

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

CAUTION: OVER ORDERING OF CDS ON SYSTMONE

Background

A Patient requested a number of prescriptions for tramadol and co-codamol online, with the prescriptions going to an online pharmacy for dispensing. The patient flagged that he was able to over order these drugs on a regular basis.

All medication was entered correctly within the clinical system. Both tramadol and co-codamol were on 'irregular repeat' within the SystmOne (S1) clinical system, then there was no warning notification that the item had been issued recently.

An audit of all patients on tramadol and co-codamol confirmed that there was a system error/issue, that when medication is on repeat via an 'irregular repeat template within S1' then no warning notifications regarding timings of previous issues flagged up. It was also noted that the irregular repeat template was not searchable.

A protocol can be used alongside the irregular repeat template. The protocol is drug specific. The practice prioritised putting the protocol in place for controlled drug medication initially and will expand this to other medications issued on an irregular repeat template.

The practice have raised the irregular repeat template issues with the system supplier, to request a development of the system to ensure warning notifications be put in place. This would negate the need to have a protocol to work alongside the irregular repeat template. The protocol needs to be activated for all staff who will be involved in the process of repeat prescribing.

Dispensing Pharmacy

All prescriptions requested by the patient went to the same online pharmacy for dispensing. The online pharmacy patient medication record has a notification that pops up if the medication has been dispensed for the patient within the last 7 days. Different pharmacists clinically screened the prescriptions, and due to human error the message was missed by a pharmacist. The pharmacy have under taken training of staff and requested development changes from the supplier of their patient medication records to prevent recurrence.

Shared Learning and Actions

No notifications of previous issues will appear for any medication issued on an irregular repeat template in S1. This may lead to over ordering of medication.

All practices on S1 must check if they use the irregular repeat template and if so, there is a system in place that notifies of previous issues in line with practice repeat prescribing protocols.

A drug specific protocol can be used alongside the irregular repeat template to create a notification. Details and screen shot are below:

The image shows two screenshots from the SystmOne clinical system. The left screenshot displays the 'Irregular Repeats Alert' configuration window. It includes a 'Trigger' section with a list of products: Tramadol 50mg modified-release tablets, Tramadol 75mg modified-release tablets, ramadol 12 hour modified release tablets 100mg, ramadol 12 hour modified release tablets 150mg, ramadol 12 hour modified release tablets 200mg, ramadol 24 hour modified release tablets 100mg, ramadol 24 hour modified release tablets 150mg, ramadol 24 hour modified release tablets 200mg, Tramadol 300mg modified-release tablets, Tramadol 400mg modified-release tablets, Tramadol 50mg capsules, and Tramadol 100mg/2ml solution for injection ampoules. Below this is a 'Version History' table:

Date	Person	Event	Version
21 Jun 2021 11:24	Mr Scott	Creation	N/A
	Greenw...		
21 Jun 2021 12:06	Mr Scott	Published	1
	Greenw...		
30 Jun 2021 13:20	Mr Scott	Amended	2
	Greenw...		

The right screenshot shows a workflow diagram for the 'Irregular Repeats Alert'. It starts with a 'Start' button, followed by a 'Go' button, then an 'Information' box, and finally a 'Next' button. A note below the 'Information' box reads: 'Please check whether this is an irregular repeat template. If so you MUST check the alert from the alerts history.'

PHARMACY SECURITY

Supermarket Pharmacy Barriers - A number of incidents have been reported where staff/members of the public have gained access to pharmacies within supermarkets due to barriers being easy to jump/climb over. Resulting in thefts due to easy access to medication. Please can we ask that **ALL** pharmacies within supermarkets review their security to ensure this is not possible going forward. If you would like help or advice regarding this please contact Ken Dale CDLO at ken.dale@nhs.net

Pharmacy Break-ins - In the unfortunate event a pharmacy is broken into, some alarm systems require two activated sensors before the police are notified. Consideration should be given to the police being contacted when one sensor is activated. There has been an increase in suspects coming through the roof space to enter pharmacies. Please ensure your security systems and sensors are located appropriately within your pharmacies to ensure the police are alerted of intruders and therefore respond effectively if this were to happen.

Prescriptions - If a pharmacy has made a dispensing error, **DO NOT** ask GPs for a new prescription to cover the error. The GP is not responsible for the error the pharmacy has made and prescriptions should not be submitted for payment were such errors occur..

Fraudulent Prescriptions - DO NOT DISPENSE. Do not hand the fraudulent script back to the patient. Inform the police and take a photocopy of the script as the police may seize the original as evidence. If your pharmacy has CCTV fitted, keep all relevant footage for the police.

DISPENSING PRESCRIPTION REMINDERS

- When handing out prescriptions **ALWAYS** check the patients address, name D.O.B and dose if Methadone/Buprenorphine. If a different person/representative is collecting the medication on their behalf, write the persons name on the back of the script for reference. If you don't recognise them ask for I.D.
- CD prescriptions only have a 28 day expiry. **ALWAYS** check the prescription date before handing out to the patient.
- We've seen an increase in Methadone handout incidents, where Methadone is being dispensed and handed out with an out of date prescription. You **MUST** check the end date of a prescription to see if its 7 or 14 days, don't just assume it's a 14 day script.
- There has also been an increase in incidents where expired CDs have not been segregated as procedure (for destruction) and have been dispensed to the patient. It is **ESSENTIAL** that all expired medication is segregated either in a separate CD cabinet or clearly identifiable so as to reduce the risk of that medication being dispensed.
- CD register entries should **NOT** be made until the actual medication has been given out to the patient. If the CD is being delivered via a pharmacy delivery driver then a clear audit trail must be in place. Once the CD has been delivered/handed to the patient, an entry is then made into the CD register. Items not delivered can be returned to stock.

Supplying Controlled Drugs via CPCS

As a Controlled Drug (CD) Team we are regularly reviewing emergency supplies of CDs made by your pharmacy/company as part of the Community Pharmacist Consultation Service (CPCS). We have seen in many areas, pharmacies supplying **HUGE** quantities of CDs that go way beyond what the Human Medicines Regulation (HMR) 2012 states:

“for a prescription only medicine shown in column 1 of the following table, the quantity of the product that is sold or supplied does not exceed that shown in column 2 for that prescription only medicine—”

<i>Prescription only medicine</i>	<i>Maximum quantity</i>
A prescription only medicine that— (a) is a preparation of insulin, an aerosol for the relief of asthma, an ointment or cream, and (b) has been made up for sale in a package elsewhere than at the place of sale or supply.	The smallest pack that the pharmacist has available for sale or supply.
An oral contraceptive.	A quantity sufficient for a full treatment cycle.
An antibiotic for oral administration in liquid form.	The smallest quantity that will provide a full course of treatment.
A controlled drug within the meaning of Schedule 4 or 5 of the Misuse of Drugs Regulations 2001 or Schedule 4 or 5 of the Misuse of Drugs Regulations (Northern Ireland) 2002.	Five days' treatment.
Any other prescription only medicine.	30 days' treatment.

We will be following up all supplies that have quantities of more than 5 days and will be asking for justification in the way of a CD report/ investigation.

May we advise that all pharmacy staff including locums are made aware of the HMR and issue only 5 days of CDs when using the CPCS.

Please find the link below for the HMR 2012:

<https://www.legislation.gov.uk/uksi/2012/1916/made>

Please email us if you would like support on this or would like to discuss this further.

GP PRESCRIBING

If a GP requires a dosette box to be supplied WEEKLY for their patient, then a 7 day prescription is required. If the pharmacy receive a script for 28 days for dosette boxes then all 4 boxes will be supplied together. You cannot do instalment prescribing on EPS.

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 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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