Medicines Safety Matters

Health and Social Care Board

Sharing Learning Across Community Pharmacy In Northern Ireland

Vol 2
Issue 3
Oct 2013

Opioid-related NPSA alerts and adverse incidents

It is important to identify, share and action any learning points from incidents involving controlled drugs. The contributory factors identified from recent incidents include:

- **Issues with the storage arrangements for CDs**
- **Discrepancies in the CD register balance**
- **Inadequate dispensing processes (e.g. no second check / only one person involved to carry out all dispensing tasks)**
- **Incorrect product or strength of CD preparation selected / supplied**
- **Medicine delivered to the wrong patient.**

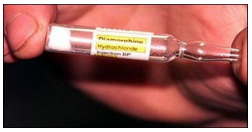
Alert

NHS National Patient Safety Agency

Further information on the risks of opiate medicines are contained within three National Patient Safety Agency[1] Alerts:

1. Ensuring safe practice with high dose ampoules of diamorphine and morphine. (SPN May 2006)
2. Reducing the risk of midazolam injection in adult (RRR0011 December 2008)
3. Reducing dosing errors with opioid medicines (RRR005 July 2008)

[1] http://www.nrls.npsa.nhs.uk/resources/type/alerts/



Community Pharmacy actions

Community pharmacists have an important role in implementing a number of recommendations from these NPSA alerts, including:

- Healthcare professionals should risk assess and have procedures in place for safely prescribing, labelling, supplying, storing, preparing and administering diamorphine, morphine and midazolam injections.
- Confirm any recent opioid dose, formulation, frequency of administration, symptoms of overdose and side effects and any other analgesic medicines prescribed for the patient.
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient.

In order to support this role, community pharmacists should review their current practice to ensure that it is in line with the recommendations. A check list relating to the NPSA opioid alerts is provided on page 2.

Good practice point

Points from the action check list should be incorporated into the pharmacy SOP for Controlled Drugs. It is recommended that compliance with the check list should be reviewed on a regular basis e.g. annually.

Check list relating to NPSA opioid alerts

Process	
SOP covers clinical assessment, dispensing, storage and supply of controlled drugs	
All staff are trained and follow the SOP	
All staff are made aware of changes to SOP	
An error log is actively maintained	
Learning from any incidents is identified, shared and actioned	
Clinical checks	
Assess clinical appropriateness of prescriptions for controlled drugs in line with the PSNI Professional Standards and Guidance for the Sale and Supply of Medicines (Where possible, check the starting and titration doses are appropriate)	
Dispensing	
Clear instructions are printed on the label and are recorded in the PMR when dispensing prescriptions	
A second check is built into the CD dispensing process	
Storage	
Store high strengths of each product separately from lower strengths	
Highlight differences in formulation e.g. immediate release/ modified release	
Carry out regular stock/register checks	
Date of compliance check: Signed:	

Primary Care Medicines Governance Team Contact Details

Team Leader:	Belfast Area:	Northern Area:	Southern Area:	South Eastern Area	Western Area
Brenda Bradley Tel: 07917544301	Briegeen Girvin Tel: 07748630415	Cheryl Ferguson Tel: 07827324494	Anne Marie Groom Tel: 07817428869	Helen Bell Tel: 07920187940	Joanne McDermott Tel: 07909757674