CONTROLLED DRUGS NEWSLETTER

SHARING GOOD PRACTICE IN THE SOUTH WEST

NHS
South Region
South West

June 2017

New Incident Reporting Tool

Exciting times ahead!! We are introducing a web based reporting tool for CD incidents, which will make it easy for you to send us the information we need. It will also streamline other CD tasks, like GP practice CD self-assessments. We will let you know when it is ready to use, in the meantime please continue to contact us in the usual way by email or phone – details on the back page.

Destruction of CDs (A Reminder)

Following the return of the recent Controlled Drugs Self-Assessment and Declaration sent to GP practices, a number of common themes have been highlighted. In particular the correct processes around the destruction of out of date CD stock.

A number of practices replied that they did not have in place a T28 exemption from the Environment Agency. This is necessary to legally allow the denaturing of obsolete CDs on the premises.
The reason why a T28 exemption is necessary is because normally a license is needed to handle waste. However, the Environment Agency accepts that there is a problem in applying this to controlled drugs which must be denatured before they can be removed by authorised waste handlers. The Environment Agency therefore permits denaturing by healthcare professionals in certain circumstances, but this is controlled by the use of exemptions issued under the Environmental Permitting (England & Wales) Regulations 2010.

In the case of CDs, the relevant exemption is the T28. This exemption can be obtained through the Environment Agency website and is free of charge and lasts for 3 years. The turnaround for applications is usually about 5 days.

The link to online registration is below:

https://wasteexemptions.service.gov.uk/

Please note that failure to have this exemption in place could leave your practice open to prosecution by the Environment Agency, and could result in a heavy fine for the practice.

We would ask that all those practices which keep stock of CDs to ensure that they register for a T28 exemption with the Environment Agency as soon as possible.

All destruction of obsolete stock of Schedule 2 CDs such as diamorphine or morphine **must be carried out in the presence of an authorised witness provided by NHS England as per the Misuse of Drugs Regulations.** Any GP, practice nurse or dispenser denaturing stock CDs without the presence of an authorised witness is breaking the law. Please request the presence of an authorised witness by emailing ENGLAND.southwestcontrolleddrugs@nhs.net

A denaturing kit should also be used to denature schedule 3, 4 and 5 CDs. Although the denaturing of these can be witnessed by another member of staff, a record of the destruction should be kept for audit purposes.

Although the use of a manufactured CD denaturing kit is the preferred method. Please note that cat litter can be used from a pragmatic perspective when manufactured CD denaturing kits are unavailable or in an emergency situation e.g. when a spillage occurs due to a dropped bottle of methadone.

Destruction of Patient Returned CDs

Only Dispensing Practices should accept unused CDs returned by patients or their representatives. **All other requests to return CDs by patients should be directed to a local community pharmacy**. Community pharmacies are paid to accept unused patient returned medication as part of their contract.
Please note that dispensing practices accepting controlled drug patient returns should use a separate patient returns register to record these returns and subsequent destruction and not use the stock CD register.
The destruction of patient returned controlled drugs (including schedule 2 CDs) can be witnessed by another appropriate member of staff and does not require the presence of an NHS England appointed Authorised Witness.

End of Life Care in Nursing Homes – advice for GP practices

Following a few CD incidents involving 'just in case' medicines prescribed for end of life care patients in nursing homes, and some problems related to the use of high dose analgesic patches on frail older patients, here are some learning points for GPs;

- Prescribing 'just in case' (JIC) medicines should be done on an individual case by case basis, rather than as a routine part of a patient being admitted to a nursing home (NH)
- JIC medicines should be written up on a separate palliative care chart, to avoid any confusion with routine 'as required' medication
- JIC medicines should be regularly reviewed by the GP and NH nurses for appropriateness, and the review should be documented in the patient's care plan
- GP practices should be aware of which of their NH patients have been prescribed JIC medicines, and be able to generate a list of these patients from their records for review. These patients should be considered and reviewed as part of the GP practice's wider palliative care patient register
- GPs should keep chronic pain opioid doses and prescribed quantities to a minimum in nursing home patients, especially keeping patients on fentanyl patches under close review

Delivery Drivers

We have been made aware of a few incidents recently involving the delivery of controlled drugs to patients These have involved incidents where delivery drivers have delivered controlled drugs to the wrong patients and an incident where medication was delivered to a patient's former address after they had recently moved to a care home. We would like to remind all pharmacies to ensure that their delivery SOPs are followed at all times and that all relevant patient information, including current address is kept updated. There should be a full audit trail available for the delivery of controlled drugs.

Some surgeries employ a system whereby each individual CD prescription is signed for by the driver collecting on behalf of a pharmacy. Please note that when a driver signs to take receipt of a prescription, he/she is then confirming that they are in possession of that prescription form. It is not acceptable for a driver to later claim that they 'didn't know what they were signing for' during an investigation into missing prescriptions. A driver signing once for a bundle of prescriptions is not helpful when later on one appears to be missing – if they are signing for several scripts, it would be good to have an itemised list for them to check off and sign at the bottom.

Confirming the Correct Dose on Discharge

We recently had an incident where a patient had been discharged from hospital and was subsequently prescribed a dose which was six times the intended discharge dose by the patient's GP.

Before going into hospital, the patient was being prescribed MST 10mg, 2 bd. The prescription that they received 5 weeks afterwards from his GP on discharge from hospital was for Longtec 120mg bd. As this was a large increase in dose (though just about plausible in the context of a five week gap), the community pharmacist queried this with the prescriber. The community pharmacist also phoned the pharmacy at the Acute Trust to see if they knew what had been issued and it was clear that the discharge dose should have been Longtec 20mg bd.

It appeared that the GP had not received any record of the discharge medication from the Acute Trust and was working from an email request from the patient's family clearly for Oxycodone HCL 120mg m/r tabs amongst other items.

When prescribing this dose, the GP had taken into consideration that prior to admission the patient had been taking MST 10 mg BD and noted the dose escalation, but given the duration of in patient stay and the rapid progression of the disease, did not think that the dose seemed unreasonable and issued the 120mg from the written request in the absence of a hospital discharge summary.

When the pharmacy called the surgery questioning the dose, the GP called the patient's wife to clarify the dose. The patient's wife read from the discharge summary that she had been given on the ward which stated that the patient was discharged with a dose of 20 mg BD.

The learning from this near miss is for GPs to be aware of high dosing of CDs and to query discharge information with the hospital before prescribing, or double check dose directly with patient/ carer's discharge sheet when the hospital discharge sheet is not directly available to the GP.

Care should also be exercised when prescribing a different opiate on discharge due to the different potencies of different opiates. Please ensure that conversion charts are used. With this particular case, oral oxycodone is twice as potent as oral morphine.

Prescribing for Chronic Pain

The BMA published a briefing paper in March 2017, setting out a range of recommendations for governments, policy makers and healthcare professionals, with the aim of supporting safer prescribing for chronic pain. Chronic pain is a complex condition, which is now recognised as a long term condition in its own right.

https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/analgesics-use

Chronic pain is defined as pain that has persisted for more than three months. The perceived intensity of the pain does not necessarily relate to the degree of tissue injury, and is influenced by many factors including the patient's understanding and concerns about the pain, anxiety, distress, expectations and previous experience of pain. Around half of patients in the UK suffering from chronic pain also suffer from depression. Chronic pain is very common, affecting between one third and one half of the UK population, with more than 10% of the population reporting that their pain is moderately or severely limiting.

Efficacy and risks of opioids for chronic pain

The majority of prescriptions for opioid analgesics are for patients with chronic non-cancer pain, and there has been a substantial increase in prescribing over the last few years. Opioids may reduce pain for some patients in the short and medium term (less than 12 weeks) but in the long term they are only effective in a minority of patients. Prescribing guidance has been relatively unsuccessful in influencing the use of analgesics, and so an on-line resource, Opioids Aware, has been produced to support all healthcare professionals, patients and carers in understanding the potential benefits and harms of opioid treatment.

http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

The main message is that the risk of harm increases substantially at high dose, and above an oral morphine equivalent daily dose of 120mg, further benefit is unlikely.

In patients with chronic pain, there have been reported fatalities in patients with sleep apnoea who are prescribed opioids, particularly when prescribed with other sedative drugs, particularly benzodiazepines.

Supporting the management of patients with chronic pain

- Prescribers must expect analgesics to fail for the majority of patients – the focus of treatment should be on reducing a patient's pain with a view to improving their quality of life
- If opioids are to be used, a trial should be initiated to see if pain is reduced – if not, they should be stopped
- Sufficient resources for adequate consultation times and regular reviews are needed – pharmacists can have a useful role in pain management in primary care settings
- Where pain is associated with high levels of distress and disability, or where severe pain remains refractory to treatment, referral to specialist pain services is indicated
- Long waiting times contribute to problems – it is important for patients with chronic pain to have access to clinical psychology and specialist physiotherapy early in their treatment pathway. Encourage your local Sustainability and Transformation Partnership to prioritise commissioning these services!

The Keeping of CD Registers

Following the return of recent Controlled Drugs Self-Assessment and Declarations sent to GP practices, it was noted that there was a lot of variation in how long CD registers were kept by the practices, following their completion. A number of practices had declared that they keep CD Register records for 2 years. Although all registers must be kept for a minimum 2 years from date of last entry**, if these registers contain any records of destruction of CDs, then they must be kept for 7 years.**

Process for Reporting Missing Prescriptions

If any prescription forms are lost, please let us know as soon as possible, by phone or email (as at end of newsletter). This is important because they may fall into the hands of someone trying to obtain medicines by deception. If the lost prescription has already been written for the patient, it could be presented by someone else, or a handwritten addition made requesting a medicine liable to misuse or diversion could be made. If the lost prescription forms are blank, they have a high value on the street for obtaining medicines by fraud. We will need a set of information from you to allow us to send out an alert to local pharmacies, if necessary – we can send you a form to fill in.

If you would like some guidance on improving security of blank prescription forms in your surgery, we have a checklist that has been produced in liaison with NHS Protect.

Recently Reported CD Errors

During the period July to December 2016, the incident reports made directly to the Accountable Officer for CDs by community pharmacies have included the following : the wrong strength supplied; balance discrepancies; reports of missing CDs; wrong formulation dispensed; methadone spillages; reports of oversupply; prescriptions being incorrectly suspended, locums not being able to find prescriptions within the pharmacy and prescribers not being informed when a patient misses three days of their supervised dose. There have still been errors reported which have involved confusion over immediate and modified release preparations, in particular tramadol.

Other incidents have included:

A prescription was written for morphine Sulphate MR Tablets with a dosage of two tablets every 12 hours. This was a new medication for this patient. The label was misprinted to say two tablets every two hours. The patient followed these directions and was unwell. The reason why this error occurred was because the ‘1’ button was not depressed fully when typing in the dosage interval when generating the patient’s medication label. This error was not spotted during the dispensing and checking processes and the patient wasn’t counselled by the pharmacist as to the correct dosage interval either.

A series of prescribing mistakes by Out of Hours doctors were made when prescribing for a patient. An oral dose conversion from oxycodone to morphine was halved instead of doubled. The resultant handwritten prescription was written for a form of morphine which did not exist (Zomorph 20mg tablets) and therefore could not be dispensed. This error was highlighted to the prescriber and a rewritten prescription was requested, however the doctor on duty accidentally picked 200mg caps on the Adastra system and generated a prescription for Zomorph 200mg capsules instead.

Outside of Primary Care, there have been errors involving the confusion of Oramorph and Oxycodone, with Oramorph being administered by mistake to a patient instead of the prescribed Oxycodone and a night nurse administered a controlled drug without a second check giving Oxynorm instead of the prescribed Oramorph.

We would like to remind pharmacists to ensure that they follow their SOPs when supplying substance misuse medication to third parties collecting on behalf of a patient. Generally it is a condition of treatment that a 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 that medication 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 cannot be obtained. However, the exercise of judgement is restricted to cases where there has been no response by the drug service or prescriber to the pharmacist's enquiry. If a pharmacist makes a supply in these circumstances then it would be advisable to make a note of the reasons. Please note that permission should always be sought before making such supplies and for each individual supply. The drug service may issue an authorising document allowing third party collections for a stated period of time, but open ended authority is not recommended.

Recent incidents have included an investigation where 44 bottles of 50ml methadone were found in an unlocked flat. These had been prescribed and dispensed whilst the patient was in hospital, and collected from the pharmacy by various people with signed notes over a period of time.

Another pharmacist had allowed supervised methadone to be taken away, and had also personally delivered it to the patients to supervise in their homes. In a separate incident a GP had written a prescription for holiday supply for a patient, without telling the patient's normal prescribing service.

CD Accountable Officer Change

Finally we would like to say a fond farewell to Sue Mulvenna, who will be retiring in June. We would like to wish Sue a long and happy retirement and thank her for all of her dedication to this role and hard work over the years for NHS England and before that with Bristol CCG and PCT. Sue's replacement as CD Accountable Officer will be Jon Hayhurst, who will be starting in July.

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We can no longer receive or send faxes.