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Controlled Drugs Newsletter

NHS England Central Midlands

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Welcome to the NHS England Central Midlands Controlled Drugs Newsletter.

Prescribing for Chronic Pain—When things go wrong Faye's story, as told by her parents

Faye injured her back in 2009 and despite an operation in 2010, her pain continued and she was prescribed 80mg Oxycodone daily. By June 2013, she was taking more than 200mg oxycodone daily, along with diazepam, amitriptyline, prochlorperazine, sertraline, diclofenac, esomeprazole and paracetamol. Gabapentin had been tried, and withdrawn. Her symptoms and health problems had become steadily worse as the dose of oxycodone increased, and more medicines were added in to manage the side effects. As well as the pain, she suffered from nausea, sleepiness, fainting, muscle spasms, blistering skin problems and depression. Whilst waiting over 20 months for in-patient rehabilitation Faye had some sessions of cognitive behavior therapy from the NHS counselling service, and also started a pain management course. She showed signs of improvement and her family thought she had turned a corner, and would finally start getting better. Then, in September 2013, out of the blue, Faye suffered a respiratory arrest and died at the age of 32.

What went Wrong?

Faye's dose of oxycodone was repeatedly increased, against the advice of the pain clinic, and despite her pain not being effectively managed by it. It was way above the safe limit, now set at 120mg morphine daily equivalent dose (see Opioids Aware http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware) She was taking oxycodone with diazepam - opioid and benzodiazepine medications taken together can lead to respiratory depression, and she already had sleep apnoea https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm518110.htm

Key Learning Points

- Safety issues around opiate prescribing
- The role of oxycodone, and an understanding of the dose equivalence of different opiates
- Alternatives to opiates for managing ongoing pain
- Mechanisms for reducing high doses of medication, e.g. weekly scripts, monitored dosage system.
- Review of current prescribing in the practice
- Mechanisms for group discussions around difficult to manage cases, including a monthly patient safety meeting to review concerns about medication levels

Faye's parents have asked all healthcare professionals to think about these points

- First, do no harm
- Follow evidence based practice
- You have a duty of care
- Do not authorize prescriptions, even on specialist recommendation, if you don't think they are safe

https://improvement.nhs.uk/resources/fayes-story-good-practice-when-

Controlled Drug Incidents taken from the on line reporting tool

In the period between April 2016 and March 2017, 399 incidents were reported to the Central Midlands team. Of these the majority were incidents reported by pharmacy multiples, followed by independent pharmacies and a small number from GPs. Listed below are the top three common categories, drugs and incident themes.

Top 3 Common categories

1. Dispensing errors
2. Running balance
3. Administration errors

Top 3 Common Drugs

1. Methadone—liquid (normal and sugar free)
2. Methylphenidate—tablets and capsules
3. Buprenorphine—tablets and patches

Common themes and learning points

- Dispensing errors— Incorrect quantity , incorrect form given
- Running balance— Registers not completed in a timely fashion.
- Administration errors—Handing out errors, wrong patient, wrong drug, similar patient names not checked appropriately.

Learning Points—

- Avoid self checking unless absolutely necessary
- Check—Right drug, right form, right strength, right quantity, right label, right patient.
- Handing out—double check—right drug—right patient

Sharing learning from incidents

Incident Description

Prescription for 60 Zomorph 200mg S/R capsules 1 every 12 hours was presented to the pharmacy. The product was ordered, dispensed and handed to the patient's representative. A week later, the pharmacist received a phone call from the chief pharmacist at the nearby acute hospital, saying that the patient had been admitted with opiate overdose but was recovering and had pneumonia which may or may not have been due to the opiate overdose.

Lessons Learnt

GP intended to prescribe Zomorph 20mg twice daily which was requested by MacMillan nurse. Prescription for Zomorph 200mg was intended to be cancelled by GP. However, there was a problem with the mouse and the prescription did not get cancelled.

GP practice learnings:

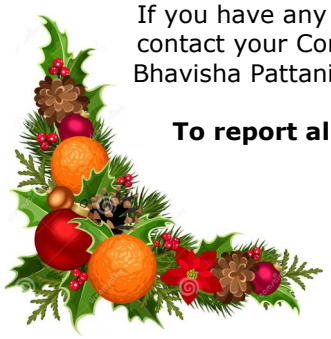
- GP SOP/protocol now in place.
- CD prescriptions not raised late in the evenings due to fatigue.
- Separation of CD prescriptions from main pile of prescriptions. All CD prescriptions to go into CD tray.
- Double check of all CD prescriptions by the pharmacy dispenser or the Nurse in charge before they are sent to the pharmacy.

Pharmacy learnings:

Patient previously only on oramorph – not queried by pharmacist.

- The pharmacy will be asking all patients if they have any new medication and writing "New" and the name of the new medication on the top of prescriptions for new medication.
- The pharmacist will query all high or unusual doses of any medication that the patient is not known to be stabilized on, with the prescriber before dispensing, labelling or assembly of affected prescriptions

Reminder



If you have any concerns or intelligence relating to the abuse or use of medication, please contact your Controlled Drugs Accountable Officer:
Bhavisha Pattani at England.centralmidlands-cd@nhs.net

To report all CD incidents, or to request a CD destruction visit, please use the CD online reporting tool available at www.cdreporting.co.uk

Seasons Greetings and good wishes for the New Year 2018.