NHS
North Yorkshire
Clinical Commissioning Group

Medicines Management Prescribing Focus – January & February 2021

Adrenaline Auto-Injectors (AAIs)

We are aware of the additional pressures currently upon practices, but wish to draw your attention to this important safety topic which will form the prescribing focus for the first two months of 2021.

Action points for practices: Please review all patients prescribed AAIs following a 2020 coroner's report

- Ensure all patients are prescribed and have two pens with which to have on their persons at all times and that this is recorded in the clinical system
- Ensure the strength of AAI is appropriate for the patient (but see below regarding 500mcg pens)
- National guidance for the prescription of AAIs is published by the British Society for Allergy and Clinical Immunology (BSACI) and not the Resus Council (the latter's advice is for treatment of anaphylaxis by health care professionals): https://www.bsaci.org/guidelines/bsaci-guidelines/adrenaline-auto-injector-2/
- Ensure patients have an appropriate action plan concerning the allergy (see also below)
- Ensure patients and relevant carers/relatives are aware of how to use the specific brand of AAI prescribed. OptimiseRx, the local prescribing support system, does alert prescribers to the need to ensure adequate training is provided to patients

Current AAI Supply Issues

- There are currently sufficient supplies of EpiPen and Jext to meet normal UK demand
- Specific batches of EpiPen 300mcg have received MHRA approval for extended use by four months beyond the labelled expiry date: https://www.epipen.co.uk/
- Clinicians should check with patients requesting prescriptions for AAIs to establish if they have one of the EpiPen batches that can be used beyond the expiry printed on the pen. If one of the listed batches is held, further supplies should be delayed, counselling the patient on the extended expiry
- There are ongoing supply issues with Emerade at the current time, as all strengths were recalled in spring 2020: https://www.gov.uk/drug-device-alerts/class-2-medicines-recall-emerade-500-micrograms-solution-for-injection-in-pre-filled-syringe-pl-33616-0015-el-20-a-23
- This means that there are **no 500mcg AAIs available** in the UK at present. This makes the need for patients who would be eligible for a 500mcg dose to carry two pens at all times even more important
- If they have not already done so, patients and/or carers should return all strengths of Emerade auto-injectors to their local pharmacy, once they have been supplied with an alternative brand

Background

In 2018 the tragic death of a young person with a known nut allergy from an acute anaphylactic reaction was referred to the coroner. The resulting inquest report from January 2020 can be found here: https://www.judiciary.uk/wp-content/uploads/2020/08/Shant-Turay-Thomas-2020-0124_Redacted.pdf

Key learning points from the report

- The patient had a severe nut allergy and was prescribed an AAI, but was not under the supervision of a specialist allergy clinic
- There was no documentation to confirm that the patient had been given an allergy action plan
- The GP practice did not realise they were the sole providers of allergy care

- The practice had not identified patient as being high risk due to severe allergy status, high BMI and co-diagnosis of asthma
- Whilst the GP knew that two AAI pens should be carried at all times, they failed to record this and they did not emphasise the reason for carrying two pens: primarily because in the event of severe acute anaphylaxis, the very strong likelihood is that both pens will need to be administered, one five minutes after the other, to keep the patient alive until the arrival of an emergency ambulance
- Erratic requesting of adrenaline pens was not explored by the GP team
- AAI administration technique was not checked
- When the AAI was changed from an EpiPen to an Emerade pen, the GPs did not reconsider the prescription and increase her dose from 300mcg to 500mcg – the GPs were falsely reassured that the Scriptswitch was a like for like substitution of one device for another.
- CCG failed to draw prescribers' attention, following Scriptswitch advice re changing from EpiPen to Emerade, of the need to reconsider the dose and to prescribe the higher dose of 500mcgs if appropriate
- No invitation was sent to ensure adequate training and understanding of the new device and its use
- The gold standard of training for use of any AAI is to give the patient the relevant placebo pen and, following appropriate instruction, ask the patient/carer to actuate the device

Additional information

- There was an update to the relevant NICE guidance in August 2020. Whilst this relates to mainly to patients who attend ED with acute allergic reactions, the information is also relevant to primary care: https://www.nice.org.uk/Guidance/CG134
- Patient treatment pathways contained within the BSACI guidance provides useful AAI specific allergy action plans for patients. These highlight that a second dose should be given after 5 minutes if still awaiting an ambulance. Action plans can be downloaded from: https://www.bsaci.org/professional-resources/resources/paediatric-allergy-action-plans/
- EpiPen trainer devices may be ordered at no cost from: https://www.epipen.co.uk/en-gb/hcp/patient-support/epipen-trainer-pen
- Jext trainer pens may be ordered from: https://adults.jext.co.uk/order-trainer-pen/

Please share the information in this letter with all relevant members of staff in the practice.

Yours sincerely,

The Medicines Management Team

Additional resources:

https://www.resus.org.uk/about-us/news-and-events/statement-anaphylactic-guidelines

https://bnf.nice.org.uk/drug/adrenalineepinephrine.html