CONTROLLED DRUGS NEWSLETTER

SHARING GOOD PRACTICE IN THE SOUTH-WEST

NHS South Region South-West

November 2015

PICKING ERRORS

We have had a number of recent instances in which a high strength preparation has been selected in error from a picking list with consequent risk to the patient. In some cases these errors have been spotted by the pharmacist, but this is not always the case.

One option suggested to us is that some GP systems distinguish between formulary and non-formulary items and therefore group them in a different way. If, for example, MST 5, 10, 15 and 30mg are formulary items and 60mg, 100mg and 200mg are not, then the 100mg tablets will appear at the top of the non-formulary group rather than between the 10 and 15mg options. We are aware that some practices have opted not to make any Controlled Drugs formulary items, but this approach seems to us to offer some safety benefits.

Another frequent error is the confusion of immediate and extended release versions of oral oxycodone. Current advice is that these should be prescribed by brand name. The table below distinguishes some common brands.

Manufacturer	Immediate Release	Extended Release
Actavis	Lynlor	Reltebon
Napp	Oxynorm	Oxycontin
Qdem	Shortec	Longtec

RECORDING DOSES

There is a good practice requirement that the quantity of Schedule 2, 3 and 4 Controlled Drugs be limited to a quantity for up to 30 days' treatment. Where prescribers believe that there is a clinical need to do so they may issue a prescription for a longer period but will need to be able to justify that clinical need and that they are satisfied that it would not cause an unacceptable risk to patient safety. Pharmacists are able to dispense Schedule 2,3 and 4 CD prescriptions ordering a supply of more than 30 days' supply. We do not expect pharmacists to investigate the nature of the need but they are entitled to ask the prescriber to verify that one exists if they think fit.

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We can no longer receive or send faxes.

We follow up such prescriptions as part of our duties under the Controlled Drugs (Supervision and Use) Regulations. We will have details of the prescribing but not of the patient. This is important because sometimes practices ask us to supply these details, which we are unable to do. Our hope would be that these circumstances would be so unusual that practices would quickly be able to identify them.

One issue that occasionally surfaces during these checks is that the prescription is actually for less than 30 days' supply but the prescription instructions do not reflect what the patient has been told verbally to do. For example, a patient who is taking one tablet twice a day may be told to increase to two, twice a day, and their prescription total doubled, but if the directions on the prescription are not amended 120 tablets will appear to be a 60-day supply. We have had instances where a patient's dose has been reduced on hospital admission to reflect the last prescription or where other doctors in the practice have done so.

SUBSTANCE MISUSE TREATMENT PRESCRIBING

One of the regular checks that we undertake is to examine the prescribing of opioid substitutes by GPs who are not operating under a formal scheme such as shared care.

Let us be clear that if a GP has the requisite training and support then there is no issue with the principle of GP prescribing. However, even in these circumstances there may be an issue if the GP is away and no partner is able to take over the prescribing.

Prescribing is only one part of the care of substance misuse patients and a GP operating outside a formal arrangement may not be in a position to offer his or her patient a full service. We recognise that there may be occasions on which offering a prescription is appropriate and necessary but we are keen that GPs should not feel that they are compelled to provide continuing treatment without support and training. We can put you in touch with local sources of advice.

Without wishing to cause alarm, professional bodies can be severe on professionals who knowingly practise outside their competence and it is not unknown for insurers to regard this as a contributory factor which may affect the cover that they provide. By contrast, practice within a formal scheme with good governance structures causes them no special concern.

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.

One 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."

SPECIMEN SIGNATURES

Practices are reminded that it may be helpful to share specimen signatures of new prescribers with local pharmacies in order to authenticate those people and reduce the risk of a prescription being refused due to an inability to identify the prescriber.

NEW, NEW, NEW!

There are quite a few changes to the law that come into force now.

A Home Office Circular introduces the new mandatory requisition form for Schedule 2 and 3 controlled drugs which comes into force on 30th November. There is a link to the form within the circular which can be accessed at https://www.gov.uk/government/publications/circular-0272015-approved-mandatory-requisition-form-and-home-office-approved-wording.

The CDF form itself is at http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/PrescriptionServices/6-1387-Form_FP10CDF_v5_final.pdf. There are some important implications for practice.

1. Only this form is permitted from 30th November. Existing CDFs that you may have will therefore be void. It does not matter when the old requisition was written – if presented after the 29th, a supply cannot be made.
2. Since the form is now available online, it is not necessary to contact this team to obtain copies. However, a prescriber code will be necessary.
3. It follows that mere possession of the form is not a guarantee that a person is entitled to possess controlled drugs, so entitlement checks will need to be made by those receiving these forms.
4. The form must be used for pharmacy to pharmacy supplies.
5. Hospices and prisons are not required to use the mandatory form when ordering controlled drugs.

There is also a new set of approved wording for instalment prescribing. This wording is mandatory but some time is being allowed for system suppliers to make the necessary changes. This will be reviewed in three to six months. The circular says "All legal prescriptions which incorporate the old wording and clearly establishes the intentions of the prescriber should be accepted and dispensed as is currently the case, unless in the professional judgment of pharmacy teams and dispensers, there are reasons why these prescriptions should not be accepted. Prescribers must therefore use either the new wording or the old wording but not a combination of both or an amended version of the old wording."

The acceptable phrases are:

- Please dispense instalments due on pharmacy closed days on a prior suitable day.
- If an instalment's collection day has been missed, please still dispense the amount due for any remaining day(s) of that instalment.
- Consult the prescriber if 3 or more consecutive days of a prescription have been missed.
- Supervise consumption on collection days.
- Dispense daily doses in separate containers.

There have also been new rules relating to the use of naloxone. From 1 October 2015, drug treatment services can order naloxone from a wholesaler so that persons engaged or employed in their services can, as part of their role, make a supply of the naloxone available to others without a prescription. This change applies to persons engaged or employed in drug treatment services under local arrangements made by an NHS body, a local authority, Public Health England or Public Health Agency. This would include pharmacies commissioned to provide opiate substitution treatment such as supervised consumption of methadone schemes or a needle and syringe exchange scheme. This does not include an obligation on the part of anyone to fund that naloxone, which is a separate issue.

NICE DRAFT GUIDANCE ON SAFE MANAGEMENT AND USE OF CONTROLLED DRUGS

A brief period remains to comment on these guidelines which are available for consultation until 25 November. They can be seen at https://www.nice.org.uk/guidance/indevelopment/gid-cdgpg/consultation/html-content. The guideline development group contains a number of representatives from the south-west.

NATIONAL REPORTING AND LEARNING SYSTEM (NRLS)

Please note that reporting incidents to us does not 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 this QR code.

CHRISTMAS AND NEW YEAR SUPPLIES

The extended seasonal public holidays mean that dispensers will not receive supplies from wholesalers for quite a prolonged period. In most cases, after ordering on the 23rd it will not be possible to replenish stocks until the 29th. It is therefore particularly important that wherever possible patients' needs are reviewed in good time so that holiday stocks are not used for patients with predictable needs.

At the current time we are experiencing shortages of a number of products. Since these are sometimes localised to particular wholesaler depots, it is not practical for us to give notice to the whole area, but we would ask that dispensers and prescribers liaise to avoid prescriptions being issued for items that are locally unavailable.

AMPOULES, VIALS AND INJECTIONS

The legal form for CD prescriptions is 'injection' and we would recommend that this is included on all prescriptions for vials or ampoules, which we would regard as the container.

- If no injection container is specified, ampoules should be supplied (as the safest option to avoid diversion of left over medicines)
- If no injection container is specified and only vials are in stock, these may be supplied if needed urgently
- Ampoules or vials are also acceptable as the form of CD, for legal purposes, in the absence of the term 'injection'
- If the word injection is included and the container is specified, then that should be supplied if in stock. If the supply is needed urgently, then ampoules or vials may be supplied where the other is stated on the prescription, if this is confirmed as acceptable by the prescriber. The prescription should be annotated to note this discussion, but the stated form of injection will suffice to make the CD prescription legal.

BUCCAL MIDAZOLAM

A recent incident suggests the need to share some learning. A child required buccal midazolam for the control of seizures. His prescriber remembered that there was now a licensed product and prescribed it in preference to the unlicensed version but did not appear to realise that the prefilled syringes, while they come in four

variations, actually contain different amounts of the same strength of solution. As a result he prescribed the 10mg syringe although the correct dose for the child was 5mg. This would have required the parents to give half a prefilled syringe, whereas the point of the range of doses is to ensure that parents need only empty one syringe of a fixed volume into the child's cheek. The pharmacist did not suggest an alteration and as a result a larger dose was given than was needed.