Vol 7. Issue 2: June 2026

MEDwatch *is the e-bulletin for all NHS Grampian Staff who are involved with patients and medicine management.*

Its aim is to improve the safety of medicines by sharing learning, and encouraging adverse event reporting from all staff groups.

Inside This Issue

MHRA Safety Roundup

Latest MHRA Roundups:

- May 2026
- April 2026
- March 2026

MHRA Drug Safety Update - ACE-inhibitors

The MHRA have shared a safety update on ACE-inhibitors and are urging healthcare professionals to be aware of the distinction between bradykinin- and histamine-mediated angioedema as treatment strategies differ significantly.

ACE-inhibitors: Be aware of the distinction between bradykinin- and histamine-mediated angioedema, as treatment strategies differ significantly - GOV.UK

NHS Grampian HEPMA Local Alert – Date & Time when recording PRN medicines administration

Situation

The date field for PRN doses is automatically populated with the incorrect date when there is an outstanding Medicine Administration Schedule (MAS).

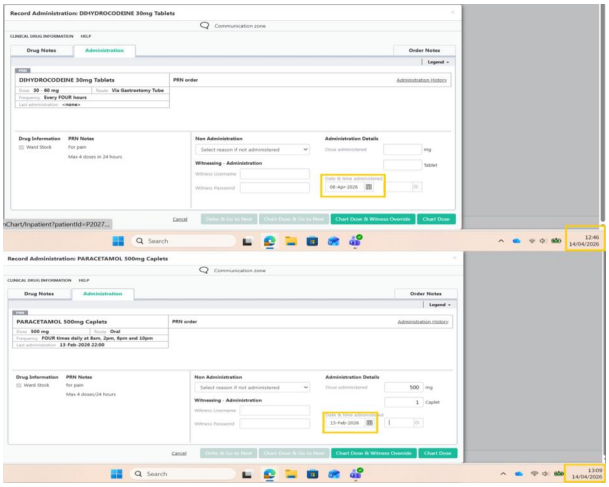
1 - Example: ***Actual date 14/04/2026***

Background

Testing has found that when there is an outstanding MAS period because of an overdue regular medication, the date field when charting a PRN dose for that patient defaults to the date associated with the outstanding MAS period/prescription date/1 minute past the last administered dose for that PRN drug.

For example:

Patient A has a dose of regular medication missed on 12/04/26, if the outstanding MAS period is not addressed when Patient A requires a PRN dose on 14/04/26 the date field is auto-populated with the first prescribing date or the last MAS period (1 minute post last administration for that PRN drug) despite the actual date being 14/04/26.



2 - Example: ***Actual date 14/04/26***

Assessment

The issue is resolved if the outstanding MAS period is kept up to date.

If the outstanding MAS period is not kept up to date and the date is not updated to the current date of giving the medication there will be an **inaccurate record** of when PRN medicines were given.

The risk of which is inadvertent overdose particularly at transitions of care (i.e. between wards and theatres).

A request has been made, via the Regional HEMA team, to add auto-populating the current date to the HEPMA enhancement list.

“Phantom” doses, erroneous doses created by the HEPMA system when a Non Administration Reason is added to a PRN Either/Or Protocol using the Quick Chart function, can impact outstanding MAS periods. Phantom doses need to be resolved by a prescriber and their presence will impact outstanding MAS periods.

3 - Example: ***Actual date of administrations was 14/04/26***

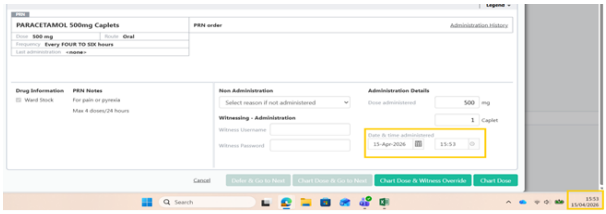
A fix for Phantom doses is expected at the next HEPMA system upgrade.

Recommendations

Staff who administer medicines using HEPMA:

- Keep outstanding MAS periods up to date as part of drug administration rounds.

- Check the date and time that is auto-populated when administering medicines to ensure it accurately reflects the date/time of administration.



4 - Example: ***Actual date 15/04/2026***

Wards who use HEPMA:

- Implement a system to ensure MAS periods are reviewed regularly and kept up to date (e.g. nurse in charge is responsible for reviewing at the start of each shift).

“Phantom” Doses:

- Occurring during a current episode of care can be resolved by a Prescriber by suspending and resuming the affected Orders ensuring that outstanding doses are not retained.
- Escalate to NHS Grampian HEPMA Team any “phantom” doses generated during previous episode of care and not resolved prior to discharge as these cannot be resolved locally.

North of Scotland HEPMA SOPs

Charting

Medicine Administration Schedule (MAS)

Phantom Dose Error

Further Support contact gram.hepmapharmacyteam@nhs.scot

Shared Learning: Phenobarbital - Brand Prescribing

Sharing Learning Points Phenobarbital Mar26

Pharmacy colleagues would like to share learning where a patient with epilepsy, who had multiple hospital admissions over a short period of time for varying medical conditions not related to epilepsy, received the wrong brand of phenobarbital during their multiple admissions and on discharge. The shared learning highlights the importance of brand prescribing for phenobarbital.

Polypharmacy Guidance

Polypharmacy guidance, which aims to provide guidance on preventing inappropriate polypharmacy at every stage of the person's journey, has been updated for 2026-2029. In addition it addresses the use of high risk medicines and ensures that information on appropriateness of medicines is shared across transitions of care.

Polypharmacy Guidance: Appropriate Prescribing

Medicines Management Policies and Guidance - where to find them?

A reminder that NHS Grampian medicines management policies and guidance can be found on the medicines management internet pages where you can also find prescribing processes guidance and information on non-medical prescribing. You do not need to use a NHS Grampian networked device to access these pages.

Policies and guidance

SPSP Adults in Hospital: Medicines

Last year Health Boards identified improving the safety of medicines in hospital as a priority for the Scottish Patient Safety Programme (SPSP) Adults in Hospital workstream. In 2025, representatives from the Acute & Mental Health Medicines Safety Group attended two meetings of a task and finish group to share the local perspective on:

- trends and themes in medicines safety in adult hospital
- opportunities for improvement identified by teams that aren't reflected in adverse event data
- what NHS Grampian is currently working on in medicines safety improvement for adults in hospital.

At the task and finish group it was agreed that a national improvement programme would focus on diabetes medicines management, incorporating transitions of care. In December 2026, a multidisciplinary Expert Working Group (EWG) was established (with representation from NHS Grampian diabetes colleagues) to:

- inform the overall aim of the programme and,
- co-design improvement resources that reflect current evidence, best practice, and practical application.

To date there have been three meetings of the EWG, including one at an in-person SPSP event in Glasgow, where EWG members have been working towards:

- agreeing the aim of the SPSP Medicines in Hospital programme
- exploring associated measures
- combining knowledge, insights and evidence to co-design the SPSP Medicines in Hospital driver diagram.

In advance of the next meeting in July, we have also submitted feedback on our ability to collect data locally for the potential measures.

Local EWG group members will continue to link with the Acute and Mental Health Medicines Safety Group via the Medication Safety Advisor and as an organisation we have registered our intent to participate in this programme of work when it opens.

Lindsay Cameron, Medication Safety Advisor and Michelle Lamont, Consultant Anaesthetist (Chair of the Acute and Mental Health Medicines Safety Group) are the NHS Grampian Leads for the SPSP Medicines workstream.

HEPMA News

HEPMA Folders

Updated folders with information on what to do when HEPMA goes down are being distributed to wards. The eHealth HEPMA Team are currently working their way round clinical areas who use HEPMA. The folder contains information on:

- Where your ward HEPMA Fallback Terminal is located
- Action cards for scheduled and unscheduled downtime
- Out of Hours Escalation Process
- HEPMA Business Continuity Procedure
- Instructions for Printing and Using MAC & MAP charts

- Fallback Terminal Checks

Please familiarise yourselves with the location and contents of these folders.

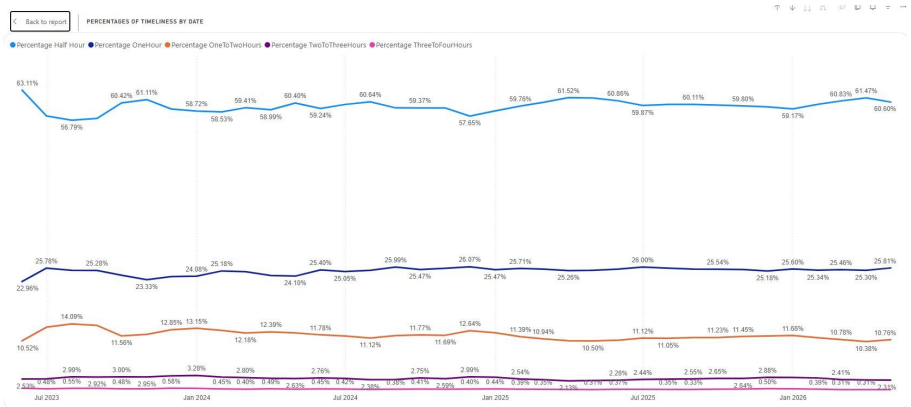
HEPMA Digital Bytes Videos

NHS Grampian eHealth Team have been putting together some short videos designed to give practical tips for using NHS Grampian eHealth systems. The series is growing and includes some useful videos on HEPMA. Digital Bytes

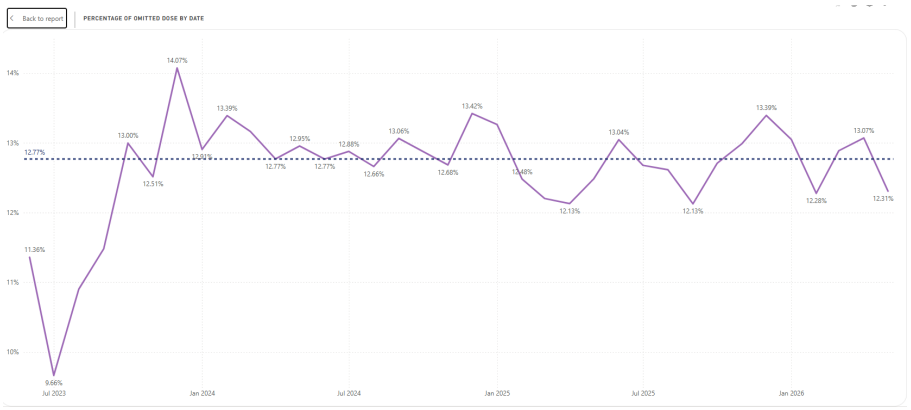
A reminder that the North of Scotland Regional HEPMA Team have also produced a number of short videos to support users navigating HEPMA. NoS HEPMA - Videos - All Documents

HEPMA Data

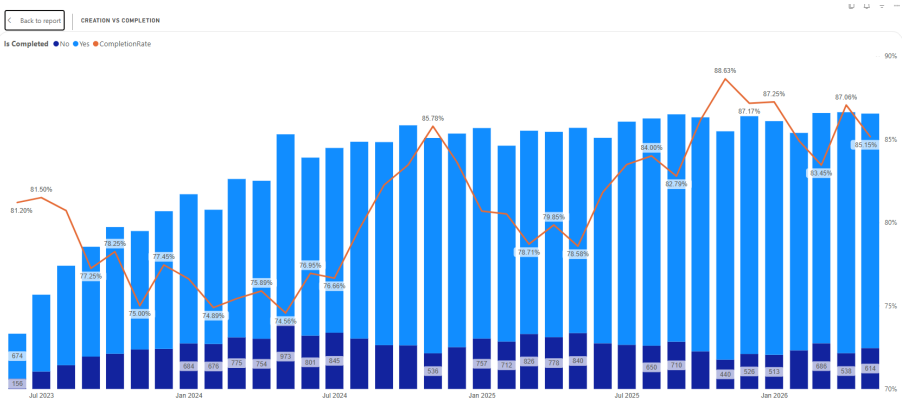
One of the benefits of HEPMA is the wealth of data we gain from it. Below are three snapshots showing our rates for timeliness of medicines administration, omitted doses and medicines reconciliation completion across the board.



5 - Timeliness of administration in relation to the prescribed time i.e. % of doses given within 30 minutes of the prescribed time etc.



6 - Percent of all omitted doses, this includes doses omitted for both clinical and non-clinical reason meaning some of these omissions will have been omitted appropriately but not all.



7 - Number of medicines reconciliations created versus number completed and the overall completion rate.

Contact

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