NHS England, East of England, Controlled Drugs Team

NHS England East of England

Controlled Drugs Newsletter

Month/Year: Feb/2024

Issue No. 26

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

Change in regional CDAO

The CDAO for NHS England, East of England is now Jane Newman

NHS England, East of England CD team

Email: england.ea-cdao@nhs.net

Jane Newman Controlled Drugs Accountable Officer

Reminders

- All CD incidents in community pharmacy and general practice should be reported to the CDAO via www.cdreporting.co.uk
- Please respond to auto-reply emails generated by the CDreporting website by logging in to your account on CDreporting to give your answer, if required
- Please ensure you have a valid T28 waste exemption to sort and denature controlled drugs for disposal in advance of any CD destruction
- If you are intending to, or already do, store schedule 2 CDs in a dispensing robot (in a community pharmacy setting), please ensure that a safe storage exemption certificate has been sought from your local area CDLO
- Please ensure you are regularly accessing nhs.net premises specific emails as important correspondence is sent via these means

Private prescribing – community pharmacy reminders

- All private prescribing of schedule 2 & 3 CDs must be written on the appropriate CD prescription forms (FP10PCDSS/FP10PCDNC) which require the practitioner to hold a private CD PIN
- Pharmacies need to submit dispensed private schedule 2 & 3 CD scripts to the NHSBSA by the 5th day of the following month
- Dentists requisitioning any schedule 2 & 3 CDs must obtain and use a private CD PIN on the FP10CDF requisition form
- Practitioners requisitioning any schedule 2 & 3 CDs for endoscopy units must also obtain and use a private CD PIN on the FP10CDF requisition form

NHS England East of England

Useful Websites

CD Reporting
www.cdreporting.co.uk

Home Office
https://www.gov.uk/government/organisations/home-office

Department of Health
https://www.gov.uk/government/organisations/department-of-health

General Pharmaceutical Council
www.pharmacyregulation.org

Care Quality Commission
http://www.cqc.org.uk/

NHS Prescription Services CD section
https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/prescribing-and-dispensing/safer-management

Community Pharmacy England
Dispensing & Supply - Community Pharmacy England (cpe.org.uk)

Shared learning case study – multi-organisational errors

A pharmacy received a prescription for midazolam 5mg/ml oral solution sugar free, supply 7.5mL. The dose was '5mg once daily as required' and was for a child aged one years old.

The pharmacy did not query this unusual prescription with the prescriber.

The pharmacy dispensed midazolam 7.5mg/1.5mL oromucosal solution (Buccolam).

Through investigations, the CD team determined that the GP had prescribed the incorrect preparation of midazolam in error. The GP had intended to prescribe midazolam 5mg/mL oromucosal solution 1mL pre-filled syringe (Buccolam).

There is a higher risk of an error occurring for medication where the strength is the same but the dose is changed because of the volume supplied, such as Buccolam syringes.

To help mitigate this, Buccolam states the suitable age range on the box/item and differentiates each strength by colour (see picture below).

It is worth noting that Buccolam can often be short dated, so it is important to ensure the expiry date is double checked when supplying.

Case study continues on page 3

Case study continued

Key Issues

- GP unfamiliar with the generic wording of the medication on the computer system and had picked the incorrect option when prescribing
- The GP considered the hospital discharge summary wording ambiguous
- Pharmacy failed to query with the prescriber the unusual preparation quantity and dose requested
- The checking process did not identify that the incorrect item had been selected and was not appropriate for the age of the patient
- Inadequate action taken following an error:
    - The patients mother was in possession of the incorrect medication for approximately 4 months before the error was realised and reported to the CDAO team
    - Because the prescription was not queried, the GP practice remained unaware of the prescribing error and issued another identical prescription for the patient

What key actions/learnings can be taken from this incident?

- GP corrected prescribing of midazolam for this patient who is now in possession of the correct medicine
- In future, the GP practice have decided to prescribe all buccal midazolam prescriptions by brand for the medium term as well as to audit all patients at the practice who are on midazolam to ensure the correct formulations were being prescribed
- GP to feedback to the hospital regarding wording on discharge summary
- The GP to ensure double checks are undertaken in relation to patient age, dosage, administration route and any other factors which are relevant for that particular drug
- Practice logged this as a significant event and held a meeting to share learnings and provide additional training for clinicians with respect to prescribing of all midazolam preparations
- Importance of reporting and communication

Case study continues on page 4

Case study continued

What key actions/learnings can be taken from this incident? (continued)

- The importance of speaking to patients or their representatives about their medicines when in the pharmacy
- The pharmacy were reminded that Buccolam packs indicate the suitable age range of the patient for each strength and should be used as guidance when supplying this medication
- The pharmacy to ensure extra vigilance when dispensing and checking Buccolam
- The pharmacy to assess suitability of dose requested to what volume is supplied i.e. it would not have been possible for the patient to measure a 5mg dose (as labelled) from a 7.5mg single use dose container
- Pharmacy to make certain that prescriptions are queried with the prescriber, if appropriate

Please share these learnings with your team.

Codeine linctus (codeine oral solutions): reclassification to prescription-only medicine (POM)

Published on 20 February 2024 following a public consultation the Medicines and Healthcare products Regulatory agency (MHRA) has decided to reclassify codeine linctus to a POM because of the risk of abuse and addiction.

Please see below link to the latest drug safety update which details advice for healthcare professionals, the recent review and the MHRA monitoring undertaken of codeine linctus side effects.

Codeine linctus (codeine oral solutions): reclassification to prescription-only medicine - GOV.UK (www.gov.uk)

Useful links:

Specialist Pharmacy Service (SPS):

- Managing the risks of using liquid oral phenobarbital – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
- Continuing management of the ADHD medicines shortage – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Home Office:

- Community pharmacy: delivering substance misuse services - GOV.UK (www.gov.uk)
- Fifteen new synthetic opioids to be made illegal - GOV.UK (www.gov.uk)
- Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk)

European Monitoring Centre for Drugs & Drug Addiction (EMCDDA):

- European Drug Report 2023: Trends and Developments | www.emcdda.europa.eu

Advisory Council on the Misuse of Drugs (ACMD):

- ACMD advice on 2-benzyl benzimidazole and piperidine benzimidazolone opioids (accessible version) - GOV.UK (www.gov.uk)

How to contact the East of England Controlled Drugs Team

East of England CD team primary contact is **england.ea-cdao@nhs.net**

This inbox is monitored during normal working hours. If you need to speak to someone urgently, please email us requesting a call back with your phone number included.

To report a CD incident or concern, please go to: **www.cdreporting.co.uk**