

BNSSSG Controlled Drugs Newsletter for Pharmacies

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

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Welcome to our new Accountable Officer!

We are pleased to announce that Sue Mulvenna is now in post as the Controlled Drugs Accountable Officer for the BNSSSG Area Team. Sue joins us from Bristol CCG where she was the Head of Medicines Management. Sue has 2 days a week to work on controlled drugs related matters and the rest of her time will be spent working as the Lead Pharmacist for the South West Strategic Clinical Networks and the Local Professional Networks.

Samantha Allen will be supporting Sue in her new role.

The purpose of the Area Team Accountable Officer is to secure the safe management and use of controlled drugs within the teams geographical area and to ensure that any contractor providing NHS services within this area that could involve controlled drugs is doing so too.

“Appropriate arrangements” for management and use of controlled

drugs must include—

(i) systems for recording concerns (including complaints), and

(ii) incident reporting systems for untoward incidents; and

(iii) up to date standard operating procedures.

If you wish to speak to the CD Accountable Officer about anything which relates to controlled drugs she is contactable on the details to the left of this article.

Oramorph incidents

The CDAO has been informed of several incidents in Bridgwater where prescriptions for Oramorph were ordered, collected and dispensed, but the patients did not request or receive the medicine.

Oramorph is a brand of morphine oral solution which due to its low strength is not subject to Controlled Drug legal

requirements, but has potential for misuse and diversion.

An alert was circulated and on the back of this a few more practices have got in touch to share similar concerns. This incident is now being investigated by the police and NHS England are trying to decide on some measures to put in place to prevent something

similar happening in the future. If you are aware of any good practice that is being undertaken in this area please get in touch.

Please remain vigilant with Oramorph prescriptions and contact the CDAO if you have anything suspicious to report.



National Pharmacy Association CD modules *England*

Napp Pharmaceuticals have teamed up with the NPA to develop a number of e-learning modules around CD's for pharmacists.

The modules include;

An introduction to Controlled Drugs

- Understanding legislation
- Medicines Act and associated regulations
- Misuse of Drugs Act and associated regulations
- Health Act and associated regulations
- The Accountable officer, authorised witnesses and their roles in the safe management of CDs
- Standard operating procedures

- The Shipman Inquiry, including amendments made to legislation as a result of the inquiry

Prescriptions and requisitions

- Prescriptions for CDs (prescription requirements, repeatable prescriptions, private prescriptions owing items)
- Instalment prescriptions for CDs
- Requisitions for CDs
- Processing private CD prescriptions and requisitions

Controlled Drugs: Record keeping and destruction

- Record keeping requirements for CDs
- The CD register

- CD running balance and stock checks
- Sativex oromucosal spray - record keeping requirements
- Destruction of patient-returned CDs
- Destruction of pharmacy stock of CDs

All of this can be found by accessing the NPA website <http://www.npa.co.uk/>



ANY CD INCIDENT

WHICH INVOLVES

PATIENT CARE OR

PUBLIC SAFETY

MUST BE

REPORTED TO

THE CDAO

Safeguarding Children

Many types of medication are extremely dangerous to children and unfortunately there have been a number of incidents in our area where children have gained access to their parents medicines.

As a result of this a leaflet has been produced by Safer Bristol and the Bristol

Safeguarding Children's Board to provide guidance for parents who use methadone, alcohol or other drugs on what they need to be aware of and what they can do to keep their children safe.

The leaflet is called 'Keeping your child safe' and is available from

www.bristol.gov.uk or by calling 0117 914 2222.



If you are a parent and use methadone, alcohol or other drugs you need to be aware of what you can do to keep babies and children safe.

SOPs and reporting forms

A number of SOPs and standard reporting forms have been developed by the Area Team and we have been made aware that not everyone has access to these. If you would like to see any of the SOPs or require a reporting form please get in touch using the contact de-

tails on the front page of this newsletter. The documents available are as follows;

- SOP for the management of CD destructions
- SOP for the safe handling of CDs by Healthcare Professionals employed in the

community and GP Surgeries

- Discrepancy and Incident SOP
- Incident reporting form
- Discrepancy reporting form
- CD destruction template

Clarity on reporting spillages

We receive a large number of reports relating to liquid spillages and there appears to be uncertainty about what is the appropriate action to take when this happens.

If you have a spillage in your pharmacy please ensure that you undertake the following:

- Notify a colleague of the spillage and if possible show them the spillage so they can act as a witness

- Promptly clean up the spillage with paper towels, tissues or anything else absorbent and dispose of these appropriately ideally with a witness present

- Calculate the spillage as accurately as possible and update the register with the remaining stock balance

- Explain the spillage in the CD register and ideally get a witness of the spillage to sign the register

- Inform the accountable officer at your earliest convenience



Methadone dispensing

A large number of the incident & discrepancy reports we receive concern methadone. In order to minimise the risk we suggest the following are considered:

- Is the prescription still valid? (doses have been supplied in excess of those prescribed)
- Is the patient known to the pharmacist? (clients have been incorrectly identified & received another client's dose)

- What are the collection arrangements? (daily, weekly, etc. Clients have been supplied with methadone which is not accordance with the collection arrangements)

- Is there a procedure in place for dealing with and reporting spillages? (spillages do occur & a procedure should be in place for staff to follow when this occurs)

To submit your private prescriptions to NHSBSA go to www.nhsbsa.nhs.uk/2473 & select 'submission document for submitting CDs through a private account'

Controlled drugs destruction process

It is a legal requirement for stocks of Controlled Drugs (CDs) to be destroyed in the presence of an Authorised Witness.

There is a different understanding of the destruction process across BNSSSG so we thought it would be useful to provide an overview.

- Practices/community pharmacies are to contact Area Team to inform them when

they have CDs that need to be destroyed in the presence of an Authorised Witness (contact details on front page of this newsletter)

- Once a date has been agreed a Record of CD Destruction Form will be sent out. This form must be completed and returned the Area Team prior to the visit date

- CDs for disposal must be stored in the CD cupboard,

segregated from CD stocks in use, be clearly marked for disposal but remain part of the running stock balance in the CD register until destroyed

- On the day of the destructions please ensure that a nominated member of staff is available to undertake the destructions

- Nominated staff member to destroy CDs, make entry

in CD register and sign Record of CD Destruction Form

- A copy of the record of CD Destruction will be kept on file by BNSSSG Area Team indefinitely

Collections by third parties

There has been a recent incident in our area where an underage person was found to be collecting controlled drugs for a family member and was using them himself.

The need for the collector of certain controlled drugs to sign the reverse of the prescription form plainly allows for a third party to collect drugs. However, pharmacies and dispensing practices have a duty to ensure that the person collecting is authorised to make that collection. The patient is free to nominate whomever they wish, but the dispenser may take the view that a particular person is not suitable for example if a child was sent. This decision should be made in accordance with SOPs. Please ensure that the entry in the CD register records whether ID was requested.

With substance misuse clients it is generally a condition of treatment that the client must collect themselves. Please assume that these drugs should not be given to anyone else unless specifically authorised unless in exceptional circumstances if you cannot get hold of the prescribing doctor or drug service.

CDAO

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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/>

Overview of reported incidents and discrepancies

The chart below provides an example of the different types and number of controlled drug incidents or discrepancies reported to the BNSSSG Area Team Controlled Drugs Accountable Officer from community pharmacists, prescribers and other providers between April 2013 and mid October the end of January 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.

Incident type	No of reports
CD Discrepancies – shortage	60
Wrong quantity given	44
Other	44
Sugar v Sugar Free methadone	34
CD Discrepancies - overage	25
Smashed/spilt methadone	18
Wrong strength of CD	15
Wrong patient given CD	12
Lost/stolen prescriptions	12
Missing CDs	10
Didn't notice change to prescription	6
Wrong drug supplied	6
Handed out on the wrong day	3
Incorrect instructions	2