NHS ENGLAND & NHS IMPROVEMENT

CONTROLLED DRUGS TEAM MIDLANDS

Drug & Alcohol Services and Community Pharmacies Newsletter

Special Edition **May 2022**

Due to pharmacies' interactivity with service users on a more frequent basis, they are able to report back to Drug and Alcohol Services (DAS) on patients' wellbeing, highlighting issues such as patients looking unwell, attending intoxicated or missing collections of their prescribed medication.
This newsletter highlights ways in which Drug and Alcohol Services and pharmacies can work together to ensure that patients receive safe and appropriate Opioid Substitution Treatment (OST). In this newsletter you will find examples of good practice, ways to ensure effective communication and case studies of incidents submitted to the Midlands Controlled Drugs Accountable Officers (CDAOs).

Good Practice

- If pharmacies are aware of a patient's change in circumstances, such as a hospital admission or police custody, they should inform the DAS. This will enable the DAS to liaise with the appropriate organisations to ensure the continuation of OST and to support patients' discharge back into the community setting
- All members of the pharmacy team should have read relevant Standard Operating Procedures (SOPs) and should be aware of the Service Level Agreement (SLA) in place with the DAS to ensure that it is always followed even if the responsible pharmacist on duty is a locum
- Pharmacies should always check the prescriptions received from the DAS to ensure they meet all legal requirements, for example, have been signed by the prescriber, the correct wording has been used if prescriptions cover bank holidays, and highlight any change in doses
- Pharmacies should always record the conversations with the DAS in the patients' medical records (PMR). This should include the date of the conversation and the name of the person to whom they have spoken. We also recommend having a communications book to hand over key messages for the week, especially if locums are working.
- Due to ongoing issues reported with the Royal Mail service, pharmacies should proactively check they have received follow-on prescriptions and highlight when these are missing in advance of the start date so a contingency plan can be implemented
- Pharmacies who provide a Needle Syringe Exchange Scheme should link in well with patients, offer harm reduction advice, encourage the use of clean equipment and the return of used equipment
- CD balance checks should be completed in line with your organisation's SOP to identify CD balance discrepancies so they can be resolved in a timely manner
- All collections of OST prescriptions by a patient's representative and/or a delivery of OST prescriptions should be approved and agreed in advance with the DAS

Ensuring Effective Communication

- Pharmacies should follow the guidance in their SLA on reporting missed doses, for both titration and consecutive doses
- Pharmacists can support patients by passing on reminders for clinical appointments or messages from the DAS where communication is challenging, e.g. patient does not have a contact number or a fixed abode
- If a pharmacy has an unscheduled closure, it is important to consider the impact it may have on patients' treatment. Patients and the DAS should be notified as soon as possible so alternative arrangements can be put in place for patients to prevent the use of illicit drugs. We take this opportunity to remind pharmacies to inform the Primary Care Contracts Team at NHS England and NHS Improvement of any unscheduled closures
- Before prescriptions are sent to pharmacies, DAS staff members should ensure prescriptions are signed by the prescriber, the correct wording is used if prescriptions cover bank holidays (if appropriate), and any important messages are communicated to the pharmacy, such as changes in patients' doses and voiding of prescriptions they may already have in their possession

Both Drug and Alcohol Services and pharmacies should report any incidents or concerns involving CDs to their NHS England and NHS Improvement CDAO by submitting an incident report on the online reporting tool (www.cdreporting.co.uk) .

Case Study - Scenario 1

A patient was arrested for drug offences. The Police contacted the DAS Criminal Justice team leader to report that they had found 90 bottles of methadone in the patient's cupboard with their name and dates on the bottles. The Police were very concerned about the significant number of bottles that were found.
The DAS immediately suspended the prescription in place at the time and informed the pharmacy. The patient was asked to attend a face to face consultation with the DAS's doctor/prescriber where a new prescription was issued for re-titration and the patient was changed to supervised consumption.
The DAS investigated and reflected further into this incident and it was found that there were no recent drug screens for this patient. The root causes for this incident identified were:

- COVID-19 - the DAS were not seeing patients face to face and consequently did not drug screen the patient
- Change of key worker (member of staff left the DAS)

Learnings:

- The DAS shared this incident with all members of staff across the county
- By being able to resume face to face appointments, the DAS had the opportunity to drug screen patients - in this scenario, if this had been done the DAS may have picked up that the patient had not been taking their medication
- The DAS shared/discussed the incident at their "incident panel" and learning hub, which is attended by all staff
- The DAS put a system in place which highlighted:
  - patients who hadn't had a medical review in 6 months or over
  - patients who hadn't had a urine screen in 3 months or over
- This new process ensured that the DAS could determine and bring in such patients for reviews

Case Study - Scenario 2

A locum pharmacist supplied methadone 1mg/ml to a patient after they had missed three consecutive doses. The underlying causes which may have contributed to this incident were the following:

- Rushing work as it was a busy day
- Not checking the instalment record on the back of the prescription
- Not checking the methadone register
- Demanding/difficult patient

As soon as the incident was identified the following actions took place:

- The DAS provider was immediately notified
- The patient had a meeting with the prescriber and drug treatment service
- The patient's daily dose was re-titrated
- Warning notes/messages highlighting the error were added on to patient's PMR for example, advice to pharmacy staff to double check prescription instalments record alongside the methadone register
- A warning note was added to the methadone section of the CD cabinet to highlight the need to double check previous collections against the prescription before dispensing and handing out further supplies to patients

Learnings:

- Message added on the patient's PMR to alert pharmacists and dispensers to be vigilant when supplying methadone
- Warning note to be placed on the methadone section of the CD cabinet to highlight the need to double check previous collections against the prescription before dispensing and handing out further supplies to patients
- Implemented a third check when handing out any prescription. The need to double check the item, strength and formulation against the prescription has also been highlighted
- Uncollected doses from previous collection due dates for methadone patients to be continuously marked on the prescription when this occurs. This practice will be continued by regular pharmacist and it will also be relayed to future locum pharmacists by the means of an additional message which will be included on the pharmacy's essential reminders list provided to locums when they work in the store

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