Sharing Good Practice between cgl Spectrum & Local Pharmacists in Hertfordshire

Welcome to the first edition of our Toolkit designed to share good practice and lessons learned from medication incidents involving our clients.

Making contact with Spectrum Services

Our **Single Point of Access** telephone number is **0800 652 3169,** which operates after working hours. There is always a member of staff who has access to our service user database and can assist you with your queries.

Please contact annamarie.felice@cgl.org.uk with your comments or questions relating to the content in this newsletter.

At cgl we collate information relating to incidents caused by ourselves and by third parties such as pharmacists and service users.

In accordance with Controlled Drugs (Supervision of Management and Use) Regulations 2013 we are required to provide the Local Intelligence Network quarterly occurrence reports with details regarding the management or use of controlled drugs to the NHS England CDAO.

This toolkit is an outcome action from some of the recurring incidents that have arisen. We wish to share the learning with our partner pharmacies to help improve practice, increase service quality and reduce incident occurrence. If you have examples of good practice that others could benefit from considering, & you would be willing to share, please contact us.

Dispensing error where service user is in receipt of the wrong medication or dosage

Between July and December '17, eight incidents were reported where clients were given another service user's medication or the wrong dosage from their own prescription.
In one of these incidents a service user prescribed 6mgs diazepam per day received 6 x 10mgs diazepam tablets instead of 6 x 2mgs tablets for two days. The service user lived with his parents and he took the full amount without question. This was a Saturday. On the Sunday a telephone call was made to our Single Point of Access Help Line. We were informed that the paramedics were called in to assess the patient; on this occasion admission to hospital was not required. He was reviewed again on the Monday at the hub Clinic.

In another example a service user prescribed 35mls of Physeptone (Methadone) daily supervised per day was dispensed 50mls for Saturday and 50mls to take home for Sunday. On realising the error the pharmacist called our Single Point of Access Help Line to help contact the client. The police were also called to undertake a welfare check which was promptly done. She declined medical intervention and the police were satisfied that she was not in immediate danger.

Incidents of this nature can be avoided with well-established Standard Operating Procedures being followed during dispensing. Pharmacists are encouraged to ensure a double check by a second member of staff.

NALOXONE (PRENOXAD) TAKE HOME - The success of the Naloxone Take Home Programme via the Needle & Syringe is very much dependent by your efforts and enthusiasm in making this a successful venture. Please remember that you will need to order five Take Home Naloxone (Prenoxad) kits upfront and maintain a stock of five kits throughout. **Please ensure that you do this and invoice us accordingly.**

Missed doses

As part of your Service Level agreement you should be letting the local hub know if a service user has missed *3 consecutive doses* of their opioid substitute medication and you should not dispense any remaining medication until advice has been sought from the prescriber. After three days the individual's tolerance to the opioids may be reduced and to continue with their current substitute medication potentially puts them at risk of overdose. Consider working in advance of the service user turning up for their medication, on Day 4, to avoid delays when the client is in the pharmacy. Be mindful of weekend doses missed.

28 day rule on the validity of prescriptions In the last quarter one locum pharmacist questioned the validity of a prescription as the signature date exceeded the legal 28 day rule. Medication was not dispensed for 1 day. The Drug Misuse Dependency 2017 Guidelines clearly explain that "*all CD prescriptions are valid for 28 days after the appropriate start date on the prescription. The appropriate date is **either** the issue date **or** any other date indicated on the prescription (by the prescriber) as the treatment start date before which the drugs should not be supplied, whichever is the later. There are specific circumstances, normally at holiday periods, where the pharmacy may be closed on the treatment start date. If the issue date is before the treatment start date and the appropriate Home Office wording is included regarding pharmacy closed days the pharmacist can exercise professional judgement on the appropriate supply date to ensure there is no disruption to treatment".*

In this incident Spectrum staff brought to the pharmacist's attention that cgl prescriptions clearly record dispensing dates for each dosage making each prescription valid. The pharmacist continued to dispense medication against the same prescription thereafter.

Prescribing members of Staff

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