CONTROLLED DRUGS NEWSLETTER

SHARING GOOD PRACTICE IN DEVON, CORNWALL AND THE ISLES OF SCILLY

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INCIDENT REPORTING

One of the pieces of information that we routinely capture is the time that elapsed between an incident taking place and the report arriving with us. This is often longer than we would expect and in some cases we hear about incidents from other sources but those involved do not report them at all.

The regulations impose a duty on all of us to share information in a timely manner. **We interpret that as meaning that we should expect at least a preliminary report by the next working day after the event was discovered.** We fully understand that the immediate concern upon discovery must be the safety of patients and that takes priority but we expect a report to the relevant Accountable Officer promptly thereafter. This will normally be from a local person. We are aware that some SOPs require reports to be made by a central office; if so, that office should make them promptly. Please remember that while your report may seem relatively unimportant, it may be part of a wider picture of poor practice.

While we are happy to take a telephoned report in the first instance we will ask you to forward an emailed or faxed copy for our records. There is no particular form that must be used; if you use such a form for internal reporting, we are happy to receive a copy to reduce workload.

Reports should be made to the secure email address (see left). Telephone calls for advice can come to the Deputies but we will usually need a written report of any incident.

METHADONE BALANCE DISCREPANCIES

The measures that we use for dispensing have allowable limits of error. These vary from 1% for a 500ml measure (so when we read 500ml, that is actually 495-505ml) to 10% on a 10ml measure (0.9-1.1ml would be compliant). Moreover, it is likely that the manufacturers will have included a small overage. As a result, however careful we are, balance checks for liquid medicines are likely to show some variances.

We accept that many SOPs require a report to be made to the AO for any balance discrepancy and we are always happy to receive them. This article describes how we will deal with those discrepancies.

Investigating discrepancies in liquid stocks

Many SOPs already cover this, so follow your own if you have them.

The commonest reasons for discrepancies are overage in delivered containers, measurement slippage and wrong product selection (sugar-free dispensed but an entry made for a sugared product). The size and direction of a discrepancy may give you a clue – overage should lead to your having more product than you expected, so it can't be a reason for a shortage, and it is typically of the order of 10-15ml on 500ml. If you have a shortage in one form of methadone and an overage in the other, that suggests an incorrect product choice.

If you have more methadone than you should have:

Have you missed entering a delivery?

Have you entered out a supply that was not made?

Have you entered a supply twice?

Are you including a patient return in your stock?

Only having excluded these can you consider an overage (unless you actually measured an overage).

If you have less methadone than you should have:

Have you entered a delivery twice?

Have you missed entering a supply?

Have you entered a delivery that was not made or made only in part (i.e. 3x500ml invoiced but 2x500ml received)?

Whenever you report a balance error for a liquid, we need to know two facts:

1. The size of the discrepancy, and
2. The total amount dispensed since the last correct balance check

We do not need to know the amount you have in hand, because that is not part of the calculation.

Divide the discrepancy by the total amount dispensed; if the result is less than 0.01, then you can correct the balance in your CD register yourself. We would not require you to report this, though if your SOP says that you should, we're happy to receive it. Ordinarily, we would take no further action, and we would not regard this as an error.

If the result of this sum is more than 0.01, we will take action depending on the result you get and the size of measures you have had to use to measure the doses required. Some examples may make this clear.

Adrian has found that his methadone balance is 15ml less than expected. Since his last balance check he has dispensed 1800ml. The number we want is therefore 15 /1800, which is 0.0083. This is less than 0.01, so Adrian can just adjust the balance in his register himself. If his SOP requires it, he can inform us, but we do not require it.

Barbara has an error of 3ml and has used 50ml since the last correct check. This is more than 0.01 but the volume she has used is very small and therefore the allowable error on the measures she has is larger. We would ask her to correct the balance in her register, noting that she has reported it to us and that we have agreed to the correction.

> 10.6.13 Balance adjusted by 3ml due to natural wastage during measuring, following discussion with Deputy Accountable Officer
>
> Barbara Curnow

A sample register entry to cover Barbara's amendment.

Charles has discovered an error of 150ml and has used 2500ml since his last correct check. This is 0.06. This is the same figure as Barbara's but because Charles' dispensed volume is higher we would expect more a smaller proportion of error than for Barbara. We would ask Charles to correct his register as above, but we may ask for additional information to explain the discrepancy.

Debbie notices that her balance in the cupboard is 1845ml, but her register says 1750ml and she is concerned that the overage is 95ml which is over 5% of the balance in the cupboard. She has checked that sugar-free methadone has not been dispensed instead. When investigating she realises that the balance hasn't been checked for 3 weeks and in that time she has dispensed 10 full bottles of 500ml. Rather than calculating against the balance in the cupboard, 95ml is 1.9% of the 5000ml dispensed over the previous 3 weeks. This would be a reasonable quantity as overage where the overage is usually 10 to 15ml for

each full bottle. Debbie then realises that she should check her balances more frequently, and amends her balance accordingly with a footnote to explain the build-up.

Whenever a balance adjustment is made in the register there must be an explanation attached.

UNUSUAL QUANTITIES

The default position is that prescribing of controlled drugs should be for no more than 30 days a time. However, there may be good reason to prescribe larger quantities in some circumstances, such as a patient taking a prolonged holiday.

We would expect dispensers to query such requests as a matter of course, but in addition it is likely that prescribing of this nature will be referred back to us by the NHS Business Services Authority's pricing division for us to verify the appropriateness of the prescribing. In the nature of things, this will probably be around three months after the event, at which point recalling the decision process may be difficult. For these reasons we urge prescribers to note the reasons for prescribing larger quantities in the patient's notes, and it is helpful if they also inform us pro-actively so that we do not need to trouble them later.

This approach is, of course, predicated on the prescribing being clinically appropriate. Prescribing controlled drugs several weeks in advance of use will not often be good practice and that may have to be justified separately. There may also be concerns about the safety of a patient holding large quantities of controlled drugs, and, in the case of holidaymakers, there may be laws governing the holding of controlled drugs in the country of destination.

HANDS, SPARE PAIR OF…

The AO team is now being supported by Sally Dutton (sally.dutton@nhs.net, tel. 01752 434942) who will be helping us on a part-time basis with administrative and governance tasks. Sally's main role is to provide Primary Care Support for pharmacy.

REPORTS TO NRLS

There is concern nationally at the under-reporting of CD incidents to the National Reporting and Learning System. This is suspected because reporting rates vary greatly by geographical area and between pharmacy chains. Please ensure that reports are made – we do not forward them, so separate reports to us and to NRLS will be needed. By the same token, they do not forward them to us. You can report incidents to the NRLS at http://www.nrls.nhs.uk/report-a-patient-safety-incident/.

The fact that you may already have reported a serious incident to another team within NHS England does not mean that you need not contact us.

Fentanyl patches

One persistent source of errors is the use of fentanyl patches. A joint CQC/NHS England patient safety group is considering how these incidents can be reduced, and is likely to recommend that patient notes should include some method of ensuring that the site of a patch and the date on which it was applied can be clearly seen.

It is likely to be left to providers to determine how this is achieved, but body maps help to show position, and some carers use a "waltzing" system for noting the dates: every day they must mark the patient chart, and they follow a "change-2-3, change-2-3" rhythm. The requirement to write something every day ensures that the chart will be looked at. There are, of course, other ways of achieving this, but whatever method is used, its success should be audited at intervals.

Submitting your private prescriptions to NHSBSA

You can download the submission form by going to:

http://www.nhsbsa.nhs.uk/2473.aspx

and then clicking on

Submission document for submitting controlled drugs through a private account.

The document to which this links changes each month so we cannot link you to the document directly.

CONTROLLED DRUGS LOCAL INTELLIGENCE NETWORK

The first meeting of the new CDLIN was held on 6th June. The CDLIN must cover the whole area, but it was agreed that the LIN would meet once a year as a whole body, and twice a year in sub-LINs based on Cornwall, South and West Devon, and North and East Devon. Dates and venues will be forwarded in due course.

BNF 65

The latest edition of the BNF contains a revised morphine-fentanyl equivalence table on page 21. There are now some differences between the BNF, local formularies and the conversion tables incorporated within some other documents. It will take some time to make any changes thought necessary, but we thought attention should be drawn to this revision.

LEARNING FROM LOCAL INCIDENTS

There are some persistent themes in incidents reported to us, and we offer some here for readers to reflect upon.

It is not unusual for containers of liquid controlled drugs to contain an overage, and discrepancies in contents are sometimes observed for loose tablets too. We do not expect you to break the seals on packs on arrival merely to check the contents; when deliveries are entered in the register on receipt, you can assume that they contain the stated amount (unless that is demonstrably not the case). Some pharmacists remeasure the volume at the point of first opening the bottle. A shortage is unlikely to be due to underfilled containers.

We have had at least two instances of patients being given incorrect quantities when a dose of methadone has been pre-measured and the patient has not turned up on the expected day, so that a smaller quantity should have been dispensed. If you pre-prepare methadone please ensure that your SOPs are clear about what to do with uncollected doses.

A pharmacy was unable to supply an instalment on a blue FP10MDA prescription due to a stock shortage. They hoped to receive a supply in the afternoon, but they had not made any contingency plan nor had they informed the prescriber. Our contracted substance misuse services are not able to replace prescriptions at short notice and contingency plans should not rely on such replacements.

A care home was in the habit of returning empty boxes of fentanyl patches to their CD cupboard. Nobody was quite clear why this was being done, apart from a vague idea that an inspector may once have suggested it. However, a result of this was that an empty box was included in a stock count. At some point, it appears that an equivalent amount of stock was removed, either for disposal or improperly. This could not have happened if the empty boxes had been destroyed, and we cannot think of any good reason not to do so promptly.

SUDDEN UNEXPECTED DEATHS

When a person dies unexpectedly or in some other circumstances, Her Majesty's Coroner may require to see the medicines that the deceased person was using at the time of death. We therefore suggest that unwanted controlled drugs are not returned to pharmacies for destruction within 7 days of a death. Where members of the public return them to a pharmacy, the pharmacy may wish to ensure that they are asked whether the patient has died so that such drugs can be quarantined for the required seven days just in case. A pharmacy is unlikely to have information that would clarify whether the medicines can be destroyed at once, so the safer course is to assume that they cannot.

PRESCRIPTION DOSES FOR SYRINGE DRIVERS

Please note that prescriptions for controlled drugs that do not contain a valid dosage cannot be dispensed. This is causing delay in treatment where a syringe driver has been requested but no dosage appears on the prescription. "As directed" is not a valid dosage, nor is "As on syringe driver sheet". The dosage must appear on the prescription itself. We recognise

that this may change subsequently, but a failure to give a starting dosage impedes patient care and causes distress to families who frequently do not understand why they cannot have the drugs that have been prescribed.

IDENTIFICATION PROCEDURES

At intervals we see incidents in which either a prescription form or the controlled drugs dispensed from it are given to the wrong person. This may be because procedures have not existed, because they have not been followed or because they are not fit for purpose.

Prudence dictates that the same procedures should be followed for handing over a prescription form for controlled drugs as for the drugs themselves. We have seen instances of unauthorised people collecting prescriptions where the practice is unable to say who came for them because they do not check identification in those circumstances, whereas they would if they were handing over a dispensed item.

We have also had instances of people with similar names being given each other's controlled drugs. Of course, we do not want to see patients being unable to obtain necessary drugs because they cannot present acceptable identification, but some practices exhibit notices reminding patients that ID procedures may have to be followed and listing the types of evidence that they will accept.

2ND QUARTER OCCURRENCE REPORTS

Just a reminder that designated bodies (organisations that have AOs) and provider organisations are due to submit their occurrence reports at the end of June.