CONTROLLED DRUGS NEWSLETTER

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

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GREETINGS FROM THE ACCOUNTABLE OFFICER TEAM

Following the changes in the NHS the Accountable Officer function that previously sat with PCTs moves to the NHS England Area Team, details of which appear in the sidebar.

The new regulations specify organisations that must have an Accountable Officer for Controlled Drugs, and others that should appoint an Accountable Person. All Accountable Officers should attend the Locality Intelligence Network meetings (LINs) and Accountable Persons may do so.

The arrangements for CDLINs going forward will be discussed at the Peninsula CDLIN meeting on 6th June but will be guided by three principles:

- Regular meetings help to share learning and hence meet the statutory duty of the CDLIN
- Effective sharing limits the numbers present so that all can participate, so there are advantages in smaller CDLINs
- Meetings should be as local as possible and should not replicate each other

Authorised witnesses for destruction of Controlled Drugs

The AO Team is much smaller than used to be the case for each PCT. We are therefore dependent on other authorised witnesses to supervise destructions.

Please note that no witness is needed for destructions of patient-returned controlled drugs, but a witness is required for out of date CDs or those stock drugs otherwise surplus to requirements. As a rule of thumb, if it was not entered out of the CD register, it is a stock item requiring a witness.

Before we can witness any destruction, you must take three steps:

- You must have registered a T28 exemption with the Environment Agency to permit denaturing of waste generated on the premises (see p2).
- You must complete a list of items to be destroyed which we will email you upon request.
- You must ensure that an adequate denaturing kit is available.

Next CDLIN meeting – 6 June 2013 at Saltash

Remember!

In community practice a schedule 2 or 3 controlled drug cannot be given by emergency supply, except for phenobarbital used in the treatment of epilepsy. A fax may be used to allow a dispenser to prepare medication, but the CD cannot be released without the original prescription.

Once a controlled drug has been dispensed, a spillage cannot be replaced without a new prescription. A spillage before issue can be replaced but local SOPs should be followed to ensure that a proper record is kept.

We continue to see prescriptions issued for which no dose is written. Please note that "as directed" is not an acceptable instruction, nor is "per syringe driver sheet". This is because the prescription itself must bear the instructions or it is not legal. "One as directed" or "10mg as directed" would be legal, but not usually good practice.

When opioids are prescribed, dispensed or administered, except in emergencies, the healthcare practitioner concerned should:
• Confirm any recent opioid dose, formulation, frequency of administration and any other analgesics used by the patient.
• Ensure that a dose increase is intended and safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose).

T28 Exemptions

Normally, a licence is needed to handle waste. However, the Environment Agency accepts that there is a problem in applying this to controlled drugs which must be denatured before they can be removed by authorised waste handlers. The EA therefore permits denaturing by healthcare professionals in certain circumstances, but this is controlled by the use of exemptions issued under the Environmental Permitting (England and Wales) Regulations 2010. In the case of CDs, the relevant exemption is T28.

This can be obtained through the EA website, is free of charge and lasts for three years. You can register for a T28 exemption at http://www.environment-agency.gov.uk/business/topics/permitting/116338.aspx. Please note that you must do this for each premises at which destruction will take place.

There is an additional exemption for bringing drugs for denaturing to a central point which now permits branch surgeries to transport them to the main surgery, for example, provided that professional requirements are met and there is no risk to the environment. See http://www.environment-agency.gov.uk/static/documents/Business/MWRP_RPS_004_v3_Denaturing_drugs_-_July_2012.pdf for details.

LEARNING FROM LOCAL INCIDENTS

A pharmacy dispensed out of date fentanyl patches. The mistake was noticed later and the stock collected and replaced.

This ensured that the patient was not inconvenienced, but please note that there was no legal authority for the second supply. The correct course of action was to obtain a further prescription. The pharmacy, of course, could not claim two payments, but should hold the second prescription within its records.

This incident could have been avoided if the pharmacy had checked the expiry dates of its stock more regularly and practiced effective segregation of out of date stock. There are a number of ways that this can be achieved, but if your SOPs do not already specify a method, you could try:

- *Checking every date when stock is counted and marking stock close to expiry with a coloured sticker*
- *Keeping time-expired stock in a sealed plastic bag clearly labelled Out of Date Stock, and patient returns in another sealed plastic bag so neither can be used by mistake*
- *Noting the presence of out of date stock in the register may alert colleagues to the need for extra vigilance; for example, if you have 10 injections of which 2 are out of date, you could describe the stock held as 8 + 2 o.o.d.*

Next CDLIN meeting – 6 June 2013 at Saltash

Please ensure that the name and address of every person receiving a prescription or a supply of medication is checked in line with your organisation's SOPs. We know of three incidents over the last few months where incorrect supplies have been made because the name and address hadn't been checked.

a) A client received 45ml methadone supervised administration which was intended for another client a few hours after receiving his normal daily dose of supervised 40ml methadone.

b) 70ml methadone intended for another patient was supplied to a patient in addition to collecting her own methadone. This patient usually presents at the pharmacy with her partner who also collects methadone, and the pharmacist assumed that she was picking up her partner's prescription as well, so another patient's prescription was supplied instead

c) A patient who was due to receive 60ml methadone supervised received 70ml methadone intended for another patient as a take away dose. The two patients had the same initials and this was cited as a contributory factor in this error occurring.

A prescription which had been suspended by the prescriber continued to be dispensed 3 days after the suspension date. The pharmacy had been informed of the suspension by a telephone call from the prescriber which was confirmed by fax.

While these circumstances are unusual, it is not uncommon for changes in doses to be missed. Particularly in substance misuse, it is likely that there will be times when there are two prescriptions for the same patient in a pharmacy to ensure continuity of supply, but there may also be changes during the life of a prescription. Please ensure that pharmacy internal communication procedures are robust so that all relevant information is actioned and that procedures for dealing with obsolete prescriptions are observed.

A pharmacist received a prescription for 588 diazepam 2mg tablets. She queried the quantity with the surgery. The surgery staff advised that they would check with the GP and phone the pharmacist. The surgery responded 4 hours later but the patient had returned in the meantime to collect the prescription. The pharmacist asked the patient if she was expecting 588 to which she replied that she was and the pharmacist dispensed this quantity to the patient. The surgery did say that this was an error and that 98 tablets had been intended.

There are a number of issues here from which we can learn. The error was due in part to an auto-calculate function on the surgery prescribing system, and we would have hoped that the prescriber would have read the prescription before signing it. If you are concerned with any aspect of a prescription that you have been presented with, please ensure that these

PRESCRIBING BY PERSONS OTHER THAN THE REGULAR PRESCRIBER

A prescriber who does not have access to patient notes is often at a disadvantage. For that reason we do not expect out of hours practitioners to issue more than will cover the patient until their own GP can pick up the prescribing. While we would not want to restrict out of hours prescribers unduly, there are limited circumstances in which they will initiate prescribing for a syringe driver (except, of course, where this has been foreseen by the patient's GP).

Prescribers have long exercised caution around providing controlled drugs to temporary residents and others not known to them. As a result, some patients now request alternative medicines that they believe may be more easily obtained such as pregabalin, gabapentin and tramadol. We have also seen instances where misusers have requested innocuous drugs to disguise their intentions; for example, a patient requested sodium valproate, phenytoin and pregabalin but then threw away the valproate.

REPORTING INCIDENTS

We are always keen to hear as soon as possible about incidents, and a telephone report is welcome. However, we will still need a written (e-mailed) follow-up. Please do not rely on others to inform us – reports from some chain pharmacies' head offices are still not arriving in a timely manner. If an apparent incident is satisfactorily resolved, we are very happy to close it.

concerns are resolved to your satisfaction before dispensing to a patient. It may also help colleagues if the rationale for unusual prescribing is noted in the patient records – if another GP could have been confident that the logic for prescribing 588 tablets would have been in the notes, he or she would have felt more secure about countermanding it. There are also opportunities to improve the way in which a query about controlled drugs is handled by all our practices. How can reception staff identify questions where there is some urgency about a reply? Should the query have been routed to another doctor rather than waiting for the original prescriber? And is it better for professionals to speak directly to each other about such queries rather than by messages passed by intermediaries?

A prescription was written for buprenorphine 10mcg and buprenorphine 5mcg patches. The prescriber intended to supply two patches of each strength and had written the quantity of each patch in words and figures in line with CD prescription writing requirement, hence, x 2, two patches. A pharmacist dispensed four patches of each strength and argued that because the quantity was written in both words and figures, the quantity intended by the prescriber was ambiguous.

Even if it were ambiguous, the prescription should not have been dispensed until the ambiguity was resolved.

Other learning:

- Buprenorphine 2mg tablets were dispensed to a patient instead of the prescribed buprenorphine 200mcg. It was apparent from the dosage instructions that the prescription had been intended for the management of pain rather than substance misuse.
- 4 days of methadone were supplied to a patient instead of 3 days' supply as the patient had not collected on the previous day, and the prescription had not been endorsed as Not Collected.
- A shared care prescription dated for and dispensed in October, had September collection dates in the body of the prescription, as the prescription was repeated from the previous month.
- Please pay special attention to quantities supplied - 3 boxes of Fentanyl patches were supplied to a patient from a prescription for 3 patches.
- Please ensure that any PIL supplied to patients do not contain any loose tablets.
- Please be aware of pack sizes: in one incident 60 Zomorph capsules were supplied to a patient instead of 56. The pharmacist had thought that the pack size was 56.

CIRCULATION OF THIS NEWSLETTER

We will send this newsletter electronically to all CDLIN members, and via professional newsletters. If you are aware of others who wish to have copies emailed to them, please contact Wendy Vincent (wendyvincent@nhs.net) who will add them to a supplementary list.