CONTROLLED DRUGS NEWSLETTER

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

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SAFEGUARDING CHILDREN

A report has been issued by Derbyshire Safeguarding Children's Board into the death of a small boy whose mother gave him 10-20ml of methadone. The report can be viewed at http://www.derbyshirescb.org.uk/user_controlled_lcms_area/uploaded_files/REDACTED_BDS12_Final_Overview_report_27Nov13.pdf

While this review was expressly concerned with methadone use in a substance misuse setting, common sense suggests that there is the potential for similar outcomes whenever a controlled drug enters a home. We repeat here those recommendations which relate to healthcare provision in order that colleagues can reflect on their practice and ensure that local procedures provide equivalent assurance.

There were concerns that information was not shared adequately.

All providers of substance misuse services should undertake a review of the arrangements for the prescription and monitoring of methadone for parents with children under 5. This should include:

- A review of prescribing guidelines, policies and procedures.
- A review of those guidelines for parents with children under 5.
- An explicit identification of risks and steps taken to mitigate such risks with related action plans.

To ensure compliance with;

- The required risk assessment,
- Guidance to parents,
- 'Think family' standards, and the
- Distribution of safe storage box facilities for all service users who have children under 5 years of age.

A multi-agency assessment led by the prescriber must always be undertaken before methadone is taken to a home where children and young people under 18 reside or visit. Prescribers should regularly ask their patients about their contact with any children and review the prescription in the light of this or new information.

All prescribing services should always consider the role and capability of non-drug abusing partners and ensure that they are seen alone and, if appropriate, referred to services that can support them in their safeguarding role.

Electronic Systems should be developed to ensure that all drug using adults who may present risks to children are flagged accordingly.

Controlled Drugs are controlled precisely because they may represent a danger to people who are unaccustomed to taking them. In order to allow them to be distinguished readily, they tend to be brightly coloured, which makes them more attractive to small children. Part of the standard dispensing procedure in pharmacies should be to remind patients to keep these out of the reach of children, but unfortunately a high proportion of such drugs are dispensed via third parties such as carers.

With this in mind, we are currently devising a small flyer that can be issued with medicines to patients couched in slightly different terms. Rather than reminding patients to keep medicines out of the reach of children, we are asking them to identify a place where medicines can be safely stored and which children cannot access, and to remember that even though they may not have small children themselves, they need to continue children who may visit. We will email the flyer to you when it is ready.

THE SINGLE OPERATING MODEL

Bridget has been closely involved in an initiative of NHS England which is seeking to develop good practice by harmonising processes across the country. As a result of this, some of the stationery previously used in the south west will be changing (though we are proud to say that in a number of cases our templates have been selected as the norm). If you request new forms from us please destroy the previous equivalent form.

PRESCRIPTION FORMS BEARING CONTROLLED DRUGS

Recent incidents indicate a weakness in systems operated by some practices. Pharmacies have reported non-receipt of prescriptions containing controlled drugs, and the practices have declined to replace them. While these can no doubt go missing in the post or elsewhere, in the particular cases we have recently had it has transpired that the prescription had not actually been signed and issued by the doctor, although the practice computer system showed that one had been generated. It is good practice to record the collection of such prescriptions, perhaps by means of a signing sheet. This may also save staff time if one goes astray.

HANDOVERS

When a patient is moving between dispensers, the prescriber should ensure that it is clear which dispenser should provide their medicines on the handover day. Asking the patient whether they have already had some methadone may not produce an honest answer.

Picking lists

Please note that prescribing systems often do not list options in order of strength, but by alphanumeric order. Thus it is likely that the strength below 10mg will be 100mg rather than 15mg, and the strength between 10mg and 30mg may be 200mg. This has contributed to some prescribing errors. Please expand the entry fully when prescribing. There is guidance at http://www.connectingforhealth.nhs.uk/systemsandservices/eprescribing/refdocs/opiates.pdf **.**

Substance misuse – 3 day rule

If a client misses 3 days' supply of their prescribed medication (NOT 3 pickups) it is normal practice to notify the prescriber and not to dispense again to that client until they have been reassessed. This is not a punishment for the client, but an essential safety measure designed to reduce the risk of dispensing to a person whose tolerance of their medication has been reduced. It is good practice to note that the prescription is on hold pending a reply to prevent accidental dispensing.

Please note that if the prescription specifies that a supply must not be made if 3 days have been missed, it cannot be reactivated once that has happened, and a new prescription will be required.

If the client claims to have used alternative sources during the three days that is taken into account by the prescriber; it does not allow dispensers to make a supply.

COLLECTIONS BY THIRD PARTIES

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 such drugs. However, pharmacies and dispensing practices have a duty to ensure that the third party 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 is sent. The decision as to whether a third party is authorised to collect on behalf of a patient should be made in accordance with a practice's SOPs. A formal written consent is not normally needed, and it may be reasonable to presume that a collector is authorised if there is a known connection with the patient. Please ensure that the entry in the controlled drugs register records whether identification was requested. It is good practice to note what that identification was (though it is not a legal requirement).

The position with substance misuse clients is rather different. Generally, it is a condition of treatment that the client attends in person to collect. This condition can be varied by the prescribing service, either on a single occasion or for the longer term. **The rule is therefore that these drugs should not be given to others unless specifically authorised**; there may be very exceptional circumstances in which, in the professional judgement of the pharmacist, it is necessary for patient care to allow a third party to collect because the permission described above cannot be obtained. However, the exercise of judgement is restricted to cases where there has been no response by the drug service or prescribing doctor to the pharmacist's enquiry; it does not extend to deciding whether to ask for permission. If the pharmacist makes a supply in those circumstances, it is good practice to note the reason.

The prescribing services will confirm the authority to collect by fax. There is guidance that a new fax should be supplied for each pickup; in our view this may be burdensome, and we see no objection to the issue of an authorising document allowing third party collections for a stated period of time, but an open-ended authority is not good practice.

SPILLAGES OF LIQUID CONTROLLED DRUGS

When a liquid is spilled we have to balance the need for accuracy in management of controlled drugs with the health and safety implications of having a dangerous liquid on the bench or floor. In our view, the health and safety requirements mean that the spillage must be promptly cleared up but we would expect the following to be considered.

1 The fact that there has been a spillage should be shared with a colleague who should, so far as possible, confirm the identity of the spillage.

2 The spillage should be mopped up. Any paper towels, tissues or absorbent used should be placed in a CD destruction container. It is not necessary to retain them for inspection.

3 It will not always be possible to calculate the exact amount of the spillage, but the best estimate should be made.

4 Conduct a stock check of the item and make an entry in the register giving the current verified stock. You should distinguish between measured and estimated spillages.

> Examples:
>
> John measures 50ml methadone in a glass measure but knocks it over. The spillage is therefore known to be 50ml and can be noted precisely in the register.
>
> James knocks over a stock bottle of methadone. According to the register, it should have contained 400ml. When it is righted and measured, it is found to contain 280ml. If the 400ml figure has not been checked recently, it may not be correct – all we know is that there is now 280ml, so the entry in the register notes that there was a spillage estimated at 120ml, and the balance is noted as 280ml.

5 As with any other CD incident, the accountable officer should be informed.

REPORTING INCIDENTS TO THE ACCOUNTABLE OFFICER

In discussion with a pharmacy about an incident, it was discovered that the pharmacy's SOPs required them to notify their head office who would decide whether the Accountable Officer should be informed.

Under section 13 (2) (b) of The Controlled Drugs (Supervision of Management and Use) Regulations 2013, the Accountable Officer is required to make arrangements for determining whether incidents or concerns that relate to a relevant individual's performance in connection with the management and use of controlled drugs require investigation; to this end, our arrangements for Devon and Cornwall require disclosure within one working day of the incident. **Any incident that bears or could have borne on patient care must be reported.**

A delay of up to a day is reasonable where the issue is a stock discrepancy. This will allow time for a proper stock check to be conducted, and if the apparent discrepancy is resolved there is no need to inform us.

We monitor the time elapsed between an incident and the corresponding report which will inform our assessment of a provider's management of controlled drugs. While each case is judged on its merits, we will take a more critical view when that report has not been made promptly, because that is, in itself, a breach of professional duty.

NEW PRESCRIBERS

It is good practice to inform pharmacies of new prescribers who are employed within your practice and to provide specimen signatures. There are increasing concerns that this courtesy is being neglected, as a result of which dispensing is delayed and patient care may be affected. There is no mechanism to inform pharmacies automatically of changes in practice membership.

SUBMITTING YOUR PRIVATE PRESCRIPTIONS TO NHSBSA

You can download the submission form by going to **http://www.nhsbsa.nhs.uk/2473.aspx** and then clicking on "Submission document for submitting controlled drugs through a private account."

SYRINGE DRIVER PRESCRIPTIONS

We continue to see problems because prescribers are specifying doses "as per syringe driver sheet" or with similar phrases. The directions for use must appear on the prescription form, or it is not valid and cannot be dispensed. There cannot be a cross-reference to another document. We must also remind prescribers (again) that "As directed" is not a legal direction.

Please note also that the formulation (injection, tablets, capsules etc) must be written on the prescription. It cannot be implied, so "MST 30mg" is not a legal description.

CHANGING HOURS

The recent Christmas and New Year period has brought up the question of pharmacies changing their normal working hours. We assume that the proper procedures for doing so have been followed, but it is still necessary to ensure that patients – particularly regular substance misuse patients – are informed. The normal pattern is that clients are asked not to collect in the last half-hour of the working day to allow the necessary checks and register entries to be made, but plainly this requires that they know what the end of the day is. If you close earlier than usual, clients must be informed. If you work extended hours, you need to clarify whether later collections will be possible or not.