NHS ENGLAND & NHS IMPROVEMENT
MIDLANDS (LINCS, LLR & NORTHANTS)

Controlled Drugs Newsletter

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Controlled Drugs Accountable Officer

Bhavisha Pattani

CD Team contact details:

England.centralmidlands-cd@nhs.net

0113 824 9614
0113 824 8678

2. Opioid Training Module for Pharmacy Professionals

An opioid learning module is available on the Centre for Pharmacy Postgraduate Education (CPPE) gateway page, for pain, under core/foundation learning, through the MHRA.

Registered pharmacy professionals can access this through the CPPE gateway at

https://www.cppe.ac.uk/gateway/pain

The module is also available on the MHRA website for all at ***http://www.mhra.gov.uk/opioids-learning-module/con143740***

IN THIS ISSUE:

Welcome to the NHSE & NHSI Midlands Update

1. Controlled Drug Pharmacy Visits

NHS England and NHS Improvement is required to carry out periodic Controlled Drug Formal Reviews with Community Pharmacies within Central Midlands. The purpose of conducting the CD formal reviews is to ensure that all aspects relating to the prescribing, monitoring, safe management and disposal of all schedules of CDs, including processes, within the pharmacy is in line with regulations.

A member of the Controlled Drugs Team contacts the pharmacy to arrange a convenient time for the review to take place. The Responsible Pharmacist and/or Pharmacy Manager should be available for the review.

Documentation supporting these processes, including Standard Operating Procedures for Controlled Drugs, are examined as part of this review. The Controlled Drugs Team requires copies of current Controlled Drugs SOPs for reference at the meeting so should be in place at the pharmacy and easily accessible for the Controlled Drugs Team.

The regulations state that all healthcare organisations, including the independent sector, are responsible for assuring compliance to legislation around the safe management of CDs. Safe management must be an integral part of clinical governance processes.

Duty of collaboration is a requirement of the CD Regulations and requires responsible bodies to co-operate by sharing information about healthcare professionals that relate to the management and use of CDs. This will involve identifying cases where further investigation and action may be required.

Concerns of any aspect of the safe management of controlled drugs must be reported in the first instance to the Controlled Drugs Accountable Officer.

3. Substance Misuse 3-Day Rule

There has been some confusion around the 3-day rule for substance misuse clients prescriptions and the rules not being followed, the Drug and Alcohol misuse service have supplied the statement below set out in the SLA:

"If the client misses three consecutive doses the pharmacy must contact the Drug and Alcohol Services and discuss the appropriateness of dispensing the dose."

If a client has missed collecting three consecutive doses and it is not possible for the pharmacy to speak with the Drug and Alcohol Services at that time, as it is outside normal opening hours, the pharmacy will not dispense the dose.

4. CQC Nigel's Surgery 28: Management of Controlled Drugs Update

The CQC have updated their guidance on the safe management of CDs

(https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-28-management-controlled-drugs)

This guidance is aimed at GP practices and summarises the current requirements and provides some practical guidance for practices.

5. Case Study 1

A care home patient was prescribed Pregabalin 300mg capsules twice daily, but the pharmacy dispensed Gabapentin 300mg capsules twice daily in error. The patient received their medication in a monitored dose system (MDS) for three weeks before the error was noticed. As a result, the patient suffered increased seizures. The pharmacy was contacted, and the correct medication was dispensed and delivered.

* **What are the key issues in this case?**
  - Wrong drug dispensed
  - Checking procedure not followed
  - Error not picked up for three weeks
  - Patient suffered an increase in seizures

* **What key actions/learnings were taken following this incident?**
  - Warnings placed onto the patient's PMR to warn of previous error
  - Warnings placed on the drug entries on PMR to warn of the potential for confusion
  - All staff appraised on this error and extra vigilance urged

6. Case Study 2

As part of a quarterly audit a patient was identified who had been prescribed excess quantities of MST 10mg tablets.
A patient received a prescription for 224 MST 10mg at a dose of 4 tablets twice daily. The rest of the patient's medication had been changed to weekly prescriptions, however the quantity of the MST was not adjusted. The patient received 224 MST 10mg tablets every week instead of monthly.
This was highlighted to the practice and they were asked to discuss this incident at their clinical meeting and reflect any learnings.
The pharmacy was contacted to check what quantities had been dispensed. The information supplied didn't match the information taken from EPACT.

* **What are the key issues in this case?**
  - MST quantity not reduced to reflect weekly prescriptions
  - GP not checking quantities prescribed
  - Quantity not queried by the pharmacy
  - Large quantity of CDs dispensed to patient over a 3-month period

* **What key actions/learnings were taken following this incident?**
  - When the MST incident came to light the surgery contacted the dispensing pharmacy to inform them of the prescription error. The pharmacist reassured the surgery that only the weekly quantity of MST was dispensed to the patient on each occasion and not the error quantity.
  - Practice staff have been instructed to check with a clinician in the event that there are any queries concerning medication quantities / frequency and furthermore instructed that no changes are to be made to frequencies or quantities except under clear instructions from a GP.
  - A list of commonly prescribed Controlled Drugs has been given to practice staff as a quick reference guide for the purpose of identifying Controlled Drugs. This list is supplementary to the `CD' annotation within the clinical system which clearly identifies CD medicines within the patient's electronic medical record.
  - In addition to the above `in-built' alert message in the clinical system, the prescribing calculator is also being activated (instead of relying upon manual calculations where changes to frequency and/or quantity are necessary).
  - An audit of controlled drugs was also performed. From this audit the Practice is maintaining a list of patients who warrant closer observation and/or more frequent medication reviews with a clinician (GP, surgery clinical pharmacist and if appropriate a hospital or community-based specialist).
  - Pharmacy intervention should have been made by the pharmacy alerting the GP practice about the quantity error and getting the prescription changed.

Incidents and Concerns

All incidents and concerns raised involving CDs must be reported to the CD Accountable Officer. Concerns may include patients potentially misusing or abusing drugs, prescribing concerns, dispensing concerns etc.

To report all CD incidents, concerns or to request a CD destruction visit, please use the CD online reporting tool available at

www.cdreporting.co.uk

7. Requesting a CD Destruction

For all authorised CD destruction visits :

- **All CD destruction requests should be made via the On-line Reporting Tool**
- ***www.cdreporting.co.uk*** **using the options - Reporting Forms – Destruction Request**
- **Please ensure you have the following in place:**
  - **Denaturing Kits**
  - **Gloves & mask if necessary**
  - **Medicines waste disposal bin**
- **All items to be destroyed are recorded in the CD register**
- **The quantities have been checked and are accurate**
- **NHSE & NHSI are only providing a witness to the destruction and are not able to assist with the destruction process**
- **Any CDs returned by patients or carers should have already been destroyed**