

Welcome

Welcome to the second edition of a special newsletter highlighting some recent Controlled Drug errors and issues, from which shared learning can be gained. This has been written in response to demand from Community Pharmacists during a recent LPC Pharmacy Forum where we had the opportunity to discuss some anonymised incidents and to explore the learning as a result

Controlled Drug Incidents

- **Regular Balance Checks and Timely CD Destruction;** There have been a few incidents recently where there have been missing out of date CDs, including unexplained discrepancies from the CD register. Regular balance checks, ideally weekly, would make resolution of any balance discrepancies easier. The timely destruction of out of date CDs would also help to resolve this issue.
- **Atypical Prescribing.** Please be aware of any unusual or excessive prescribing of CDs and prescriptions with ambiguous directions. We had an incident recently when Buprenorphine 5mg and 10mg patches were prescribed on the same prescription form. The prescriber's intention was to start with the 5mg and when these had finished to commence using the 10mg. The patient misunderstood these directions and thought they had to use both strengths together. This was spotted by the pharmacist, checked with the prescriber and the correct dosage instructions were communicated to the patient.
- **Incorrect Quantities.** Please be aware that there have been errors in quantity when dispensing Concerta XL. In some cases this has been attributed to tablets being trapped behind a dessicant, when dispensing from the original container.

NFA on CD prescription forms

I understand that there has been confusion in some quarters regarding whether it is legal to dispense prescriptions which have 'NFA' or 'No Fixed Abode' as the address. The Home Office view is as follows;

Regulation 15 of the Misuse of Drugs Regulations 2001 requires an address of the patient to be included in a prescription for Schedule 2 and 3 controlled drugs. In the case of persons of no fixed abode, the use of 'NFA' meets the requirement under the MDR 2001 for an address to be provided. It is of course the pharmacist's responsibility to ensure that where there is doubt, reasonable steps are taken to check with the prescriber to establish genuineness of the script before dispensing. However, the use of a Post Office box number is not acceptable for the purposes of the 2001 Regulations.

In the absence of any other factors, there is no risk to a pharmacist who dispenses a script with a NFA provided they are satisfied, or have taken steps to satisfy themselves that the script is genuine.

Supervised Consumption Service Level Agreement

A reminder that when dispensing for a substance misuse client, the dose cannot be dispensed to the patient's representative to take away unless there is prior agreement with the Drug Service.

The protocol for a client who is unwell is that the pharmacist contacts the Drug Service who will then contact the client. If the client has a legitimate illness then he/she would be asked to provide a letter, saying they authorise a named person to collect the prescription. The named person would then have to attend at the pharmacy with photo identification. The Drug Service would let the pharmacist know who they should expect to collect the prescription.

Again, can I give a further reminder that if a client misses a dose then the Drug Service should be informed and that if a client misses 3 consecutive doses or more, then the dispensing is withheld and the client referred back to the Drug Service.

4.2 All missed doses should be reported to the client's key worker the following working day.

4.3 Medication must not be dispensed to any client who has missed three consecutive doses. This is due to reduced opiate levels within the body and an increased risk of overdose. In all instances of a client attending for their medication after missing three consecutive doses, the pharmacist must withhold the client's daily dose and refer the client back to their key worker or prescriber before any further dispensing occurs. The pharmacist should also inform the key worker that a dose has been withheld and must not issue any further medication unless a specific instruction to endorse this has been given by the key worker/prescriber or their nominated deputy at the prescribing agency.

Alerts

On occasions it is necessary for the Compliance and Alerts Team to send out alerts to community pharmacies with details of missing prescriptions and patients who may try to obtain medicines inappropriately. Please note that these alerts are private and confidential and the information is only to be shared between relevant members of staff. On no occasions should this information be shared with members of the public.

Contact Details

Please continue to inform the Accountable Officer's Department of any CD related issues.

Every effort is made to ensure the accuracy of information in this Newsletter. This information is published only for NHS use in the Devon Health Community.	NHS Devon Accountable Officer's Department		
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