November 2018

NHS England

North Midlands Controlled Drugs Newsletter

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Report ALL CD incidents, concerns and occurrence reports via the CD on-line reporting tool: www.cdreporting.co.uk

CD Local Intelligence Network

Next CD LIN meetings:

Shropshire & Staffordshire
23 January 2019

Derbyshire & Nottinghamshire
6 February 2019

This newsletter contains local and national CD information to support safe use and handling of controlled drugs.

Changes to Classification of Controlled Drugs

1. Cannabis based medicinal products classified as Schedule 2 controlled drugs — under the Regulations, which came into force on 1st November 2018 unlicensed cannabis-derived medical products prepared for use by a specific patient, may be prescribed by a doctor listed on the specialist register of the General Medical Council. *Further info will follow.*
2. Pregabalin and Gabapentin are to be re-classified as Class C / Schedule 3 (with exemption from safe storage) Controlled Drugs from April 2019. Further details on these changes are expected soon.

Fentanyl — Serious Patient Safety Concerns

Concerns continue regarding the use of Fentanyl Patches. The MHRA has issued further advice highlighting reports of life-threatening adverse reactions and death after fentanyl overdose in people who were using the patches to control pain.

Factors related to unintentional overdose include dosing errors (by healthcare professionals, patients, or caregivers); accidental exposure (particularly in children and babies); and exposure of the patch to a heat source, possibly resulting in increased fentanyl absorption.

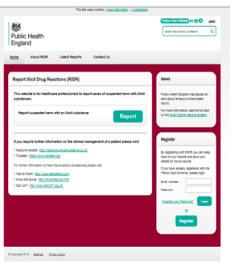
Healthcare professionals should support the safe use of Fentanyl Patches by providing appropriate counselling to patients on the possible risks of using the patches, ensuring they are safely disposed of, and providing information on what to do in an emergency.

Reporting Illicit Drug Reactions (RIDR)

Reminder to Report and Respond to emerging drug health harms using the RIDR system:

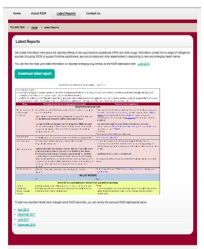
REPORT *new and unusual illicit drug adverse reactions you encounter on-line via*

report-illicit-drug-reaction.phe.gov.uk/



RESPOND, *for an update on current issues related to new psychoactive substances and drug harm, see*

report-illicit-drug-reaction.phe.gov.uk/latest-information/



Learning from Recent Incidents

Actions for Prescribers and Practice staff : Requests to Re-issue Repeat Prescriptions

There have been concerns raised by Coroners regarding the re-issuing of repeat prescriptions following a patient's death. It is strongly recommended that practices have a robust process in place to review requests for lost prescriptions.

Learning actions

- *question the patient closely as to the circumstances of the loss and record their responses*
- *any decision to re-issue or not should be made by a clinician and documented in the patient's record*
- *if appropriate to re-issue the prescription, only supply the quantity required to keep them in line with other monthly repeat medication*
- *monitor closely and consider weekly prescriptions where there is concern or repeated lost prescriptions particularly of those drugs subject to abuse*

Duplicate Prescribing of Shared Care Medicines

There has been a recent incident where a patient had duplicate prescriptions for a CD. One from a specialist team and another from their GP. This was picked up by the pharmacist who only issued a single supply.

Learning action

For any medicine where there is shared arrangement in place for prescribing, agree dates for handover of supply to minimise duplication which could lead to patient harm.

Actions for Community Pharmacy : Dispensing Errors

We have received a number of dispensing error incidents where incorrect quantities or the wrong strength of CDs have been issued.

Learning action

Check balance in CD register at time of dispensing and record entry at time of issue to patient. Complete stock-checks as planned.

Actions for Prescribers, Nurses and Pharmacy Staff : Opioid Prescribing and Administration Requiring Reversal with Naloxone

Take care when prescribing, supplying and administering opioids including opioid patches e.g. Fentanyl following further reports of life-threatening adverse reactions and death after overdose in people who were using the patches to control pain.

Learning actions

Think carefully about all factors when prescribing and administering opioids in particular:

- *Consider patient parameters including age, renal function, weight*
- *Confirm recent opioid dose, formulation and frequency of administration, including the use of breakthrough doses. Check other medicines that have been prescribed for the patient*
- *Ensure dose titration is appropriate and safe*
- *Ensure the prescription is clear including which formulation is to be used*
- ***Opioid patches***
  - ⇒ *ensure only the new patches are in use. Remove old patch*
  - ⇒ *Communicate when a patient requires the use of a Fentanyl Patch between different care settings*
  - ⇒ *minimise the potential for transfer of patches between individuals during skin contact*
  - ⇒ *Dispose of patches safely to prevent accidental exposure*

Healthcare professionals should support safe use of Fentanyl Patches by providing appropriate counselling to patients and carers on the possible risks of using the patches, ensuring they are safely disposed of, and providing information on what to do in an emergency.