March 2017

North Midlands Controlled Drugs Newsletter

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CD Reporting Tool
www.cdreporting.co.uk

Occurrence Reports

You can submit your quarterly occurrence report via the dedicated inbox for your locality: Derbyshire & Nottinghamshire **england.nottsderbycontrolleddrugs@nhs.net** or Shropshire & Staffordshire **england.cd_x24n@nhs.net**

Support for GPs

NHS England has made support available for GPs and GP trainees suffering mental ill-health and addiction see: https://www.england.nhs.uk/2017/01/accessing-care/

The Controlled Drugs Newsletter contains local and national CD information. You can use the dedicated email inboxes to contact us. For Shropshire & Staffordshire email england.cd_x24n@nhs.net and Derbyshire & Nottinghamshire email england.nottsderbycontrolleddrugs@nhs.net

Sharing Learning from Incidents

- Over 800 Zomorph capsules of various strengths were returned to a practice following the death of a patient suggesting that the patient was not complying with their prescribed regime—highlighting the need for regular review of opiate doses for patients with chronic pain issues.

We recommend patients on long term opiates for chronic pain are reviewed to assess compliance and current need and consider if doses can be reduced or even stopped.

Any total daily dose of morphine of 100mg or more is associated with increased risk of debilitating side effects and mortality – so it might worth reviewing opiate use in these patients initially.

All Schedule 2 controlled drugs should not be prescribed as routine repeats and best prescribing practice is a maximum of 30 day's supply.

There is some useful information at http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware to help prescribers with safer prescribing of opioids.

- A review into a drug treatment patient's death found that the patient had missed 3 days supervised consumption from the pharmacy. No one informed the keyworker/ prescriber and he was found dead at home a few days later. Local service specifications require pharmacists to always contact a keyworker/prescriber when multiple doses are not collected.

- It is well known that codeine is a drug of abuse. Concerns regarding codeine linctus misuse have increased nationally. Please ask all pharmacy staff to be vigilant when unusual requests, or requests for large quantities for codeine linctus are made over the counter. Contact the CDAO team or Police CDLO if you have concerns

UKMi are now hosted on a new website https://www.sps.nhs.uk/

Specialist Pharmacy Service

In recent months they have published a number of useful documents such as:

- https://www.sps.nhs.uk/articles/how-do-you-minimise-the-risks-of-medication-errors-with-buprenorphine-patches/
- https://www.sps.nhs.uk/articles/which-opioids-can-be-used-in-renal-impairment/ (based on pharmacokinetic studies)
- https://www.sps.nhs.uk/articles/how-should-dentists-prescribe-store-order-and-dispose-of-controlled-drugs-2/

Care Quality Commission

Another useful CD resource that is produced by CQC which is an easy to read guide for GP practices can be found at: http://www.cqc.org.uk/content/nigels-surgery-28-management-controlled-drugs

NHS England North Midlands Controlled Drugs Newsletter

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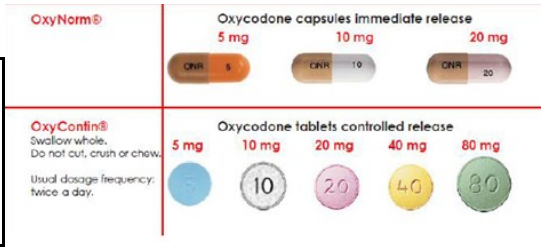
Preventing Harm from Oral Oxycodone Preparations

Nationally there have been medication incidents involving oxycodone where the following factors have been identified as contributing to confusion regarding dosing.

- Naming of the various oxycodone products
- Different rates of release available

Oxy**contin**® - Oxycodone **continuous slow release**	Oxy**norm**® - Oxycodone **normal** or **immediate release**
Tablets Slow release – dosing is 12 hourly	Capsules, injection and liquid Give dose every 4-6 hours PRN



Oxycodone should be prescribed by brand name to avoid confusion.
Healthcare professionals are requested to take care in prescribing, dispensing and administering the correct oxycodone preparation.

With thanks to NHS England— London CD support team

CDAO National Controlled Drugs Group

The National Controlled Drugs Group was set up as part of the strengthened governance arrangements, put in place for CDs following the Shipman Inquiry. The national group have set up four sub-groups for patient safety, vigilance, policy & operational issues and prescription monitoring. Recently published newsletters containing learning to share has been taken from real case studies these can be found on CQC website http://www.cqc.org.uk/content/use-controlled-drugs#vigilance
In the latest issue of the vigilance Sub-Group's newsletter, the focus is on thefts of CDs that have led to harm as a result of individuals taking CDs that were not prescribed or intended for their use.
The patient safety newsletters latest issue focuses on risks of drug-drug interactions, drug doses in renal impairment, the safer use of naloxone and an article on prescribing opioids for chronic pain.

CD Register Entries

A number of dispensing incidents/discrepancies are not being identified until the end of the day or the following day, due to a delay in making CD register entries and conducting stock balance checks. Discovering an error promptly can reduce the potential for patient harm, as the patient is less likely to have consumed the incorrect medication.

Ensure the destruction of patient returned and obsolete CDs happens regularly. Non multiples can request an authorised witness visit at www.cdreporting.co.uk

Methylphenidate Discrepancies

The number of methylphenidate discrepancies has increased across the Country which may be due to a manufacturers issue. This has been raised as a concern, manufacturers have confirmed that these overage/underage's are within acceptable tolerance.

However while MHRA review this concern we recommend that pharmacy staff count the quantity at dispensing, (explaining opening of packs if necessary, as some packs have the wording do not accept if pack opened) and to remove the desiccant out of the containers when dispensing.

Key Messages

- **Review prescribing of patients taking high doses of opiates for chronic pain**
- **Healthcare professionals are requested to take care in prescribing, dispensing and administering the correct oxycodone preparation.**
- **Always count the quantity in sealed packs of CDs at dispensing**
- **Carry out regular controlled drugs stock balance checks—ideally weekly**