NHS
Midlands and Lancashire
Commissioning Support Unit

Controlled Drug prescribing incident- Lessons Learnt

Prescribing tip for actioning by practice team

The prescribing tip takes the form of a case study relating to an incident which has recently occurred in a local GP practice. **The practice is keen to share the details so that similar incidents can be avoided in other practices. The case illustrates the need for practices to have robust systems in place when information is being passed from one care provider to another and the pitfalls that can occur when this is not done well.**

Poor transfer of care or the handover of communication is widely recognised as a major preventable cause of harm. A recent UK study assessed the rate of failure in the processing of actions in hospital discharge summaries in patients aged over 75 years. The study found that 46% of emergency admission discharge summaries requiring an action in primary care had one or more failures to complete those actions and a small proportion of patients were harmed by these failures. Requested medication changes were not made 17% of the time, and 26 to 27% of requested tests and follow-up were not completed.

The following case study is taken from a local practice and resulted in a patient receiving excessive quantities of controlled drugs.

- The practice received a controlled drug (CD) report which highlighted a large quantity of 12 x 1000ml oxycodone 5mg/5ml solution had been issued by the practice for a single patient over a five month period.
- The patient was identified as an elderly patient who was receiving care from the local hospice.
- The patient's pain control was being jointly managed by the hospice and the pain team at LTHtr. The practice issued prescriptions for oxycodone (liquid & tablets) but was not directly managing the patient's pain relief.
- Over time the patient attended the hospice & doses of oxycodone were amended. **However, correspondence from the hospice was infrequent & the patient's elderly wife was left to communicate changes to the practice. On one occasion she phoned the practice to update them & indicated that *prn oxycodone liquid had been increased from 2.5-5ml 4 hourly prn to 25ml qds.***
- This information was taken at face value, not queried & subsequently the prescription was amended accordingly. The quantity issued to the patient on each prescription increased from 500ml to 2L.
- **No correspondence was received from the hospice confirming the dose.**
- For the next five months 2L of oxycodone liquid continued to be ordered & taken **despite consultation entries indicating the patient felt confused & unwell.**
- Five months later a detailed review by the hospice pharmacist queried the high prn dose of oxycodone liquid and at this point the dose of oxycodone was reviewed and reduced

Failures in the system:

- Lack of up to date correspondence from outside organisations
- Information taken via the telephone from a family member and not verified in any way
- GP not aware of *high dose* requested and didn't question it

Lessons learnt

- Practice no longer accepts phone requests for adjustments to the dose of medication. All requests need to be accompanied by a written authorisation before an amendment to a medication regime is made.

To contact the Medicines Optimisation Team please phone 01772 214302