NHS ENGLAND & NHS IMPROVEMENT

CONTROLLED DRUGS TEAM MIDLANDS

Controlled Drugs Newsletter

Spring Edition **April 2021**

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

Midlands' Controlled Drugs Accountable Officers

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Pregabalin - Lyrica: reports of severe respiratory depression

On the 18th February 2021 the MHRA have issued a drug safety update that relates to reports of severe respiratory depression, including some cases without the presence of concomitant opioid medicines. The full alert can be accessed at ***https://www.gov.uk/drug-safety-update/pregabalin-lyrica-reports-of-severe-respiratory-depression***. The update provides clear advice for healthcare professionals and advice for patients and carers.

Advice for Healthcare Professionals:

- Consider whether adjustments in dose or dosing regimen are necessary for patients at higher risk of respiratory depression, this includes people:
  - With compromised respiratory function, respiratory or neurological disease, or renal impairment
  - Taking other CNS depressants (including opioid-containing medicines)
  - Aged older than 65 years
- Report suspected adverse drug reactions associated with use of pregabalin on a Yellow Card - ***https://yellowcard.mhra.gov.uk/*** (see reporting section).

Advice to give to patients and carers:

- Some patients have experienced breathing difficulties when taking pregabalin – certain people may need a lower dose to reduce the risks of these issues
- Contact your doctor if you notice new or increased trouble breathing or you experience shallow breathing after taking pregabalin; a noticeable change in breathing might be associated with sleepiness
- Read the leaflet that comes with your medicine and talk to your doctor or pharmacist if you are worried about the other prescribed medicines you are taking with pregabalin
- Avoid drinking alcohol during pregabalin treatment

Learning from Pregabalin Prescribing Monitoring

As part of the Controlled Drugs Team Monitoring of Pregabalin prescribing in GP practices, a patient was identified for review who was receiving a daily dose of Pregabalin up to 2000mg in addition to also being prescribed Oxycodone. The BNF recommended maximum dose for pregabalin is 600mg and there is an increased risk of harm when Pregabalin is prescribed in combination with opiates as it can cause CNS depression.

The patient concerned has complex health needs which include severe long-term pain. Whilst the patient is being supported by the pain team and is awaiting further treatment a review of the patient's medication was completed. A planned reduction regime has been put in place to reduce the pregabalin and will then review the oxycodone dose. The possibility of alternative non-pharmacological treatments is being explored and the long term the plan is to switch to an alternative pain relief.

Private Prescriber Notifications

Individuals who are registered as private prescribers are reminded that if there are any changes to their registered details, they must inform the Controlled Drugs Team in a timely manner. Delays in notification can impact upon the timescale it takes to get systems updated so that prescription pad orders are processed correctly.

Lockdown methadone dispensing incident 'directly contributed to death' *credit – Pharmacy in Practice

A recently published Coroners report highlights the tragic circumstances around a young man's death. Please discuss this incident to raise awareness and as a reminder of what can go wrong, during your own team/clinical governance meetings.

A young man who was known to have drug dependency issues and had been receiving support and treatment for this; was found deceased in April 2020 at his home address, in Suffolk. The medical cause of death was confirmed as: 1a Methadone toxicity.

Prior to the Covid-19 pandemic lockdown, his methadone prescription was for daily dosage bottles. Due to Covid-19 his prescription was reviewed and changed to collection once every 14 days. On the 15th April he collected his dispensed Methadone from the community pharmacy to cover the 14-day period. He was issued three bottles, these bottles contained 100ml, 156ml and 500ml of methadone respectively. The methadone given was not in daily doses bottles as prescribed. He was found deceased at home 2 days later. He was last seen by his family on the 15th April 2020 when he appeared fit, well and in good spirits, the coroner said that there was no evidence to suggest that he had intended to take his own life.

Despite the risk mitigation put in place that only daily usage bottles should be prescribed, the coroner said that Mr MF's access to increased quantities of methadone directly contributed to his death. "It is therefore probable, that due to a lack of a measuring jug, Mr MF guessed his first dose from the larger methadone bottles with tragic consequences".

We can share any learning if/when this becomes available from Coroners Court. You can find the initial report at: ***https://www.judiciary.uk/wp-content/uploads/2021/01/Matthew-Fitten-2020-0275.docx_Redacted.pdf***

Remote Consultations

The Covid-19 pandemic has resulted in a dramatic increase in remote consultations (phone/video link/online). This has also led to incidents whereby individuals have obtained inappropriate prescriptions and supplies of medicines, including controlled drugs, by exploiting the lack of direct face to face contact with their GP.

The GMC has produced guidance (including a helpful flowchart) to help doctors manage risks around remote patient treatment and prescribing whilst still providing effective patient care. This guidance can be found at: ***https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations*** .

If a remote consultation is deemed appropriate:

- Ensure you are speaking to the right person - check that their date of birth, name and address match the details on their GP record. Use this opportunity to check if there have been any changes to recorded telephone numbers/contact details for the patient;
- Ensure that you have access to their medical records (including their prescribing history);
- Consider if the medication being sought is liable to abuse, overuse/misuse or if there is a risk of addiction. If it is, check if there is any evidence from their recent prescribing history of possible over-frequent prescription seeking;
- Ensure systems are in place to highlight prescribing of medicines liable to abuse, overuse, misuse or where there is a risk of addiction; and ongoing monitoring is required;
- Be vigilant to repeated requests for such medicines and review frequently;
- If there is concern regarding a patient, liaise closely with the community pharmacy to monitor supply.

Community pharmacies are reminded to:

- Be vigilant for repeat requests and/or prescriptions for medicines liable to abuse/ overuse/misuse and highlight any monitoring requirements on the patient's PMR;
- Relay any concerns to the prescriber if patient safety may be at risk;
- Ensure CCTV systems, if present, are working effectively.

Good practice in prescribing and managing medicines and devices

The GMC have produced guidance on good practice in prescribing and managing medicines and devices which comes into effect on the 5th April 2021 which can accessed here:
https://www.gmc-uk.org/-/media/documents/prescribing-guidance-before-cie_pdf-85470847.pdf?la=en&hash=EBC2C2FCDD5F7481667629E891F4BFB8A792F59D

Key Updates to the guidance include:

- New advice for doctors not to prescribe controlled drugs unless they have access to the patient records, except in emergencies.
- Stronger advice on information sharing, particularly when a patient refuses consent to share information with other relevant health professionals.
- Alignment with updated 'decision making and consent' guidance, highlighting the importance of good two-way dialogue between patients and doctors in all settings.

The Community Pharmacy Patient Safety Group Advice

At the Controlled Drug Accountable Officer and Superintendent meeting back in December, there was a discussion regarding hand out errors related to face mask/coverings. The Community Pharmacy Patient Safety Group took an action to consider if any guidance or support tools could be developed. Further to this, the group have developed a "top-tips" document for pharmacy teams. The guidance can be accessed on their website ***https://pharmacysafety.files.wordpress.com/2021/02/tips-for-avoiding-handout-errors-during-the-pandemic-final.pdf***