Controlled Drugs: Learning from Incidents

North of England Commissioning Support

Partners in improving local health

September 2019 Issue 13

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

Communication between Pharmacies and Substance Misuse Services

REMINDER: All community pharmacies should be notifying substance misuse services if a client has missed 3 consecutive doses. It is the pharmacies responsibility as part of the SLA with NHSE, when providing the substance misuse service.

Good practice for communication:

- Notify the substance misuse service if attendance to the pharmacy is erratic.
- Keep a record of phone calls regarding clients to the substance misuse service - including the person you have spoken to (i.e. communication log/diary).
- If a message has been received from a hospital regarding the admission of a client and said client then attends for prescription, please ensure you contact the hospital to confirm clients discharge (as some hospitals have an at home policy which does not mean they have been discharged or not received their dose.)

DO NOT ACCEPT CLIENTS WORD OF DISCHARGE

Signposting to Specialist Pharmacies for 'End of Life' (EOL) Medication:

- If you **are not** a specialist pharmacy please ensure you are aware of the specialist pharmacies in your area.
- If you **are** a specialist pharmacy, please ensure you are keeping the required items and appropriate stock levels of medication.
- If you receive a prescription for EOL medication and are unable to fulfil this, please signpost to the nearest specialist pharmacy.
- **GP practices** also need to be aware of the list of specialist pharmacies and to signpost DN's and relatives appropriately.

DRUG INFORMATION PLEASE BE AWARE:

- **Oxycodone 5mg/5ml liquid** - Please check the expiry date once opened as some brands (including Oxynorm) now only have a 30 day expiry.
- **Methylphenidate** - BNF guidance states: 'Different versions of modified-release preparations may not have the same clinical effect. To avoid confusion between these different formulations of methylphenidate, prescribers should specify the brand to be dispensed.'

REMINDER FOR GP PRACTICES

If you haven't already done so, please can you complete and submit the online CD Declaration. All PM's received a link and password in June via email. If you did not receive this, please contact our team: england.cumbrianortheast-cds@nhs.net

Have you seen the NECS Medicines Optimisation website?

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

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Reporting Controlled Drug Incidents

Any incident involving CDs (Schedule 2 to 5) **MUST** be reported to the Controlled Drugs Accountable Officer as soon as possible.

Community pharmacies report CD incidents to england.cumbrianortheast-cds@nhs.net or to the Controlled Drugs MO Team - see contact details below.
GP practices report CD incidents via SIRMS https://sirms.necsu.nhs.uk/

Timely reporting of any CD incident is essential to allow the CD Team to support and advise where appropriate during any investigation. Ideally CD incidents should be reported within 48 hours. Examples of incidents that should be reported are as follows: Balance discrepancies, spillages, breakages, lost/stolen medication/prescriptions, dispensing/administration/prescribing errors, drug seeking behaviour, delivery errors, inadvertent destruction of stock CDs and any concerns regarding individual professionals.

Common Dispensing Incidents

Methadone incidents:

When dispensing methadone prescriptions please ensure the following:

- A valid prescription is present
- The client **has not** missed 3 consecutive days
- Correct formulation is chosen
- All prescription details correspond to the client by confirming - name, address, D.O.B and expected dose
- End date of prescription

Tramadol incidents:

When dispensing tramadol prescriptions please ensure the following:

- Correct formulation is chosen
- Correct strength is chosen
- Correct product is chosen
- All prescription details correspond to the patient by confirming - name, address, D.O.B.

Please note: There has been an increase in incidents where **Tamsulosin** has been dispensed instead of tramadol. A good practice recommendation would be to separate these products on your shelves, highlighting the name of the product so it stands out to the dispensers.

Pregabalin and Gabapentin incidents:

Since the rescheduling of pregabalin and gabapentin to a schedule 3 controlled drug, there has been frequent dispensing errors, where the wrong product has been given i.e. gabapentin has been dispensed instead of pregabalin and vice versa.
Good practice would be to follow the same advice given above for tramadol incidents.

If you need advice, or would like 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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