January 2016: Issue 1

Controlled Drugs Newsletter

Happy New Year and welcome to the first NHS England Central Midlands Controlled Drugs Newsletter.

Changes to Controlled Drug Legislation

- A Home Office Circular introduced the new mandatory requisition form for Schedule 2 and 3 Controlled Drugs and a new set of approved wording for instalment prescribing.
- Use of the standardised FP10CDF requisition forms becomes a legal requirement from 30th November 2015. It is available electronically and can be downloaded from http://www.nhsbsa.nhs.uk/PrescriptionServices/1120.aspx)
- The form should be used by health professionals entitled to requisition Schedule 2 and 3 CDs in the community, including from wholesalers.
- Where CDs are transferred between pharmacies, the pharmacist receiving the supply must provide a requisition (FP10CDF) and the supplier should submit the original to NHSBSA using their private CD submission code. Both pharmacists must ensure that the correct entries are made in their respective CD registers within 24 hours. Dispensing doctors **may not** supply CDs against requisitions unless they have a MHRA wholesaler licence.
- Hospices and prisons are exempt from the mandatory requisition requirement.
- Ketamine was rescheduled from Part I of Schedule 4 to Schedule 2 to the 2001 regulations from 30th November 2015 with the effect that all the requirements applicable to Schedule 2 drugs, will apply to the use of ketamine in research, industry and veterinary and healthcare sectors from this date.
- Further information can be found on the Home Office Circular: https://www.gov.uk/government/publications/circular-027201approved-mandatory-requisition-form-and-home-office-approved-wording

NHS England Central Midlands

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New email address for the reporting of all CD incidents and concerns :
England.centralmidlands-cd@nhs.net

Sharing learning from incidents

CD incident involving Fentanyl 100microgram/hour Patches

Incident Description

- Out of hours GP carried out review and noticed that patients' medication list contained a prescription for fentanyl 100mcg/hr patches. No underlying condition which warranted this medication and summary sent to patients GP by out of hours service, containing advice to review patients medication list regarding fentanyl patches.
- Patient deteriorated, ambulance called and taken to ED and then transferred to AMU. Following a pharmacy medication reconciliation, doctor prescribed fentanyl patches. Patient discharged to a care home for rehabilitation. The 100mcg/hr fentanyl patches were dispensed and sent to the care home with other medications.
- Fentanyl 100mcg/hr patch administered in care home. Patient had a respiratory arrest, ambulance called, patient required ventilation and admission to a critical care unit.

Key Findings

- Fentanyl patches were transcribed in error to the back sheet of the patients medication list by the community pharmacy — they were never dispensed.
- Fentanyl patches dispensed by acute provider following discharge — they were never administered as were prescribed for the day following discharge.
- 100mcg/hr fentanyl patch administered in care home.

Actions/Learnings

- System for pharmacy using 'back sheets' changed across large community pharmacy provider nationwide.
- Care home implemented pain care plans and revised medication training and administration systems.
- 111 service reviewing communication sent to GPs and how to alert to GPs easily to key information.

Questions that would have stopped this incident happening:

- Community Pharmacy – 'Why are there patches on this record but no prescription?'
- GP surgery – 'Why does the OOH doctor think there are patches on this patient's prescription?'
- Acute Trust – 'Where is the patch this patient should be having?'
- Care home – 'Why can't I find the patch to remove before I put a new one on?'

CQC Update

CQC have established under the CD National Group, four sub-groups to focus on the key areas of thefts and frauds (vigilance), patient safety, policy and operational issues and prescription monitoring. They will produce quarterly newsletters to report on their findings and signpost guidance.

First issue of the newsletters from the Patient Safety sub-group and the Vigilance sub-group can be found on the CQC website (www.cqc.org.uk/content/use-controlled-drugs). These newsletters cover case studies - GP patient registration fraud, oxycodone medicine incidents and supervised consumption