Dear Colleagues

To: all SW Community Pharmacists
dispensing opioid substitution therapy (OST)
by FP10MDA instalment prescriptions

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Re: **dispensing opioid substitution therapy (OST) by FP10MDA instalment prescriptions – lessons learned and Christmas 2016**

Following a SW audit of reported CD incidents involving methadone from Jan to July in 2016, several recurring themes were identified, which apply to all OST prescribing. This letter is intending to share the learning across all SW Community pharmacies so that SOPs for OST prescribing can be reviewed.

Methadone given to the wrong patient

The giving out of methadone to the wrong patient continues to be a common error because the proper checks involving the dispensed medicine, the prescription and the patient are not done. Even if a patient is known to you, it is still important to adhere to your hand out SOPs. These will normally say to **check the patient's name, address and/or date of birth every time** before administering or handing out medicines. These checks should be made with reference to the prescription form, with a **re-check of the labels of the dispensed medicines** for the name and quantity before hand out. When supplying medication to treat substance misuse, it is also good practice to ask the patient what dose or quantity they are expecting as an additional check. If the wrong prescription is handed out, there could be serious consequences for both the patient and pharmacist. Here are some real examples of when this error has occurred:

- A pregnant woman was given a high dose of someone else's methadone
- A man living in a hostel was given 70mls instead of 20mls, and refused to seek medical help; the pharmacist phoned the hostel every 2 hours through the night to check he was still alive
- A man who took away someone else's 560ml bottle of methadone was not contactable by the pharmacist or surgery for several days

Any one of these could have resulted in an avoidable death. Our Police CD Liaison Officers have advised that if you do administer or supply a patient with someone else's methadone and the Shared Care Services are not able to locate the patient for assessment, then the police should be involved as an urgent safeguarding support.

Bank Holiday methadone mix ups: Over Easter 2016 there were 5 incidents of methadone supply disruption due to confusion over supply dates. The Home Office approved wording for Instalment prescribing (see link below) can be mixed and matched to express the prescriber's intention;

https://www.gov.uk/government/publications/circular-0272015-approved-mandatory-requisition-form-and-home-office-approved-wording/circular-0272015-approved-mandatory-requisition-form-and-home-office-approved-wording

There is no leeway within the legislation for pharmacists to supply OST earlier than the date of the first instalment specified on an instalment prescription. Thereafter – as long as the appropriate Home Office Wording is included on the prescription—the pharmacists can make a professional decision to supply earlier than the prescribed instalment date, in order to cover bank holidays, when the pharmacy is closed. It is helpful if the bank holiday pick-up days can fit in as much as possible with normal pick up days – if in doubt, check with the Drugs team.

Recommendations for community pharmacists and staff –

- Encourage your staff to check instalment prescriptions immediately upon receipt. If they start on a day your pharmacy will be closed, then contact the Drugs Team as soon as possible to request rewriting the prescription to start on a Tuesday, Wednesday or Thursday. If necessary to start on a Monday or Friday, they could consider issuing two prescriptions. For example: one prescription for supply up to and including Tuesday; one prescription for supply starting on Wed. Subsequent prescriptions can then start on the Wednesday.
- Pay particular attention to starting dates around the Christmas 2016 period when the bank holiday falls on Tuesday.
- Please continue to be proactive and work with your Drugs Teams to ensure that your patients can easily access their OST medication appropriately.

3 day rule

There were several incidents where pharmacists supplied methadone to patients who had not picked up their methadone for 3 or more days. The reason for the 3 day rule is that patients can quickly lose tolerance when they stop taking their OST medication, and to resume on the same dose can be dangerous. It is important to contact the prescriber if 3 or more consecutive days of a prescription have been missed. The prescriber will need to assess the patient before deciding whether to continue with the current prescription, or replace it with a different dose. Please ensure that

- All staff are aware of this safety rule
- If a prescription is suspended or cancelled, there are systems in place at the pharmacy to clearly identify this to all staff

Thanks to all the pharmacists who have reported CD incidents to me, this is very important in order to share the learning and improve patient safety in relation to controlled drugs. You can contact me on 0113 8248129 or by email on ENGLAND.southwestcontrolleddrugs@nhs.net

Best wishes

Sue Mulvenna Head of Pharmacy and CD Accountable Officer NHS England South West