Medicines Safety Tablet Press

Medicines safety newsletter for GPs, nurses and pharmacy teams
NHS Northamptonshire ICB

December 2025

- **Medication not given: discharge from an acute hospital to the community**
  This Health Services Safety Investigations Body (HSSIB) report highlights concerns around gaps in patient records and loss of critical information between hospitals and primary/community care. It reinforces the importance of ensuring patients are properly educated when discharged from hospital, especially if managing their own medicines.

- **Style Guide for Medication Directions**
  We have produced a Style Guide for Medication Directions. The Neonatal and Paediatric Pharmacy Group (NPPG) have published recommendations for Labelling of Dispensed Oral Medicines for Children. This advice sets out the suggested style of labelling for medicines for children. Standardisation of directions will help reduce inconsistency, potential for confusion and dosing errors. To promote a consistent approach to medication directions we suggest following the principles of the NPPG advice for both adult and paediatric patients where possible. The Northamptonshire formulary directions on SystmOne have been updated following the NPPG advice.

- **National Patient Safety Alert - Harm from incorrect recording of a penicillin allergy as a penicillamine allergy**
  There are reports of healthcare staff recording a patient's penicillin allergy as a penicillamine allergy in electronic prescribing systems. This look-alike sound-alike error risks a patient with a known penicillin allergy being administered a penicillin based antibiotic and having a potentially fatal anaphylactic reaction.

  Primary care and secondary care should
  - Identify patients recorded as having a penicillamine allergy by running a report in relevant digital systems (see below).
  - Clinically review the accuracy of the allergy status and amend accordingly
  - Ensure allergy records in electronic prescribing and related digital systems that record allergy status are updated.

  Ardens searches are available to identify patients with a Penicillamine allergy coding.
  SystmOne - Ardens Prescribing Alerts ➡ Allergies ➡ Allergies | ?Review if true penicillamine allergy
  EMIS – Ardens ➡ 2.22 Prescribing -Alerts ➡ Allergies | ?Review if true penicillamine allergy

  To prevent reoccurrence, practices should implement additional checks when staff (especially non-clinical staff) input allergy status into GP systems, eg consider the need for a clinical review if penicillamine is the stated allergen.

  Clinical review of patient's allergy status is essential as a minority of patients may have a genuine allergy to penicillamine. Additionally, there is significant risk to assigning a penicillin allergy to a patient who is only intolerant of penicillins (i.e. does not have an anaphylactic reaction but experiences nausea or other symptoms) - around 6% of people's records carry a penicillin allergy label but up to 90–95% of these labels are thought to be inaccurate. Patients with a penicillin allergy label receive alternative antibiotics resulting in; less effective management of serious infections and increased harm, length of hospital stay, NHS costs and antimicrobial resistance. Please see our Penicillin allergy de-labelling guidance.