CONTROLLED DRUGS NEWSLETTER

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

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NHS England

Area Team for Devon, Cornwall & Isles of Scilly

THE SCOPE OF OUR WORK

There seems to be some confusion about the scope of our role. The purpose of an NHS England Area Team accountable officer is to secure the safe management and use of controlled drugs within the Team's geographical area and to ensure that any contractor providing NHS services within this area that could involve controlled drugs is doing so too.

"Appropriate arrangements" for management and use of controlled drugs must include —
(i) systems for recording concerns (including complaints), and
(ii) incident reporting systems for untoward incidents; and
(iii) up to date standard operating procedures.

As a result we ask provider bodies and contractors to forward regular occurrence reports and to give us annual declarations that these systems exist. However, please note that our remit extends to controlled drugs, and does not include other types of incident report.

PRESCRIPTION DOSES

Within hospitals it has long been common for prescribers to prescribe a total dose for a patient, and to leave it to pharmacists to supply appropriate strengths. This is not permitted in community practice, where a prescription must specify the dosage form and how a dose is to be made up. For example, sustained-release morphine 40mg would not be acceptable, because it does not specify whether tablets, capsules or sachets are intended, nor does it specify how the 40mg dose is to be put together (4 x 10mg? 30mg + 10mg?)

NEW PRESCRIBERS

It is helpful to pharmacists if practices notify them of new doctors about to join the practice and provide a sample signature so that it will be recognised when controlled drugs prescriptions are written. This is especially important for GP registrars who will be signing prescriptions bearing other people's details. Where locums are used on a short-term basis it helps if they add their name in block capitals near their signature when they prescribe controlled drugs.

BLISTER PACKS – VARIATION IN PRACTICE

Dispensers[1] differ about the desirability of putting controlled drugs within monitored dosage systems or other blister packs. This is not a matter upon which there is a firm rule, but there are implications arising from this decision, three of which we raise here.

Whatever is done, the quantity originally prescribed should be supplied or the prescription should be amended by the prescriber to reflect the amount dispensed. If 60 Zomorph capsules are prescribed, but only 56 are needed to fill the blisters, the prescriber should be invited to amend the prescription. While it is arguable that supplying a lesser quantity is not illegal, to do otherwise means that the practice notes and the patient dispensing records will not tally.

There have been instances of damage to blister packs resulting in the loss of tablets. A prescription-only medicine lost in this way cannot simply be replaced. Note also that if a care home is receiving the blister, it must be stored securely.

The third issue is that of stability. Good data are lacking and it is therefore a question of professional judgement for the person dispensing the medicines. It is evident that colleagues are arriving at different decisions on this point. In the absence of clear evidence, there is no reason why everyone should come to the same conclusion, but it would be convenient for patients if each dispensary followed their own rule consistently.

QUANTITIES EXCEEDING ONE MONTH'S SUPPLY

A pharmacist has raised the question of a regular prescription for 84 days' supply of controlled drugs. This was covered in the last issue, but we repeat part of the relevant advice here.

Normally, prescribing of controlled drugs should be for no more than 30 days at a time. However, there may be good reason to prescribe larger quantities in some circumstances, such as a patient taking a prolonged holiday.

We would expect dispensers to query such requests, but in addition it is likely that this will be referred back to us by the NHS Business Services Authority's pricing division for us to verify the appropriateness of the prescribing. This will probably be a few months after the event, at which point recalling the decision process may be difficult. For these reasons we urge prescribers to note the reasons for prescribing larger quantities in the patient's notes, and it is helpful if they also inform us pro-actively so that we do not need to trouble them later.

This approach is, of course, predicated on the prescribing being clinically appropriate. Prescribing controlled drugs several weeks in advance of use will not often be good practice and that may have to be justified separately. There may also be concerns about the safety of a patient holding large quantities of controlled drugs, and, in the case of holidaymakers, there may be laws governing the holding of controlled drugs in the country of destination.

Fentanyl patches

A joint CQC/NHS England patient safety group is likely to recommend that patient notes should include some method of ensuring that the site of a patch and the date on which it was applied can be clearly seen.

It will be left to providers to determine how this is achieved, but whatever method is used, its success should be audited at intervals.

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.

The document to which this links changes each month so we cannot link you to the document directly.

Tramadol consultation

The Home Office is currently consulting on proposals to add tramadol to schedule 3 under the Misuse of Drugs Act 1971; it is also consulting on whether safe custody arrangements for tramadol should be waived if schedule 3 status is agreed. The consultation can be found at https://www.gov.uk/government/consultations/scheduling-of-tramadol-and-exemptions-for-temazepam-prescriptions **and runs until 11 October.**

[1] We use *dispenser* here to mean a pharmacist or dispensing doctor or a relevant member of their staff, not just someone whose job title is "dispenser".

INCIDENT REPORTS – A SUMMARY

As at 12th August, we have received 100 incident reports. These can be categorised thus:

- Discrepancies discovered on balance checks 26

In a number of cases, no recent balance check had been performed which made tracking down the immediate cause of the discrepancy very difficult. One cause was the de-blistering of the wrong number of tablets or capsules for multi-compartment compliance aids.

- Wrong product dispensed 17

Please note that if this happens the incorrect product, having been dispensed, cannot be returned to stock and dispensed again. Some of these instances related to a change of product prescribed that went unnoticed by the dispenser.

- Wrong quantity of correct product dispensed 24

Some of these were miscountings. In a handful of substance misuse cases, the pharmacist supplied the amount they thought was wanted but had miscalculated the number of days' supply needed. There were several cases of patients being given original packs in error when a part pack was prescribed (eg 56 MST prescribed, 1x60 given, 4 fentanyl patches prescribed but 1x5 given).

- Supply made to wrong patient 8

In 7 cases ID checking procedures were not correctly followed. The 8th related to a practice prescribing for the wrong patient.

- CD supplied on wrong day 4

This category includes instances of administration of fentanyl patches on the wrong day.

- Others:

Stock missing from patient's home	4	Out of date medication provided	2
Incorrect destruction practice	3	Patient obtaining more than one prescription	2
Incorrect labelling	2	Apparently inappropriate prescribing	2
Theft from dispensaries	2	Register entries not made correctly	1
Spillage	2	Carer aggressive when supply refused	1

LOCUMS AND SOPs

Locums are able to use either the SOPs for the practice in which they are working or their own SOPs. While very few maintain their own SOPs this has the potential advantage of familiarity with the contents. However, they must be comprehensive; an attempt to use a mixture of the two sets of SOPs is likely to lead to conflicts and incompatibilities.

It must always be clear to both the employing practice and the locum which SOPs the locum is using and employers are responsible for training locums in the use of their controlled drugs SOPs. Equally, where a locum has followed an employer's SOP and an untoward incident has occurred, we expect the employer to support the locum to learn from the event, even though they are not employees.

LEARNING FROM LOCAL INCIDENTS

We have had recent incidents in which care homes providing nursing services held syringe drivers but did not have trained staff able to operate the particular model of drivers held, with consequences for good patient care. Some models of syringe driver are no longer supported and therefore refresher courses are no longer available. We understand that it may not be practical to have a suitably-trained nurse on every shift, but we would expect homes offering nursing care to be able to evidence recent training for a sufficient number of staff to ensure good care. While generic syringe driver training is useful, we would expect nurses to be able to operate the drivers their home uses.

Not all pharmacies have the luxury of enough pharmacists to ensure that one is always available during opening hours. There have been instances of controlled drugs going missing when they have been delivered during a break so that nobody is able to lock them in the controlled drugs cupboard immediately. Rather than ask the courier to return (which may not be possible) someone has signed for the delivery but has been unable to secure the products, which have subsequently disappeared. Standard operating procedures should set out the procedure to be followed after such deliveries. There may be an alternative lockable drawer, or the recipient may keep them in their possession until they can be secured (but this is open to misinterpretation unless specifically authorised under the SOPs).

FP10PCD and CDF FORMS

These are the pink private prescription forms and buff-coloured requisition forms used for controlled drugs. These are issued as controlled stationery, and it is the responsibility of the recipient to ensure that they are stored accordingly. It is good practice to verify the stock held at intervals to ensure that all the forms ordered can be accounted for.

It also appears that some dispensers may be forgetting to send the originals of these forms with their monthly prescription bundles. Photocopies should be retained by the dispensing pharmacy or dispensing practice.

FP10PCD forms are personal to a prescriber. If a prescriber ceases to practice, the forms concerned should be returned to us or securely destroyed. There is a simple procedure for this:

1. Telephone or email us to tell us how many forms you have to destroy
2. We will check that against our issue records and inform you if there is any cause to delay destruction (e.g. you have 3 to destroy but our records suggest that you should have 13) or that you can proceed with destruction
3. Telephone or email to confirm that this has been done.

If you have pink FP10PCD forms bearing the PCT stamp, please note that these will cease to be usable shortly. Please order replacements now and destroy the old ones when the new CCG ones arrive.

OCCURRENCE REPORTS

Just a reminder that designated bodies (organisations that have AOs) and provider organisations are due to submit their occurrence reports at the end of September.

CD LIN MEETINGS

North & East Devon	Middlemoor Police Headquarters, Exeter EX2 7HQ	8th October 09:30 – 12:15
South & West Devon	Peninsula House, Kingsmill Road, Saltash PL12 6LE	10th October 10:00 – 13:00
Cornwall	Bodmin Police Hub, Tollgate Road, BodminPL31 2FJ	23rd October 10:00 – 13:00

Formal notification with agendas will be sent to attendees nearer the time.