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Controlled Drugs: Learning from Incidents

NHS
North of England Commissioning Support

Partners in improving local health

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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

LEAN

Durham Constabulary have seen reports of individuals trying to obtain high strength cough medicines in large quantities during the Covid pandemic. This has been localised in certain areas across the UK. It is thought this is linked to a substance referred to as LEAN. **Lean is also known as purple drank, purple lean, sizzurp, dirty sprite, and lean drink**. It is made from a combination of high strength cough medicine, carbonated soft drinks, and hard, fruit-flavoured sweets/candy. The popularity of the substance has increased amongst young people due to it being referenced by several high profile artists in song lyrics. Alongside this is has been linked to the death of several celebrities in America.

If you are aware of any incidents/issues regarding this please contact your local constabulary.

CRUSHING BUPRENORPHINE TABLETS

It is evident that many pharmacies are still crushing buprenorphine tablets even though prescribers are not indicating this on prescriptions PLEASE only crush the buprenorphine tablets if the prescriber has requested this on the prescription. Buprenorphine crushed is an unlicensed preparation.

Community Pharmacy Investigations

If a pharmacy has an issue with a staff member involving a crime. It is imperative that not only the staff members organisation/company be informed but also the **Police and GPhC (if applicable)** should be informed. Past incidents have shown staff being dismissed following such actions but leaving it too late or lack of evidence for police to take action/support the pharmacy.

CANCARD

The Department of Heath and Social Care (DHSC) and Home Office are very clear that they do not endorse and/or support the use of this card.

The individuals within a number of organisations who do endorse the card, are not speaking on behalf of their organisation (for example the Police).

The view remains that the cannabis product should be prescribed (and supplied) in line with the 2018 regulations in order for the Cannabis to be in lawful possession. It is recommended that GPs **do not confirm** a diagnosis but ask CanCard to contact the prescriber of the cannabis product as it is **NOT** prescribed in primary care.

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

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CPCS - INAPPROPRIATE SUPPLIES

There has been incidents reported locally regarding multiple requests for CDs from the same patients through the urgent medicines strand of the CPCS. These requests are often coming through from NHS 111 Online and there is no failsafe in their systems, which prevent a patient from making such requests numerous times, even within the same day.

The CPCS Toolkit states “pharmacists must be vigilant and bear in mind that some patients may try to use the CPCS to gain inappropriate supplies” and “the pharmacist needs to balance the potential for mis-use versus the need and the impact on the patient of not supplying a medicine. It is particularly important to check the patient’s NHS Summary Care Record (SCR)...”.

The GP must be notified of all supplies made to a patient as soon as possible. The PSNC website (CPCS FAQs) note that “The urgent supply will only be visible on the patient’s SCR if the information is received from the pharmacist and added to the patient’s record at the GP practice as an acute or repeat item”. It will appear as ‘prescribed elsewhere’ under the relevant acute or repeat list. Any concerns about multiple users should be flagged to the GP via the feedback process and the GP can add a ‘Special Patient Note’ to the patient’s care record which would flag this concern to NHS 111 when future requests are made.

For all schedule 4 or 5 CDs the maximum quantity that can be supplied is **five days** treatment.

The CD Medicines Optimisation Team have raised this loop hole with 111 NHSE and will feedback any actions accordingly at the next CD LIN Meetings in February and the next issue of the CD Bulletin.

If pharmacies have any concerns over drug seeking behaviour, please contact the patient’s surgery to make them aware.

DRUG AWARENESS

Gabapentin / Pregabalin - If you already have a Look-Alike Sound-Alike (LASA) procedure for your pharmacy, ensure that gabapentin/pregabalin are included. Some pharmacies have also added shelf stickers reminding staff to double check they have picked the right product.

Concerta / Xaggitin**/ Lisdexamfetamine -** Recently there have been a number of balance discrepancies reported involving the afore mentioned medication. On investigation it has been found that the quantity in the sealed original container has contained 1 more or 1 less. Actions: When opening a sealed container please count the number of tablets in the bottle **before** dispensing.

RETURNED CD STOCK DISPENSING ERROR

When a Schedule 2 CD has been dispensed to a patient in error and returned to the pharmacy they are **NOT TO BE TREATED AS A PATIENT RETURN.** Rather the stock must be returned into the registers and highlighted as an error and segregated for destruction by an authorised witness. This is due to the fact that the returned incorrect medication is still classed as pharmacy stock. The running balance should be annotated with the quantity segregated (in the same way as out of date stock) until destroyed in the presence of an authorised witness.

NEW NORTH CUMBRIA CONTROLLED DRUG CONTACT

You may already be aware that Phil Utting—Senior Medicines Optimisation Technician in North Cumbria has moved on to pastures new. We wish him all the best in his new role and going for-ward Emma Post will now be managing the North Cumbria CD incidents, Destructions and que-ries (contact details on page 3)

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LEARNING FROM CORONER REPORT

A CCG received a coroners letter regarding an incident that a young cancer patient was involved in. The patient had reportedly taken an accidental overdose of oral morphine solution which sadly resulted in the patient passing away. This occurred during COVID and resulted in the patient not being seen face to face. A shared lesson learnt is now going to be put in place, and response will be sent back to coroner,

The report has also been sent to Department of Health and discussed confidentially at the CCG exec.

Lessons Learnt:

Tighten up script instructions on opiate scripts, to include a specific statement of the maximum quantity to be taken in 24 hours, with strict instructions about dose measurement (a particular point for liquid medication).

Find out if it is possible to remove the script instruction of "as directed" from all present and future scripts. This will apply to every script, and is not specifically a point about opiates.

Increase the use of default instructions for opiate scripts. To be picked up with NECS

Prescriptions for all new instant-release opiates to be acute scripts for at least 3 months before a prescriber can decide that it is safe for them to move to a repeat script. Look into whether it is possible to set up an alert system as part of this. Initial patients to be reviewed within 12 weeks.

Audit all repeat opiate scripts.

Undertake a medication review every 3 months of all opiate scripts.

Practice pharmacist to produce webinar based on incident and CROP data report for all prescribers within the practice. All prescribers will be expected to attend or view the webinar

FRAUDULENT PRESCRIPTIONS

Community Pharmacies – if you receive a prescription which has been altered in any way that is not counter-signed by the prescriber or a potential fraudulent prescription - **DO NOT** issue any items on the prescription. Inform the prescriber that the prescription has been altered and **A NEW PRESCRIPTION** is required in order to supply the item to the patient. The prescription **MUST NOT** be handed back to the patient and **MUST BE KEPT** in case the police require the original.

Prescribers – if you are notified by a pharmacy that a prescription has been altered by the patient, please **DO NOT** request the pharmacy to issue the items and quantities that were prescribed. The pharmacy will require a **NEW PRESCRIPTION.**

Any prescription that is altered by persons other than the prescriber is an illegal prescription and **CAN NOT** be dispensed.

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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