CONTROLLED DRUGS NEWSLETTER

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

Volume 1 / Issue 4

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DESTRUCTION WITNESSING BY CCG PERSONNEL

The number of destructions of obsolete stock controlled drugs and the increased geographical footprint of each Accountable Officer's team has meant that it was impractical for Darren and Graham to witness all the destructions in a reasonable time. CCG staff are often better placed to do this, but this is not a core CCG function.

We are pleased that our CCG partners have agreed to undertake much of this witnessing for us. The mechanism for this is that individual CCG staff members have been approved as witnesses by Bridget Sampson with the agreement of their line managers. It is therefore possible that the destruction of your controlled drugs will be witnessed by CCG staff. However, any enquiries or reporting continue to be made to the Accountable Officer team at NHS England. CCGs are only undertaking routine witnessing – though, of course, they may want to discuss controlled drugs during their ordinary daily business.

NEW CONTACT DETAILS

Please note that Darren and Graham have now been given NHS England mobile phones, which means a change of telephone number for each of them. Their new numbers appear in the block to the left of this paragraph.

ROBOTIC DISPENSING OF CONTROLLED DRUGS

The Home Office Drugs branch has reported some misunderstanding on the position of dispensing robots. It seems that the impression may have been given that robots have been given some kind of general exemption from legislation. This is not the case. The police can, if so minded, issue a certificate for a dispensing robot as a secure alternative to an authorised cabinet, but this is done on a case by case basis.

The Home Office's opinion is that a robot can, in principle, be sufficiently secure, but an exemption must still be sought. See page 9 of http://www.cqc.org.uk/sites/default/files/media/documents/partner_organisation_activities_2012.pdf for details.

CARE HOMES – VERIFYING THE AMOUNT PRESCRIBED

A recent incident has highlighted a weakness in systems operated by some care homes.

Prescriptions requested by the home were forwarded directly to the pharmacy, as a result of which the home did not check that what was prescribed matched what had been ordered. The pharmacy noticed the changed quantity, but assumed that this was in order. When the drugs were delivered, the requested amount (rather than the delivered amount) was entered into the register. The result was that at a later date the home spent a lot of time trying to find "lost" capsules that they had never received in the first place.

Plainly there are questions about the value of stock checks if this could go undetected for a while, but it is expected that homes should receive some notification of the amounts that they should anticipate so that any queries can be addressed in a timely way without affecting patient care. In this case, the home should have noticed that the delivery note bore a quantity lower than they were expecting.

IDENTIFYING PATIENTS

We make no apology for returning to a subject that has caused concern in the past because we continue to see serious events due to a failure to identify patients correctly before dispensing to them. This is particularly an issue where pharmacies pre-dispense bottles for substance misuse patients.

There are a number of possible protocols for ensuring that the client presenting receives the correct medicine but the important point is that the client's name and address are checked. Ideally this should involve asking them to supply the details, rather than simply answering the closed question "Are you Mr X of address Y?"

CQC ANNUAL REPORT ON THE SAFER MANAGEMENT OF CONTROLLED DRUGS

This can be viewed at
http://www.cqc.org.uk/sites/default/files/media/documents/cdar_2012.pdf

A few key points appear below.

2012 was the last full year in which PCTs held responsibility for assessing the governance arrangements for controlled drugs within primary medical services. From April 2013, CQC will regulate this sector.

The Home Office is amending legislation to require mandatory use of the standard CD requisition form.

Table 1 below (from this CQC report) gives a list of the new governance arrangements since April 2013.

Picking lists

Please note that prescribing systems often do not list options in order of strength, but by alphanumeric order. Thus it is likely that the strength below 10mg will be 100mg rather than 15mg, and the strength between 10mg and 30mg may be 200mg. This has contributed to some prescribing errors. Please expand the entry fully when prescribing. There is guidance at http://www.connectingforhealth.nhs.uk/systemsandservices/eprescribing/refdocs/opiates.pdf **.**

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.

Substance misuse – 3 day rule

If a client misses 3 days' supply of their prescribed medication (NOT 3 pickups) it is normal practice to notify the prescriber and not to dispense again to that client until they have been reassessed. This is not a punishment for the client, but an essential safety measure designed to reduce the risk of dispensing to a person whose tolerance of their medication has been reduced. It is good practice to note that the prescription is on hold pending a reply to prevent accidental dispensing.

Table 1: Key changes to controlled drugs governance arrangements

Governance arrangements to 31 March 2013	New governance arrangements after 1 April 2013
Primary care trusts CDAOs lead the local intelligence network for the primary care trust (PCT) area – controlled drug designated bodies and responsible bodies are members of the CD LIN.	**NHS England Area Teams** NHS England CDAOs are the assigned lead CDAOs. They determine the CD LIN areas and membership.
	Clinical commissioning groups and support units Not required to appoint a CDAO but have a duty of cooperation to the lead CDAO in investigating concerns and analysing data.
NHS hospital trusts and foundation trusts Organisation's CDAO has responsibility for all aspects of safe and secure handling of controlled drugs. Provides quarterly occurrence reports to PCT CDAO.	**NHS hospital trusts and foundation trusts** As before, but provides occurrence reports to lead CDAO.
Independent hospitals Organisation's CDAO has responsibility for all aspects of safe and secure handling of controlled drugs. Provides quarterly occurrence reports to PCT CDAO.	**Independent hospitals** As before, except where an exemption applies, for example: • Small hospitals (fewer than 10 staff). • Larger businesses that employ more than 10 staff, but which do not generally have a high degree of controlled drug use. Provide occurrence reports to lead CDAO.
	Armed forces The headquarters of reserved or regular Armed Forces have now been given the status of a 'designated body' so a CDAO must be appointed. The Armed Forces must determine how they discharge this function. Lead CDAOs can now invite such personnel to be members of CD LINs.
Social enterprises and community interest companies (SEOs and CICs) Non designated bodies, so not required to appoint a CDAO and not required to be members of CD LINs. However, they should have governance arrangements in place to ensure safe management of controlled drugs and reporting of controlled drug concerns.	**Social enterprises and community interest companies (SEOs and CICs)** Only required to appoint a CDAO if their activities come within the definition of a 'hospital'. However, commissioners will expect adequate CD governance arrangements to be in place and SEOs and CICs can consider appointing a designated senior officer for this purpose.
Private clinics, private doctors Non-designated bodies, so not required to appoint a CDAO and not required to be members of a CD LIN. Should have appropriate arrangements in place for the safe management of controlled drugs. For those not registered with CQC, the PCT CDAO has the right of entry to investigate reported controlled drug concerns.	**Private clinics, private doctors** As before, 'powers of entry and inspection' provisions to secure the safe management and use of controlled drugs on premises registered as providing healthcare services that are not subject to inspections by regulatory bodies, and should have appropriate arrangements in place for the safe management of controlled drugs.
Social care settings Non-designated bodies, so not required to appoint a CDAO and not included as members of CD LINs but should have appropriate arrangements in place for the safe management of controlled drugs. Regulated by CQC (a responsible body member of the CD LIN) who should ensure controlled drug concerns are reported to the CD LIN. Also individual duty to report concerns to the PCT CDAO/CD LIN.	**Social care settings** As before but the individual duty to report concerns is to the Area Team lead CDAO.
Primary medical services and primary dental services Inspection by PCT CDAO. Self-assessment and declaration requested by the PCT. Individual duty to report concerns to the PCT CDAO. Should have appropriate arrangements in place for the safe management of controlled drugs.	**Primary medical services and primary dental services** Primary medical and dental services are now registered with CQC. There should be appropriate arrangements in place for the safe management of controlled drugs. Lead CDAOs should request periodic declarations or self-assessments from a range of healthcare providers regarding their management and use of controlled drugs, if they are not required to appoint a CDAO. This includes GPs on a medical performers' list and providers of dental, nursing or midwifery services. Individual duty to report concerns to the lead CDAO.
Community pharmacists Controlled drug concerns reported to PCT CDAO and GPhC.	**Community pharmacists** Controlled drug concerns to be reported to lead CDAO and GPhC.

SAFER USE OF CONTROLLED DRUGS

This programme of work managed jointly by CQC and NHS England has produced simple factsheets on the safer use of fentanyl and buprenorphine transdermal patches, oral oxycodone and MS syringe drivers. These can be seen at http://www.cqc.org.uk/service-providers/special-reviews-and-inspection-programmes/controlled-drugs/use-controlled-drugs .

The key actions from each of these are given below.

Checklist for safer use of fentanyl and buprenorphine transdermal patches

1. Transdermal fentanyl patches should be restricted to patients that are already receiving regular doses of opioids
    i. Do not use for acute pain.
    ii. Do not use in opiate naïve patients.
2. Before using a CD transdermal patch, calculate the total daily dose of all the opioid analgesics that the patient has received previously. This is usually in morphine equivalents. Use locally or nationally approved dose conversion charts to do this. There are dose conversion charts in the 'Prescribing In Palliative Care' Section of the BNF and in manufacturers' guidance (SPC).
3. Determine a new dose of analgesia to be delivered by transdermal CD patch in morphine equivalents. For changes in analgesia, as a 'rule of thumb', the total daily dose should not be increased in steps greater than 50% of the previous daily dose. Again use a conversion chart to determine the total daily dose of analgesia by CD transdermal patch(es) and where necessary divide by 24 to equate with the micrograms/hour strength of available products. To deliver the intended dose more than one CD patch may have to be used.

NB - Formally double check the calculations and where possible have the patient's dose independently verified.

4. Ensure only those CD transdermal patches intended for current use are applied.
Patches are skin coloured and may not be easy to locate. Formally record the anatomical position of currently applied patches so that this information is readily available to inform future decisions and actions.
5. Prescribe by brand and ensure patients using CD transdermal patches have adequate prescriptions and supplies to minimise interruption and omission of therapy. Patches must be removed and replaced at intervals in accordance with the manufacturers' guidance (SPC).
6. Consider that patients may exhibit symptoms of opioid withdrawal when a CD transdermal patch has been omitted. The cause of these symptoms may not be recognised and patients may be treated with benzodiazepines for these symptoms, rather than have opioid therapy for their analgesia re-instated, if necessary at a reduced dose.

Checklist for safer use of oral oxycodone

1. Oxycodone should only be used as a second-line strong opioid, if morphine is not suitable or cannot be tolerated. The specialist pain or palliative care team should be consulted for advice in cases of complex pain management.
2. Obtain details of the previous daily dose and frequency of administration of previous analgesics used by the patient.
    i. Ensure where a dose increase is intended, that the calculated dose is safe for the patient (for oxycodone in adult patients, not normally more than 50% higher than the previous dose).
    ii. Where the patient was previously taking another opioid analgesic use a locally or nationally approved dose conversion chart to accurately determine the equivalent daily dose of oxycodone. Dose conversion charts can be found in the' Prescribing in Palliative Care' section of the BNF.
3. Confirm the appropriate medicine formulation is being used. There are fast acting short duration (e.g. OxyNorm) and slow acting, long duration (e.g., OxyContin) oxycodone products. There are significant risks of overdose when a fast acting product of short duration is used in error for the slow acting, longer duration products. Where possible prescribe by brand name to reduce confusion.
4. Check for therapeutic duplication of strong analgesics by two different routes of administration. There may have been an error and the previous route of administration may not have been cancelled.
5. Confirm any use of oxycodone concentrate products. There are significant risks of overdose if a concentrate product is used in error for a normal strength product.

6. Any use of oxycodone medicines ‘as required’ should have clear guidance on the frequency that the doses can be administered.

Checklist for safer use of ambulatory syringe drivers

1. Introduce ambulatory syringe drivers with safer design into practice as soon as possible.
It is recommended that no MS syringe drivers are used in NHS and independent healthcare providers providing NHS funded care, by December 2015 at the latest.
2. Take steps to reduce the risks of rate errors while MS syringe drivers remain in use, based on a locally developed risk reduction plan which may include:

i. raising awareness
ii. providing information to support users with rate setting
iii. using lock-boxes.

CHECKING DOSES OF OPIATES

In 2008 the then National Patient Safety Agency released Rapid Response Report RRR05 on Reducing Dosing Errors with Opioid Medicines. This required that:

> When opioid medicines are prescribed, dispensed or administered, in anything other than acute emergencies, the healthcare practitioner concerned, or their clinical supervisor, should:
> • Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records.
> • Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose).
> • Ensure they are familiar with the following characteristics of that medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effects.

Recent incidents suggest that this advice has been forgotten. It is good practice to note the form that any confirmation took (e.g. “checked PMR for previous dose”) and that the dose has been questioned with the prescriber.