CONTROLLED DRUGS NEWSLETTER

NHS England South West

NHS ENGLAND SOUTH WEST

Summer 2022

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.

Supplies of controlled drugs made without a valid prescription

We have received reports of incidents in which community pharmacy staff have supplied medicines containing methylphenidate, gabapentinoid, and tramadol to patients without a valid prescription - as an emergency supply.

Please remember that with the exception of the supply of phenobarbital for the treatment of epilepsy, emergency supplies of schedule two and three controlled drugs are not permitted by the regulations. Community pharmacy staff should signpost such requests to the patient's own GP, or to the appropriate out of hours medical provider (normally via 111) so that a prescriber may issue a valid prescription if appropriate.

We have also been made aware of incidents where methadone has been supplied to patients without a valid prescription because either a new prescription had not arrived at the pharmacy from the prescriber in time, or supplies had inadvertently been made against prescriptions that had been fulfilled and so were no longer valid.

When emergency supplies of schedule four and five controlled drugs are made, including those made through the *Community Pharmacist Consultation Service* (CPCS), the quantity of medication that can be supplied is limited by regulation to that sufficient for up to five days' treatment.

If any community pharmacy has erroneously supplied schedule 2 or 3 controlled drugs without a valid prescription, or made an emergency supply of an excessive quantity of schedule four or five controlled drugs then please do report as an incident to us via www.cdreporting.co.uk.

Bagging Errors

We have many incidents reported to us in which patients received medicines that were intended for another patient.

This occasionally happens when medicines appropriately labelled with different patients' details are placed in the same prescription bag.

The risk of harm to patients in these cases is significant as patients have sometimes mistaken these other medicines for their own.

We also have incidents reported where patients have received stock boxes (i.e. split bulk packs) in their prescription bags in addition to their own assembled medication.

Please ensure that you are aware of the potential for these errors when checking and bagging medication and please ensure that your relevant standard operating procedure is always followed.

Buprenorphine dispensing errors

We would like to remind pharmacy staff to please take care with different buprenorphine presentations. It is frequently reported to us that buprenorphine oral lyophilisates (Espranor®) have been supplied when buprenorphine sublingual tablets have been ordered on prescription. This is inappropriate as the two formulations are not interchangeable.

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 initial dissolution of Espranor is faster than that for generic sublingual tablets as it is absorbed more quickly. If a patient is to be changed between the two formulations, then this will require a new prescription with an appropriate dose.

There does appear to be a lack of understanding by some pharmacy staff regarding the difference between these preparations, with there being a mistaken belief that Espranor is merely a proprietary brand of buprenorphine sublingual tablets. We have some excerpts from incident reports below:

"Pharmacy A dispensed Espranor against a buprenorphine sublingual prescription. The pharmacist said Espranor is a branded version of buprenorphine".

"Client attended pharmacy B to collect his Subutex® but was informed that they didn't have any in stock and was offered Espranor instead. Client declined as he knew Espranor was different to Subutex… The pharmacy staff then managed to locate some Subutex and supplied that".

"Client prescribed buprenorphine 8mg sublingual tablets but reported being given Espranor for the first week of his prescription by pharmacy C. He experienced withdrawal symptoms when switched back to sublingual buprenorphine in the second week."

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.

Supplying stock of schedule 2 and 3 controlled drugs

We are aware of cases where requisitions have been written and presented on invalid stationery. Individual practitioners who wish to requisition schedule 2 or 3 controlled drugs from community pharmacies must use the correct form. This is the FP10CDF and is available to download.

If the stock being requisitioned is for use in private practice, then the completed form must include the prescriber's six-digit controlled drugs prescriber code. An NHS prescriber code can be used if the requisition is for NHS use. Note that using a GMC or other professional registration number is not acceptable.
Pharmacy contractors are required to submit completed FP10CDF forms for audit purposes each month using submission document FP34PCD which is also available to download.

If a prescriber requires a CD PIN to either prescribe privately or requisition CD stock then please tell them to contact us.

As part of our monitoring of submitted FP10CDF requisition forms, we recently became aware of a supply of ketamine to a paramedic. Please note that the only controlled drugs that paramedics can lawfully requisition are diazepam, and/or morphine sulphate injection (to a maximum strength of 20mg), and/or oral morphine sulphate.

‘LASA’ errors – gabapentin and pregabalin

Mix-ups between gabapentin and pregabalin are commonly reported to us and this is a common ‘LASA’ (look alike sound alike) error.

If pregabalin and gabapentin are interchanged in error, there could be a high risk of patient harm as there is a very significant difference in potency between these two medications. Patients may suffer unpleasant side effects including, but not limited to, dizziness, confusion, agitation, restlessness, disorientation, gastrointestinal upset, double vision, slurred speech, drowsiness, loss of consciousness, and lethargy.

LASA errors are often linked to several contributory factors including human error. To avoid these, it is advisable to have several risk minimisation measures in place to reduce the likelihood of these errors occurring. These can include visual warnings; shelf stickers; prompts on PMRs; and of course revisiting your assembly and checking standard operating procedures. The physical separation of stock is another measure that is often taken to help reduce the risk of a ‘LASA’ error occurring. Although in this example, it is likely that these medicines are already well segregated within a dispensary as their names are not close alphabetically.

Other ‘LASA’ errors involving controlled drugs that have been reported to us have included:

Elvanse® (lisdexamfetamine) preparations supplied instead of Equasym® (methylphenidate) - and vice versa, and administration errors where Oramorph® (morphine) is administer when Oxynorm® (oxycodone) has been prescribed.

The Community Pharmacy Patient Safety Group has issued some guidance on Look Alike Sound Alike Drugs (link below) which will be useful.

https://pharmacysafety.files.wordpress.com/2019/12/lasa-one-pagers-191219.pdf

Remember that gabapentin and pregabalin are schedule 3 controlled drugs and it is not possible to make an emergency supply of these.
Any private prescriptions for these drugs must be written on a pink FP10PCD form bearing an appropriate private controlled drug prescriber code.

Identity checks for delivery drivers

We were made aware of an incident in the region in which a bogus caller posed as a community pharmacy delivery driver at a medical practice reception and tried to collect prescriptions on behalf of a local pharmacy.

Surgery staff became suspicious as they did not recognise the caller and challenged them. They then left the premises.

We would remind all staff to be alert to the possibility that bogus callers may try to fraudulently collect prescription forms or medicines and to please check the credentials of any person purporting to be collecting on behalf of local pharmacies, or care homes, or patients, especially in cases where the driver is unknown to staff.

Community pharmacies should ensure that their own delivery drivers have an appropriate form of identification, as proof of identity may be requested by surgery staff.

If a bogus driver should present, then please contact the Police on 101 or 999 as appropriate and do please also let us know.

28 and counting…

There continues to be a theme in incidents in which 30 tablets or capsules have been supplied when 28 were ordered on prescription (or 60 in place of 56). Please do not assume that medicines containing controlled drugs are packed in multiples of 28 – very few are, when compared to other medicines.

Speak up! Do you know who to contact if you have a concern about misuse of controlled drugs?

One of the investigations that NHS England is currently undertaking involves significant misuse of drugs by a healthcare professional in this region. This investigation has identified that over two years ago, a community pharmacist identified concerns about the healthcare professional and reported these to a local medical practice but did not share this concern with us.

We understand that the community pharmacist was unsure of how to contact the Controlled Drugs Accountable Officer to raise their concerns, and furthermore was concerned about what impact reporting would have on their relationship with the medical practice.

It appears that misuse of drugs then continued for a further two years, until a related concern involving patient harm was reported by a community nurse through the correct channels and appropriate action could then be taken to protect patients.

Readers are asked to note the contact details for the regional Controlled Drugs Accountable Officer below. Please make a note of these so that if you need to report concerns about the misuse of controlled drugs, you can do this promptly via the correct channels.

- When things go wrong, we need to make sure that reflection and learning take place, and that improvements are made
- If we think something might go wrong, it's important that we all feel able to speak up to prevent harm.

Healthcare staff should feel able to speak up when they have concerns, and registered staff are expected to do so. If you raise an honest concern and you are mistaken you will not be criticised. If you'd like to discuss any barriers to speaking up do get in touch.

Balance checks for schedule 2 controlled drugs

We have received increasing numbers of reports of balance discrepancies. In many of these cases balance checks were not being completed in accordance with SOPs, with some pharmacies not completing balance checks for several weeks or months.

Having regular and frequent balance checks helps to resolve discrepancies quickly. Organisations need to consider the most appropriate frequencies for both checking and recording stock. NICE Guidance NG46 states: *"the frequency of stock checks should be based on the frequency of use, and informed by controlled drug related incidents, and risk assessment. For most organisations stock checks should be at least once a week, but they may be more or less often depending on the circumstances."*

Remember to ensure obsolete stock awaiting destruction in the presence of an authorised witness is accounted for when conducting checks.

CONTACT US

Accountable Officer
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REPORT A CONTROLLED DRUGS INCIDENT OR CONCERN

Online at:
www.cdreporting.co.uk

"Health and high quality care for all, now and for future generations"