

# CONTROLLED DRUGS NEWSLETTER

SHARING GOOD PRACTICE IN THE SOUTH WEST



December 2016

## Hand out Errors in Community Pharmacies

The handing out of medication to the wrong patient continues to be a common error.

Most of the hand out errors that have been reported to us have involved giving methadone to the wrong patient, with 15 cases of this happening between January and July this year. There were also 8 hand out errors which involved other CDs not prescribed for the treatment of substance misuse. These had all occurred because proper checks involving the dispensed medicine, the prescription and the identity of the patient were not carried out.

Even if a patient is known to you, it is still important to adhere to your hand out SOPs. These will normally say to **check the patient's name, address and/or date of birth every time** before administering or handing out medicines. These checks should be made with reference to the prescription form, with a **re-check of the labels of the dispensed medicines** for the name and quantity before hand out. When supplying medication to treat substance misuse, it is also good practice to ask the patient what dose or quantity they are expecting as an additional check.

If the wrong prescription is handed out, there could be serious consequences for both the patient and pharmacist. Here are some real examples of when this error has occurred:

- A pregnant woman was given a high dose of someone else's methadone
- A man living in a hostel was given 70mls instead of 20mls, and refused to seek medical help; the pharmacist phoned the hostel every 2 hours through the night to check he was still alive
- A man who took away someone else's 560ml bottle of methadone was not contactable by the pharmacist or surgery for several days

Any one of these could have resulted in an avoidable death. Our Police CD Liaison Officers have advised that if someone else's methadone is administered or supplied to a patient and the Shared Care Services are not able to locate the patient for assessment, then the police should be involved as an urgent safeguarding support.

## Bank Holiday methadone mix ups

Over Easter 2016 there were 5 incidents of methadone supply disruption due to confusion over supply dates. The Home Office approved wording for Instalment prescribing (see link below) can be mixed and matched to express the prescriber's intention;

There is no leeway within the legislation for pharmacists to supply OST earlier than the date of the first instalment specified on an instalment prescription. Thereafter – as long as the appropriate Home Office Wording is included on the prescription—the pharmacists can make a professional decision to supply earlier than the prescribed instalment date, in order to cover bank holidays, when the pharmacy is closed. It is helpful if the bank holiday pick-up days can fit in as much as possible with normal pick up days – if in doubt, check with the Drugs team.

Recommendations for community pharmacists and staff –

- Encourage your staff to check instalment prescriptions immediately upon receipt. If they start on a day that your pharmacy will be closed, then contact the Drugs Team as soon as possible to request rewriting the prescription to start on a Wednesday or Thursday for example. If it is necessary to start on a Monday or Friday, issuing two prescriptions could be considered. For example: one prescription for supply up to and including Tuesday; one prescription for supply starting on Wednesday. Subsequent prescriptions can then start on the Wednesday.
- Please pay particular attention to starting dates around the Christmas 2016 period when the bank holiday falls on a Tuesday.
- Please continue to be proactive and work with your Drugs Teams to ensure that your patients can easily access their OST medication appropriately.

## 3 day rule

There were several incidents where pharmacists supplied methadone to patients who had not picked up their methadone for 3 or more days. The reason for the 3 day rule is that patients can quickly lose tolerance when they stop taking their OST medication, and to resume on the same dose can be dangerous. It is important to contact the prescriber if 3 or more consecutive days of a prescription have been missed. The prescriber will need to assess the patient before deciding whether to continue with the current prescription, or replace it with a different dose. Please ensure that

- All staff are aware of this safety rule
- If a prescription is suspended or cancelled, there are systems in place at the pharmacy to clearly identify this to all staff

## Presentation of Fraudulent Prescriptions

Recently there have been a number of fraudulent prescriptions presented at community pharmacies in Bristol. These had been typed onto blank printer FP10 prescription forms which had been stolen from a surgery. They were written for fictional elderly patients for diazepam, nitrazepam and zopiclone. The drug names were sometimes spelt incorrectly and prescribed at much higher dose than would normally be expected for an older person. The prescriptions sometimes included the use of awkward phrases such as ‘nightly’ and handwritten

annotations. The individuals presenting these prescriptions purported to be collecting them on behalf of elderly relatives. These fraudulent prescriptions were generally presented at pharmacies out of hours when it wasn't possible for the pharmacist to corroborate the prescriptions with the surgery. On two occasions the prescriptions had been 'snatched back' when the pharmacist refused to dispense them and were then later presented again at other pharmacies.

When presented with what is believed to be a fraudulent prescription out of hours when it is not possible to corroborate the prescription with the prescriber, we would ask pharmacists to be aware of the possibility that the prescription could be snatched back and to copy the script if you can and retain any CCTV footage. Please ensure that the personal safety of staff is paramount at all times.

To reduce the chance of a fraudulent prescription which has been 'snatched back' being dispensed at another pharmacy, it has been suggested by one of our local CD Liaison Police Officers that the pharmacist at the pharmacy where the prescription was originally presented can write the words:

**'Presented at (*name of pharmacy*) on (*date*)'** at the top of the prescription form.

## 30 Days' Supply

Following the recent monitoring of local CD prescribing, it was noted that a number of prescriptions had been written for up to 2 months' treatment. Although it is not a *legal* requirement, there is a strong recommendation that prescriptions for Schedule 2, 3 and 4 CDs are limited to the quantity necessary for up to 30 days' treatment.

This is a good practice requirement rather than a legal requirement because there may be circumstances where there is a genuine need to prescribe more than 30 days' supply.

In circumstances where the prescriber believes that a supply of more than 30 days' medication is clinically indicated and does not pose an unacceptable risk to patient safety, the prescriber should:

- Make a note of the reasons for this in the patient's notes
- Be ready to justify the decision if required

## Emergency Pharmacy Use of FP10 CDF Requisition Forms

An incident was reported to us recently where a prescription was presented to a pharmacy for 10 diamorphine 10mg ampoules for a syringe driver. The pharmacy had 3 ampoules in stock which were dispensed to the patient's representative and the remainder of the prescription was owed until the following day. Unfortunately due to an ordering error the stock was not received by the pharmacy during the following morning. Due to the urgency of this prescription, the dispenser drove to a neighbouring pharmacy belonging to the same company, where the balance of the prescription was dispensed using the same prescription form.

Part of the learning following this incident, is that staff are clear about the requisition process and to have FP10 CDF requisition forms available so that CDs can be legally requisitioned from other pharmacies in urgent situations such as this.

A reminder of the link to the mandatory FP 10 CDF requisition forms has been provided below

<http://www.nhsbsa.nhs.uk/PrescriptionServices/1120.aspx>

## Erroneous Destruction of Stock CDs

We have recently had 2 cases of stock CDs being destroyed in error by pharmacy and practice staff.

Please ensure that there is adequate segregation and labelling of patient returned medication and obsolete CD stock within the CD cupboard, so that any obsolete stock is not destroyed in error, without the presence of an authorised witness, as patient returned medication. After consultation with the appropriate local CD Liaison Police Officer, a pragmatic solution has been reached in all of the cases that have been reported to us locally so far, involving the erroneous destruction of CD stock. Please be aware, however, that the occurrence of this scenario in another part of the country had recently resulted in a pharmacist receiving a formal police caution.

And on that note...We'd like wish all readers of our CD newsletter, seasonal greetings and best wishes for the New Year from the local Controlled Drugs Team!!

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We can no longer receive or send faxes.