NHS England and NHS Improvement, East of England, Controlled Drugs Team

Controlled Drugs Newsletter

This newsletter contains local and national CD information to support the safe management and use of controlled drugs

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NHS England And NHS Improvement, East of England CD team

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THANKS TO ALL COLLEAGUES

We are sending this newsletter out with many of the restrictions from the COVID-19 pandemic having been lifted in England. Things are far from back to "normal", though, so I would like to thank you all, from myself and the rest of the team, for your continued hard work in keeping services going.

NICE Chronic Pain Guidelines

On 7th April 2021, NICE made recommendations for a range of effective treatments for people with chronic primary pain. In the UK the prevalence of chronic pain is uncertain but appears common, affecting perhaps one-third to one-half of the population. The prevalence of chronic *primary* pain is unknown but is estimated to be between 1 and 6% in England.

The guidelines include emphasis on:

- Collaborative care and shared decision making;
- Gaining a better understanding of how the pain personally affects a persons life;
- Being honest about the uncertainty of prognosis.

The guidelines recommend such treatment as:

- Exercise programmes;
- Psychological therapies;
- Acupuncture.

The guidelines advise that people with chronic primary pain should not be started on commonly used drugs including paracetamol, non-steroidal anti-inflammatory drugs, benzodiazepines or opioids. This is because there is little or no evidence that they make any difference to people's quality of life, pain or psychological distress, and can cause harm, including possible addiction.

For more information visit: NICE recommends range of effective treatments for people with chronic primary pain and calls on healthcare professionals to recognise and treat a person's pain as valid and unique to them | News and features | News | NICE

Inside this issue:

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

Pharmaceutical Services Negotiating Committee
http://psnc.org.uk/dispensing-supply/

MHRA Drug Safety Update February 2021 - Pregabalin (Lyrica): reports of severe respiratory depression

On 18th February 2021 the MHRA issued a drug safety update relating to reports of severe respiratory depression, including in some cases without the presence of concomitant opioid medicines. The full alert can be accessed at Feb-2021-DSU-PDF_final.pdf (publishing.service.gov.uk) The update provides clear advice for healthcare professionals and advice for patients and carers.

Advice for Healthcare Professionals:

1. Consider whether adjustments in dose or dosing regimen are necessary for patients at higher risk of respiratory depression. This includes people:
   - With compromised respiratory function, respiratory or neurological disease, or renal impairment;
   - Taking other CNS depressants (including opioid-containing medicines);
   - Aged older than 65 years.
2. Report suspected adverse drug reactions associated with use of pregabalin on a Yellow Card - https://yellowcard.mhra.gov.uk/ (see reporting section).

Advice to give to patients and carers:

1. Some patients have experienced breathing difficulties when taking pregabalin – certain people may need a lower dose to reduce the risks of these issues;
2. Contact your doctor if you notice new or increased trouble breathing or you experience shallow breathing after taking pregabalin; a noticeable change in breathing might be associated with sleepiness;
3. Read the leaflet that comes with your medicine and talk to your doctor or pharmacist if you are worried about the other prescribed medicines you are taking with pregabalin.

CD Destruction and Authorised Witnesses

Due to the pandemic, there may be some pharmacies that have accumulated CDs that need to be destroyed and might not know how to request an Authorised Witness (AW).

Pharmacies with more than five branches may have their own AW duly authorised by an NHS England CDAO. Pharmacies with less than five branches should submit a **destruction request** form via www.cdreporting.co.uk; following this you will be contacted in due course and a visit from an AW will be arranged. In either case, your SOP should state how to request an AW.

Please see link below from the PSNC for more information on CD destruction and Authorised Witnesses: Controlled Drug regulations : PSNC Main site

CQC Annual update: The safer management of controlled drugs 2020. Published July 2021

The CQC annual CD report made four recommendations for improvement: a need for organisations to include controlled drugs governance as part of their COVID-19 recovery plans; a need to enable all health and care staff to freely engage and participate in activities that support reflection and learning; the collaboration of those leading and working in local health and care systems to reduce risks of avoidable harm associated with controlled drugs; and all personalised patient care being prioritised by health and care staff in the context of controlled drugs. To address these concerns, CQC recommend:

- By including controlled drugs governance as part of recovery plans, services will be able to manage and mitigate risk in the most appropriate way;
- Health and care providers should use their pandemic experiences as an important opportunity to reflect on and share learning. This should include positive experiences, innovative and good practice, as well as when things have gone wrong which can be used to improve safety;
- Collaboration should be encouraged between those working in local health and care systems, as people have better experiences and outcomes when local providers of health and care services work well together;
- Those working in adult social care have an important and valuable role in ensuring that controlled drugs are used safely and in escalating concerns to the appropriate healthcare professionals, as incidents involving controlled drugs highlight the importance of appropriate prescribing and supply – not just at the outset, but also for ongoing review and monitoring.
- Full report available at: The safer management of controlled drugs: Annual update 2020 | Care Quality Commission (cqc.org.uk)

LASA (look-alike, sound-alike) errors: Pregabalin and Gabapentin

In April 2019 Pregabalin & Gabapentin were rescheduled as controlled drugs, and since then NHS England & NHS Improvement have been notified of a large number of incidents involving these drugs. The majority of these have been 'LASA' errors. In the East of England in the financial year 2020/21, 24 of these errors were reported and 13 of these resulted in the patient taking the incorrect medication. Most errors involved medication of strengths 100mg and 300mg.

In one instance—an example of the 'Swiss cheese effect' - a prescription for 28 Gabapentin 100mg capsules was dispensed as 28 Pregabalin 100mg capsules. The error was not spotted at the accuracy check and the medication was delivered to the patient's care home, where it was administered to the patient for 25 days.

If Pregabalin/Gabapentin are supplied in error, patients may suffer unpleasant side effects including, but not limited to, dizziness and somnolence, confusion, agitation, restlessness, disorientation, gastrointestinal upset, double vision, slurred speech, drowsiness, loss of consciousness, and lethargy.

LASA errors are often linked to a number of contributory factors including human error. To avoid these, it is advisable to have several risk minimisation measures in place. Working collaboratively and sharing learning at incident reviews and Community Pharmacy Patient Safety Group meetings help minimise the risk of harm to patients.

Several measures have been considered to reduce the likelihood of LASA errors occurring including physical separation of stock; visual warnings; shelf stickers; prompts on PMR; and revisiting checking procedures/SOPs.

Reminder: Maximum 30 days supply

To help ensure controlled drug safety it is important to comply with the guidance that prescriptions for Schedules 2, 3, and 4 CDs should be limited to 30 days treatment, especially when being prescribed for acute conditions.

In exceptional circumstances, to cover a justifiable clinical need and after consideration of any risk, a prescription may be issued for a longer period, but the reasons for the decision should be recorded in the patient's notes. The dispenser should query with the prescriber if more than 30 days treatment are prescribed, including on private prescriptions.

As a cautionary note, it is important to also consider this when prescribing and dispensing patches - these are often miscalculated and there have been instances where supplies have been made in excess of the 30 day treatment range.

Shared Learning

An incident was recently submitted which involved clinicians at a GP practice reducing the quantity of a patient's morphine (Oramorph 10mg/5mL solution) due to severe overuse. The investigation brought to light that the patient had been prescribed excessive quantities of medication relative to the dose; the patient was prescribed 300mL of Oramorph per month but the dose meant the patient only actually needed a maximum of 140mL. We encourage vigilance from healthcare professionals to make sure dosage is aligned with supplied quantity of medication.

Mis-Sold THC Vapes

An incident was reported in Greater Manchester in June 2021 involving a 15 year old that collapsed after vaping what had been sold as THC liquid. After testing, the sample was found to contain a SCRA (synthetic cannabinoid) called ADB-FUBINACA, which is thought to be up to 140 times the potency of THC and was the SCRA found in crystals mis-sold as MDMA. The sample was found to also contain vitamin E acetate which, in February 2020, the CDC (The US Centre for Disease Control) found evidence of causing lung disease.

Useful Links

- The government has appointed an independent advisor to drive forward progress in tackling drug misuse across society. Action to tackle misery of drug misuse - GOV.UK (www.gov.uk)
- A free course to become a CPCS ready pharmacist CPCS Workshops | RPS (rpharms.com)

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 continuously monitored. If you need to speak to someone urgently please email us requesting a call back with your phone number included.

Requests for urgent CD alerts can be made via the CD Team: to request an alert form please email england.ea-cdao@nhs.net

To report a CD incident or concern, request an Authorised Witness or submit an annual CD declaration please go to: **www.cdreporting.co.uk**