BNSSSG Controlled Drugs Newsletter for Pharmacies

Autumn 2013

New Structure

This is the first newsletter since the role of the Controlled Drugs Accountable Officer (CDAO) transferred from PCTs to NHS England Area Teams and we want to start by saying thank you to all of you for your support throughout the transition. It has taken a while to get our systems in place but hopefully you are all now aware of who to contact when, and if not then this newsletter should provide you with some further clarity.

The CDAO now falls under the remit of the Bristol, North Somerset, Somerset and South Gloucestershire (BNSSSG) Area Team which is part of NHS England. Caroline Gamlin (BNSSSG Medical Director) has been undertaking this role up until now. However, we are pleased to announce that Sue Mulvenna is going to be taking over this role and will be in post from January 2014.

If you wish to know more about the restructured NHS then the Kings Fund have created an animation which provides a good overview. It can be viewed at: http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

Please ensure that SOPs have been updated to reflect the changes to the system and methods of reporting.

Please continue to report all incidents and discrepancies and don't hesitate to contact us with any controlled drug related queries.

Controlled drug errors, incidents or concerns should be reported to your Area Team CD Accountable Officer.

Email: england.bnsssg-controlleddrugs@nhs.net

Phone: 0113 825 3568

Fax: 0117 900 3409

Inside this issue:

Pharmacist Shared Learning	2
Locum Identification	2
CD Destructions	2
Changing Status of Tramadol	3
Lisdexamfetamine Advice	3
Opiate Patches	3
Useful Contacts	4
Reporting Update	4

Pseudoephedrine reminder

There have recently been a large number of incidents where people have attended at community pharmacies in the North Somerset area to purchase Pseudoephedrine or Ephedrine containing products along with iodine products which are renowned for being used to make methylamphetamine, also known as 'crystal meth'.

Thank you to those of you who have been in touch to report these incidents. We are pleased to confirm that thanks to the information you have provided 5 arrests have now been made. Both the BBC and Bristol Post have reported on this www.bbc.co.uk/news/uk-england-somerset-24761824

This is a recurring issue so please continue to be vigilant. Any suspicious attempts to purchase products should be reported to the Area Team Controlled Drug Accountable Officer or local Police Controlled Drug Liaison Officer; Pete Collins Tel: 01275 816628 or email: peter.collins@avonandsomerset.police.uk

Don't forget the RPS has clear guidance on the quantities of pseudoephedrine/ephedrine that can be sold over the counter.

Pharmacy Shared Learning

We have received a number of incident reports where staff have failed to notice changes to prescriptions and have dispensed the incorrect amount. This highlights the need to thoroughly check each prescription even if they are for regular patients known to the pharmacy.

We received a report about an opiate naive patient who was dispensed 100mg morphine. The GP had meant to prescribe 10mg but unfortunately clicked on the wrong amount. The patient took two tablets and this resulted in them being admitted to hospital. To ensure this does not happen again please make sure that you check the patient's PMR and query high dose opiate or unusual prescribing where appropriate.

There have been a large number of incidents where sugared methadone has been given instead of sugar free and vice-versa. Please consider the below actions which some pharmacy staff have adopted to minimise the potential of this type of error occurring include;

- Annotating the patient medication record accordingly
- Highlighting 'SF' on the prescription form with a highlighter pen
- Making dispensary staff aware which patients take each formulation
- Preparing of all Sugar Free prescriptions first, then placing all the prepared prescriptions and stock bottles back in the CD cabinet before preparing all Non Sugar Free prescriptions or vice versa.
- Separation of Sugar Free and Non Sugar Free preparations as far as possible

All CD discrepancies and incidents should be reported to the Accountable Officer

Locum Identification

We have recently had an incident where a lay person took on the identity of a pharmacist and spent the day working as a locum in order for them to obtain controlled drugs.

Community Pharmacies are advised to be extra vigilant when using the services of locum pharmacists they do not know, even if they come through an agency. It is good practice to check photo identity (e.g. smart card, driver's license) as well as valid GPhC registration when the pharmacist is not known to the organisation.

Destruction of Out of Date CDs

The GPhC have undertaken a number of pharmacy inspections and a common issue seems to be that there are a number of out of date schedule 2 and 3 CDs on premises.

To arrange for an authorised witness to attend to witness destructions please email england.bnsssg-controlleddrugs@nhs.net or call 0113 825 3568.

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.

Pharmacies should have an appropriate number of destruction kits in stock. for the destruction.

Changing Status of Tramadol

The Department of Health consultation on the changing status of Tramadol ended on 11th October 2013.

The Advisory Council on the Misuse of Drugs (ACMD) had issued recommendations to the Department of Health that Tramadol be controlled as a class C substance under the Misuse of Drugs Act 1971 and listed in Schedule 3 of the Misuse of Drugs Regulations 2001. This recommendation was prompted by an increasing number of reports within the NHS of Tramadol's misuse and harms.

The Royal Pharmaceutical Society has backed the Government's proposed reclassification of tramadol to a Schedule 3 Controlled Drug, but has also raised concerns about how pharmacies will deal with the resulting storage requirements to meet safe custody provisions.

Where storage may become an issue, ideas that have been proposed include; pharmacies might wish to consider having more than one delivery day if they anticipate that this may be a problem. Or potentially by keeping stock levels low extra space may be created but may not be practical depending on the pharmacy population.

We wait to hear the outcome of the Department of Health consultation.

Lisdexamfetamine Advice

Earlier this year the Medicines and Healthcare products Regulatory Agency (MHRA) granted a licence for the use of Elvanse in the UK for the treatment of attention deficit hyperactivity disorder (ADHD).

Lisdexamfetamine is itself an inactive pro-drug but it is rapidly metabolised to dexamphetamine which then has the potential to exert the physical and social harms associated with amphetamines as a class, although there may be some differences attributable to its prolonged pharmacokinetic profile.

At the time of writing lisdexamfetamine is a non controlled drug however this is being reviewed by the Advisory Council on the Misuse of Drugs (ACMD). The interim recommendation of the RPS and the Home Office is that pharmacists should treat lisdexamfetamine similarly to Schedule 2 CDs for the purposes of transportation, safe custody, record keeping and supply to patients . Emergency supply in the absence of a prescription should not be carried out.

Please ensure that you undertake regular balance checks to reduce the likelihood of discrepancies occurring

Opiate patches

A total of 5,139 patient safety incidents relating to fentanyl or buprenorphine patches have been reported nationally between the July 2009 and July 2012.

Patients should be advised how to use patches, including correct administration and disposal, frequency of patch application and symptoms and signs of opioid overdosage. Patches should be removed immediately in case of breathing difficulties, marked drowsiness, confusion, dizziness or impaired speech and patients should seek prompt medical attention. Patients should be reminded that they should allow several days to pass before a new patch is applied onto the same area of skin.

Heat can cause increased drug absorption and so patients should be advised not to expose the patch to direct heat such as heating pads, electric blankets, hot-water bottles, heated water beds, heat or tanning lamps, intensive sun bathing, prolonged hot baths, saunas or hot whirlpool spa baths.

Useful Contacts

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

Phone: 0113 825 3568
Fax: 0117 900 3409
E-mail: england.bnsssg-controlleddrugs@nhs.net

GPhC Inspectors

Somerset — Barry.Cohen@pharmacyregulation.org

BNSSG — Deborah.Hylands@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/

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 2013. The number of incidents and discrepancies reported is consistent with the 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
Wrong quantity	30
Smashed/spilt methadone	11
Sugar v Sugar Free methadone	20
Wrong patient given CD	9
Wrong strength of CD	8
Didn't notice change to prescription	7
Lost/stolen prescriptions	7
Missing CDs	5
Wrong drug supplied	3
Handed out on the wrong day	2
Incorrect instructions	2
Incorrect label	1
Dispensed without prescription	1
Out of date prescription dispensed	1
Wrong brand	1
Wrong form	1
Wrong name	1
CD Discrepancies - overage	15
CD Discrepancies – shortage	35