tayside hospital discharges are on the EDD system; a target of 50% by March 2012 has been set. An electronic Pharmacy Care Plan (ePCP) attached to EDD is also being tested in Perth Royal Infirmary and Ninewells Hospital. This allows pharmacists in hospital and GP practices to share information on care issues. A future phase of development will explore links to community pharmacy.

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Palliative Care Education Events

A big thank you to everyone who attended the palliative care education events in 2011. I hope the experience was an enjoyable one. There are a couple of sessions planned for early 2012, details below. I look forward to seeing you there!

29/02/2012 – Palliative Care Update (Full day). Palliative Care Education Unit, Royal Victoria Hospital, Dundee. This event is open to all community pharmacy staff. Funding is available to attend. Further details to follow. To register, please contact Carol Adamson (email carol.adamson@nhs.net or phone 01382 596992.

05/03/2012 – NES - Palliative Care in Non-Malignant Disease. Ninewells Lecture Theatre One. 7pm – 9.30pm. Pharmacist session can be booked through PORTAL.

Shirley Kelly
Macmillan Lead Pharmacist (Palliative Care)
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Pharmacy Technician Update

Registration Update

Figures from GPhC dated 19th August 2011 showed that there were 174 pharmacy technician registrants with a home address within Tayside. Local data suggests that there are 98 from the community sector and 76 from the managed care sector. There is still a backlog of applications to be processed at GPhC. If you or a colleague have applied for registration and not been accepted onto the register yet, you can contact the GPhC pharmacy technician registration section on tel: 0203 365 3560 or www.pharmacytechnician@pharmacyregulation.org. If you have any questions about pharmacy technician registration please contact Monica Hunter (details below).

NES CPD for Pharmacy Technicians

Did you know that NHS Education for Scotland provide CPD support for pharmacy technicians? There are distance learning packs, evening training sessions and webinars which pharmacy technicians can access for free. To gain entry to this training resource you only need to open a learning account with the NES Portal www.portal.scot.nhs.uk. The first evening session developed specifically for pharmacy technicians was 'Smoking Cessation' held on 02/11/11 in Ninewells Hospital, Dundee and was a great success. The next sessions are 'Safer Management of Controlled Drugs' on 23/02/12 and 'An Introduction to Stoma Care' on 20/03/12. Booking for these sessions can only be done through a Portal account. For help creating a Portal account and booking training, please phone NES Pharmacy on 0141 223 1603.

CPD Recording Training for Pharmacy Technicians
How are you getting on with recording your CPD? Do you have any worries or questions? Monica Hunter is delivering CPD training sessions on request according to local demand. So far 75 pharmacy technicians have participated in the training and their confidence in how to record an entry has increased significantly. Common worries are what to write about, how much text is needed, where to start on the cycle and how to keep a CPD portfolio. Others just need reassurance that what they are recording meets the standards. If you think you would benefit from CPD training please contact Monica.

Smoking Cessation Training for Pharmacy Staff
NHS Tayside will be running a one-day smoking cessation training session on 08/02/12 at Kings Cross Hospital in Dundee. The target audience is pharmacy technicians, dispensing assistants and counter staff who currently deliver smoking cessation advice or plan to commence this role. Course flyers and application forms will be posted on the generic mailbox. For further information please contact Monica Hunter.

Monica Hunter
Lead Pharmacy Technician for Education, Training & Development
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Pharmacological Management of Hyperlipidaemia – Update

The Tayside Area Formulary (TAF) section on lipids has been updated and now gives the following advice regarding the prescribing of ezetimibe:-

Ezetimibe is restricted to use in combination with a statin for patients who have failed to reach target cholesterol levels with optimised doses of statin alone. Patients should have tried both a lipophilic (simvastatin or atorvastatin) and a hydrophilic (pravastatin or rosuvastatin) statin and concordance with treatment should be considered. Ezetimibe may be considered on its own where statins both lipophilic and hydrophilic are inappropriate or poorly tolerated. Co-administration of ezetimibe with fibrates is not recommended due to lack of safety and efficacy data. Ezetimibe has no outcome data to demonstrate that its cholesterol lowering effect reduces cardiovascular morbidity or mortality and is not recommended in primary prevention. Inegy® is a combination of ezetimibe with different strengths of simvastatin. It should be reserved for patients who require more convenient dosing regimen than the separate individual constituents.

As highlighted in the previous newsletter General Practices are currently working on a project reviewing their prescribing of ezetimibe in light of this guidance (patients with familial dyslipidaemias are excluded from this).

Common questions about lipid management

1. Primary Prevention – when should it be offered?
SIGN 97 recommends offering statin treatment to patients over 40 with ASSIGN score >= 20%.
Patients with a total cholesterol >7.5 and those with total cholesterol: HDL cholesterol ratio >6 are at high risk and should be treated with a statin irrespective of the assign score. This is also the case for patients with familial Hyperlipidaemia who should be treated. Risk scores do not apply to these individuals. If the risk score is less than 20% consider other factors such as whether the patient has another condition that increases risk e.g. CKD or rheumatoid arthritis. Dietary advice should be given to all patients.

2. What about patients with diabetes?
Lipid-lowering drug therapy with simvastatin 40mg or atorvastatin 10mg is recommended for primary prevention in patients with type 2 diabetes aged >40 years regardless of baseline cholesterol.

3. What should be prescribed?
Simvastatin 40mg should be used first line or if contra-indicated then atorvastatin 10mg. If this isn't tolerated then consider reducing the dose of simvastatin or switching to a hydrophilic statin.

4. What if a statin isn't tolerated?
Re-iterate the importance of a healthy diet.

5. What about targets for primary prevention?
For primary prevention a standard dose of simvastatin 40mg or equivalent is the usual dose. No further titration is necessary except for patients at high risk. These patients are confirmed with Hyperlipidaemia and patients with a baseline cholesterol >7.5 or total cholesterol: HDL ratio >6. These patients should be treated to a target of cholesterol <5mmol/l.

6. What about secondary prevention?
Simvastatin 40mg is a suitable starting point. If cholesterol targets are not reached then a high intensity statin could be used (this is any statin which produces greater HDL lowering than simvastatin 40mg) e.g. atorvastatin 40mg. Rosuvastatin may be used if cholesterol targets are not reached. If statins have been optimised then the addition of ezetimibe to a statin can be considered. Concordance with treatment should be considered throughout this process. Referral to the cardiovascular risk clinic may be required if target levels are still not reached.

7. What about high risk patients?
An intensive lipid-lowering therapy with atorvastatin 80mg should be considered for patients with diabetes and acute coronary syndromes, objective evidence of coronary heart disease on angiography or following coronary revascularisation procedures.

8. Myopathy and Intolerance - what should be considered?
In May 2010, the MHRA released a Drug Safety Update which highlighted the increased risks of myopathy associated with simvastatin 80mg. This suggested that patients prescribed simvastatin 80mg shouldn't have this stopped but should have a review with respect to myopathy risks. The risk of myopathy is increased in women, elderly patients, renal impairment, hypothyroidism, thistory of muscle problems and the presence of interacting drugs.

Patients should be advised to report muscle pain, tenderness or weakness. If this is the case Creatine Kinase (CK) levels should be checked. If these are significantly elevated (5x upper limit of normal) the statin should be stopped. Not all patients with muscle pain have a raised CK – a statin 'holiday' may help to distinguish drug effects from other causes.

9. What about fibrates and nicotinic acid?
Fibrates are useful where hypertriglyceridaemia is a problem. They don't have the same outcome data as statins and aren't as useful at lowering LDL, although they do help to increase HDL. They provide an option in secondary prevention where statins can't be prescribed. Nicotinic acid is licensed in secondary prevention, but its use is limited due to side effects. It is sometimes used to manage dyslipidaemias.

Dr Christine Maple
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