Controlled Drugs:
Learning from Incidents

North of England Commissioning Support

Partners in improving local health

July 2020 Issue 16

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

Incident Reporting

As we are slowly getting back to working as normal following the extremely stressful period during the CoVid pandemic, can we remind you all to return back to reporting all errors and incidents involving Controlled Drugs.

Examples of incidents that should be reported include:

- Fraudulent / forged prescriptions
- Lost / stolen prescriptions and /or medication
- Controlled drug balance discrepancies
- Dispensing errors involving controlled drugs
- Prescribing errors involving controlled drugs
- Spillages

Community pharmacy incident reporting forms can be found on the CD page of the NECS Medicines Optimisation Website (address at the bottom of the page). Or by contacting a member of the team.

GP practices report any incidents using SIRMS https://sirms.necsu.nhs.uk/

CD Destructions—The team is recommencing destruction requests and visits to premises to witness the destructions. Therefore, please notify the team of any requests for authorised witness destructions of schedule 2 CD stock. We may contact you prior to the visit to agree COVID -19 safe arrangements. During the visit we will be wearing PPE and would expect the staff to maintain social distancing. CD Destruction request forms are available on our website

Serious Incidents—Within the North East and Yorkshire Area Team, there have been three reports this quarter of **Morphine Sulfate 10mg/5ml Oral solution** being administered as intravenous and subcutaneous injections. Fortunately no serious harm was caused. After investigations the most common cause was that the correct syringe was not used to draw up the oral solution—i.e. an iv syringe was used instead of an oral syringe. Other factors were staff errors due to insufficient training. Action plans have been implemented, however we wish to raise awareness of these incidents.

If dispensing or prescribing oral solutions please make sure that the organisation have the correct equipment to administer the solution, especially if doses are small.

Have you seen the NECS Medicines Optimisation website?

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

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Learning from Incidents—Substance Misuse Service

Currently the team become aware of substance misuse incidents from the substance misuse services (SMS) and then have to contact the pharmacy for further information. Pharmacies are still required to notify the NHS England CDAO of any incident involving a substance misuse client as well as the substance misuse service, including missing / lost prescriptions. (see the front of the newsletter for the type of incidents that should be reported to the team).

Some of the common type of incidents that we are notified about:

Prescription Issues

Pharmacy staff should be reading the prescription instructions thoroughly

- Is this the correct client?
- How many doses are required?
- Is the client due a supervised or carry out dose?
- Has the dose changed, if yes does the label reflect the new volume?
- Has the prescription been annotated correctly following the supply?
- Has the pharmacy received any communication to void the prescription and has this been followed through?

Missed methadone doses

We are still receiving reports of no communication to substance misuse services if clients miss 3 consecutive days. If the third consecutive day will fall across a weekend, please contact the service on the Friday prior. This requirement is part of the terms of service, when providing the substance misuse service.

Methadone Sugar-Free Mixture / Methadone plain Mixture / Physeptone cross-over

One of the most frequently reported CD incidents received, actions implemented include:

- To sort prescriptions into SF, plain and brand before dispensing, highlighting in different colours if necessary
- Only have one form of methadone mixture out of the CD cupboard at a time
- Pharmacies with more than one CD safe keeping SF and plain in separate safes

Selling inhalers—We have received reports of patients selling inhalers, usually the reliever. When prescribing or dispensing inhalers for patients, check to see if they are using more than usual. Pharmacy staff can notify the GP practice if they think this is happening and GP practices may want to review the patient to asses the inhaler use.

Injecting Benzodiazepines– It has been reported in South Tyneside that some clients have been crushing benzodiazepine tablets, mixing with boiled water and injecting. This can cause some serious symptoms such as: blue mouths or tongues, froth around the mouth, drowsy or slurred speech, appear to be nodding off when sitting or standing, clumsy or unsteady on their feet, walking with a limp or noticeable swelling in their limbs.

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:

Northumberland Tyne & Wear and North Cumbria	Emma Post	0191 2172983	emma.post@nhs.net
Durham Darlington & Tees	Laura Luke	01642 745429	l.luke@nhs.net / emma.post@nhs.net
CD Liaison Officer for all areas	Ken Dale	07919071655	ken.dale@nhs.net