

# CONTROLLED DRUGS NEWSLETTER



SHARING GOOD PRACTICE IN DEVON, CORNWALL AND THE  
ISLES OF SCILLY

Volume 2 / Issue 4

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**Area Team for Devon,  
Cornwall & Isles of Scilly**

## PREPARING FOR THE HOLIDAY PERIOD

There have been recent cases of patients and their carers being unable to access necessary drugs such as diamorphine promptly over the weekends. With the holiday period approaching we are asking pharmacies to review their stockholding to reduce these difficulties.

One issue seems to be that pharmacies have stocks on Friday morning, but their stocks are being depleted during the day as they resupply existing patients, and they are then not able to obtain fresh stocks for the weekend. We can understand the desire to see that patients are reviewed before the weekend, but the practice of leaving this until Friday may be adding to the pressure on the system.

With regard to this holiday period, there will be deliveries from wholesalers on **Saturday 27<sup>th</sup> December**, but orders for these will probably have to be placed by the middle of Wednesday morning. We are therefore asking practices to review their existing palliative care patients in time to send the prescriptions to pharmacies by **Tuesday 23<sup>rd</sup> December**. This will allow pharmacies to replenish their stocks in time to provide for newly initiated patients over the Christmas period.

## PREVENTING HARMS FROM THE USE OF METHADONE

The clinical subgroup of CQC's controlled drugs national group has produced a new newsletter and supporting information covering the "Safer Use of Controlled Drugs - Preventing harms from the use of methadone" which can be viewed at <http://www.cqc.org.uk/content/use-controlled-drugs> (or scan the QR code below)



The newsletter makes seven recommendations to practitioners:

1. They are competent to prescribe, dispense or administer in the context of use.
2. The methadone dose is safe for those who may be opioid/opiate naïve as a consequence of intentional/unintentional withdrawal or initiation of treatment.
3. Those who prescribe, dispense, administer or take methadone are fully aware of the potential for harm if:
  - The drug is taken to excess (in any context);
  - Combined with alcohol, and other drugs; and
  - Is given to someone with insufficient tolerance to the dose.
4. The concurrent use of methadone with other opioid(s)/opiate(s) or respiratory depressants can result in a cumulative respiratory depressant effect leading to serious patient harm. Clinicians should review these medicines and avoid their use if possible; and if prescribed, patients should be made aware of potential interactions.
5. All those involved in the use of methadone recognise the potential dangers if children have access to methadone.
6. The correct formulation has been prescribed, dispensed and administered and that a x10 error is not possible due to confusion between the 1mg/mL and 10mg/mL concentrate.
7. Supervised consumption is available and used to ensure compliance while preventing diversion; and allowing for individual progression to recovery and self-management.

It has been the practice in Cornwall not to prescribe concentrated opiates as a matter of routine. Where there are good reasons to do so, the prescriber has confirmed this directly with the dispensing pharmacist so that the pharmacy knows the use of concentrate is intentional.

Since good patient care may require a prescriber to provide methadone outside a shared care framework in emergencies, it is not practical to restrict the right to prescribe. However, we would expect that continuing methadone prescriptions would only be issued by suitably trained professionals working within a network of support. If prescribers find that they have to prescribe repeatedly in these circumstances we would be happy to hear of it so that we can organise suitable support.

We would recommend that when a patient is counselled about the safety implications of points 3, 4 and 5 a record is made that this information has been given.

## CORRECTING ERRONEOUS RECORDS

Two recent incidents in different settings suggest that it may be useful to give some advice about alterations to records.

Errors of any kind in controlled drugs registers should not be obliterated. Erroneous entries should be marked with an asterisk or bracketed with the reason for the error indicated by a numbered footnote which should also be signed and dated. For example, sugar-free methadone may have been dispensed but the entry made in the register for standard (sugared) methadone. In this case, we would leave the entry legible, note the error in the margin, and then add an entry to correct the balance e.g. Correction of incorrect entry – 50ml for Mr X incorrectly entered – balance 620ml.

In one incident a dispensing doctor prescribed 10 x 5mg diamorphine. The dispensary was only able to supply 5, so 5 were marked as owed. Subsequently the patient's dose was increased, and the doctor was concerned that the patient might collect both the owing 5mg doses and think both 5mg and 10mg were to be used. She therefore attempted to remove the owing from the record, but did so by deleting the original (already dispensed) prescription and replacing it with a new one for 5 x 5mg. While this prevented dispensing of the owing, it meant that the date on the prescription appeared to place it after it had been dispensed and introduced a mismatch between the prescribing and dispensing records. It also meant that a prescription was printed which might have been dispensed again.

An additional lesson from this case was the need to log out of terminals after use. The practice discovered during their internal investigation that their system no longer logs them out automatically after a period of inactivity. As a result the doctor producing the 5 x 5mg prescription inadvertently did so under another doctor's login. **It is good practice to log out of clinical systems after use.** Some practices prefer their staff not to switch off their terminals, but they should still log out of all systems and the operating system (e.g. Windows) to prevent unauthorised access.

A locum asked a patient's representative to clarify the dose of oxycodone that the patient was receiving and, based upon information supplied, prescribed more doses per day than the patient was actually taking. The pharmacist dispensed the oxycodone but the error was then noticed. The locum supplied a replacement prescription but asked the pharmacist to destroy the original prescription and delete any mention of it from the patient medication record.

This was incorrect advice. The original prescription was the legal justification for the pharmacy to dispense the oxycodone; if it is destroyed that appears to show that the oxycodone has been supplied without a valid prescription. The correct action would have been to annotate the record rather than to delete it.

## NHS ENGLAND REORGANISATION

Readers may have seen that the NHS England structure is being revised to give directors oversight over a wider area. The plan is to combine the south-western Area Teams so at some stage this team will merge with its counterparts further into England.

At this stage we do not know what the consequences will be for this newsletter, but we expect that it will continue in some guise in the year ahead. The future arrangements for CD LINs and reporting of controlled drugs issues will be shared when we know exactly what they are, but we anticipate no change to the next cycle of CD LIN meetings (see sidebar for details).

## DELAYED REPORTING

We continue to receive reports of incidents some time after they took place. We would expect to hear within a working day, even if inquiries have not been finished – the report can be topped up later. We record the time lag in reporting and that can influence our view of the adequacy of the response to an incident.

## COMPLIMENTS OF THE SEASON

May we wish all our readers a Merry Christmas and Happy New Year!



## DENTISTS' PRIVATE CD CODES

The Area Team PCD code for dentists is 611433. Prescriptions with the old PCT codes will only be linked to this Area Team until the end of January 2015 and any dentist wishing to continue to prescribe privately will require stationery with the 611433 code before then.

If you hold pink private prescription forms, please check the preprinted code. If it is 611433 you can continue to use them. If not, please apply to us for replacements. Please don't delay!

## SUBMITTING YOUR PRIVATE PRESCRIPTIONS TO NHSBSA

Download the submission form at <http://www.nhsbsa.nhs.uk/2473.aspx> (or use the QR code below) - click on "Submission document for submitting controlled drugs through a private account."



## NATIONAL REPORTING AND LEARNING SYSTEM (NRLS)

Please note that reporting incidents to us does not obviate the need or meet the duty to report to NRLS. We do not forward your reports.

## NEXT CDLIN MEETINGS

North & East Devon	3 February	Middlemoor Police Station
Cornwall	11 February	Peninsula House, Saltash
South & West Devon	26 February	Bodmin Police Hub