NHS England - Midlands Controlled Drugs Newsletter

Spring Edition 2025

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

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Midlands Controlled Drugs Accountable Officers

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IMPORTANT INFORMATION

SINGLE REGIONAL E-MAIL ADDRESS CONTACT FOR MIDLANDS-WIDE NHSE CONTROLLED DRUGS TEAM

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News around Controlled Drugs

1. Collection by a representative of a drug misuse patient

If a substance user wants a representative to collect a dispensed CD on their behalf, pharmacists are advised to first obtain a letter from the substance user that authorises and names the representative. This includes substance users detained in police custody who should supply a letter of authorisation to a police custody officer to present to the pharmacist.

A separate letter should be obtained each time the substance user sends a representative to collect, and the representative should bring identification. The pharmacist must be satisfied that the letter is genuine. It is also good practice to insist on seeing the substance user in person at least once a week unless this is known not to be possible. The record of supply in the CD register should include details of the representative.

If the directions on the prescription state that the dose must be supervised, the pharmacist should contact the prescriber before the medicine is supplied to the representative – since supervision will not be possible. It is legally acceptable to confirm verbally with the prescriber that they are happy with this arrangement since supervision, while important, is not a legal requirement under the 2001 Regulations. An appropriate record of this conversation should be made.

It would not be necessary to contact the prescriber if the substance user has been detained in police custody and the representative collecting the dose is a police custody officer or a custody healthcare professional. This is because the administration of any Schedule 2 or 3 CDs in custody will be supervised by a healthcare professional.

If the dose is usually supervised, but has been supplied, the pharmacist should consider annotating the prescription and patient medication records to advise others that the dose has not been supervised in the pharmacy.

Practice Issues

• It is good practice for the person collecting a Schedule 2 or 3 CD to sign the space on the reverse of the prescription form that is specifically for this purpose. A supply can be made if this is not signed, subject to the professional judgement of the pharmacist

• Instalment prescriptions only need to be signed once

• A representative, including a delivery driver, can sign on behalf of a patient. However, a robust audit trail should be available to confirm successful delivery of the medicine to the patient

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2. ⚠ Significant incident - patient return of Controlled Drugs

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A pharmacy received a patient return of 3303 Sevredol 10mg tablets from the relative of a deceased patient. On investigation it was found that the GP surgery had issued 10052 tablets since December 2017. The patient appeared to have been taking 25mg a day on average but had been prescribed a dose of 40mg.

There had been monthly refills since December 2017 but because the dose matched the quantity and the refill interval, nothing untoward triggered on the pharmacy system.

Despite all the returned tablets being accounted for, and assuming the others were taken appropriately there still appeared to be a risk to patient safety.

The surgery was notified for further investigation and management of the incident with escalation to the partners meeting.

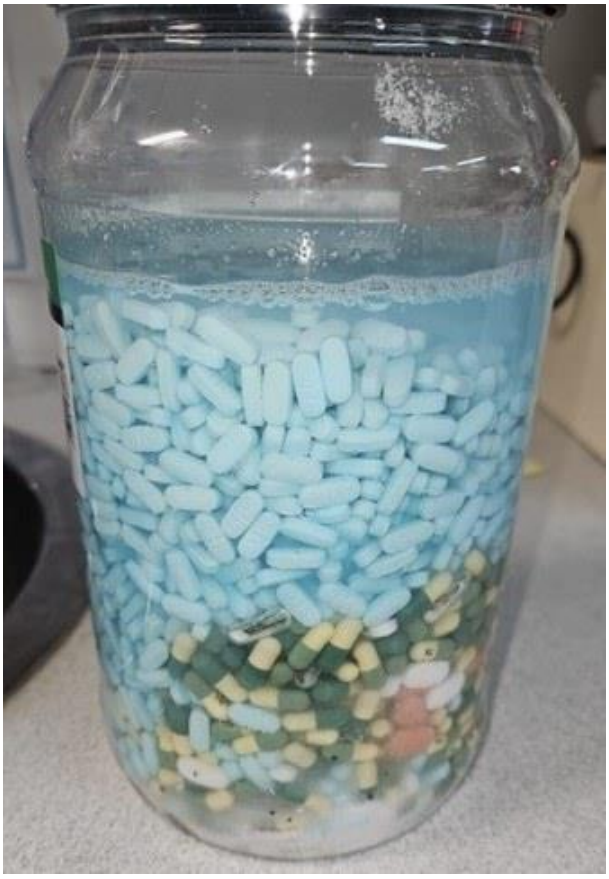
Recommendations

The opioid reviews are currently undertaken every three months. The suggestion was made to review the audit template which currently asks for information around quantities supplied, safe storage and disposal. A recommendation was put forward to ask patients how many unopened packs of medication they already have at home. The number of boxes could be added to the audit document to ensure that appropriate quantities are supplied thereby avoiding similar incidents in the future.

All patients on opioids should be reviewed regularly to ensure that the medication is being taken as prescribed and appropriate quantities are prescribed only after review.

Apart from the patient safety risk highlighted, the pharmacy team had to spend a significant amount to time denaturing the medication and completing the necessary documentation.

*1 - **Boxes of Sevredol 10mg tablets returned to the pharmacy***



*2 - **Denatured CDs (Sevredol 10mg - blue tablets)***

3. Training video for Pharmacy Teams on safe use of fentanyl patches

Source: Community Pharmacy Patient Safety Group

The Community Pharmacy Patient Safety Group has produced a 10 minute training **video** to promote the safe use of fentanyl patches to community pharmacy teams. The training covers the following:

- The clinical check of the prescription
- Patient counselling points regarding safe storage, application, removal and disposal of patches
- Managing patient expectations regarding onset of effect
- Recommended advice regarding drowsiness, alcohol and driving
- Avoidance of external heat sources
- Signs of overdose and action to be taken if overdose is suspected

Link for the video: Community Pharmacy Patient Safety Group: Focus on Fentanyl video

4. MHRA Drug Safety Update - Prolonged-release opioids: Removal of indication for relief of post-operative pain

Source: Medicines and Healthcare products Regulatory Agency

The indication for the treatment of post-operative pain has been removed from the licences of all prolonged release opioids due to the increased risk of persistent post-operative opioid use (PPOU) and opioid-induced ventilatory impairment (OIVI).

For complete information, use the link **Prolonged-release opioids: Removal of indication for relief of post-operative pain - GOV.UK**

5. Guidance - Medicine choices in opioid substitution treatment

Source: Department of Health and Social Care

Clinicians should use this guidance, alongside Orange Book, to inform their prescribing of oral methadone & buprenorphine (BPN) as substitute medication to people who are in

treatment for opioid dependence. Further guidance on BPN long-acting injections will be published in 2025.

For complete information, use the link **Medicine choices in opioid substitution treatment - GOV.UK**

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6. The public health risks of counterfeit pills

Source: The Lancet Public Health

Synthetic illicit drugs (e.g. nitazenes) are increasingly packaged in counterfeit pill form, often indistinguishable from authentic pharmaceuticals. This exposes more consumers to unintentional illicit synthetic drug use, necessitating a swift public health response.

Link for the article: **The public health risks of counterfeit pills - The Lancet Public Health**

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7. Revised Summary of Product Characteristics (SmPC): Lyrica (pregabalin) capsules

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Updated SmPC now states that patients treated with pregabalin should be monitored for signs and symptoms of pregabalin misuse, abuse or dependence, such as development of tolerance, dose escalation and drug-seeking behaviour.

Link: **Lyrica 75 mg hard capsules - Summary of Product Characteristics (SmPC) - (emc) | 10302**

Regulation 28 Notices

- ***Ref: 2024-0644*** ***Dependence and Overuse of benzodiazepines and codeine*** - death due to excess prescribed medication which the patient had become dependent on and addicted to. Patient had access to excess medication because of medical prescribing decisions and arrangements leading up to a bank holiday period.
- ***Ref: 2024-0656*****: Overdose of prescribed medicine** - death due to excess consumption of prescribed medication. Duplication of a prescription occurred, due to the patient changing their choice of pharmacy, and effective steps were not taken to ensure cancellation of the initial prescription leading to the patient having double the intended quantity of medication.

Reminders

Methadone dispensing – take home doses

We would like to gently remind all community pharmacies providing take home doses of methadone to patients, that all doses should be provided in individually labelled bottles. This significantly reduces the risk of an incorrect dose being taken. A large bottle containing multiple doses, unless stated otherwise on the prescription, should not be considered.

Incidents and Concerns

All incidents and concerns raised involving CDs must be reported to the CD Accountable Officers. Concerns may include patients potentially misusing or abusing drugs, prescribing concerns, dispensing concerns etc.

To report all CD incidents, concerns please use the online CD reporting portal

CD Destructions

It is a legal requirement under the 2001 CD regulations to have stocks of obsolete, expired and unwanted Schedule 2 CDs destroyed in the presence of an Authorised Witness.
Please complete the CD Destruction form on the CD reporting portal CD reporting portal - www.cdreporting.co.uk

PLEASE REMEMBER:

- Out of date schedule 3 CDs (e.g. temazepam, tramadol, gabapentin, pregabalin, buprenorphine, midazolam) **do not require the presence of an Authorised Witness**. It is recommended for the denaturing to be witnessed by another member of staff, ideally a registered healthcare professional and familiar with controlled drugs
- **Denaturing is required for all schedule 2, 3 and 4 (part 1) -** expired, obsolete or unwanted stock and patient-returned CDs
- **Record Keeping** - patient returned CDs and their destruction should be recorded in a separate Patient Returns Register. Concerning schedule 2 CDs an entry should be made in the appropriate CD register