BNSSSG Controlled Drugs Newsletter for Community Pharmacies and GP Practices

Summer 2014

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

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CD Fax

As you should all be aware we have a new CD fax number— 0117 315 0410.

We had to change our number as the SW Commissioning Support Unit were no longer supporting fax as a method of correspondence. By the end of March 2015 it is hoped that we will have completely phased out the use of fax and instead will have adopted an online reporting system such as the one developed by the Greater Manchester Area Team— http://www.cdreporting.co.uk/.

We know that this will cause some issues for some of you and we would very much like to hear from you about what those issues will be so we can try and put a plan in place to resolve them. Please contact us on the details to the left and let us know what affect moving to an online reporting system and no longer being able to contact us by fax will have on you.

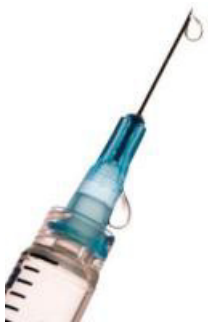
Misappropriation of CDs in the area— Please be vigilant!

We have been made aware that a large number of CDs have gone missing from various pharmacies in our area and it is believed they have been misappropriated. It appears that the medicines have been ordered and delivered but not booked into the CD register. The Police are investigating this but in the meantime we ask you to carefully monitor CD balances particularly for methylphenidate and dexamphetamine and contact us straight away if you find a discrepancy or have a concern with your paperwork.

Patient seeking IM Pethidine

The CD Accountable Officer has been informed of a temporary resident in our area who has been seeking IM pethidine. The patient is male and states he has renal colic and haematuria. When looking back through our known prescription medicines misusers file we found that the same patient undertook similar activities back in 2001.

Please act cautiously when prescribing pethidine for temporary residents and make every effort to speak to their GP prior to doing so. Pethidine is no longer recommended for use in primary care for any indication.



Disposal of unwanted or unused patient controlled drugs

A recent query around best practice for the disposal of unwanted or unused patient controlled drugs following a GP home visit has raised a few issues that might be useful for all health care professionals in similar situations to consider.

In the query, a GP had been involved in caring for a palliative patient who had been on a number of controlled drugs. Following the patient's death, the GP was worried about the controlled drugs being potentially misused by family members. The GP practice had a policy of not accepting patient returns and to ask a relative (or in other cases the patient) to take the unwanted medication to a pharmacy for destruction. However it was felt that in this instance it would be safer to take away the medicines.

Also family members may be distressed and bereaved following the death of a loved one and so the return of the controlled drugs to a pharmacy would not necessarily be a priority meaning they would not be returned immediately and potentially creating a risk in the home.

In general, the patient/patient's relatives should be advised that when the patient's prescription medications including controlled drugs are no longer required they should be returned to a pharmacy for safe destruction. However, where the health care professional has concerns relating to the safe destruction of these drugs it may be appropriate for nursing or medical staff to facilitate the disposal of controlled drugs to ensure this is undertaken in a safe and appropriate way. This could involve the nurse or visiting GP taking the controlled drugs to a local community pharmacy themselves with a list of the medicines taken signed by the patient or a relative. It would, however, be important to ensure that a member of the pharmacy team countersigns the patient nursing or medical record to ensure a clear audit trail of this action. This would usually only be in more unusual or exceptional high risk circumstances, with each case being assessed on an individual basis. Risk assessments would include; medication storage in the home – are the medications locked away or left out? Are there safety issue relating to young children in the home or suspected issues of misuse from family members or visitors?

In addition, to help minimise these potential risks, the quantities of controlled drugs prescribed should always be considered carefully, balancing the quantities prescribed to be sufficient so the patient won't fall short but also minimising quantities to reduce risks in the home as well as medication waste. The NHS England Community Pharmacy Specialist Medicine Service helps to improve access to key medicines including certain controlled drugs in listed community pharmacies with good opening times, so large quantities of controlled drugs will seldom need to be prescribed. For information about the service contact England.bnsssg-pharmacy@nhs.net.

Transdermal fentanyl patches: Reminder potential for life-threatening harm from accidental exposure, particularly in children

Accidental exposure to transdermal fentanyl can occur if a patch is swallowed or transferred to another individual.
A recent EU-wide review emphasised the need for safe handling of patches. To date the MRHA have received three Yellow Card reports of describing accidental contact with or transfer of fentanyl patches.

Children are at risk as they may touch, suck, chew, or swallow a patch that has not been disposed of properly. Also, children have a lower threshold for fentanyl overdose than adults. Two of the three Yellow Card reports received to date concerned children.

The MRHA therefore would like remind you to provide clear information to patients and caregivers regarding risk of accidental patch transfer and ingestion of patches, and need for appropriate disposal of patches. Advise patients and caregivers to follow the instructions on the patch carton and in the accompanying leaflet. If a patch is transferred to another person, it should be removed immediately and the individual should get urgent medical help. If a patch is swallowed, the individual should get medical help immediately

Please report any cases of accidental exposure where harm has occurred or suspected side effects to your CDAO and via the Yellow Card Scheme (www.mhra.gov.uk/yellowcard)

Self prescribing and prescribing for family members

Although it is not illegal, it is strongly advised in the GMC's 'Good practice in prescribing and managing medicines and devices' guidance (2013) that GPs **do not prescribe** for themselves or their family except in exceptional circumstances. In recent years there have been a number of cases where GPs have self-prescribed and have been subject to fitness to practice proceedings. If doctors do feel that there is an exceptional circumstance to prescribe for themselves or family members they must immediately make a clear record justifying why there was no other alternative, and also inform their own, or the other person's, GP about which medicines have been prescribed.

Prescribing controlled drugs is even higher risk and the GMC guidance states that you must not prescribe controlled drugs for yourself or someone close to you unless no other person is available with the legal right to prescribe and the treatment is immediately necessary to save a life, avoid serious deterioration in health or alleviate otherwise uncontrollable pain or distress

From a pharmacy perspective **we would urge pharmacists to challenge all self-prescribed medication** and particularly if the prescription is for CDs. Please also inform your CDAO.

Tramadol—Useful Information

- Tramadol is not subject to safe custody requirements in community pharmacies or GP Practices
- Records do not need to be kept in the CD register
- Tramadol prescriptions must state;
  - Patient name and address
  - Prescribers name and address
  - Be dated and signed
  - Specific the drug name, strength and form
  - Total in quantity in words and figures and the dose
  - Dosage instructions

- Tramadol cannot be supplied as an urgent or emergency supply by a community pharmacist
- Tramadol cannot be issued by repeat dispensing prescriptions
- Tramadol can be dispensed for more than 30 days however it is good practice that prescriptions should be for a maximum of 30 days.
- Tramadol prescriptions are valid for 28 days. Pharmacists cannot dispense a balance for tramadol after 28 days. However, instalment prescriptions for tramadol that last for longer than 28 days are allowed if the first instalment is dispensed within the 28 days.
- Tramadol should be denatured before disposal. Destruction does not need to be witnessed by an Authorised Witness and no records need to be kept although best practice would recommend you do so.

Drugs and Driving

The Department for Transport has introduced a new offence of driving with certain controlled drugs above specified limits in the blood; this is likely to come into force on 2 March 2015. The list of drugs includes some licensed medicines. Anyone found to have any of these drugs in their blood above the specified limits will be guilty of an offence, whether their driving was impaired or not.

However, there is a medical defence for people taking the drugs for medical reasons, if their ability to drive was not impaired. The conditions of the medical defence state that the individual is not guilty of an offence if:

- the medicine was prescribed, supplied, or sold to treat a medical or dental problem, and
- it was taken according to the instructions given by the prescriber or the information provided with the medicine.

It is recommended that you give the following advice to patients:

- Continue taking your medicine as prescribed
- Check the leaflet that comes with your medicine for information on how your medicine may affect your driving ability
- It is against the law to drive if your driving ability is impaired by this medicine
- Do not drive while taking this medicine until you know how it affects you (especially just after starting or changing the dose of the medicine)
- Do not drive if you feel sleepy, dizzy, unable to concentrate or make decisions, or if you have blurred or double vision

For more information see http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON432898.

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 2014 and July 2014.

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.

Other incidents include; missing CDs, overlapping prescriptions, oxynorm doses poured down the sink in error, CDs stolen during a burglary, fraudulent scripts, missed register entries, OOD stock accidently destroyed

Type of Incident or Concern	Number of reports
Discrepancies - 43	Shortage: 31
	Overage: 12
Incorrect quantity	16
CD given to the wrong patient	10
Wrong strength CD	6
Smashed or spilt CD	6
Out of date/invalid prescription	6
S v SF	5
Lost or stolen prescription	4
CD handed out on wrong day	4
Incorrect label	2
Wrong form	2
Wrong brand	1
Others	20

Review of reports and Destructions

We have been undertaking a review of the incident and discrepancy reports we have received since April 2013 and it is interesting to note that some pharmacies have not had a single CD incident or discrepancy in this 16 month time period. We will be looking into this over the next couple of months to assure ourselves that it this is not due to a lack of reporting. Community pharmacists are generally very good at reporting incidents and although the number of reports from GPs has increased recently we still feel that we have work to do to increase reporting from GPs.

Out of date CD destructions

Our authorised witness has recently attended at a number of premises where there has been a large amount of out of date stock. Although there is no specific limit on how long you can have out of date CDs we recommend you arrange for an authorised witness to attend to destroy your out of date stock before a large amount accumulates to save stock getting muddled.

If you have out of date CDs which need destroying in the presence of an authorised witness please email england.bnsssg-controlleddrugs@nhs.net or phone 0113 825 3568.

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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/