Patient Safety Newsletter

Produced by the CQC National Controlled Drugs Patient Safety Sub-Group

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Introduction

Hello there and welcome to the first of our new style newsletter of our Patient Safety sub-group (this was formerly known as the Clinical sub group). As many of you will be aware, the sub-group is one of four sub-groups reporting into our National Controlled Drugs (CDs) Group which was set up as part of the strengthened governance arrangements put in place for CDs following the Shipman Inquiry. The National CD Group meets quarterly and comprises representatives from those regulators and agencies with a CD remit. The sub-group feeds into that group and is made up of members from the regulators, the NHS England Patient Safety Team, CD Accountable Officers, hospital and community pharmacists and we invite other healthcare professionals and organisations as and when required. We hope that by working together, we can shine a spotlight on risks and harms to patients from CDs, share learning from real incidents and remind you of useful bits of guidance.

About the newsletter

We will share with you patient related CD incidents; learning and guidelines brought to our attention and signpost you to recent or relevant guidance. We really welcome your input and feedback and urge you to share the newsletters with your Medication Safety Officers (MSOs) and other staff to raise awareness. By sharing learning we hope to improve the overall arrangements for CDs and minimise future harm to patients.

Safety steps:

Oxycodone medicine incidents

We have been made aware of several incidents related to the use of oxycodone.

Firstly, the wide array of branded products currently being used across primary and secondary care can cause confusion and it is important to confirm the appropriate formulation is being used. There are both fast acting short duration products such as Shortec and Oxynorm and slow acting, long duration products such as Longtec and Oxycontin available and there is a significant risks of overdose when a fast acting product of short duration is used in error for the slow acting, longer duration products.

Secondly, we have also had reports of oxycodone 10mg/ml being prescribed instead of 5mg/5ml by mistake, leading to patients ending up in hospital.

Safety steps:

Confirm any use of oxycodone concentrate products.

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

Monitor the use of `as required' doses of oxycodone for breakthrough pain to identify escalating doses. Reconfigure pick lists to separate different strengths and concentrations.

Advice for prescribers on the risk of the misuse of pregabalin and gabapentin

Reporting
Remember to report CD incidents to your NHS England Lead CDAO

Report suspected ADRs on a Yellow Card.

Next Issue
Share your learning with us for inclusion in future issues

Contact Us
CDsubgroups@cqc.org.uk

Slow release morphine doses case study
A patient who had been receiving 30mg of slow release morphine sulphate tablets in hospital as MST 3x10mg tablets was discharged. The GP then wrote a prescription for 30mg tablets and the patient took 3, thinking that the tablets were an alternative brand.
Safety steps:
It is common practice in hospitals for doses to be defined by size, not by composition (e.g. MST 30mg). Patient counselling and specifying the composition of the dose (1x30mg or 3x10mg) might have prevented this.

Practical pointers - Supervised consumption

Musts:
Use a quiet, private area of the pharmacy.
Ask the patient for proof of identity and what dose they usually take. Check this against the dispensed dose in the container and the prescription.
Do not dispense if the patient has missed three or more consecutive doses or appears intoxicated.
Be courteous, respectful and non-judgmental - most patients take their medication as prescribed when on supervised consumption but there is a small group that may attempt to divert it. It is important to check for this as set out below:

Methadone Oral Solution:
Get the patient to check the name, quantity and dose on the label, before self-administration.
Make sure the dose is swallowed by offering a drink of water after the dose.
If the patient is reluctant to speak before taking the dose, they may have cotton wool or absorbent material in their mouth to absorb the methadone - a simple greeting can help detect this.
Avoid patient use of a can of soft drink to wash down their methadone as they may use it to discharge the dose of methadone into the can for sale later.

Buprenorphine:
Get the patient to first remove any chewing gum from their mouth.
Offer the patient a drink of water before administration to moisten the mouth and speed up dis-solution of the tablet(s).
Pop the tablets out into a clean, dry medicine cup and hand this to the patient.
The patient should tip the tablets under the tongue, and be advised not to handle them or swallow them and to swallow as little saliva as possible whilst the tablet(s) dissolve - patients on high doses may need to split the dose to take a few tablets at a time.
Observe the patient until the tablets have started to dissolve, in order to make diversion difficult.
Ask the patient to remain in the pharmacy until all that is left under the tongue is a chalky residue – this will be achieved within five to ten minutes.
The patient may attempt to conceal the tablets in their mouth or spit out and reclaim them so offer the patient a drink of water and engage in conversation to minimize the chance of this happening.