CONTROLLED DRUGS NEWSLETTER

SHARING GOOD PRACTICE IN THE SOUTH-WEST

NHS South Region South-West

July 2015

PROMPT REPORTING

A recent serious incident causes us to return to this issue. A healthcare professional has a duty to inform us of any incident involving a controlled drug. That is a personal duty and cannot be delegated to others. They may also have a contractual duty to inform their employers, but that does not mean that they can pass the duty of informing us on to that employer. This is particularly important where patients may be at risk; it may be difficult for a healthcare professional to assess the risk to the public, but it will be even more difficult for an employer at a distance.

A good example occurred recently when a carer complained that a pharmacy had dispensed a smaller quantity of a controlled drug than was ordered. Had the carer not complained, we would not have known of the incident. In fact, the pharmacy had dispensed the item correctly and it is likely that the items were lost in the home, but it became clear that there was a safeguarding issue with one of the patient's carers. The police were aware of the general risk but could not act until we forwarded the information. As a result the patient may have been at risk for longer than necessary.

We must make the point that this is precisely the kind of information sharing that the Controlled Drugs (Supervision and Use) Regulations were introduced to enforce. We have a duty to share information with responsible and delegated bodies like the police, as they have to share it with us, but we cannot do so if practitioners do not inform us promptly.

For some time we have logged the time that elapses between an incident and our receipt of the report of that incident. It is clear that some contractors perform much better than others.

Please note that a failure to report a controlled drugs incident may be a failure to meet professional standards. We are not judges of professional standards, so we will forward the details to professional bodies for their consideration.

We regret having to be so forceful, but delays that have, on occasions, extended to months mean that patients are at risk from poor practice, so these delays cannot be tolerated.

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We can no longer receive or send faxes.

SOLUTIONS ON THE STREETS

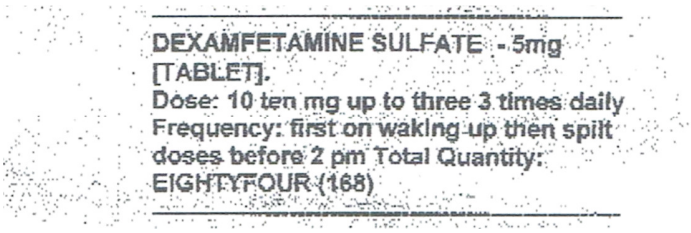
Lately there have been reports of Oramorph and generic morphine sulfate solutions being readily available on the streets. Oramorph is not subject to the same legal controls as some other morphine preparations, but is still highly desirable to substance misusers. Some GP systems allow it to be added to patients' regular repeat items which may mean that requests for repeat prescribing or increased quantities are not receiving the scrutiny that would be desirable.

It is, of course, not possible to give a fixed view on how long a bottle of Oramorph should last. However, a patient who is receiving 500ml per fortnight is consuming over 70mg of morphine a day. If they are using it for breakthrough pain that sort of level might suggest a review of their background analgesia. A calculation of this kind for each patient would be a useful first step in assessing whether a patient (or someone who cares for them) may be diverting morphine.

Prescribers may want to review their liquid morphine prescribing with some simple checks:

1. Search records for Oramorph or morphine sulfate oral solution. For each patient:
2. Check that the morphine has not been inappropriately added to their repeat list
3. Calculate the amount of morphine that they appear to be taking each day based on the amount prescribed and the intervals between scrips. Remember that 1ml = 2mg.
4. If the calculation at (3) appears high, consider whether their other analgesia is optimal.

CURIOSITY


DEXAMFETAMINE SULFATE - 5mg
[TABLET].
Dose: 10 ten mg up to three 3 times daily
Frequency: first on waking up then spilt
doses before 2 pm Total Quantity:
EIGHTYFOUR (168)

This is an unusual item but it serves as a helpful reminder. It was part of a prescription brought to a community pharmacy. The prescriber originally produced the prescription for 84 tablets, but was then persuaded by the patient to give two months' supply to cover an expected holiday. (There is no criticism of the prescribing, which was clinically appropriate.) The doctor over-wrote the number and expected that the software would automatically amend the wording, which it obviously did not do, and which the prescriber failed to check.

The outcome was that the pharmacist could not dispense the item, because it was not clear what number was required, with consequent inconvenience to the patient.

TRANSFERRING PRESCRIPTIONS TO DISPENSERS

A recent set of amendments to the Controlled Drugs Regulations have opened up the prospect of issuing controlled drugs through the Electronic Prescription Service. This is now legal, but at present the software has not been updated to reflect this. The introduction of EPS for controlled drugs has obvious benefits in reducing transcription errors and therefore maintaining patient safety and we hope that there will be rapid uptake when it becomes possible.

In the meantime we have to manage with alternative methods. We have been asked whether it is necessary to use signed-for postal services when sending prescriptions by post. We recognise that there are costs involved in doing so and we would not insist upon recorded delivery being used, but it may be a good choice when large bundles of prescriptions are being forwarded.

Alternatives include hand delivery or including a faxback sheet in the envelope so the pharmacy can confirm receipt. This works best when the sheet bears the numbers of the individual prescriptions sent since on rare occasions an individual prescription is added to the wrong envelope, which may be detected by this means.

BAGGING AND CHECKING

One of the great advantages of the controlled drugs management system is that we can learn from each other and question our own practice. This is particularly valuable in areas where there is no single "best practice".

We were notified about a practice that seems to us to incorporate additional risk. How do you prepare a prescription which includes both controlled drugs and other medications and ensure that both parts are actually issued to the collector?

Many dispensaries use baskets to keep medications together. In some cases these will include controlled drugs so that the whole prescription is checked together; others prefer to check the non-CD items, and add and check the controlled drugs at the time of issue.

If you check all the medicines together, since controlled drugs require secure storage you then have two options.

- The whole parcel can be placed in the CD cabinet. This takes up valuable space and contravenes the general rule that the CD cabinet should be kept for CDs only, but it ensures that the medicines stay together.
- The CDs can be separated and stored in the cabinet while the rest of the parcel goes into the usual bagging system, in which event there needs to be a sticker or other method to ensure that the CDs are returned to the bag before issue.

An example of a proprietary CD sticker for attachment to bags

If, however, you check the other medicines and do not dispense the controlled drugs prior to collection you will need a system that prompts staff to retrieve the bagged items so that the controlled drug can be added.

In a recent case the practice was complicated by a decision to bag items to keep them together for checking. A relief technician unfamiliar with this practice assumed that items in bags must have been checked and handed them out before a final check had been made.

Whatever system is used, it is vital that the staff handing the medicines out are clear:

- Whether a controlled drug is included (so the prescription needs signing by the collector)

DRIVING UNDER THE INFLUENCE OF DRUGS

The new regulations relating to driving while under the influence of drugs have received substantial publicity in the professional journals. Background information can be found at https://www.gov.uk/drug-driving-law.

You will see that one element of the defence that drivers have is that they have followed advice from a healthcare professional. It is expected that this will be given by the prescriber and repeated by the dispenser. This is straightforward for new patients but practices need to think about how they give the advice to existing patients. They cannot rely on dispensers given that up to a third of patients do not collect their medicines in person.

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. You can report at http://www.nrls.nhs.uk/report-a-patient-safety-incident/healthcare-staff-reporting/ or via QR below.

- Whether a controlled drug needs to be added, and
- Whether the medicines have undergone their final check.

OPIATE SUBSTITUTES AND PATIENTS IN CUSTODY

There are occasions when a person who is receiving instalment prescriptions for methadone or buprenorphine is in police custody and is therefore unable to collect in person. Where the service user does not consume their dose this is straightforward; a presenting police officer or civilian who has ostensible authority from the service user can act as their collector. This does not necessarily mean written authority; a telephone call from a custody nurse may be a common alternative.

We have been asked whether it is lawful to give a dose specified for supervised consumption to the officer in these circumstances. There is no barrier to doing so and it is usually desirable in terms of securing good patient care. The instruction to supervise consumption is not legally binding and it is acceptable for the pharmacist to give it to someone else to supervise if the circumstances warrant it. It is good practice to record that the dose was not supervised and any supervision fee should not be claimed (though, of course, the dispensing fee should be claimed).

IS IT AN ADDRESS?

There is confusion about those cases where a prescription does not bear an ordinary house address. In particular, there are women's refuges in the South West which do not bear any physical address for the protection of the residents, all correspondence being to a proxy PO Box. Recently a pharmacist refused to dispense a prescription bearing such an address.

The Home Office policy position has always been that the use of a PO Box number does **not** comply with the requirement for an address under the MDR 2001. This applies to both patients and prescribers. The only exception to the requirement for an address under the regulations is the use of No Fixed Abode (NFA) for patients who do not have a fixed address.

In the case of patients under witness protection, the Home Office and ACPO (now NPCC) have provided a view that broadly the provisions under the MDR 2001 will, under normal circumstances, still apply in these cases. This means that an address would be required on the script. However, to note, the regulation does not require the "home address" of the patient and provided a pharmacist has taken reasonable steps to establish that the prescription is genuine i.e. a call to the Doctor's surgery to confirm that the GP's address can be used or that the NFA script is genuine, then the requirement under the 2001 Regulations would be met.

Please note that this is only a policy view and final interpretation of the legislation remains the responsibility of the courts.