

Controlled Drugs: Learning from incidents

This bulletin contains local and national CD information for shared learning.

BE AWARE: EPS SYSTEM FRAUD

A non-registered pharmacy staff member falsely returned electronic prescriptions to the NHS spine as 'not dispensed' after the individual patients had received their controlled drugs from the pharmacy. The staff member then used the original patient details at another pharmacy to obtain the supply from the returned electronic prescriptions. This was for her own use and happened on two occasions. The first prescription was for 84 Gabapentin 300mg Capsules and 224 Tramadol 50mg Capsules. The second prescription was for 56 Pregabalin 25mg Capsules and 200 Tramadol 50mg Capsules.

The pharmacy manager was alerted to the incidents when attempting to 'submit' the prescriptions for payment on EPS and the computer sounding out an error tone. Upon investigation it was established that the prescriptions had been dispensed within the pharmacy but it was also established that the further supply had been made elsewhere and payment claimed.

The police and our CD team were involved in the investigation of the incident. The staff member's employment was terminated and they were issued with a police warning linked to support within a drug rehab programme..



DELIVERING CONTROLLED DRUGS TO PATIENTS

There has been an increase in incidents across our region with deliveries of controlled drugs going missing / being stolen from patient's homes. Incidents include pharmacy delivery drivers leaving them in porches, on steps and in wheelie bins when the patient or relative is not home. Pharmacies involved in these incidents have put the following in place to avoid reoccurrence:

- Arrange a convenient delivery day with the patient when they are at home
- Ensure a signature is obtained on delivery
- If nobody is home the medication must be returned to the pharmacy and either a new delivery date arranged or the patient has to organise collection of the controlled drugs with the pharmacy

Please can we encourage ALL pharmacies where possible to put these procedures in place. Further advice is available on request.

Further guidance can be obtained in section 5v of the following document: [Guidance for the safe custody of controlled drugs and drug precursors in transit \(accessible version\) - GOV.UK \(www.gov.uk\)](https://www.gov.uk/guidance/guidance-for-the-safe-custody-of-controlled-drugs-and-drug-precursors-in-transit-accessible-version)

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Changes to the Controlled Drug Reporting Website

The Controlled Drug reporting website – www.cdreporting.co.uk has undergone a review and development process and as a result, the website has been upgraded and some of the reporting modules have been re-designed or modified based on comments from users and to make the reporting modules compatible with other national reporting systems. This is a very exciting re-launch that has been designed to improve upon the way the reporting of concerns, incidents and other controlled drug functions currently happen and to further standardise processes across regions to comply with the Dame Janet recommendations from the Shipman enquiry. The CD Reporting website changed on Thursday 1 December 2022 and from this date there will be several more updates and changes to improve this reporting process.

If you require more information on what the reporting website offers please click on the link:

[NHS England — North East and Yorkshire » Controlled Drugs Accountable Officer](#)

How well do you know your patients?

A drug and alcohol service praised a pharmacy involved in the following scenario: The service received a telephone call from a pharmacist at the clients' pharmacy, it was a welfare call. The client had been to collect a prescription and his hand was very swollen, requesting to collect antibiotics however at the time of presentation there was no information on the spine. So left straight away. Pharmacist was concerned as client does not look well, appeared gaunt and yellow and they were concerned for his welfare. This information was passed to the client's keyworker who contacted the patient and sought him medical attention as he needed to attend hospital.

This demonstrates good practice and concern from the pharmacist involved as she knew her clients very well and was concerned for their welfare.

Topical testosterone (Testogel): risk of harm to children following accidental exposure

Premature puberty and genital enlargement have been reported in children who were in close physical contact with an adult using topical testosterone and who were repeatedly accidentally exposed to this medicine. To reduce these risks, advise patients to wash their hands after application of topical testosterone, cover the application site with clothing once the product has dried and wash the application site before physical contact with another adult or child.

Single Point of Contact (SPOC)

The Criminal Justice & Community Single Point of Contact (SPOC) directory consists of contact details of Criminal Justice organisations and Community Drug and Alcohol treatment providers throughout England & Wales. The main purpose of this directory is to promote successful communication and pathways between organisations for those individuals moving from Criminal Justice organisations to Community providers and vice versa as well as supporting effective Continuity of Care across the system.

If you need advice, or would like an article to be included in a future issue, please contact the relevant member of the Controlled Drug Team below, for your area:

Northumberland Tyne & Wear and North Cumbria	Emma Post	0191 2172983	emma.post@nhs.net
Durham Darlington & Tees	Victoria Bennett	01642 745429	victoriabennett1@nhs.net
Yorkshire and Humber	Mandi Silver		england.yhcdao@nhs.net
CD Liaison Officer for all areas	Ken Dale	07919071655	ken.dale@nhs.net
Lead CDAO for North East & Yorkshire Area	Gazala Khan		england.yhcdao@nhs.net

