Controlled Drugs: Learning from Incidents

North of England Commissioning Support

Partners in improving local health

July 2015 Issue 1

NECS supports the NHS England Area Team Controlled Drugs Accountable Officer in ensuring the safe management and use of controlled drugs within the North East & Cumbria region. Based on the commonly reported incidents and the lessons learned, we aim to share good practice across the region

Balance discrepancies

We regularly receive reports of lost tablets or capsules

Before you assume that they have been thrown away, consider:

Are all other balance correct? – do you have a corresponding discrepancy in a different formulation which may indicate a dispensing error e.g. Zomorph, MST and Morphgesic?

To reduce the likelihood of inadvertent disposal of CD medicines:

Flatten boxes before discarding

Check that all blisters are empty

Unfold patient leaflets before disposal as tablets may be trapped

Verify with a colleague that a box is empty before discarding

For liquid discrepancies

If the product is not used very often, once you have checked the volume, place the bottle in a bag and seal the bag with date, volume and signature—make sure it is tamper evident

Fully drain stock bottles and measuring cylinders/flasks

If you have found a discrepancy don't keep re-measuring as this will compound the discrepancy

Spillages

Spillages can also be a cause of anxiety, and we are often asked for advice.

If you spill a CD liquid:

Mop up the spillage with paper towels and retain all towels in a sealed bag within the CD cabinet awaiting authorised witness destruction. Label the bag to make it clear what the contents are, and that it is awaiting destruction

Follow your company SOP with regard to annotating the CD register

To reduce the risk of spillage:

Keep the bench free of clutter, making sure you have space to work

Ensure you are working on a flat surface

Secure lids tightly when you are finished as they can come loose when shaking the bottle or reaching down from the shelf

Ensure the correct capacity bottle is used when you are dispensing from Methasoft / Methameasure systems

Ensure bottles are clean on the outside, as dried liquids can cause bottles to stick to one another causing accidents, breakages and spillages when the bottle is taken down from the shelf

Have you seen the NECS Medicines Optimisation website?

http://medicines.necsu.nhs.uk/controlled-drugs/

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Common reasons for methadone discrepancies:

The most common reasons for methadone discrepancies are: overage in delivered containers, measurement slippage and wrong product selection (sugar-free dispensed but an entry made for a sugared product).

The size and direction of a discrepancy may give you a clue – overage should lead to your having more product than you expected, and it is typically of the order of 10-15ml on 500ml.

If you have a shortage in one form of methadone and an overage in the other, that suggests an incorrect product choice or a dispensing error. If you have more methadone than you should have:

- *have you missed entering a delivery?*
- *have you entered out a supply that was not made?*
- *have you entered a supply twice?*

Reporting a balance discrepancy

We require you to report all shortages to us. For overages you will need to consult your standard operating procedure

Reporting a shortage

Report your incident to the CD Team. The contact details of the CD team are shown in the box below

Whenever you report a balance error for a liquid, we need to know two facts:

- the size of the discrepancy
- details of any investigations carried out since discovery of the shortage

Correcting the balance in the register

Once we have discussed the CD shortage and all parties are happy that the discrepancy can't be resolved, we would ask you to correct the balance in the register, noting that you have reported it to us and that we have agreed to the correction.

Below is a sample register entry to cover an amendment:

Following the internal review process a discrepancy of include details (quantity, form, strength) remains unresolved. Name (Senior Medicines Optimisation Technician) or Dr Mike Prentice (Accountable Officer) was notified on date and an occurrence report submitted to Dr Mike Prentice (Accountable Officer Cumbria North East Region) on include date. New balance is include details of new balance.

Future articles / contact us:

If you need advice, or have an idea for an article to be included in a future issue, please contact one of the Controlled Drugs Team Senior Medicines Optimisation Technicians or the CD Liaison Officer:

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