BNSSSG Controlled Drugs Newsletter for GP Practices & Community Pharmacies

Autumn 2014

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Inside this issue:

Pregabalin and gabapentin misuse potential	2
Common incidents—advice	2
CQC Annual Report & Self Assessment tools	3
Ketamine consultation	3
Obtaining private CD codes—pharmacies	3
Individuals of Concerns	3
CDs in Care Homes	3
Overview of incidents and discrepancies	4
Lessons learnt from CD abuser case	4

Prescription security

There have been a number of incidents in our area recently where prescription forms have been stolen from GP Practices and presented at community pharmacies as forgeries.

The BNSSSG Area Team has been working with NHS Protect to develop a prescription form security self-assessment tool. The tool will be circulated within the coming weeks but in the meantime we ask you to be aware that this in an issue and to ensure that your prescription forms are kept as securely as possible e.g. keeping empty consultation rooms locked and prescriptions and stamps out of sight.

If you have any good practice that you would be happy to share with other practices around prescription form security we would really like to hear from you on the contact details on the left of this page.

Community pharmacies please be on the lookout for fraudulent prescriptions. Any handwritten Rx (or handwritten additions) should be examined carefully and checked with the prescriber if in any way suspicious. They are most likely to be low schedule CDs such as diazepam or codeine. We have had occasional typed forgeries identified, but these are much harder to spot. Please be alert!

Pharmacies with Wholesalers Dealers Licenses

Any company or individual wishing to wholesale deal (defined as selling, supplying or procuring to anyone other than the end-user) medicinal products within the EU must hold a wholesale dealer's licence (WL). Community pharmacies are exempt for supply of medicines to individuals on prescription but not for medicine stock.

For those who are unsure who hold WL licences in their area the link below takes you to the Department of Health and MHRA Register of Licensed Wholesale Distribution Sites (Human and Veterinary) 2014.

http://www.mhra.gov.uk/home/groups/is-lic/documents/publication/con2025604.pdf

For stock supply of controlled drugs a Home Office CD licence is also required.

Be aware of the misuse potential of pregabalin and gabapentin

NHS England

Pregabalin is licensed for the treatment of epilepsy, generalised anxiety disorder and neuropathic pain. However, pregabalin as well as gabapentin are also becoming highly sought after because of their use in enhancing the effects of opiates and also have their own inherent abuse potential. This was originally identified in the prison population, but is also now misused in the general population too.

Pregabalin experimenters may often have a history of recreational polydrug misuse. Pregabalin may be sold as a street drug under a number of pretexts including mood enhancer, to augment the effects of other drugs, to manage opiate withdrawals and cravings or as a substitute for other drugs such as cocaine.

Prescribers should be aware of the potential for misuse of this drug. If a patient demonstrates suspicious behaviour related to pregabalin (e.g. appearing to seek larger than needed doses, losing prescriptions, frequent over-ordering, specific named requests for pregabalin without supportive medical documentation), the possibility of abuse or diversion should be considered and a cautious approach with action taken as deemed appropriate to the situation. Clinicians should also exercise a similar level of caution with gabapentin.

Locally there have been reports of patients requesting this for Generalised Anxiety Disorder (GAD) but without any supporting information being supplied to the prescriber that this has been prescribed previously.

Wherever possible, NICE guidance for the treatment of GAD must be considered and patient assessment undertaken to confirm diagnosis and the most appropriate treatment. The NICE guidance (CG113 – Generalised Anxiety Disorder and panic disorder in adults) makes the following recommendations for drug therapy:

1. First-line: A generic SSRI. (Including those not licensed for GAD, e.g. sertraline)
2. Second-line: An alternative SSRI or an SNRI (Serotonin and Noradrenaline Reuptake Inhibitor).
3. Third-line: Pregabalin – if SSRIs and/or SNRI are ineffective or not tolerated.

If it is deemed appropriate that pregabalin is the most appropriate medication for the patient, then it should be monitored for adverse effects and effectiveness.

Common incidents and advice on how to deal with them

We are finding that many incidents and discrepancies are being reported without the appropriate actions having being undertaken.

For incidents such as; dispensing the incorrect quantity, drug or form; dispensing to the wrong patient; S v SF mix-ups; dispensing against out of date/invalid prescriptions and balance discrepancies please ensure you do the following as standard;

Actions to undertake if CD incident is identified	Actions to undertake if discrepancy identified
- Contact the patient and prescriber straight away and advise of the incident. If a patient has been supplied with too many CDs and it is felt there is risk involved with them being in their possession, collect the excess medicines as soon as possible. If a patient has been supplied with fewer CDs than prescribed ensure the patient is provided with the correct amount as soon as possible. Once the above has been completed ensure that an investigation is conducted into how the incident happened. Share the learning from investigation with all staff to prevent from occurring in the future. Review SOPs and update if necessary. Report internally as required and to the CDAO. In your report ensure to outline what steps you have taken to prevent from reoccurring.	Check recent dispensing with patients to ensure they have received the correct quantity and product. If a patient has been supplied with too many CDs and it is felt there is risk involved with them being in their possession, collect the excess medicines as soon as possible. If a patient has been supplied with fewer CDs than prescribed ensure the patient is provided with the correct amount as soon as possible. Check CD register to ensure deliveries and prescriptions have been entered in correctly Check electronic CD register (if applicable) Are calculations correct in paper register? Is out of date/unusable stock separate and has this been checked? Check stock levels of similar products e.g. methadone DTF and SF If discrepancy is still unresolved increase balance checks and monitor carefully Report internally as required and to the CDAO. Clearly outline the steps you have taken to resolve.

CQC CD Annual Report & new Self Assessment Tools

NHS England

The CQC Safer Management of Controlled Drugs Annual Report has been published recently. The report can be viewed at http://www.cqc.org.uk/content/controlled-drugs.

On this link you will also find some controlled drugs self assessment tools for primary and secondary care. BNSSSG has already undertaken a self assessment of GP and dental practices this year however this could be used if you encounter issues prior to the next Area Team self assessment.

Ketamine Consultation

The open consultation is seeking views on the recommendation to reschedule ketamine to a schedule 2 CD.

The consultation is open until 9th November and you can provide your feedback at https://www.gov.uk/government/consultations/ketamine-rescheduling-consultation

Obtaining private CD codes

For pharmacies who require a private CD code please email england.bnsssg-controlleddrugs@nhs.net. In your email please provide your NHS contactor code, the pharmacy name, trading name, full address and phone number.

For GPs who require a private prescribing code please also send an email to the above address and outline why you require the code. We will then provide you with a form to complete which asks for the information that will be included on your private prescribing forms.

Individuals of concern in BNSSSG

There are a number of patients in our area who have been inappropriately seeking controlled drugs. Alerts have been circulated about these individuals but we wanted to recirculate information about them so that you will be more likely to identify them if they attend at your premises. All of the below patients are fully registered at practices in our area and their issues are trying to be managed by a GP. If you believe that any of the below individuals attends at your premises please contact the CDAO on the details on page one.

- Male, late 20's - This patient has been attending at numerous surgeries in Bristol area seeking tramadol and pregabalin. The patient usually states that he has just arrived in the UK from Tehran.
- Male early 30's - Patient attends at emergency departments and GP Practices. A diverse range of dates of birth and cover stories has been used to obtain CDs although a common theme relates to pain relief required for a recurrent shoulder injury.
- Female, mid 50's - Individual has recently been changed to controlled pick up of codeine and as a result is attempting to obtain supplies elsewhere. The medication she is specifically seeking is tramadol.
- Female, late 40's - Patient has been attempting to multi-register at practices and specifically tries to obtain dihydrocodeine and zopiclone tablets.
- Male, born in 1994 - Patient trying to register with multiple practices as a temporary resident. The patient alleges temporomandibular joint (TMJ) pain dysfunction syndrome and has requested codeine, naproxen, lansoprazole, sertraline, amoxicillin, meloxicam and pseudoephedrine.

Poor care in relation to CDs in care homes

There have recently been a number of reports to the CDAO outlining concerns in relation to controlled drugs administration in care homes.

In one case an investigation showed that there was a breakdown in communication between staff, there were multiple MAR sheets and nurses were not attending EOLC training as recommended. Since multiple organisations are involved in providing and maintaining these services (LA, CCGs, NHS England, CQC) it is difficult to ascertain who has overall responsibility for this.

Therefore, the BNSSSG CDAO is going to lead on this as a work stream to make sure this is an area which is taken seriously.

If you have any concerns relating to controlled drugs in care homes please contact your CDAO on the contact details on

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 September 2014 (quarter 1 & 2).

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.

Useful contacts

BNSSSG CDAO
BNSSSG Medical Directorate
NHS England
South Plaza
Bristol
BS1 3NX

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/

Type of Incident or Concern	Number of reports
Discrepancies - 60	Shortage: 40
	Overage: 20
Incorrect quantity	19
CD given to the wrong patient	12
S v SF	10
Smashed or spilt CD	10
Wrong strength CD	8
Dispensing against out of date/invalid prescriptions	8
Dispensed on wrong day	6
Lost or stolen prescription	5
Wrong form	3
Wrong label	3
Wrong CD	2
Wrong brand	1
Other	36

Lessons learnt from prolific CD abuser case

Most of you will be aware of a Bristol resident who committed a number of unforgettable wrongdoings in order to obtain inappropriate treatments and drugs. The individual deceived staff right across the health sector and caused an enormous amount of stress and upset to NHS staff and members of the public all over the country. A document has been drafted by the BNSSSG CDAO which provides a summary of how the individual operated, actions taken by BNSSSG, the problems encountered and lessons learned. We aim to share the document across all health sectors in the hope that it will ensure we are better prepared to deal with individuals like this in the future at both a national and local level. In the meantime please see below an outline of the main learnings for GP Practices and Community Pharmacies;

- Better communication between healthcare about suspicious behaviour—if you have concerns about a patient ensure you raise them with someone in a central role in your organisation even if your suspicions are apparently unfounded.
- Always follow up on phone calls regarding CD prescribing—where this was done in this case the numbers were for random businesses out of the yellow pages. Treat mobile phone numbers with suspicion.
- Don't be persuaded by patients in possession of medicines, equipment or paperwork— this individual had collected a large array of items such as syringe drivers, oxygen cylinders empty meds packaging, forged letters etc. Just because a patient has this equipment does not mean they have obtained it legitimately.
- Community pharmacy should be careful not to act as a middle man if requested for a need for replacement CDs.
- Community pharmacy staff should ALWAYS check the identification of their locums (preferably photo ID) even if employed through an agency
- Any temporary resident requests for controlled drugs should always be treated with extreme caution and only small amounts (if any) should be prescribed before speaking to their previous practice.