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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 controlled drugs for temporary patients

Following some incidents we recommend that prescribers ensure that they are only providing CDs to those patients who they can verify as being clinically appropriate.
Some examples of information prescribers should seek to obtain prior to issuing supplies are:

- Formal identification, passport, driving licence
- Formal letters from healthcare organisations indicating specific treatments and or medication
- Request details of their current GP and seek clarification about medicines and treatment
- Access to the patients Summary Care Record

Below is the guidance taken from the GMC website.
Prescribing Guidance: Sharing information with colleagues (section 33).
http://www.gmc-uk.org/mobile/14320 - Section 3

If a patient has not been referred to you by their general practitioner, you should also:

a. Consider whether the information you have is sufficient and reliable enough to enable you to prescribe safely; for example, whether:
i) You have access to their medical records or other reliable information about the patient's health and other treatments they are receiving.
ii) You can verify other important information by examination or testing
b. Ask for the patient's consent to contact their general practitioner if you need more information or confirmation of the information you have before prescribing. If the patient objects, you should explain that you cannot prescribe for them and what their options are.

CQC Update

Vigilance Sub-Group's newsletter Volume 1 Number 4
This issue focusses on fraud and theft involving CDs.
http://www.cqc.org.uk/content/use-controlled-drugs#vigilance

Patient Safety Newsletter Volume 1 Number 3
This issue focusses on risks of drug-drug interactions, drug doses in renal impairment, the safer use of naloxone and share an article on prescribing opioids for chronic pain.
http://www.cqc.org.uk/content/use-controlled-drugs#patient-safety

OTC PRODUCTS CONTAINING CODEINE

We have been advised of a growing concern for patient safety with the abuse of **OTC products containing codeine**.
Patients may try to achieve a high, or an altered state of mind by way of the codeine. Alone, this can create addiction and the ongoing related harms of misuse.
When combined with the intake of ibuprofen, paracetamol or other medications, this may lead to acute and significant harm e.g. gastric bleeds with ibuprofen and liver damage with paracetamol.
We understand that there may be a trend where patients may try to extract the codeine from the combined product.

Example cases

A patient has had multiple hospital admissions with low haemoglobin counts. This is due to blood loss arising from the quantities of ibuprofen taken to achieve sufficient codeine for their needs.

A 17-year old patient challenged by his mother advised that this is a new craze with the understanding that this will be replicated with many other younger people.

ACTION:
We advise enhanced vigilance and oversight for all OTC sales where these contain codeine.
There is no simple or single method to distinguish a legitimate OTC purchase from a purchase for abuse. We advise the usual practices of verifying use, frequency, need, symptoms etc. and declining any acute or repeat sales if you have suspicion of abuse.
If you have any concerns or intelligence relating to the abuse use, please contact your Controlled Drugs Accountable Officer :

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Sharing learning from incidents

Incident Description
A patient had their oxycontin 40mg modified release preparation switched to Reltebon 40mg modified release preparation in September by the CCG pharmacy technician. The oxycontin was removed from the present screen. Messages were put on the prescribing screen for Reltebon that this was a substitute for the Oxycontin. The patient ordered the Oxycontin from their repeat prescribing slip. Both Reltebon and Oxycontin were ordered in November. The Pharmacist dispensing the medication, identified this and contacted the surgery that both oxycodone preparations had been prescribed.

Lessons Learnt

- Review all future switches from proprietary products to branded generics
- If future changes are made then consideration to be given to retrieve existing repeat prescribing slips and issuing amended updated slips directly to the patient or their carer.
- A list of all prescribing switches that the CCG are making to be given to the prescription clerk.

Other incidents reported from recent switches

Patients changed from oxycontin to Longtec – Longtec was not recognised and prescribers had added oxycodone back onto the system so potential for patient harm from double dosing.

A similar problem was identified with Matrifen and fentanyl patches.

All prescribers, practice staff and patients (and local community pharmacists) need to be aware of when switches are made.

Another problem reported was OPTIMISE flashing up Haptasocin as a replacement for Transtec and this has been accepted, without realising that Haptasocin is a 72 hour patch whilst Transtec is 96 hours (Optimise does say this but is not immediately obvious unless the whole message is read).

The danger is patients will think their patch is no longer working and could be unnecessarily increased to a higher strength patch when in fact they would only need to change the Haptasocin patch after 72 hours.