BNSSSG Controlled Drugs Newsletter for Community Pharmacies

Community Pharmacies fighting CD fraud!

Community Pharmacies across Bristol, North Somerset, Somerset and North Somerset are our main source of information about controlled drugs related incidents, and this has made a huge difference to our success in stopping fraudulent activity around obtaining controlled drugs for misuse or diversion.

Sharp eyed pharmacists have noticed unusual behaviour, especially around collection of repeat prescriptions for Oramorph, which has resulted in an ongoing investigation by the police and Counterfraud. It turns out that Oramorph prescriptions are being requested and collected without the knowledge of the patient. We are hopeful that the individual(s) involved will soon be apprehended and other people discouraged from doing this.

Even with regular patients, it is always good to keep an eye on cumulative quantities of Oramorph supplied on repeat prescription. In a recent example a patient received 3 x500ml Oramorph in a single month. This could have been a fraudulent order, but also if this much Oramorph was being taken for breakthrough pain this would not be best practice in terms of pain control, and so either way this should be discussed with the prescriber.

Thanks for your help with this—if you have any more information do let us know!

Your CDAO is Sue Mulvenna. Please get in touch if you have any queries in relation to controlled drugs

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Inside this issue:

Reducing doses

We have received a number of reports where pharmacists have become aware that patients are trying to reduce their methadone dosage but have not informed the appropriate health care professionals.

One patient had decided to take 80mls of his 130mls dose for a number of days and then took the full 130mls as he was feeling uncomfortable. This poses a risk of overdose to the patient. If patients do request less please refer them back to their GP or shared care worker for them to discuss and also notify them yourself.

Please ensure there is a protocol in your SOPs with regards to clients not consuming the full quantity of their medication or requesting an unplanned reduction.

Top tips for safer CD dispensing

Pharmacists will be aware that when dispensing opiates and other drugs liable to misuse and diversion, there is a lot more to consider than just whether the prescription form meets all the legal requirements.

Pharmacists form the last defence against prescribing mistakes and fraudulent requests, and their vigilance can save lives.

We had an incident locally where the prescriber accidentally selected morphine 100mg instead of 10mg from the computer pick list, for an opiate naïve patient. The 100mg dose was dispensed and the patient ended up in hospital.

For patients prescribed high doses of opioids, **confirm any recent opiate dose** and frequency of administration and any other analgesic medicines (with patient, their representative, or through PMR). Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not **normally** more than 50% higher than the previous dose).

For every one mistake that gets through to the patient, many are avoided by pharmacists making the right checks. Do take the time to make a note of any near misses with opiate overdoses, and let me know.

Pharmacists are well placed to keep an eye on repeated orders for opiates, as the frequency of repeat prescription requests is often not picked up by GP surgeries.

Are medicines like Oramorph, codeine or tramadol being prescribed on repeat more often than they should be? If another member of the family, a friend or a carer is picking up repeats, are the medicines reaching the patient?

We have seen cases locally where young people have been ordering and obtaining opiates on repeat prescription which were meant for other members of the family, and have harmed themselves with these medicines.

Diverted prescription medicines are now the fastest growing group of drugs being seized by the police locally. Whilst police seizures of heroin are now declining across BNSSSG, a range of prescription drugs are being targeted for diversion onto the streets. These include tramadol, diazepam, clonazepam, lorazepam, pregabalin and gabapentin. The prisons have also recently noticed an increase in the misuse of nefopam.

If you have concerns that opiate medicines (or other medicines likely to be abused or diverted) are being over-ordered, please discuss with the prescriber. If you feel that action is not being taken by prescribers to manage these situations, do let me know and I will follow it up.

Please continue to report any CD concerns you have to the CDAO

Substance misuse dispensing

If a client misses 3 days' supply of their prescribed medication it is normal practice to notify the prescriber and not to dispense again to that client until they have been reassessed. Note that the prescription is on hold pending a reply to prevent accidental dispensing.

If the prescription specifies that a supply must not be made if 3 days have been missed, it cannot be reactivated once that has happened, and a new prescription will be required.

If a dispensed dose is spilled by the client, even in the pharmacy, it cannot be replaced without a new prescription. An emergency supply is not possible.

Fraudulent veterinary prescriptions

We have been made aware that nationally there has been a rise in the number of fraudulent veterinary prescriptions that have been presented at community pharmacies.

Whilst veterinary prescriptions are not intended for human use, the medicines that are prescribed can be used to treat both humans and animals alike. The controlled drugs in question appear to be diazepam, dihydrocodeine, clonazepam, and in some cases tramadol is also being requested.

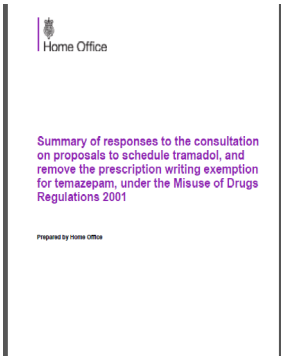
Should you have concerns in relation to fraudulent veterinary prescriptions please dial 101 in the first instance and notify your CD Accountable Officer.

Review of psychoactive substances

A review of new psychoactive substances was launched in December to look at how the UK's laws and enforcement against 'legal highs' can be improved. Options include the expansion of legislation to ensure police and law enforcement agencies have better tailored powers.

Further information is available on the Government's website https://www.gov.uk/government/news/review-launched-to-target-reckless-trade-in-legal-highs.

Scheduling of tramadol and exemptions for temazepam prescriptions - consultation response


Home Office

Summary of responses to the consultation on proposals to schedule tramadol, and remove the prescription writing exemption for temazepam, under the Misuse of Drugs Regulations 2001

Prepared by Home Office

Tramadol: The government has considered the concerns raised in the consultation and has decided to place tramadol in Schedule 3 to the Misuse of Drugs Regulations 2001 when it is controlled later this year, but with exemption from the safe custody requirements.

Temazepam: The government assesses that on the available evidence, the existing exemption for temazepam prescriptions are no longer warranted and has decided, in principle, to implement legislative changes to remove the exemption, subject to advice from the Advisory Council on the Misuse of Drugs.

https://www.gov.uk/government/consultations/scheduling-of-tramadol-and-exemptions-for-temazepam-prescriptions

CDs & Wholesalers Dealers authorization for human use/ wholesale dealers' authorisations

Following some confusion in this area the Department of Health recently published a letter which summarised the circumstances in which it is necessary for pharmacies which are supplying controlled drugs, to hold a wholesale dealers authorization for human use.

The letter stated that any supply of stock medicines on a commercial basis by a pharmacy now requires a WDA to be held by the supplying pharmacy. This change has affected pharmacies providing stock medicines to another legal entity with or without a formal contract in place.

If a WDA(H) is required and supplies include CDs it is likely that a corresponding Home Office CD license will also be needed by the pharmacy to legalise the supply.

Please take account of these changes when considering whether you need to apply for necessary licenses.

If you have any questions please call 0203 0806844 or email pcl@mhra.gsi.gov.uk.

Overview of reported incidents and discrepancies

The chart below provides an overview of the controlled drug incidents and discrepancies that have been reported to the BNSSSG Area Team Controlled Drugs Accountable Officer from community pharmacists, prescribers and other providers between April 2013 and March 2014.

The number of incidents and discrepancies reported is consistent with the previous levels of reporting to the PCT CD Accountable Officers, which is good/encouraging.

Please continue to report details of any complaints, incidents or concerns involving the management and use of CDs to the Accountable Officer so that we can continue to share learning.

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Avon LPC
http://psnc.org.uk/avon-lpc/nhs-england/bristol-n-som-s-glos-and-somerset/bnsssg-controlled-drugs-resource-page/

Somerset LPC
http://psnc.org.uk/somerset-lpc/our-news/controlled-drugs-autumn-newsletter/

Type of Incident or Concern	Number of reports
Discrepancies - 102	Shortage: 76
	Overage: 26
Incorrect quantity	58
S v SF	40
Wrong strength CD	22
Smashed or spilt CD	21
CD given to the wrong patient	16
Missing CDs	15
Lost or stolen prescription	13
Did not notice change to prescription	9
Wrong drug issued to patient	6
CD handed out on wrong day	5
Reducing doses at patients request	4
Out of date prescription	2
Others	46

Common mistakes guidance

There are several common mistakes arising from the CD incidents reported to us. Dispensing the wrong type of methadone happens a lot; some pharmacies have addressed this by marking the SF prescriptions with a highlighter pen, and dispensing the SF and non-SF prescriptions as two separate groups. If you have any unusual prescriptions e.g. SF and colour free, or concentrated methadone, then it is particularly important to highlight on the script and PMR. Always check if a new prescription has changed in dose or form before producing labels from the PMR. Take time to check patient details carefully before giving methadone or buprenorphine out, especially if there is a commotion going on and you feel under pressure.

CD stock is often lost in the MDS filling process; it is safer to take the exact number of CD tabs/caps needed to the MDS filling area, to avoid remaining meds being thrown away with the empty packaging.