CONTROLLED DRUGS NEWSLETTER

SHARING GOOD PRACTICE IN DEVON, CORNWALL AND THE ISLES OF SCILLY

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CONTACT US

Accountable Officer:
Bridget Sampson
☎ 0113 824 8960
@ bridget.sampson@nhs.net

Deputy Accountable Officers:
Darren Barnett (Mon-Fri)
☎ 0113 824 8813 or 07747 443418
@ darrenbarnett@nhs.net
Graham Brack (Mon-Tue)
☎ 0113 824 8964 or 07747 455068
@ graham.brack@nhs.net

Secure email address:
accountableofficerdcios@nhs.net

Administrative Support:
Sally Dutton
☎ 0113 824 8797
@ sally.dutton@nhs.net

NHS England

Area Team for Devon, Cornwall & Isles of Scilly

REPORTING THE ERRORS OF OTHERS

For understandable reasons, there has been a reluctance to report the errors of other health and care professionals. The clear thrust of the post-Shipman reforms has been that patients must be protected, and the community pharmacy contract is about to be altered to require pharmacies to report errors that they detect, not just those that they make. We have not seen the detail of this requirement at present, but it has led to consideration of the wider duty to report errors.

What should a professional do when they detect an error? We see three actions that are necessary.

1. The prime duty is to safeguard the patient so, if you can reduce the risk by contacting them, that is the first thing to do.
2. The person who made the (apparent) error should be informed. There is no need to start a dialogue about it, but they cannot learn from an incident that they do not know has occurred.
3. The matter should be reported through the normal error reporting systems including – where controlled drugs are concerned – to the AO team. Report it to the AO to whom you would normally report, not necessarily the AO of the person making the error. AOs will route the information between them.

It may be necessary to contact the person having care of the patient to alert them to possible consequences – so we would expect community pharmacists to inform the patient's GP if the patient has taken something incorrect or has missed something that they should be taking.

KEEPING US INFORMED

We receive plenty of reports, but we also hear of incidents that have not been reported to us. This may arise when one provider contacts another to sort out a problem, but if we do not hear about it we lose the chance to gather any lessons from the event. For example, we have had some reports of pharmacies not receiving instalment dispensing prescriptions on schedule but these are anecdotal because we have few reports from either party and so we cannot assess how common a problem it is.

REPORTS TO PREVENT FUTURE DEATHS

When coroners hold inquests, if they believe that an organisation could take steps to prevent a future death they can issue a report (sometimes known as a Regulation 28 report) requiring that organisation to consider what could be done and reply within 56 days. These are publicly available and we routinely review them to see whether there is any application to the management of controlled drugs. There have been a number of these in recent months which we offer here as a means of encouraging sharing of learning.

1. A patient with complex needs was discharged from hospital on Friday afternoon. His care package was not delivered and he committed suicide on Sunday. The coroner asked whether discharge on a Friday is inherently risky and how delivery of care is assured.
2. A family was killed by a man who had previously made threats to their wellbeing. A misunderstanding of the circumstances in which such information can be shared meant that the threat was not disclosed to the man's mental health team. While the circumstances are unusual it may be appropriate to consider whether staff members are clear about the occasions on which confidentiality can legitimately be breached.
3. A mental capacity assessment was carried out by a carer who had not been trained to do so. The healthcare professionals appeared to have relied upon (or been influenced by) this assessment and there had therefore not been the independent check that might have been desirable.
4. In a couple of cases, a person other than a healthcare professional (in one case, a practice receptionist) was operating a triage system. The patient was expected to say if they felt their systems warranted immediate referral to a doctor. The mother of a baby did not know that the child had pneumonia and as a result was given an appointment with the practice nurse rather than a doctor. The nurse failed to diagnose the severity of the condition and the baby died. In both cases, the coroner suggested that a triage system should have its decisions audited by an experienced person to ensure the quality of the dispositions made.
5. A pharmacist queried a hospital prescription for prednisolone 95mg daily. The consultant's secretary appears to have thought that the query was about what the prescription said, and not whether the dose was appropriate, and assurances were therefore given that the medicine should be dispensed. The coroner suggested that when prescribers exceed BNF recommended doses or prescribe outside normal indications they should explicitly note the fact or indicate in some way that they are aware of the high dose. Plainly there are complications in following this advice in palliative care, but it may warrant consideration as a general principle. It is also important that those receiving telephone queries ensure that they repeat back the nature of the query to avoid misunderstanding.
6. A carer visited a patient to support them in taking their medication. Having prepared the morning dosage, she left, having failed to notice that the patient was dead. While this obviously required some explanation, the wider concern is that she had initialled the medicines chart; the coroner felt that this indicated a failure to understand what she was signing for, and called into question her signing of her other patients' charts. It suggests that we might usefully check whether staff truly understand the reasons for signing any particular document.
7. A serious incident requiring investigation had proceeded to an inquiry, but the results were not promptly shared with frontline staff, resulting in a repetition of the event.
8. In a case within our area, a person receiving methadone was prescribed weekly pick-ups. Her partner consumed her supply and died. The client claimed not to have been told that her medicine could be dangerous to others. it is likely that such warnings were given but it would have been helpful to have specifically noted the fact in the patient record. At the dose prescribed, even a day's take-home dose could have been fatal but the continuing need for supervised consumption should reflect the risk to others in the household and the client's reliability in keeping her doses securely.

TRAMADOL

Tramadol is now a schedule 3 controlled drug. This means that it cannot be prescribed electronically (at present) or via repeat dispensing schemes, nor can emergency supplies be made by pharmacies. It is exempt from safe storage requirements. Please note that this also applies to branded tramadol products, not just the generics.

PART-DISPENSED PRESCRIPTIONS

There will inevitably be occasions when the whole prescribed quantity cannot be dispensed. It is important that the registers and patient records accurately reflect what has been provided and what remains to be issued (and the date when the 28 day validity of the prescription is reached and the supply cannot be made). It is not practical for us to dictate how this should be done in each practice, but it is important that dispensers have a system that will meet these requirements. In particular, a pharmacist or dispenser who is faced with dispensing the owing quantity needs to have a system that tells them what remains to be given and the date by which it must be completed.

There is an added complication in the case of dispensing practices. We have had a case in which a dispensing practice had a patient who no longer required a supply that was owed because his dosage had increased. The prescriber wanted to ensure that the owing amount was not issued in addition to the higher dose but chose to delete the original prescription which had been partly dispensed and issue a new prescription for the lesser amount on a later date. This caused confusion because the patient record now appeared not to show the original supply but to show a different prescription which the patient (rightly) denied having received. Moreover, the doctor issuing the replacement left themselves open to questions about what they had done with the controlled drugs apparently prescribed, which might have been avoided.

Given that elements of the patient record may be relied upon by others it is important that, so far as possible, they accurately reflect the patient's care. In case the record did not and there was a risk that the patient might have been denied a painkiller because they had apparently already received it.

EMPLOYMENT OF LOCUMS

A patient managed to obtain employment as a healthcare professional – and hence access to stocks of controlled drugs – by impersonation. The professional involved was blameless and had no knowledge of the impersonation. It is believed that the patient and the professional may never have met. However, the patient had ascertained that the professional was not known to the place where she sought work and the identification processes in place failed to catch her out.

Obviously the starting point will be verification that the person is entered on the appropriate professional register and not subject to restrictions on their practice which might disqualify them from that employment. However, it is important that some official photographic identification is examined too. A passport, driving licence or possibly an NHS Smartcard may suffice.

28 AND COUNTING…

There has been a little 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 controlled drugs are packed in multiples of 28 – comparatively few are.

CQC ANNUAL REPORT The Management of Controlled Drugs 2013

This report can be viewed at http://www.cqc.org.uk/sites/default/files/20140811%20CQC%20Controlled%20drugs%20annual%20report%202013%20final.pdf (or use the QR code below). We are pleased to report that this Newsletter was praised there as an example of best practice – but it would still be worth reading even if this were not the case!

DENTISTS' PRIVATE CD CODES

The Area Team PCD code for dentists is 611433. Prescriptions with the old PCT codes will only be linked to this Area Team until the end of January 2015 and any dentist wishing to continue to prescribe privately will require stationery with the 611433 code before then.

If you hold pink private prescription forms, please check the preprinted code. If it is 611433 you can continue to use them. If not, please apply to us for replacements. Please don't delay!

SUBMITTING YOUR PRIVATE PRESCRIPTIONS TO NHSBSA

Download the submission form at **http://www.nhsbsa.nhs.uk/2473.aspx** (or use the QR code) - click on "Submission document for submitting controlled drugs through a private account."

PRE-DISPENSED METHADONE

We continue to see instances of this being wrongly handed out, either because the patient is wrongly identified or the medicine has been incorrectly dispensed in the first place (sugar-free v standard, for example). It is often unclear how the pharmacist issuing the supply can be assured that the bottle contains the right thing. We have also had an incident in which the pharmacy customarily prepares a week's doses on the weekend – presumably their prescriptions cover the supplies being made – but because the second Monday was a bank holiday the pharmacist on the following Saturday had to add additional days to the pre-prepared parcels. He miscalculated the number of days needed for a client.

We reiterate our view that pre-dispensing introduces an additional risk that must be managed by suitable standard operating procedures. The fact that we have to raise this repeatedly suggests that procedures in place are not working.

RISK ASSESSMENT

We would expect prescribers to give some thought to the safety of other household members when prescribing controlled drugs. At the time of dispensing, the patient should be counselled about the importance of keeping their medicines securely, but this does not avoid the need to weigh up any risk implicit in the prescription of larger quantities. There have been instances of people with dementia who have taken the medication prescribed for others in error, to give just one example.

We plan to run a patient education campaign encouraging the public to find a safe place to store their medicines, and to remind them that the person at risk may be a visitor such as a grandchild.

PATIENT INFORMATION

Following recent news stories it seems some patients misunderstand the information available to pharmacists at the time of dispensing. As a result, patients may not disclose changes to their medication in the belief that the pharmacist will already know them.

In particular, patients do not generally realise that pharmacists do not have access to their telephone numbers. While patients are not obliged to share these, it may be helpful to have numbers for patients regularly receiving controlled drugs, especially if they are making holiday plans that may need to be confirmed before their supplies are assembled.

TRANSDERMAL PATCHES

If you have read this newsletter for a while, you will know that this is a subject to which we repeatedly return. It is a matter of concern at a national level that there are so many instances of patients being put at risk by either a failure to apply a patch on schedule, a failure to remove the previous patch, or simply inappropriate use of patches.

We would expect those who apply patches to have systems that enable them to see quickly when the last patch was applied, when the next should be applied and where the last one was sited. A helpful refinement which has been suggested by a Care Home is to require those applying a patch to sign to say that the previous one has been removed.

NEXT CDLIN MEETINGS

North & East Devon	3 February	Middlemoor Police Station
Cornwall	11 February	Peninsula House, Saltash
South & West Devon	26 February	Bodmin Police Hub

NATIONAL REPORTING AND LEARNING SYSTEM (NRLS)

Please note that reporting incidents to us does not obviate the need or meet the duty to report to NRLS. We do not forward your reports.