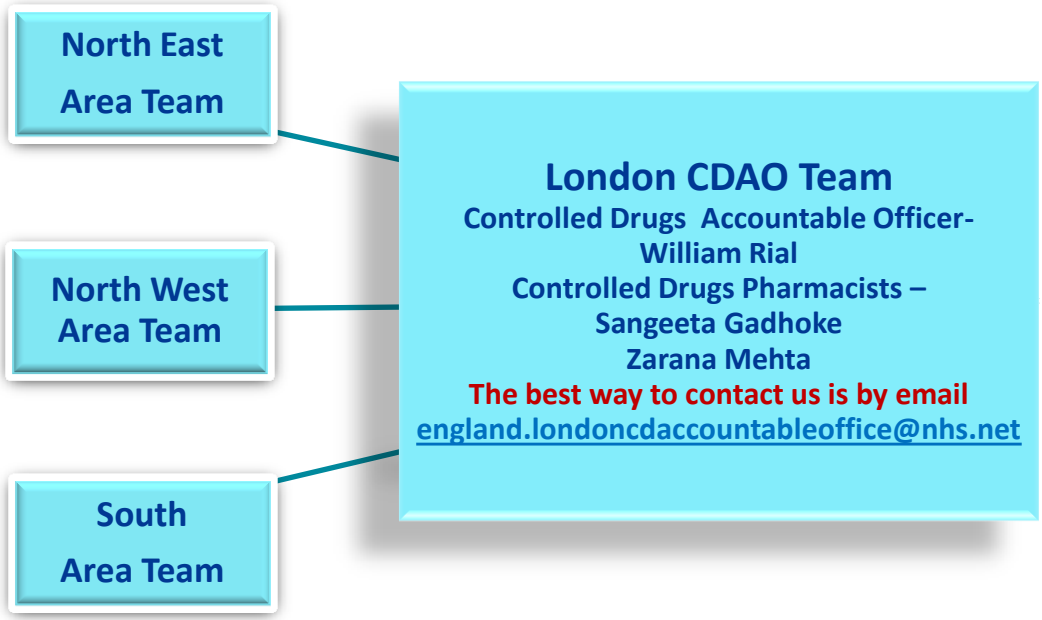
Update from the London Region CDAO

December 2014

This is the first update since the function of the Controlled Drugs Accountable Officer (CDAO) transferred from PCTs to NHS England.
We want to start by thanking all of you for your support and patience throughout the transition.
It has taken a while to get our systems in place but hopefully you are now aware of who to contact and when.
If not then this update should provide you with some further clarity . Please share with your team.

The CDAO function now falls under the remit of NHS England and for the London Region Area Teams, the CDAO Team is:



Although the CDAO has three personalities, one associated with each of the London Area Teams, the function is delivered on a largely regional basis. Across the London Region the CDAO is responsible for the oversight of governance around the safe management and use of controlled drugs in NHS and independent healthcare . **Please update your policies as appropriate .**

Are you reporting concerns and incidents involving controlled drugs?

During Q1 and Q2 2014-15, 1,112 occurrences were reported to the NHS England-London Region CDAO. Of these, 74 were escalated as concerns. Any significant CD incidents which occur in between the submission of quarterly occurrence reports should be reported at the time to the London Region CDAO. We would like to share some of the common themes / lessons learned with you.

Security of Prescriptions

There has been an increasing trend for fraudulent prescriptions to be presented at pharmacies, particularly independent pharmacies.

- Prescription form stock and practice/hospital stamps **should always be stored securely when not in use**.
- If prescriptions are stolen, please advise the Police by phoning 101. If a CD prescription is involved, or it is suspected that stolen prescriptions will be used to fraudulently obtain CDs, please also report the loss to the CDLO (Controlled Drugs Liaison Officer) and the NHS England-London Region CDAO, so that an alert may be considered.
- If you have CCTV please ensure it is working and recording; this may provide valuable evidence in identifying the suspect.
- **You may find** the additional guidance for prescribers & practice managers of use -see links on next page

Ambulatory syringe drivers

Incidents involving MS Syringe Drivers continue to be reported to NRLS post publication of the NPSA Rapid Response RRR019: 'Safer Use of Ambulatory Syringe Drivers' in 2010.

CQC recommendations[1]:

- Introduce ambulatory syringe drivers with safer design into practice as soon as possible.
- It is recommended that no MS syringe drivers are used in NHS and independent healthcare providers providing NHS funded care, by December 2015 at the latest.
- Take steps to reduce the risks of rate errors while MS syringe drivers remain in use, based on a locally developed risk reduction plan which may include:
  i. raising awareness
  ii. providing information to support users with rate setting
  iii. using lock-boxes

Private CD prescribing

In order to prescribe schedule 2 and/or 3 controlled drugs (including temazepam and tramadol) privately, to be **dispensed in the community:**

- Prescribers must be allocated a Prescriber Identification Number (PIN).
- Prescriptions must be written on the appropriate FP10PCDNC forms, which are an item of controlled stationery**.**
- A PIN application form can be obtained from the London Region CDAO.
- Once a completed form is received, the London Region CDAO will request a PIN for the prescriber from the NHS Business Services Authority and order an initial supply of 10 FP10PCDNC forms for the prescriber.
- The time period between receipt of a completed application and the initial supply of prescriptions arriving with the prescriber is approximately 20 working days.

Information Governance Reminder

When reporting an incident to the London Region CDAO, please do not send patient identifiable data unless you are using an nhs.net email. If we require this information we will contact you.

TOP TIPS

Instalment dispensing:

Errors in start & finish dates especially when prescribing for closed days such as Bank Holidays are common. Check in advance that scripts issued cover Bank Holidays, correlate with opening/closing days of pharmacies being accessed and periods when a service user is on holiday. Remember even if you provide a prescription to cover the supply retrospectively, an illegal supply would have been made by the pharmacist.

Instalment dispensing:

Many pharmacists are not informing the prescriber /service when a patient **misses 3 doses**. You may wish to discuss this with your local pharmacist especially if you have chaotic patients, as there can be significant harm if the normal dose is supplied subsequently**.** The pharmacist can better manage the care of the patient if they are aware in advance.

Safer use of fentanyl and buprenorphine CD transdermal patches[2] :

1. Transdermal fentanyl patches should be restricted to patients that are already receiving regular doses of opioid.
Do not use for acute pain , **Do not use in opiate naïve patients**.
2. Before prescribing a CD transdermal patch, calculate the total daily dose of all the opioid analgesics that the patient has received previously. This is usually in morphine equivalence.
3. Use locally or nationally approved dose conversion charts to do this.
4. Ensure only those CD transdermal patches intended for current use are applied.
Patches *may* be skin coloured or transparent, and so may not be easy to locate.
Formally record the anatomical position of currently applied patches so that this information is readily available to inform future decisions and actions.
5. Consider that patients may exhibit symptoms of opioid withdrawal when a CD transdermal patch has been omitted.

Safer use of oxycodone medicines[3]:

1. Oxycodone should only be used as a second-line strong opioid, if morphine is not suitable or cannot be tolerated.
2. Obtain details of the previous daily dose, and frequency of administration of previous analgesics used by the patient.
3. Confirm the appropriate medicine formulation is being used.
There are fast acting short duration (e.g. Oxynorm) and slow acting, long duration (e.g. Oxycontin) oxycodone products. There are **significant risks of overdose** when a fast acting product of short duration is used in error for the slow acting, longer duration products.
4. Check for therapeutic duplication of strong analgesics by two different routes of administration. There may have been an error and the previous route of administration may not have been cancelled.
5. Confirm any use of oxycodone concentrate products. There are **significant risks of overdose** if a concentrate product is used in error for a normal strength product.
6. Any use of oxycodone medicines 'as required' should have clear guidance on the frequency that the doses can be administered.

Useful links

Prescription security

Security Management Aide-memoire for Prescribers

Security Management Aide-memoire for Practice managers

The above documents along with further information on medicines security can found on NHS Protect's website at: www.nhsbsa.nhs.uk/4430.aspx

References:

1.CQC Safer Use of Controlled Drugs (CD) - Preventable harm still occurring with CDs administered via MS Syringe Drivers
http://www.cqc.org.uk/sites/default/files/documents/safer_use_of_controlled_drugs_-_for_the_web_-_preventable_harm_still_occurring_with_cds_administered_via_ms_syringe_drivers.pdf

2. CQC Safer Controlled Drug Use - Preventing Harms From Fentanyl and Buprenorphine Transdermal Patches
http://www.cqc.org.uk/sites/default/files/documents/safer_controlled_drugs_guidance_for_the_web_fentanyl_and_buprenorphine_transdermal_patches_updated_v3.0.pdf

3. CQC Safer use of Controlled Drugs - Preventing Harm From Oral Oxycodone Preparations
http://www.cqc.org.uk/sites/default/files/documents/safer_use_of_controlled_drugs_-_guidance_for_the_web_-_preventing_harm_from_oral_oxycodone_medicines_v2.0.pdf