Keep Taking the Tablets Newsletter

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NHS Dorset

Reminder - semaglutide (Rybelsus®): transition to new formulation & risk of error

The initial formulation of semaglutide tablets (Rybelsus® in 3 mg, 7 mg, 14 mg strengths) is being replaced with a new formulation which has increased bioavailability resulting in lower doses to attain the same drug exposure (1.5 mg, 4 mg, 9 mg tablets). The co-existence of both formulations during the current transition period could potentially lead to confusion and pose a risk of medication errors, resulting in increased exposure of semaglutide, and gastrointestinal adverse events e.g. nausea, vomiting and diarrhoea.

For more information refer to the manufacturer letter and patient transition guide.

Patient safety spotlight: the under-recognised risk of toxicity of propranolol in overdose

Following several Prevention of Future Death Reports, the General Pharmaceutical Council (GPhC) has produced patient safety spotlight information, exploring the risks of harm from propranolol, in particular the risk of toxicity in overdose. In 2022-2023 the National Poisons Information Service (NPIS), received 358 enquiries involving intentional propranolol overdose. In 12 cases the overdose resulted in death. Read about the recommendations for safer prescribing of propranolol, especially in patients that may be more at risk of intentional overdose, on the GPhC website.

Levetiracetam (Keppra®) oral solution: risk of errors with change to oral syringe

A new 5mL dosing syringe (delivering up to 500mg) will **replace** the 3mL syringe (up to 300mg) for Keppra® oral solution 100mg/5ml – used in children aged 6 months to 4 years. When prescribing or dispensing, healthcare professionals should appropriately counsel caregivers about the change from 3ml to 5ml syringe and how to measure the dose using the new 5mL syringe. Both sizes may be available at the same time, increasing the risk of incorrect doses being administered. For more information refer to the healthcare professional letter from UCB Pharma, which contains illustrations of the change to the syringe markings.

Keep the warmth, lose the risk: MHRA and National Fire Chiefs warning

As colder weather arrives, the Medicines and Healthcare products Regulatory Agency (MHRA) and the National Fire Chiefs Council (NFCC) are urging the public to be aware of fire risks linked to emollient skin creams. To help keep people safe this winter, the MHRA and NFCC are highlighting three simple precautions:

1. Keep away from flames

Avoid smoking, candles and other naked flames and open fires if fabrics have dried on emollient products. Contaminated fabrics can catch fire quickly and cause a fire to spread quickly.

2. Keep warm safely

Sit at least 1 metre away from open fires and heaters, sitting too close could set light to fabrics.

3. Wash bedding and clothing regularly

Wash items at the highest temperature recommended on the care label to help reduce cream build-up. Washing does not remove residue completely, so continued caution is important.

Read more on the Gov.uk website.

Drug shortages/supply issues

- There is a shortage of 80mg and 160mg modified release capsules of propranolol. Immediate release formulations remain available and can support an increase in demand. Detailed advice for prescribers can be found on the SPS drug supply tool (free login needed).

Name change to the Dorset formulary on SystmOne

The prescribing formulary on SystmOne has changed name. It is now called "**NHS Dorset formulary**". To continue using it as your default formulary on SystmOne, it needs to be re-selected, as per the following steps:

1. Click Setup > Users & Policy > Organisation Preferences
2. Open the 'Prescribing' folder in the tree on the left, then select 'Prescribing from Formulary'
3. In this dialog box, we recommend selecting the option for 'Show a warning when a user issues an item that is not in a formulary' (add a message in the box to suggest staff refer to the formulary)
4. Select 'Show the default formulary' when from the 'When opening the browser' dropdown list and click 'OK'.

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5. Select clinical tools > drug & appliance browser
6. In the dialog box that opens, select the tab for 'Settings'
7. Select the 'NHS Dorset formulary' in the 'Default formulary' drop down list
8. Click 'Close'.

Changes to BD pen needles / insulin syringes

Starting in January 2026, Embecta will begin putting BD pen needles and insulin syringes in new Embecta-branded packaging across the UK. The changes include removal of the BD logo, simplification of product names and harmonised colour coding. Most PIP codes remain unchanged.

Quick bites

- The Dorset Formulary is available at: www.dorsetformulary.nhs.uk.
- Please find attached with the newsletter two shared learning summaries describing learning from patient safety incidents related to use of unopposed oestrogen for HRT and antibiotic treatment for Clostridium Difficile infections.
- The NHS BSA have advised that there are many GPs in the Dorset area that are not using the correct prescriber code in SystmOne. Please check the NHS BSA list to ensure the correct codes are in use. GP codes are not transferrable therefore a unique code should be in use in each practice that a GP prescribes in. For more help with this, email hayley.braid@nhsdorset.nhs.uk.
- Health Innovation Wessex (formerly Wessex AHSN) has just migrated over to a new website. They have shared the following updated links: Medicines Optimisation homepage, Medicines Safety Improvement programme (MedSIP) and Programme toolkits (e.g. reducing harm from opioid use, polypharmacy) – free login needed to access the toolkits.
- The Summary of Product characteristics (SPC) for Wegovy® (semaglutide) has been updated to note data from epidemiological studies that it may indicate an increased risk of non-arteritic anterior ischaemic optic neuropathy during treatment. Patients reporting a sudden loss of vision should be urgently referred for ophthalmological examination.
- An assessment of Tegretol 100mg/5ml liquid product's label in another country found that the propylene glycol content exceeds the recommended threshold for neonates (1 mg/kg/day). The SPC has therefore been updated to note that it is no longer recommended for use in neonates <4 weeks or below 44 weeks post menstrual age for pre-term babies. Refer to the healthcare professional letter on this topic.

REGIONAL MEDICINES INFORMATION SERVICE

If you work in primary care (including community pharmacy), specialist medicines advice can be obtained from SPS via **0300 7708564** or email asksps.nhs@sps.direct. (Staff in Dorset NHS Trusts should seek advice from their pharmacy teams).