CONTROLLED DRUGS NEWSLETTER

NHS ENGLAND SOUTH WEST

April 2019

STAY ONE STEP AHEAD – LEARN FROM THEMES IN REPORTED INCIDENTS

In this newsletter we share the learning from themes in the incidents that are reported to us, as well as offering a general update on topical issues.

Example Incident – 'methadone supplied to the patient's brother in error'

Unfortunately, we do have to return to the issue of 'hand out' (supply) errors. These incidents involve supplies being made to the wrong patient due to inadequate ID checks.

A recent case involved methadone being supplied to a person who was standing in the pharmacy but hadn't asked for any medication. This person was in fact the brother of a patient who was prescribed methadone and had been mistaken for him by a member of pharmacy staff.

The methadone was then given to the patient's brother without any ID checks being made, after which he promptly left the pharmacy.

The supply of controlled drugs on instalment prescriptions is a high-risk activity and it is important to be vigilant with all aspects of the task. Pharmacy staff should follow their SOP when making such supplies. The SOP will detail what ID checks are required every time a supply is made.

It is unfortunately common for one patient to be supplied with another patient's medicine and the potential for harm is significant.

Please read you SOPs for this task and consider whether you follow the steps involved routinely.

Example incident – 'ex-care home staff diverting CDs'

We recently had an incident where a former care home staff member used their old ID badge lanyard as a means of identification to inappropriately collect controlled drugs from their local community pharmacy.

These would normally have been delivered and not collected, but the pharmacy staff handed over the full supply intended for the care home to this former worker in good faith.

The individual did this with the intention of diverting the controlled drugs. They have now been prosecuted.

Please be vigilant when supplying medicines to people that claim to work for a care organisation. If anything is unusual about such a request, check with the genuine care organisation's staff before supplying.

Fentanyl patches: Lessons learned from the death of a child - safe handling of medication patches

A child in Cornwall sadly died due to a fentanyl patch belonging to the parent attaching to the child's skin. This is a sobering reminder of the importance of patients keeping their medicines out of reach and sight of children. We would like to share some of the specific learning that has come to light because of this case:

- Please read the MHRA alert on this issue - this includes a letter for patients and care givers.
- Review the route of medication prescribed when performing a medication review. If patches are prescribed, is it still the safest and most effective way to administer the medication?
- Note the potency of fentanyl patches: a 25 microgram/hr patch is equivalent to an oral morphine dose of up to 90mg in 24 hours
- Patients who are prescribed medication in patches should be informed that sleeping in the same bed as their children is especially risky
- When patients remove a fentanyl patch they should fold it firmly in half so that the sticky side sticks to itself. It should then be put into the pouch and then in the bin out of reach and sight of children and pets
- Patients should never share their prescribed medication with anyone else

Controlled Drugs registers

We have dealt with cases in which the controlled drugs registers in pharmacies were being tampered with. Stock discrepancies were being covered up by staff making an entry to state that a balance check had occurred, and correcting the balance in the register to match the stock balance in the CD cabinet. This can easily be spotted by reviewing register entries and seeing that the running balance is not following a proper sequence.

The register is a legal document and entries in this register should be handled with vigilance and respect. It is a criminal offence to tamper with it in this way. If your CD registers have unresolved discrepancies or erroneous entries and you are not sure what to do, please contact us and we will help you to get to the bottom of it.

Safer delivery of dispensed medication

Many delivery errors have been reported to us recently by community pharmacies. We would like to make people aware of recent guidance entitled 'Safer Delivery of dispensed medication from Community Pharmacies' issued by the Community Pharmacy Patient Safety Group which provides a number of actions to help prevent this type of error.

Prescriptions lost within a pharmacy

We would ask community pharmacy staff to be mindful of their internal processes for ensuring that delivered post is not mislaid or lost after being delivered to the pharmacy.

A recent case involved an envelope full of prescriptions posted to a pharmacy by the local substance misuse treatment prescriber that was subsequently reported as missing by the pharmacy after signing for it on receipt of the delivery.

A 'thorough search' of the pharmacy failed to yield this missing letter.

This loss necessitated a missing prescription alert to be sent out to other local pharmacies and a visit to the pharmacy by the Police Controlled Drug Liaison Officer, after which the missing envelope was found to be in a dispensary drawer.

Fraudulent prescriptions and forgeries - how to report this crime

As stated above, we have recently received many incident reports involving the presentation of fraudulent prescriptions at community pharmacies. Once it has been established that a prescription is fraudulent, this should be reported by the pharmacy to the Police on 101 or 999 as appropriate. We have some local guidance on what to do on our website.

To aid any subsequent Police investigation, it is recommended that when reporting the presentation of a fraudulent prescription, that the potential vulnerability of and any safeguarding concerns for the person / who attempted, or succeeded in the theft should also be stated. People who are attempting to obtain controlled drugs in this way are often caught up in behaviour that will be harming themselves or others. It is not a victimless crime.

It is worth noting that in 2018 The Plymouth Coroner formally raised a 'Regulation 28' letter with an aim to prevent further deaths of members of the public who illegally access prescription drugs by fraudulent means. The raising of this issue by the Coroner is to try to limit and tackle this inappropriate supply and to prevent a route by which prescription drugs can enter an illegal drugs market.

Please do look out for fraudulent prescription alerts which have been issued by this team and please link any new crimes to the Crime Reference Number contained within these alerts if relevant. The establishment of these as a series of crimes will raise the Police profile of the case and so any linking to a previously reported crime from the alerts we circulate is appropriate. The Police will then issue a new Crime Reference Number to you which you should also report to us.

Pregabalin and gabapentin

You will hopefully have seen the many recent communications on the change in legal status of these drugs, from the PSNC, NHS England, and our regional newsletter.

Be mindful that supplying medication from prescriptions issued before 1 April may not be legal after that date if they do not comply with the new requirements – this applies when supplying owings too.

Bagging Errors

As well as delivery errors we are also aware of several incidents that have involved prescription items labelled with different patient details being placed in the same prescription bag. This has resulted in patients receiving medication intended for different patients. In addition to this we have also had incidents where patients have also received stock (i.e. bulk packs) in their prescription bags in addition to their intended medication.

Please ensure that you are aware of the potential for this error when checking and bagging medication and please ensure that your relevant SOP is always followed.

Mix-ups of oxycodone and Oramorph®

It has been noted recently that there have been reports of administration errors involving liquid morphine and liquid oxycodone preparations. These incidents have involved one drug being administered when the other is intended.

Upon investigation, we understand that brands of oxycodone are often mistaken for brands of morphine (especially Oxynorm® when Oramorph® is prescribed), and vice versa.

Prescription security

We would like to make practices aware of recent incidents which have involved the theft of blank prescription forms and the subsequent use of these forms to try to fraudulently obtain controlled drug medication from community pharmacies. The high standard of some of these forgeries has resulted in supplies being made. The thefts of these blank prescription forms have usually taken place from printers in unlocked rooms. This offence was all far too easy to commit, and the Police have asked us to remind surgeries that blank prescriptions should be removed from rooms when they are not being used.

Please note that the CQC has published guidance in support of the NHS Counter Fraud Authority guidance of March 2018 "Management and control of Prescription forms" in the form of a tips and myth busters factsheet "Nigel's surgery 23: Security of blank prescription forms". In their guidance they suggest that "it is not advisable to leave the forms in printer trays when not in use or overnight.

The NHS CFA guidance says all prescriptions should be removed from printer trays and locked away when not in use or out of hours

Patient Returned Medication from Nursing Homes

We received a recent query about whether medicines from a care home with both nursing and non-nursing residents should be returned to a pharmacy for disposal.
A patient living in a care home in which *most* residents are receiving nursing care does not fit into any of those categories covered by the national Pharmacy Contract's Terms of Service as it is not a "private household", nor "an establishment which exists wholly or mainly for the provision of residential accommodation." Instead, it exists mainly for the provision of nursing care, even if this patient isn't receiving such care.
On the basis that the pharmacy is only remunerated to dispose of medication from those categories of accommodation listed above, such medicines should not normally be accepted as 'patient returns'. Care homes with nursing will have their own contract for the collection of clinical and pharmaceutical waste.

28 and counting…

There continues to be a spate of incidents in which 30 tablets or capsules have been dispensed when 28 were prescribed (or 60 in place of 56). Please do not assume that medicines containing controlled drugs are packed in multiples of 28 – comparatively few are, when compared to medicines in general.

Standard or sugar-free methadone oral solution?

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 selecting the wrong bulk bottle. Pharmacies where this is common practice should have procedures in place to guard against this risk. Some highlight the 'sugar free' wording on prescriptions on receipt. Others put rubber bands around the bulk bottles of sugared solution to make them feel different.

www.cdreporting.co.uk

Thank you to everyone who has reported controlled drug incidents through our online portal. Could we please ask that when you register for the site, that you use a work e-mail address (e.g. a store e-mail address) and not a personal e-mail address. Also, please ensure you report incidents with the address of the pharmacy and not your own home address (it has happened!)

Is It Empty?

We regularly receive reports of lost tablets or capsules in which the missing items cannot be traced and the conclusion is that they “must have been thrown away”.

While this is undoubtedly true in some cases, it is an unsatisfactory result from our point of view. It would be all too easy for a healthcare professional to pocket medicines containing controlled drugs and then claim that they “must have been thrown away”, so anything we can do to reduce the occurrence of this must be welcome.

Several procedures may help to reduce this, including:

- Flattening all boxes before throwing them away
- Checking that all discarded blisters are empty
- Verifying with a colleague that a box is empty before throwing it out
- Keeping ‘empty’ boxes in a safe place until the balance check has been done
- Unfolding patient leaflets before disposal to free any trapped tablets or capsules
- Taking the exact number of tablets or capsules required for a monitored dosage blister to the dispensing station rather than a full pack

Vigilance with instalment dispensing – titration doses

Please could we remind pharmacy staff to endorse FP10MDA prescriptions with whether doses have been collected by patients as soon as possible after collection, or at the end of the day if they have not? We have received reports of incidents in which patients have received two doses on the same day because the pharmacist on duty hadn’t realised that a dose had already been supplied to the patient earlier in the day.

The prescriptions had not been endorsed to the say that the dose had already been supplied. Please note that missed collections should also be endorsed as ‘not collected’.

We have also received incident reports in which missed collections have not been endorsed resulting in inappropriate supplies subsequently being made. Where a missed dose is a ‘titration dose’ (either a reducing or increasing dose) the prescriber should be contacted prior to making any further supplies rather than automatically supplying the dose applicable on the day the patient next presents.

Submitting Your Private Prescriptions to NHSBSA

Ensure you submit pink private FP10PCD forms to the NHSBSA at month end. Download the submission form - click on “Submission document for submitting controlled drugs through a private account.

EPS Repeatable Prescriptions and Diazepam

It is legally possible to issue repeatable prescriptions for diazepam (and other medicines containing schedule 4 controlled drugs). However, two considerations need to be noted.

First, most indications for diazepam are for short-term use only. The question of whether a repeat prescription is appropriate therefore needs to be considered.

Second, the first dispensing of the medicine that contains the schedule 4 controlled drug must be made within 28 days of the appropriate date, following which there is no time limit for remaining repeats

In the case of medicines containing schedule 5 controlled drugs, the first dispensing must be made within six months of the appropriate date, following which there is no legal time limit for the remaining repeats

Prescriptions for Schedule 2 and 3 Controlled Drugs are not repeatable.

Buprenorphine dispensing errors – take care with different presentations

It has been reported that some pharmacy staff have supplied buprenorphine oral lyophilisates (Espranor) when buprenorphine sublingual tablets have been ordered on prescription. Please note that this is inappropriate as the two formulations are different.

Espranor is a freeze-dried wafer (oral lyophilisate) and has been formulated to disintegrate quickly when placed on the tongue. It is different to generic sublingual tablets which are placed under the tongue. The two preparations are not interchangeable - the initial dissolution of Espranor is higher than that for generic sublingual tablets as it is absorbed more quickly. If a patient is to be changed between the two formulations then prescribers should use their professional judgement when determining the appropriate dose.

We do understand that more prescribers will be intentionally prescribing oral lyophilisates in future for both quality and financial reasons.

Any pharmacy staff who have dispensed Espranor against a prescription for buprenorphine sublingual tablets should please report this to us as a controlled drugs incident via www.cdreporting.co.uk if this has not already occurred

Selling controlled drugs

We often hear that practitioners approach pharmacies to ask them to supply them with medicines – perhaps for their doctor's bag.

Supplies such as this are wholesale supplies, and should not normally be made without a wholesale license from the MHRA. There are some exemptions to this.

Note however that it should be assumed that a Home Office license is required to supply CDs by wholesale.

If you have supplied CDs by wholesale and intend to do so in the future we would suggest you contact the MHRA and Home Office to obtain the appropriate licenses, or to be sure that these are not applicable to your circumstances.

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REPORT A CONTROLLED DRUGS INCIDENT

Online at:
www.cdreporting.co.uk