CONTROLLED DRUGS NEWSLETTER

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

Volume 1 / Issue 6

CONTACT US

Accountable Officer:
Bridget Sampson
☎ 01726 627955
@ bridget.sampson@nhs.net

Deputy Accountable Officers:
Darren Barnett (Mon-Fri)
☎ 01392 314657 or 07747 443418
@ darrenbarnett@nhs.net
Graham Brack (Mon-Tue)
☎ 01726 627845 or 07747 455068
@ graham.brack@nhs.net

Secure email address:
accountableofficerdcios@nhs.net

Administrative Support:
Sally Dutton
☎ 01752 434942
@ sally.dutton@nhs.net

Area Team for Devon, Cornwall & Isles of Scilly

PREVENTION OF FUTURE DEATH REPORTS

These were previously known as Rule 43 Reports and are generated by coroners who believe that action might be taken by bodies that would prevent similar deaths in the future. Bodies receiving such a report must respond within 56 days. The reports are collated and published every six months, and the report to September 2013 has just been issued. This can be downloaded from http://www.judiciary.gov.uk/Resources/JCO/Documents/coroners/pfds/Summary%20Report%20of%20PFD%20Reports%20Apr%20-%20Sep%202013.pdf.

One death resulted from the use of a Graseby syringe driver which the manufacturers no longer support. As a result, an organisation had devised its own training package which seemed not to have been adequate.

CQC and NHS England have issued guidance on this subject (http://www.cqc.org.uk/sites/default/files/media/documents/safer_use_of_controlled_drugs_-_for_the_web_-_preventable_harm_still_occurring_with_cds_administered_via_ms_syringe_drivers.pdf) which says:

1. Introduce ambulatory syringe drivers with safer design into practice as soon as possible.

It is recommended that no MS syringe drivers are used in NHS and independent healthcare providers providing NHS funded care, by December 2015 at the latest.

2. Take steps to reduce the risks of rate errors while MS syringe drivers remain in use, based on a locally developed risk reduction plan which may include:

i. raising awareness

ii. providing information to support users with rate setting

iii. using lock-boxes.

MORPHINE SULFATE ORAL SOLUTION

It is normal practice to provide patients receiving regular opiates with a supply of quick-acting opiate such as morphine sulfate oral solution (e.g. Oramorph) for use as breakthrough doses. The size of these doses is usually included on the prescription but no frequency is specified. However, this places an onus on the prescriber to review actual usage, both to determine whether the patient's condition is worsening and to ensure that the prescribing is safe.

In a recent example a patient received 3 x 500ml Oramorph in a single month. It transpired that she had a stock of nearly 500ml at the month's end, but this suggested that she was using about 500ml per fortnight, equivalent to about 70mg morphine per day above the regular prescription. It is arguable that if the patient consistently needs this additional dose then the baseline doses should be adjusted. In this case this suggested seven breakthrough doses each day.

The police have reported seizures of complete 500ml bottles of Oramorph from people who have not been prescribed them. We have asked practices in these localities to review their prescribing to see if any of their patients may be the source of this diverted morphine, knowingly or unknowingly.

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.

COLLECTIONS BY THIRD PARTIES

In CD Newsletter 5 we referred to the need for SOPs to cover collection of controlled drugs by a third party, and the identification requirements for third parties. The decision to allow a collection is for the dispensing pharmacy or practice to make in accordance with its SOPs – though a third party obviously cannot collect a dose requiring supervised consumption.

Generally, there is a condition of treatment that a substance misuse client collects in person, which may be varied by the prescribing service, either on a single occasion or for the longer term. In very exceptional circumstances the pharmacist may consider that it is necessary for patient care to allow a third party to collect because the variation described above cannot be obtained. However, the exercise of judgement is restricted to cases where no reply is received; 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 pharmacist is entitled to assume that the person giving permission is entitled to do so. It is for providers to ensure adherence to their own SOPs.

Prescriptions for anxiety prior to dental treatment

When a dentist believes that a patient may require an anxiolytic or sedative for use prior to an appointment, they will provide a prescription. This will be for an appropriate strength and number of doses.

Patients requesting such a prescription from general medical practices should be directed to their dentist. If a patient does not have such a prescription it indicates that their dentist does not believe that one will be needed.

We are grateful to the Local Dental Committees for bringing this risk of double scripting to our attention.

Substance misuse dispensing

If a client misses 3 days' supply of their prescribed medication it is normal practice to notify the prescriber and not to dispense again to that client until they have been reassessed. Note that the prescription is on hold pending a reply to prevent accidental dispensing.

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 a dispensed dose is spilled by the client, even in the pharmacy, it cannot be replaced without a new prescription. An emergency supply is not possible.

ATTENDANCE AT LOCALITY INTELLIGENCE NETWORK MEETINGS

Under The Controlled Drugs (Supervision of Management and Use) Regulations 2013 the NHS England Accountable Officer (Bridget, in our case) is required to establish one or more Locality Intelligence Networks (LINs) to exchange information relating to the use of controlled drugs in their area. We have three sub-locality CD LINs (Cornwall, South & West Devon, and North & East Devon) which hold separate meetings throughout the year and combine once a year.

For bodies which have an Accountable Officer, and those which are Responsible Bodies within the meaning of the regulations and therefore have a duty of co-operation, attendance at a CDLIN is mandatory in order that the LIN can fulfil its statutory duty to fully exchange information. Failure to attend will be notified to the Care Quality Commission, because the organisation cannot be said to have met its statutory duties in this respect. If the Accountable Officer of a designated body does not attend, they should send a deputy but please note that if this repeatedly happens the body's board will be asked to consider if the Accountable Officer is the right person to carry out those duties.

Some Accountable Officers have a relationship to more than one CDLIN. This can be addressed in two ways – they can send different people to the CDLINs (as Devon and Cornwall Police do) or they can agree with us which CDLIN they will attend.

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."

SUGARED v SUGAR-FREE METHADONE

One of the commonest sources of error recently has been the dispensing of the wrong type of methadone to clients. This is often associated with dispensing in advance of the client's arrival and then handing out the wrong bottle. Pharmacies where this is common practice should have procedures in place to guard against this risk.

NON-EXISTENT PRODUCTS

One way in which hospital practice differs from the community is in the way that doses can be expressed. For example, a prescription for MST 20mg tablets might be dispensed for hospital inpatients, where 10mg tablets would be supplied and the dosage instructions would be adjusted accordingly. That option is not open to community pharmacists, because no 20mg tablet exists.

This leads to a secondary problem, when the patient has received a dose divided in a particular way in hospital and is disturbed when an alternative is offered in primary care. In a recent example, a patient was prescribed MST 60mg twice daily. She had been receiving this as 2x30mg tablets twice daily and recognised that the tablet she was given was peach rather than purple. As a result, she was reluctant to take it until reassured by her pharmacist. There may be circumstances in which prescribers and dispensers could helpfully ask how patients have been taking their doses heretofore.

CO-OPERATION WITH THE ENQUIRIES OF OTHERS

All healthcare professionals have a duty of co-operation to secure safe use of controlled drugs. Our attention has been drawn to a request from the Accountable Officer of a hospital trust to pharmacies in the Plymouth area to check their dispensing records for specified lost prescriptions. A very small number of pharmacies responded. In these circumstances we would expect a response, even if it is a nil return. While management of alerts is a matter for each contractor some controlled drug alerts also require a response. A failure to respond to a reasonable request from an Accountable Officer may call into question an organisation's competence self-assessment.