BNSSSG Controlled Drugs Newsletter for GP Practices & Community Pharmacies

February 2015

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

Email: england.bnsssg-controlleddrugs@nhs.net

Phone: 0113 825 3568

Inside this issue:

Ground hog day for CD mistakes!

The CD AO role was set up to avoid another Shipman. Thankfully, it is very rare for clinicians to deliberately harm patients.

However, our incident reports and routine monitoring of CD prescribing do pick up a range of recurring mistakes which cause harm to patients, and put the public at risk.

I know that everyone is under a lot of pressure just to get through the day, but it is disappointing to everyone to see the same mistakes recurring, and very time consuming if you are involved something going wrong.

So here are just 5 things to avoid doing!

1. Opioid pick list prescribing mistakes e.g. zomorph 100mg for 10mg, oxycodone 10mg/ml for 5mg/5ml
2. Temporary resident requests for tramadol, pregabalin, diazepam etc check ID and check with their GP before further supply
3. Stolen prescription forms and pads - GPs be careful with public access to these, pharmacists think before dispensing hand written scripts
4. Excessive CD prescribing for chronic pain - get expert help
5. Methadone dispensing - beware wrong patient, wrong amount!

CD Liquid Concentrates

We have had several reports involving patient harm where oxycodone 10mg/ml was prescribed by mistake, instead of 5mg/5ml. In some cases the pharmacist picked up the error, but two patients were supplied medication and ended up in hospital.

Prescribers are asked to be extremely cautious when selecting oxycodone liquids not to select 10mg/ml in error. You may wish to consider editing your EMIS web so that the high strength is right at the bottom of your list and is less likely to be selected in error.

Community pharmacies please check any new prescriptions for oxycodone 10mg/ml to ensure they have been correctly prescribed. The higher strength is rarely used.

FAX CONTACT

Please note that as of April 2015 we will no longer be able to send or receive faxes. Please remove our fax number from your contact details.

Pregabalin and Gabapentin

Public Health England has issued some advice on the risk of the misuse of pregabalin and gabapentin. The full advice can be viewed at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf

In BNSSSG many of the fraudulent prescriptions that are intercepted are for pregabalin

Key Messages from advice:

Prescribers need to be aware that these drugs can lead to dependence and may be abused and diverted.

Pregabalin and gabapentin have a well-defined role in the management of a number of disabling long-term conditions, including epilepsy and neuropathic pain; and, for pregabalin, generalised anxiety disorder. When used for pain the drugs do not work for everyone but a proportion of patients benefit sufficiently to notice an improvement in quality of life.

Practitioners should prescribe pregabalin and gabapentin appropriately to minimise the risks of misuse and dependence, and should be able to identify and manage problems of misuse if they arise. Most patients who are given these drugs will use their medicines appropriately without misuse.

Prescribing for patients with a known or suspected propensity to misuse, divert or become dependent on these drugs may place these people at greater risks from their use. Prescribers must make a careful assessment to balance the potential benefits against the risks. However, it should be noted that such patients may also have a higher prevalence of the indicated conditions for these drugs and some may benefit from their use.

While no patient should normally be excluded from access to medications that may help them simply because of a current or past problem with misuse or dependence (or because of concern about propensity to such risk), that concern is a proper and relevant consideration in how, and even whether to prescribe these drugs. Prescribing decisions should be discussed in full with patients and they should be made aware of the importance of their co-morbidities and context in making a safe prescribing decision.

Less harmful, alternative drugs can often be first-line treatments for the indicated conditions for which pregabalin and gabapentin are now used, and may be tried preferentially in higher risk settings or in patients who may be more likely to be harmed by the drugs. NICE guidance on neuropathic pain has been updated to reflect this change in guidance; offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia).

http://www.nice.org.uk/guidance/cg173/chapter/1-recommendations

For further advice on pregabalin in neuropathic pain please also view the PrescQIPP bulletin at: http://www.prescqipp.info/newsfeed/bulletin-50-launched-pregabalin-in-neuropathic-pain

Tramadol

Tramadol became a Controlled Drug in June 2014 following recommendations from The Advisory Council of the Misuse of Drugs (ACMD) of an increasing number of reports within the NHS involving Tramadol and the significant harm when misused including death.

Pharmacies are requested to be vigilant with prescriptions for Tramadol and refer to the prescriber if any of the following apply:

- Dose exceeds BNF recommended daily dose; Adult and child over 12 years, by mouth, 50–100 mg not more often than every 4 hours; total of more than 400 mg daily not usually required
- Prescription length exceeds 30 days - recommended as good practice
- Patient appears to be over ordering
- Concerns of misuse
- Suspicions over legitimacy of patient identity , and /or a handwritten prescription

Tramadol and pregabalin are currently the most popular medicines being sought by people seeking fraudulent Temporary Resident status, or handwriting stolen prescription forms.

Sick day rules around methadone pickup

We had a recent incident reported to us where a patients representative was being given the patients methadone whilst the patient was too unwell to attend at the pharmacy. On checking with the prescriber the pharmacist was advised that this was not acceptable and that the pharmacy would have to deliver to the patient ad supervise at their home. In relation to this please consider the below guidance and ensure staff are aware of the appropriate process to follow in these circumstances.

If the patient wishes someone else to collect a dispensed controlled drug on their behalf e.g. in the event of illness, they must provide written authorisation including the name of the representative. A separate letter should be provided each and every time the patient sends a representative to collect, and the representative should bring identification. If supervision is expected, the pharmacist should contact the prescriber to check that they are happy with this arrangement. However, if it is not possible to speak with the prescriber, the pharmacist can, in the interest of the patient, make the decision to supply without supervision.

Many pharmacists are not informing prescriber/service when a patient misses 3 doses. You may wish to discuss this with your local pharmacist especially if you have chaotic patients. The pharmacist can better manage the care of the patient if they are aware in advance how best to notify the practice if the patient has not been picking up.

Liquid expiries

Children's Hospice SW pointed out that a number of patients are attending for respite care with liquid phenobarbital which had been open for quite long periods of time. The hospice checked with Thornton and Ross and were advised that it should not be used after being open for 28 days.

If you are dispensing liquid medicines which do not advise on an expiry date after opening please contact the medicines information helpline and advise the patient/parent accordingly. Also be aware that the commercially available phenobarbital 15mg in 5ml orange flavoured liquid contains a high concentration of alcohol and is not suitable for children with epilepsy; please check with the prescriber if in doubt.

Fraudulent prescriptions

There has been a spate of fraudulent prescriptions presented at pharmacies recently. The prescriptions have been stolen from a number of GP Practices in our area. **Community pharmacists are asked to treat any handwritten or amended prescriptions with extreme caution** and follow up with the prescriber if you have any concerns.

If you have concerns and are not able to speak to the prescriber straight away, if in doubt please provide the patient with the minimal amount to see them through until you have managed to validate the legitimacy of the prescription.

If you do not feel comfortable telling the patient the reason for this then consider saying that you do not have the quantity prescribed in stock and they will have to come back for the rest.

If you have confirmed that a prescription is fraudulent please contact the police on 101 or 999 as appropriate. Any pharmacy or dispensing practice detecting and retaining a fraudulent prescription and informing the correct channels may be eligible for a reward payment of up to £70.00 For further information regarding the reward scheme please contact NHS Counter Fraud Service on 0800 068 6161.

Top Tips on how to spot a fraudulent handwritten prescription

- Spelling mistakes and odd names - Joan's was recently written on a fraudulent rx as a surname
- GP signature - unusual, suspiciously legible?
- General manner of the person presenting the rx
- Odd quantities or drug combinations
- Thinks about who would be hand writing this script, e.g. a month's supply of tramadol, pregabalin, diazepam, nitrazepam - and why? Unlikely home visit??

Prescription form security: GP Practices

- Keep all prescription forms out of sight of the public
- Keep prescription pads and stamps locked away
- Avoid leaving patients alone in the consultation room, risk assess if you need to pop out
- Keep consultation rooms locked when not in use

NHS England and NHS Protect has devised a security of prescription form checklist which helps practices assess whether their security arrangements are robust. If you would like a copy of this please contact the CDAO.

Batch Prescriptions

The repeat dispensing batch CD prescription rules are outlined below;

- Schedule 2 and 3 Controlled Drugs cannot be prescribed on repeat dispensing prescriptions.
- Repeat dispensing prescriptions for Schedule 4 Controlled Drugs must be dispensed for the first time within 28 days of the appropriate date with subsequent issues valid for 12 months from the signed date.
- Repeat prescriptions for Schedule 5 Controlled Drugs are treated the same as non-controlled drugs and must therefore be dispensed for the first time within six months of the appropriate date with subsequent issues valid for 12 months from the signed date.

Schedule 4 CD's can be done by batch prescription as long as the first prescription of the batch is dispensed within 28 days of signing. The subsequent batch prescriptions must be dispensed within 12 months of the prescription being signed.

Temporary Residents Inappropriately Seeking CDs

There have been a number of reports of inappropriate Temporary Resident requests for medicines across the South West.

Going forward GP Practices should contact us if you have anyone who registers with you as a temporary resident and requests controlled drugs (e.g. morphine, oxycodone, tramadol, diazepam, zopiclone) or other medicines liable to misuse and diversion (e.g. pregabalin, Oramorph, clonazepam) where this is not confirmed as appropriate by their GP practice. We will keep a log of these individuals to see if they are attending at more than one surgery.

If you do feel it pertinent to supply please supply a minimal amount and follow-up with their regular GP as soon as possible.

Please also ensure that prescriptions for overseas patients are written on the appropriate pads. Private prescriptions for controlled drugs need to be written on a private FP10 prescription form and the prescriber must obtain a private prescribing number by contacting the Controlled Drugs Accountable Officer.

Safer Use of Oxycodone Medicines

We have had several local incidents related to the use of oxycodone. The wide array of branded products currently being used across primary and secondary care has caused some confusion. It is important to confirm the appropriate medicine formulation is being used. There are fast acting short duration (e.g. Shortec, Oxynorm) and slow acting, long duration e.g. Longtec, Oxycontin) oxycodone products. There are significant risks of overdose when a fast acting product of short duration is use in error for the slow acting, longer duration products.

Confirm any use of oxycodone concentrate products. There are significant risks of overdose if a concentrate product is used in error for a normal strength product. Any use of oxycodone medicines 'as required' should have clear guidance on the frequency that the dosses can be administered. Monitor prn use of oxycodone liquid for breakthrough pain, some patients are currently receiving 2000ml a month due to self-escalating doses.

See CQC safety guidance for more information.

https://www.cqc.org.uk/sites/default/files/documents/safer_use_of_controlled_drugs_-_guidance_for_the_web_-_preventing_harm_from_oral_oxycodone_medicines_v2.0.pdf

Preventing Harms for the Use of Methadone

The majority of controlled drugs incidents that are reported involve methadone. CQC has looked at these reports along with information provided by coroners in England and Wales and has devised some recommendations on preventing harms from the use of methadone and the safer use of methadone. The recommendations are for clinical practitioners who prescribe dispense or administer methadone.

The document is quick to read and we would recommend that everyone reviews the recommendations. The document can be accessed at http://www.cqc.org.uk/content/use-controlled-drugs

Supervised consumption

One of our GPhC inspectors has raised a concern about how community pharmacies are managing supervised consumption of medicines. Please consider the below guidelines and ensure your practices are in line.

- Supervision should take place in a consultation or quiet, private area of the pharmacy.
- The patient must be treated with courtesy and respect, in a friendly and non-judgemental manner.
- The patient's identity using name, address, date of birth and photographic ID (if available) must be confirmed.
- The patient should be asked what dose they usually take and this should be checked against the dispensed dose in the container and the prescription before the dose is issued. As we have had incidents reported previously whereby patients have been given the wrong persons dose in error.

Methadone Oral Solution:

- The patient should check the name, quantity and dose on the label, then pour the daily dose into a disposable plastic cup before self-administration. If the patient prefers they may take the daily dose straight from the labelled bottle.
- The pharmacist must be satisfied that the dose has been swallowed by offering a drink of water after the dose.

Sick/spit meth has previously been a problem in the Bristol area and providing water helps to alleviate the chances of methadone being abused in this way

Buprenorphine:

- The patient should remove any chewing gum from their mouth and dispose of it in a waste bin.
- Offer the patient a drink of water in a disposable plastic cup, before administration to moisten the mouth and speed up dissolution of the tablet(s).
- The pharmacist should pop the tablets out into a clean, dry medicine cup and hand this to the patient. This helps to ensure tablets are not diverted by slight of hand.
- Without touching the tablets the patient should tip the tablets under the tongue. They should not be swallowed. Patients should be advised to swallow as little saliva as possible whilst the tablet(s) dissolve. Patients on high doses may need to split the dose to take a few tablets at a time.
- The patient should be observed until the tablets have started to dissolve making diversion difficult.
- It is not necessary to watch the patient continuously after this initial period. The patient should remain in the pharmacy until the pharmacist is satisfied that all that is left under the tongue is a chalky residue. This should usually be achieved in 5 minutes but occasionally may take up to 10 minutes.
- Offer the patient a drink of water and engage in conversation to ensure they have not concealed the tablets in their mouth.

We have recently had an incident where a child picked up a part-dissolved subutex tablet from the floor of a consultation room

Do not dispense the dose if:

- The patient appears intoxicated
- The patient has missed three or more consecutive doses.

Beware:

Methadone Oral Solution

- If the patient is reluctant to speak before taking the dose they may have cotton wool or absorbent material in their mouth to absorb the methadone. A normal greeting or asking for address and date of birth can help detect this.
- Some patients may say they prefer to use a can of soft drink to wash down their methadone. However they may discharge the dose of methadone into the can for sale later. Make sure they have swallowed the dose first before drinking from the can.
- Methadone can be transferred to another person by "kissing".

Buprenorphine

- Some patients may attempt to divert their tablets by slight of hand. Try to ensure they do not handle the tablets.
- Some patients may attempt to spit out and reclaim the tablets. Observation for the first two to three minutes should reduce this risk.
- It is not normally possible to talk whilst the tablets are dissolving!

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 December 2014 (quarters 1, 2 & 3).

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 included; prescription pads and stamps stolen from GP surgeries in two separate incidents and fraudulent prescriptions presented at over 25 pharmacies in our area that we are aware of and a patient managed to collect their daily methadone dose whilst also receiving daily dose as an inpatient at a local hospital.

Useful contacts

BNSSSG CDAO
BNSSSG Medical Directorate
NHS England
South Plaza
Bristol
BS1 3NX
Englland.bnsssg-controlleddrugs@nhs.net

GPhC Inspectors

Somerset
Barry.Cohen@pharmacyregulation.org

Bristol & South Glos
Deborah.Hylands@pharmacyregulation.org

North Somerset
Jooman.abass@pharmacyregulation.org

Police CD Liaison Officer
Peter.Collins@avonandsomerset.police.uk

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 - 87	Shortage: 65
	Overage: 22
Incorrect quantity	31
CD given to the wrong patient	21
S v SF	19
Smashed or spilt CD	15
Wrong strength CD	14
Dispensing against out of date/invalid prescriptions	10
Dispensed on wrong day	7
Lost or stolen prescription	7
Wrong form	5
Wrong label	8
Wrong CD	6
Wrong brand	2
Other	53