Controlled Drugs: Learning from Incidents

North of England Commissioning Support

Partners in improving local health

August 2017 Issue 8

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

Increase in CD Incidents Reported on SIRMS

Safeguard Incident & Risk Management System

Across the whole of the Cumbria North East area, the number of incidents reported for 2016/2017 has increased by 11% compared to 2015/2016. *Please keep on reporting*.

NECS have a small team within Medicines Optimisation, who provide support to NHS England's Accountable Officer for Controlled Drugs. One area of support is the managing of incidents in primary care which involve controlled drugs. The team monitor and investigate all incidents reported on SIRMS by GP practices and add to SIRMS all incidents reported by other organisations, such as Community Pharmacies, Veterinary Practices, Care Homes and Dental Practices.

Number of controlled drugs incidents reported on SIRMS:

Locality / Year	15/16	16/17	Percentage increase
Northumberland Tyne & Wear	497	527	6%
Cumbria	95	112	18%
Durham, Darlington, Tees	196	235	20%

Approximately 70% of CD incidents are reported by Community Pharmacies. These relate mainly to balance discrepancies due to spillages, and to dispensing errors relating to wrong quantities or strength. Delivery of CD medicines continues to cause issues, e.g. delivery to wrong addresses because of similar names of nursing homes, street names, or incorrect postcodes.

Post-dated CD prescriptions dispensed too early

We have seen an increase in the number of dispensing errors where post-dated prescriptions have been dispensed before the date on the prescription. Practices are advised to consider highlighting the date on the delayed prescription where possible. Pharmacies are reminded to check the due date of CD prescriptions.

Practices can report an incident on SIRMS: go to https://sirms.necsu.nhs.uk
Community Pharmacies: contact the Medicines Optimisation CD Team, see contact details below.
If you suspected fraud: please contact police on 101 and NHS England, to have an alert produced and circulated on: england.pharmacyandoptometry@nhs.net

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:

Northumberland Tyne & Wear	Emma Post	0191 2172983	emma.post@nhs.net
Durham Darlington & Tees	Victoria Bennett	01642 745429	victoriabennett1@nhs.net
Cumbria	Phil Utting	01228 603050	phillip.utting@cumbria.NECSU.nhs.uk
CD Liaison Officer for all areas	Ken Dale	07919071655	ken.dale@nhs.net

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Patients with protected addresses: individuals gaining access via prescription information

Many foster carers carry a 'protected address' card for use in public places such as GP or dental practices and pharmacies to safeguard the whereabouts of some children placed in their care. We have been made aware of some individuals gaining access to these protected addresses, when prescriptions are collected / ordered on behalf of these patients.

As some pharmacies will not accept prescriptions without an address, we suggest that for patients with protected addresses, the GP practice address is used on the prescription, instead of the patient's.

Midazolam for palliative care **USE 10mg in 2ml** ***NOT*** 1mg in 1ml or 10mg in 5ml

Community nurses in both South Tyneside and Sunderland are continuing to report some prescribing of the wrong strength of midazolam by GPs, which is then being dispensed in the community without being challenged. Instead of prescribing the 10mg in 2ml as recommended in palliative patients, they are prescribing the 1mg in 1ml preparation or the 10mg in 5ml. Following one error, a patient had the incorrect dose administered.

ONLY the 10mg in 2ml midazolam should be used for palliative patients

What can happen when things go wrong when prescribing for chronic pain

Parents' view: Lessons that must be learned by all healthcare professionals

The article opposite describes parents Linda and Steve's story of their daughter Faye's sudden death following respiratory arrest. She hurt her back lifting an empty fish tank. When her pain did not resolve she had surgery, and as her pain continued, the doses and numbers of medications prescribed increased.


CONTROLLED DRUGS NEWSLETTER
SHARING GOOD PRACTICE IN THE SOUTH WEST
NHS South Region South West
April 2017
SPECIAL EDITION – FAYE'S STORY
What can happen when things go wrong with prescribing for chronic pain – lessons that must be learned by all healthcare professionals
As told by her parents, Linda and Steve
Faye (right), when she was well

The inquest did not supply the answers the parents were hoping for, and so in the article they describe how they feel that the medicines were doing more harm than good. Faye's GP practice are focusing on 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, MDS
- Mechanisms for group discussions around difficult to manage cases, including a monthly patient safety meeting to review concerns about medication

The article can be found here: http://psnc.org.uk/suffolk-lpc/wp-content/uploads/sites/108/2017/06/NHS-CD-Newsletter-Fayes-story-0617.pdf

Also, see the resources at Opiods Aware: http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

Have you seen the NECS Medicines Optimisation website?
http://medicines.necsu.nhs.uk/controlled-drugs/