Medicines Safety Alert

No. 4

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To: All GPs
All Pharmaceutical Contractors

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Dear Colleague

Re: Prescribing and Dispensing of Controlled Drugs

I am writing to alert you of the need to be vigilant when prescribing and dispensing controlled drugs that are available in a range of different strengths. There have been a number of errors reported to the Board where the patient was prescribed and/or dispensed the wrong strength of medicine.

Recently, the national media reported the case of a German doctor who attended a patient with renal colic via the Out-of-Hours service in England. The doctor administered ten times the recommended dosage of diamorphine to the patient who subsequently died.

Every member of the team has a responsibility to check that the intended dose is safe for the individual patient. Knowledge of the previous opioid dose is essential for the safe use of these products. There are a wide variety of opioid medicines, and supply shortages may result in products being used which are unfamiliar to practitioners.

The National Patient Safety Agency (NPSA) issued a Rapid Response Report "Reducing Dosing Errors with Opioid Medicines" in July 2008, which can be downloaded at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59888 .

This provided the following guidance for health care practitioners to follow when prescribing, dispensing or administering opioid medications:

1. Confirm any recent opioid dose, formulation or frequency of administration, and any other analgesic medicines prescribed for the patient. This may be done through conversation with patient or their representative, the prescriber or through existing records

2. Ensure that where a dose increase is intended, the calculated dose is safe for the patient (for oral morphine or oxycodone in adults not normally more than 50% higher than previous dose)

3. Ensure familiarity with characteristics of the medicine and formulation including starting dose, frequency of administration, standard dose increments, symptoms of overdose and common side effects before prescribing or dispensing

4. Certain preparations should be *brand* prescribed to ensure continuity of treatment e.g. sustained release preparations including opioid patches and morphine sulphate preparations. All practice staff should ensure that they are familiar with the HSCB list of items unsuitable for generic prescribing http://www.dhsspsni.gov.uk/generic-exception-list-regional-jan-10-final.pdf. This is particularly important for preparations such as morphine, where "once daily" and "twice daily" formulations may be available for the same strengths

5. If a modified release medicine is written generically, the pharmacist should confirm the previous brand (as per point 1)

6. When dispensing controlled drugs, a second check, by a different member of the pharmacy team, should be carried out to ensure that the correct drug has been selected at the correct strength with the appropriate dose as recommended by the prescriber.

Action

In light of such incidents, please ensure that your processes for managing these drugs are reviewed and updated and that staff are trained to ensure that the risk of wrong strength errors are reduced.

If you require further advice, please contact a member of the HSCB Medicines Management Team

Yours sincerely

J Brogan

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