Controlled Drug Vigilance Newsletter

Produced by the CQC National Controlled Drugs Vigilance Sub-Group

October 2016 **Volume 1, Number 4**

In This Issue

Previous issue

Volume 1, Number 1

Volume 1, Number 2

Volume 1, Number 3

CQC is the health and social care services regulator and also has responsibility for oversight of safe arrangements for controlled drugs across England, following The Shipman Inquiry.

www.cqc.org.uk

NHS Protect

NHS Protect is a member of the CQC's National CD Group and leads on work to safeguard NHS staff and resources from crime.

www.nhsprotect.nhs.uk

Reporting

Report NHS Fraud online **here** or by phoning the **FCRL** on

0800 028 4060

Introduction

Hello and welcome to the fourth and last issue of 2016, of the Controlled Drugs (CDs) Vigilance newsletter, produced by the CQC National CD Vigilance sub-group. Through this medium we will shine the spotlight on fraud and theft involving CDs. Links to previous issues can be found in the left hand column.

About the newsletter

In this issue, we focus on where CDs thefts have led to harm as a result of individuals taking CDs that were not prescribed or intended for their use. Please take time to look through the case studies and learning points and the guidance links in the left hand column.

Case studies & lessons learnt

The following case studies have been provided by members of the CD Vigilance Sub-group. The case studies demonstrate the danger when CDs and medicines are taken by individuals for whom they are not intended, often leading to fatal consequences.

Case study 1 – Patient A had a problem with his fentanyl patches falling off and was replacing them after 1-2 days. This resulted in Patient A over ordering fentanyl patches via repeat prescriptions.

Even with changing a patch every 2 days, Patient A over a 12 month period was legitimately prescribed a 520 day supply of fentanyl patches. A teenage friend of Patient A's son was found dead after ingesting a fentanyl patch. Patient A's son had been stealing his father's patches and had given one to his friend. Patient A had suspected his son of stealing his fentanyl patches. A full investigation was undertaken and it was noted there were various points at which the excessive amount of prescribed fentanyl patches could have been picked up: the staff printing off the repeat scripts; the doctors signing the repeat scripts and the pharmacy staff dispensing the prescriptions. Plans have been put in place at this practice to prevent similar recurrences in the future.

The following three case studies are examples of reported cases where healthcare professionals abused their legitimate access, to steal and misuse CDs and other prescription medicines leading to their deaths.

Case study 2 – A paramedic obtained morphine and ketamine from a

medicine pack and used the medicine to commit suicide. The medicines pack (morphine 10mg ampoules x10, ketamine 200mg/20ml ampoules x10) were en-route from the supplier to an ambulance base for overnight storage before being dispatched to an air ambulance base.

Case study 3 – A paramedic, whilst working for a private ambulance service, obtained oral morphine for his partner who later used it to commit suicide. Batch numbers tracked as part of the investigation identified it had been taken from the private provider's supply.

Case study 4 – A paramedic who was addicted to codeine but was seeking help for his condition obtained oral morphine for misuse. However he died following an accidental overdose, a consequence of a reduced morphine tolerance.

The Key Lessons:

- Patients should be advised that CDs and prescribed medicines can be harmful if used by persons for whom they are not intended.
- Patients should be given advice about securely storing their prescribed CDs in the home, to prevent illegitimate use by others.
- Patients should be encouraged to report any concerns they may have about their CDs being misused or stolen by others e.g. family/friends.
- GP Practices should ensure there are stringent processes in place for the repeat prescribing of CDs to prevent unnecessary stockpiling by patients in their homes. Patients on repeat prescriptions should be regularly reviewed and there should be a process in place for practice staff to flag their concerns.
- Pharmacists should report concerns on any excessive or unusual prescribing to their NHS England CDAO.
- All healthcare organisations should ensure there are monitoring and reporting arrangements in place to identify and act on any discrepancies, losses or thefts involving CDs.
- All healthcare professionals and staff are obligated to report their concerns to line managers/senior clinicians/Medical Director or CDAO regarding colleagues stealing and/or misusing CDs and prescription medicines.

Paramedics and medicines

A recent article published in the Journal of Paramedic Practice provides clarity for ambulance clinicians and services on possession of CDs as defined by law and the exemptions that apply. Click **here** to read more.

Buying medicines on the internet

There was a recent case involving the sad death of a young man who was purchasing significant amounts of benzodiazepines over the internet for illicit use. The MHRA recently **launched a campaign** to raise awareness of the problem of fake and unlicensed medical products, and to encourage young adults not to buy from unsafe and unregistered online sources. The message is "know what you're buying" when buying medicines or medical devices online. Please visit **here** for top tips.

Thank you!

We would like to thank you for your support and feedback. This is the final issue of this volume, we will return again in 2017 with Volume 2.

Resources

NHS Protect Medicine security webpage

Security standards for the management and control of controlled drugs in the ambulance sector

Ambulance standards FAQs

Template Ambulance CD security audit checklist

CQC Controlled Drug webpage

NICE Guideline Controlled Drugs: Safe use and management

Talk to Frank

Offers an educational and confidential advice service on drugs and legal highs. Details can be found here.

Next Issue

New volume will begin in 2017!

Information wanted

Please share your examples of good practice, policies and SOPs in relation to the articles in this issue.

Contact Us

CDsubgroups@cqc.org.uk