

# Vol 7. Issue 1: March 2026



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*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.*

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## MHRA Safety Roundup

Latest MHRA Roundups:

- [February 2026](#)
- [January 2026](#)
- [December 2025](#)

## Alerts, Notices & Shared Learning

Safety Alert: Rybelsus® (semaglutide) Tablets - New Formulation

[Rybelsus® \(semaglutide\) Tablets - New Formulation](#)

NovoNordisk has changed the formulation of Rybelsus® Tablets. Packaging and tablet shape and size have also changed (both are now smaller).

Healthcare Professionals who prescribe and/or administer medicines are asked to read the information issued by NovoNordisk, familiarise themselves with the new doses and be alert when prescribing and administering Rybelsus®. Both formulations may be in circulation until the change has been completed. Always prescribe as per the patient's current dose and formulation.

Notice: MHRA strengthening dependency and addiction warnings on medicines used to treat pain, anxiety, and insomnia

[MHRA strengthening dependency and addiction warnings on medicines used to treat pain, anxiety, and insomnia - GOV.UK](#)

The MHRA have announced that updated patient information leaflets and warnings on packaging will be introduced for gabapentinoids, benzodiazepines, and z-drugs aiming to help patients better understand the risk of dependency, addiction and withdrawal with these medicines.

Shared Learning: Wrong Patient Administration

[Sharing Learning Points Wrong Patient Administration Jan26](#)

MUSC would like to share learning from a Level 2 Adverse Event Review where a patient was given another patient's medicines, including controlled drugs, in error. This error resulted in harm to the patient.

A review of DATIX shows that each month around 1-3 wrong patient administration are reported within the acute sector each month.

### [Reminder: Dopamine agonists – a reminder to counsel patients on risks](#)

Dopamine agonist, including pramipexole and ropinirole, are used in the management of Parkinson's Disease and restless leg syndrome. They are associated with impulse control disorders including pathological gambling, binge eating and hypersexuality and patients should be informed about the risk of impulse control disorders when dopamine agonists are being prescribed.

An audit undertaken within a NHS Grampian GP practice found that of 12 patients prescribed pramipexole for restless leg syndrome between July-August 2025 none had it documented in their notes that counselling on the risks was given.

Recent UK court cases have awarded settlements to patients where it was found that the patient prescribed a dopamine agonist had not been counselled on the associated risks or prescribers had failed to review the patient's medication annually. These court cases highlight the importance of both counselling patients on the risks associated with dopamine agonists and documenting that counselling on the risks was given.

### **References**

[Dopamine agonists: pathological gambling, increased libido, and hypersexuality - GOV.UK](#)

[Parkinson's disease | Treatment summaries | BNF | NICE](#)

[Woman develops control disorder due to Pramipexole](#)

[Patient gets £70,000 payout from GP after Parkinson's drug triggered his 'uncontrollable gambling' | The Independent](#)

[Coroner's Report: Inappropriate co-prescribing in Electronic Prescribing Systems](#)

[Paula Doreen: Prevention of future deaths report - Courts and Tribunals Judiciary](#)

The Acute & Mental Health Medicines Safety Group want to share this English Coroner's Report to highlight limitations with in-patient electronic prescribing systems functionality in co-prescribing.

The case in this report relates to the death of a patient following an overdose from concurrent prescriptions of paracetamol and co-codamol which were not picked up by pharmacy, were administered by nursing staff and there was a subsequent failure to recognise overdose.

The patient had also taken over the counter paracetamol prior to attendance at the Emergency Department but this was not recorded as part of their medical history/medicines reconciliation.

Reflecting on the report through a NHS Grampian perspective:

- Prescriber conflict warnings appear in HEPMA for drug to drug interactions, drug duplicates, therapeutic duplicates and allergy/sensitivity conflicts.
- The prescriber must acknowledge the warning but the system **does not prevent** the prescriber prescribing both medicines so the prescriber must be alert to the warnings being shown and act accordingly.
- Healthcare Professionals who administer medicines should review the patient's whole record to see all prescribed medicines (not just what is available for administration at the time) and the administration history.
- Medicines reconciliation is the process of collecting an accurate list of a patient's current medicines; this includes non-prescription medicines such as over the counter medicines.

#### Useful links:

[Prescribing within HEPMA](#)

[Drug Interactions and Conflicts](#)

[Pharmacy within HEPMA](#)

[Medicines Administration within HEPMA](#)

[Single Drug Charting Workflow](#)

[NHS Grampian Medicines Reconciliation Protocol](#)

## Risk of Overdose with Propranolol and Instalment Prescribing in Primary Care

A case investigated by the Crown Office and Procurator Fiscal Service (COPFS) where a patient died from overdose of propranolol advised that one-week repeat prescriptions for patients deemed at risk of impulsive suicide would improve patient safety.

Propranolol is used to treat a range of conditions including hypertension, anxiety and prevention of migraines, and prescribing of propranolol has increased in recent years. In 2020 the Health Services Safety Investigations Body (HSSIB) reported the potential for under-recognised risk of harm from the use of propranolol and highlighted a specific group of patients who may be at an increased risk of using propranolol for self-harm because they have co-existing migraine, depression or anxiety.

Where self-harm from a prescribed medicine is considered a risk Primary Care prescribers should consider prescribing instalment prescriptions. If it is deemed necessary for a patient to receive less than the full quantity of the prescribed medication, additional directions can

be added to request instalment dispensing. For example a 28 day supply can be dispensed weekly over the course of the 28 days.

#### **Advice for General Practice:**

- Risk assess individual patients for risk of self-harm/overdose.
- If a patient is deemed to be at risk of self-harm or overdose:
  - consider the toxicity of prescribed medicines
  - prescribe the lowest effective dose
  - review the quantity supplied and consider instalment prescribing (smaller quantities should be considered as a safety measure to safeguard patients)
  - review the patient regularly.
- Consider assessing patients already prescribed propranolol for anxiety for their risk of accidental overdose and review the continued suitability of propranolol treatment in patients with co-existing migraine, depression or anxiety.
- Prescribers should be mindful of drug-drug and drug-condition interactions with beta-blockers.
- Prescribers should be aware of symptoms of an overdose of the prescribed medicine.
- When reporting a suspected overdose to the emergency services – tell them the patient has taken propranolol as propranolol can result in rapid deterioration before the ambulance arrives.
- Ensure patients are aware of the harm associated with propranolol overdose.
- Advise patients how to safely dispose of any propranolol tablets they no longer require by returning them to a community pharmacy for destruction.
- Continue to report adverse events via the adverse event reporting system in use within the practice e.g. Datix.
- Continue to report suspected adverse drug reactions via the Yellow Card.

#### **References/Useful Links**

[HSSIB Investigation report: Potential under-recognised risk of harm from the use of propranolol](#)

[Patient safety spotlight: the under-recognised risk of toxicity of propranolol in overdose | General Pharmaceutical Council](#)

[Involvement of propranolol in suicides: cross-sectional study using coroner-reported data | BJPsych Open | Cambridge Core](#)

## Updates



1 - Parkinson's 'Time Critical Medication' Infographic

## Major Clinical Risks Turas eLearning Module

This Turas module has recently been updated and covers topics that NHS Grampian consider major clinical risks including:

- High Risk Medicines
  - Gentamicin
  - Vancomycin
  - Insulin
  - Paracetamol
  - Anticoagulants
- Medication Errors
- Medicines Reconciliation

Doctors in Training are required to complete this at induction but anyone who manages or handles medicines in their role is encouraged to complete it.

## Contact

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