Shropshire Community Health NHS Trust

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3	November 2015	General update - Sections 6,9 to provide greater clarity
4	July 2019	HCA role clarification. Changes to scheduling of pregabalin and gabapentin. Change of registered nurse to registered healthcare professional where applicable Routine Use of Patient's Own Drugs for CD's
5	February 2021	Inclusion of requirements within special schools Addition of double signature for administration of gabapentin and pregabalin and greater inclusion of dental service Addition of Appendix to act as reference for staff dealing with CDs within Trust Reference to Trust Verification of Death policy. Additional information concerning dealing with fraud
6	March 2024	Change of pharmacy supplier from Lloyds to Fairview Addition of RRU wards

		Addition of integrated working with MPFT Authorisation documents provided by Severn Hospice Additional guidance on use of authorisations Additional references added

Medicines Policy

Part 2: Controlled drugs

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GLOSSARY

CD	Controlled Drug
CDAO	Controlled Drugs Accountable Officer
CDLIN	Controlled Drugs Local Intelligence Network
IDTS	Integrated Drug Treatment Service
LCFS	Local Counter Fraud Specialist
MPFT	Midlands Partnership Foundation Trust
MSO	Medication Safety Officer
PSIRF	Patient Safety Incident Review Framework
Registered HCP	Registered Healthcare Professional - This may include, nurses, dental nurses, dentists, paramedics and associate nursing staff that have undergone competence training for controlled drugs).
RRU	Recovery and Rehabilitation Units – wards based in SaTH
SaTH	Shrewsbury and Telford Hospital NHS Trust
SCHT	Shropshire Community Health NHS Trust
SOP	Standard Operating Procedure

1. INTRODUCTION

This document describes the standards required within Shropshire Community Health NHS Trust (SCHT) for the transport, administration, safe handling, record keeping and disposal of Controlled Drugs.

It should be used in collaboration with the Medicines Policy Part 1 General Principles, and any other relevant document relating to drug handling, transport, administration or destruction of controlled drugs as defined by the Misuse of Drugs Regulations 2001.

2. PURPOSE

This document applies to all staff, in any health or social care environment, employed by the organisations either directly or indirectly. It aims to reduce risk to patients, staff and the public by ensuring health professionals' awareness of their responsibilities under the relevant legislation and national and SCHT policies, procedures, guidelines and protocols that relate to the ordering, labelling, supply, storage, prescription, selection, preparation, administration to and the care and monitoring of patients, the maintenance of the statutory and SCHT patient-specific records and the disposal of Controlled Drugs.

3. RESPONSIBILITIES

The Controlled Drug Accountable Officer (CDAO)

The CDAO has responsibility for:

a. Ensuring the safe and effective use and management of CDs within their own organisations and by any body or person providing services to their organisation
b. Establishing and ensuring appropriate arrangements to comply with Misuse of Drugs legislation
c. Ensuring adequate and up-to-date Standard Operating Procedures (SOP) are in place in relation to the management and use of CDs
d. Ensuring adequate destruction and disposal arrangements for CDs
e. Ensuring monitoring and auditing of the management and use of CDs is undertaken
f. Ensuring relevant individuals receive appropriate training
g. Maintaining a record of concerns regarding relevant individuals
h. Assessing and investigating concerns
i. Taking appropriate action if there are well founded concerns
j. Establishing arrangements for sharing information
k. Producing quarterly reports of their CD occurrences and uploading to the NHS CD Reporting database. The occurrence report must describe details of any concerns that the organisation has regarding the management of CDs or confirmation that there have not been any concerns in the required timeframe.

Directors
Directors will mandate that all staff involved with controlled drugs are aware of this policy and that any incidents or concerns involving controlled drugs are reported to the Controlled Drug Accountable officer.

Line Managers
Line managers have a responsibility to ensure that this document is distributed to all relevant staff within their directorate and ensuring that staff are aware of their responsibility to read, understand and act upon the duties outlined in this document in a timely and effective manner. Managers should ensure that all staff working in their clinical area have read and signed the policy and the SOPs that accompany it.

Medicines Management Staff
Responsible for conducting review of controlled drug stock in wards, and prison healthcare areas on at least a quarterly basis and to ensure correct stock balances.

All Staff
All staff have a responsibility to read, understand and follow the recommendations laid out in this policy at all times and bring to the attention of their line manager any difficulties in achieving or maintaining compliance with these recommendations.

4. GENERAL PRINCIPLES

Controlled Drugs are important in the management of a variety of clinical conditions; however they are the subject of special legislative controls due to their potential to be abused and cause harm. This policy incorporates changes to the law which have occurred following the Shipman and Gosport inquiries.

The purpose of this policy is to outline the standards that can reasonably be expected to be adhered to by SCHT staff when dealing with Controlled Drugs, regardless of setting.

Controlled drugs are those controlled by the Misuse of Drugs Act 1971. They are identified in the BNF by the notation “CD” indicating various schedules that refer to the levels of control necessary.

Examples of controlled drugs commonly used in SCHT include morphine, fentanyl, oxycodone, amphetamines, buprenorphine, midazolam, temazepam, tramadol, gabapentin and pregabalin. Lower schedules include other benzodiazepines and the “z” drugs (e.g. Zopiclone, Zolpidem and Zaleplon).

5. STANDARD OPERATING PROCEDURES

Each of the activities concerned with CDs, regardless of where in an organisation they occur, must be described in a standard operating procedure (SOP). Healthcare professionals must be deemed competent by their clinical manager before ordering, handling, or administering controlled drugs.

6. ORDERING

ORDERING OF CDs IN COMMUNITY HOSPITAL, PRISON, MINOR INJURY UNITS, DENTAL CLINICS AND RRU WARDS

Community Hospitals / DENTAL / MIU:
Stock Orders will be made on standard CD ordering stationery (CD Ward Order Book) and countersigned by a medical or dental practitioner or a pharmacist. Stock may only be ordered via the usual supplier named in the service level agreement.

Controlled drug medication for patients in the community hospital to take home will be obtained via the Fairview “Controlled Drug order form for named patients – TTOs only” or an FP10 for dispensing at a community pharmacy.

Prison:
Stock Orders will be made on standard CD ordering stationery (CD Ward Order Book) and countersigned by the GP or pharmacist.

At the point of release, if a prisoner requires controlled drugs, the patient will be issued with an FP10 prescription for a 7-day supply until they are able to see their GP or attend clinic. All other (non-CD) medication will be issued as a TTO.

When a prisoner is being transferred to another detained estate, then the new estate should be contacted prior to transfer and informed of which CD’s the prisoner requires so a continuity of supply can be maintained. CD’s will not be transferred with the prisoner.

RRU Wards:
Within the RRU wards, controlled drugs are provided by the pharmacy team based at the Shrewsbury and Telford Hospital NHS Trust.

For stock medicines, these must be ordered in the ward CD order book, only nursing staff that are approved signatories can complete and sign the book.

For patients requiring a CD to take home, the designated sub-acute ward TTO stationary should be completed by the prescriber. In this instance, the prescriber will need to sign the TTO which acts as the prescription. This is clinically check by SaTH pharmacy team before dispensing.

For patients that require a controlled drug during their hospital stay which is not held on the routine stock list, this can be obtained by completing a SaTH CD TTO form, this should be completed in the same way as if the patient is being discharged. The TTO form will be clinically checked against the SCHT drug chart before being taken to SaTH pharmacy for dispensing.

In all instances, irrespective of the site or service, controlled drugs dispensed for individual patients must **never** be administered to other patients.

When patients bring in their own controlled drugs then these should be used over stock. A new supply of controlled drugs should be reordered in a timely way so that the patient is not without medicines and that there is the required quantity needed to take home.

7. RECEIPT

Immediately upon receipt of controlled drugs in any location authorised to hold controlled drugs, the registered HCP in charge will check the order is complete, then store in the CD cupboard and enter them into the appropriate section of the CD register.

8. STORAGE

The Misuse of Drugs (Safe Custody) Regulations 1973 imposes controls on the storage of Schedule 1, 2 and 3 CDs. The regulations apply to all Schedule 2 medicines (except quinalbarbitone), and the Schedule 3 drugs buprenorphine, diethylpropion, flunitrazepam, and temazepam. However, local policy is that the following medicines, if stocked, must be treated as if they were Schedule 2 Controlled Drugs in respect of storage and record keeping:

- **All schedule 2** (e.g., diamorphine, fentanyl, oxycodone & morphine)
- **Schedule 3** Controlled Drugs including tramadol, gabapentin, pregabalin and diazepam, some medicines within this schedule will have exemptions from full control when used within community hospitals or special schools, refer to the storage section for details and further information.
- Strong potassium chloride solution for injection 15% N.B. this is not held in any clinical setting due to safety concerns and requires Chief Pharmacist involvement if requested.
- **All Schedule 4** (e.g., Zopiclone and other Z-drugs (with an exemption for the prison setting only).
- **Schedule 5** e.g., Morphine 10mg in 5ml oral solution

For a comprehensive list of named medicines and their relevant schedule, refer to Appendix 2.

For CD stock held within any types of premises, the CD Register must be stored securely, near to the CD cupboard. The CD cupboard must be of the required type as defined in the legislation and out of sight of publicly accessible areas.

The Controlled Drugs (Supervision of Management and Use) Regulations 2013 specify that arrangements for CD storage must be covered within SOPs. All service areas handling controlled drugs must have an SOP in place for each element of CD use and line managers must ensure staff adhere to them.

To reduce the risk of mis-selection, all outer cartons of diamorphine and morphine injections of 30mg and higher must be labelled with a high visibility sticker alerting the healthcare professional to the high strength.

In addition, high strength opioid injections must be physically segregated from other strengths in the CD cupboard.

STORAGE OF GABAPENTIN and PREGABALIN IN COMMUNITY HOSPITALS

Within the community hospitals, stock pregabalin and gabapentin can continue to be stored with other medicines and are exempt from SCHT safe custody arrangements. Patients own pregabalin and gabapentin is also exempt from SCHT safe custody arrangements and can be stored and securely locked in the patient's own bedside medicine locker.

Gabapentin and pregabalin are not subject to registration requirements. Therefore, the controlled drug register does not require completion for stock administration, or patient own drug administration. This means stock received from the supplier or labelled for a patient will not require entering into any register.

STORAGE OF GABAPENTIN and PREGABALIN in RRU WARDS on SATH PREMISES

In all instances, Gabapentin and Pregabalin will be treated as if it were a schedule 2 controlled drug, meaning that it must be locked within the CD cupboard and entered into the CD register. Two signatures will be required for any administration which takes place.

STORAGE OF GABAPENTIN and PREGABALIN in SPECIAL SCHOOLS

Within Severndale Specialist Academy School and The Bridge Special School, pregabalin and gabapentin that are brought into school by young people for administration by SCHT Special School Nursing Team are exempt from safe custody arrangements and can be kept in the appropriate medication storage facility within each school.

Gabapentin and pregabalin are not subject to registration requirements. Therefore, the controlled drug register does not require completion; however, the medication administration record for the young person must be completed as per local procedures.

STORAGE OF GABAPENTIN and PREGABALIN IN THE PRISON

Following receipt of guidance from NHS England, the following advice has been recommended for HMP Stoke Heath Integrated Care:

There will be additional expectations that health and justice providers must meet to maximise the safe handling of pregabalin and gabapentin in all health and justice secure environments.

As for other Schedule 3 CDs, additional operational changes for the handling of pregabalin and gabapentin are required in health and justice settings, which align with health and justice standards and best practice. As the scheduling of these medicines is the same as tramadol, the health and justice policy for tramadol handling has been used as the basis for the handling of pregabalin and gabapentin in health and justice settings. This therefore means, both gabapentin and pregabalin must be treated as a Schedule 2 CD and will require:

- Completion of CD registers for receipt of stock
- Completion of CD registers for any administration
- Full audit trail for any destructions that are undertaken

STORAGE OF MIDAZOLAM in SPECIAL SCHOOLS

Within Severndale Special Academy School and The Bridge Special School, emergency buccal midazolam will be recorded on the authorised record sheet for the individual child instead of using the patients' own controlled drug register. Special School Nursing Team will undertake monthly stock checks.

STORAGE OF MIDAZOLAM in DENTAL CLINICS

Midazolam will be treated as a Schedule 2 drug for both the oromuscosal and the intravenous products, therefore, storage must be in a locked CD cupboard.

In the event administration is required, a dental nurse is able to book the drug out of the CD register as per local SOP's, but only the Dental Officer is permitted to administer the drug.

Reconciliation of the CD register will take place on each working day the clinic is open.

COLLECTION OF MEDICINES FROM THE COMMUNITY PHARMACY ON BEHALF OF THE PATIENT (RECEIVING TREATMENT AT HOME OR IN COMMUNITY HOSPITALS):

Community nursing teams

Registered HCP's (usually a Registered Nurse in these instances) are legally able to collect Controlled Drugs (CDs) from a pharmacy for a patient under their care provided that the CDs have been prescribed by an authorised prescriber and dispensed for that patient. However, this should be reserved for exceptional circumstances, and the registered HCP must expect to be asked to prove their identity and provide personal details to the pharmacist for the record of collection. The registered HCP must deliver the drug directly to the patient's home after collection from the community pharmacy. Drugs must never be stored in the office or taken home for later delivery.

Community hospital teams

On occasion, there may be a requirement for a registered HCP, or other member of the ward team to collect a prescription from the local pharmacy for a patient within their care or requiring discharge with a CD. Only when other options have been exhausted should this occur. However, in the event that it does, the information in the previous paragraph should be followed. There should be an expectation that identification will be required and that the registered HCP or other person employed by the ward should then immediately return to the hospital ward and follow procedures to sign the CD into the register unless the patient is immediately leaving the ward.

9. PRESCRIBING

Controlled drug prescribing must be carried out by a registered medical or dental prescriber, or by some non-medical independent prescribers in certain circumstances (see Medicines Policy Part 6: Non-Medical Prescribing). The appropriate prescription forms must be used. Supplementary prescribers may prescribe Controlled Drugs only in accordance with a clinical management plan which has been signed by the independent prescriber. The legal responsibility for prescribing lies with the doctor or non-medical prescriber who signs the prescription.

Patients who are opioid naïve should be commenced on the lowest effective dose of opioid based on the patient's overall condition, age, co-morbidities and current medication.

Where controlled drugs are to be supplied to community hospital patients at discharge, these must be prescribed on the Fairview "Controlled Drug order form for named patients – TTOs only". When a discharge is urgent or unplanned and requires controlled drugs as a TTO, use an FP10 prescription as an alternative.

For patients in the RRU setting, use the dedicated RRU ward TTO forms in order to obtain a supply from SaTH pharmacy for any patient being discharged with CDs.

The following information must be present on controlled drug prescriptions, in accordance with the Misuse of Drugs Regulations 2001 (and subsequent amendments) in addition to mandatory content such as name, address and age of patient if under 12 years, they should also include date written / generated and an electronic signature for

EPS (Electronic Prescription Service) or a wet signature in indelible ink when FP10 prescriptions / paper medicine charts or TTO requests are handwritten and the prescriber address (exception for paper drug charts):

a. Name of the drug
b. Form of drug, e.g. capsules, even if there is only one dosage form available or if it is implicit in the proprietary name (e.g. Zomorph)
c. Strength of drug
d. Full dosing instructions.

The following examples of doses are **not** acceptable:

- as directed
- when required
- titration dose
- as per chart
- daily
- decrease dose by x a day

e. The total quantity of the preparation, or the number of dose units, in **both words and figures**
f. The words “For dental treatment only” if issued by a dentist

A prescription for a controlled drug is valid for a period of 28 days.

Prescriptions for Schedule 2, 3 and 4 Controlled Drugs should be limited to a supply of up to 30 days, unless there are exceptional circumstances, when the reason for a longer supply should be recorded in the patient’s notes. Justification may be sought for prescription lengths longer than this recommendation.
For patients being released from the prison, a **maximum** seven-day supply will be prescribed.

SCHT policy is to treat morphine sulphate 10mg in 5ml oral solution as a controlled drug even though it has a legal CD classification of Schedule 5. In exceptional circumstances it is permitted for an emailed authorisation to be made e.g., by Shropdoc to ensure timely treatment (see below for schedule 4 controlled drugs). However, in all other aspects of use (e.g., storage, record keeping, destruction), the appropriate controlled drug processes must be followed.

Emailing prescriptions of schedule 2 and 3 controlled drugs is not legally permitted. *Do not confuse the word prescription with authorisation, as these are treated differently.*

In exceptional circumstances (e.g., out of hours) a “Shropdoc Email Authority to Administer Medication” form may be used to initiate use of schedule 4 / 5 controlled drugs (e.g., diazepam, lorazepam or morphine sulphate 10mg/ml oral solution) within the community hospital setting on the basis that the medication is prescribed onto the patient medication card as soon as practicable the following day. The printed / email authorisation must be securely attached to the medication card and the original authorisation received on the ward within 72 hours.

N.B. In instances where a syringe driver authorisation is required and Shropdoc are unable to visit, if the patient already has a syringe driver in place and the correct medicines in stock, then an authorisation can be emailed to prevent delays in administration.

This is on the understanding that the medication held by the patient has already been prescribed. Ensure the email is also printed and communicated within the team to prevent errors or duplication.

For patients without a syringe driver, the patient must be seen face to face by a prescriber so that appropriate medicines can also be prescribed.

Within RRU's, any patient requiring a CD must be seen by a prescriber, this is usually a SCHT prescriber, for management out of hours, refer to the on-call folder as this is a changing picture. There is no allowance made for emailed or scanned documentation if the patient is clerked out of hours, they must be seen by a prescriber.

10. ADMINISTRATION

Before administering any CD to a patient, the healthcare professional must be satisfied that written authorisation had been issued by a medical prescriber in accordance with legal requirements laid down in the Misuse of Drugs Act 1971. Guidance can be found in the Controlled Drugs and drug dependence section of the BNF.

Only registered HCPs who have been assessed as competent by their clinical manager are allowed to administer controlled drugs to a patient independently. This assessment must form part of the annual appraisal.

Every healthcare professional has a responsibility to check that the intended dose of an opiate drug is safe for the individual patient. If unsure, they should check a relevant reference source or seek further advice.

Knowledge of the previous opioid dose is essential for the safe prescription and administration of these medicines. For opiate drugs, dose increases are not normally more than 50% higher than the previous dose. When a prescription contains a dose increase greater than 50% of the previous dose, clarification from the prescriber must be obtained.

Naloxone (reversal agent for opiate induced respiratory depression) must be available in all SCHT clinical locations where injectable opioids are stored or administered.

Services that administer from CD stock:

The administration of Controlled Drugs must be made by a registered healthcare professional (usually a registered nurse) and documented on the drug chart or electronic Prescribing and Medicines Administration (ePMA) record. A second registered healthcare professional is recommended to act as an authorised witness to the administration. This includes pregabalin and gabapentin.

The authorised witness should be another registered healthcare professional but in exceptional circumstances when this is not possible e.g. only one registered HCP on duty then a CD administration may be made without a witness.

Due to the requirement for student nurses to gain experience of controlled drug administration during their pre-registration placement, it will be deemed acceptable for nursing students to administer controlled drugs under the following circumstances:

- the nursing student will be fully supervised by a registered nurse (this cannot be a nursing associate)
- accountability of the administration will be solely that of the registered nurse
- the student will sign as the administrator, the nurse that acts as the witness will sign as a witness on the drug chart or electronic / administration record
- the controlled drugs register is completed and signed by both parties ensuring it is clear within the register that one party is a student
- any concern is raised as soon as is practicable with the Practice Education Facilitator and the student

When a witness was not available, a competent HCA (see SOP 01.10) **"Health Care Assistants (HCA's) Providing an Authorised Witness Signature for the reconciliation of Controlled Drugs (CDs) in CD Registers"** may accompany the registered HCP to reconcile the physical amount remaining in the cupboard with the quantity recorded in the register following the administration.

HCA's **cannot** witness the administration of controlled drugs, only the count following the administration.

The appropriate entry must be made in the Controlled Drugs register at the time of administration.

Details of stock items administered by the health professional should be recorded in the Controlled Drugs register and must include:

a. Date and time of administration
b. Date issued
c. Name of person to whom the CD was issued
d. Quantity issued
e. Balance
f. Signature(s) of person(s) making the entry

Each page of the register must have the correct product heading to which the entries below refer.

Where records cannot be reconciled i.e. too much or too little physical drug when compared to the record), the designated manager MUST be informed immediately and a Datix report initiated. If this discrepancy involves controlled drugs, the Accountable Officer must be made aware within 24 hours.

Services that administer from Patient's Own CD Drugs (CD PODs)

Community Hospitals, RRU's and Prison:

The use of CD PODs is acceptable during a patient stay within Community Hospitals, RRU's and Prison. In these instances, the CD PODs must be logged into the Patient's Own CD Register and locked in the appropriate CD cupboard, the only exception to this is gabapentin and pregabalin (refer to section 8 for additional information on storage and use of CD's within the relevant settings).

Administration of CD PODs will be made whenever possible by two registered healthcare professionals. In the event of only one registered member of staff being on duty, then a CD administration may be made without a witness. This includes gabapentin and pregabalin.

Following the drug administration, a competent HCA (see SOP CH 01.10 **"Health Care Assistants (HCA's) Providing an Authorised Witness Signature for the reconciliation of Controlled Drugs (CDs) in CD Registers")** may accompany the registered HCP to reconcile the physical amount remaining in the cupboard with the quantity recorded in the register as described previously.

Within Community Hospitals, Gabapentin and pregabalin will not be recorded within the CD register however, best practice must be followed with the recommendation that a second checker will be responsible for checking the correct medicine is given against the prescription record. Where a patient has brought their own stock into the hospital, these will be locked in the patient's medicine locker along with any other PODs.

In the instance of the RRU ward and prison, gabapentin and pregabalin will be treated as a **full CD** and there will be no exceptions. Procedures for handling POD's must be adhered to at all times as previously described in Section 8 (Storage).

Where records cannot be reconciled i.e., too much or too little physical drug when compared to the record), the designated manager MUST be informed immediately and a Datix report initiated. If this discrepancy involves controlled drugs, the SCHT Accountable Officer must be made aware within 24 hours, when required.

Datix reports involving the RRU ward may be shared with the CDAO at SaTH, this will be undertaken by SCHT MSO when reported by SCHT staff and by SaTH MSO when the incident was reported by SaTH staff, this ensures robust communication and supports partnership working.

Community Nursing administration of CDs (patient's own) in the Patient's Home:

Controlled drugs must only be administered in line with relevant legislation and local standard operating procedures. CDs within the patient's home may have come from a variety of sources including, the patient's GP, hospital (acute and community), Virtual Ward or Shropdoc. In these instances, the medicine has been prescribed and a Patient Specific Direction or 'Authorisation' document is provided to administer against. The authorisation is a template created by Severn Hospice and approved by the System Integrated Medicines Optimisation Committee for use by multiple organisations and GP surgeries as well as Severn Hospice. This authorisation will usually be printed (e.g., by the G.P. using a code which is embedded into EMIS), *there is no legal requirement for the authorisation to have a 'wet' signature when electronically created, as it is not a prescription. In such cases, it is acceptable for the authorisation to be emailed to the nursing team managing the patient.*

It is best practice that a secondary signatory (witness) should be obtained for the administration of controlled drugs, however it is acknowledged that registered HCP's working in the community will often be lone workers. In a patient's home, where a registrant is administering a controlled drug that has already been prescribed and dispensed to that patient, obtaining a secondary signatory should be based on local risk assessment.

Where a witness is available, it is good practice that the second signatory witnesses the whole administration process.

Details of patients' own Controlled Drugs administered by the registered HCP should be entered into the nursing records before leaving the patient's home. Details should include:

a. Date and time of administration
b. Name, form and strength of drug administered
c. Route of administration
d. Dose of drug administered
e. Count of stock remaining
f. Signature of the healthcare professional administering

Known palliative care patients should be flagged to the out of hours doctor service and medication records made on appropriate community nursing documentation which remain at the patient's home.

In the event of an emergency where there are not sufficient supplies of a controlled drug in the patient's home, further supplies can only be obtained via FP10 at a community pharmacy or through current out of hour's arrangements.

At each visit to a patient's home by a registered HCP, the quantity of drugs remaining MUST be reconciled with the patient's record. Where records cannot be reconciled i.e., too much or too little physical drug when compared to the record), the designated manager MUST be informed immediately and a Datix report initiated. If this discrepancy involves controlled drugs, the SCHT Accountable Officer must be made aware within 24 hours.

Special Schools Administration of patient's own medicines:

All Schedule 2 medicines will be locked away and both the CD register and MAR chart completed. This requires 2 signatures for both the register and MAR sheet. A Nursing Associate may act as a second check for the administration of the controlled drug by a registered nurse as referenced in Medicines Policy – Part 1, General Principals.

Schedule 3 medicines (including midazolam) the MAR chart is completed but there is no requirement to enter into a CD register. This allows for Emergency administration to align with individual patient protocols at the school.

Administration of opioid substitution therapy in Stoke Heath Prison

The provision of the integrated medicines transfer service (IDTS) at the prison (HMP Stoke Heath) is overseen by Midlands Partnership Foundation Trust (MPFT) in conjunction with SCHT as part of the Stoke Heath Integrated Care partnership. This includes the procurement, storage, prescribing, dispensing, administration and disposal of Methadone and Buprenorphine.

For the purposes of dispensing methadone, the service utilises Methasoft software which interfaces with SystmOne to support automated dispensing. In certain circumstances,

SCHT may be required to aid administration, in these instances, SCHT must ensure they have read all relevant SOP's and received training on Methasoft prior to undertaking this task.

11. SYRINGE DRIVERS

Practitioners administering drugs via a syringe driver must have undertaken the required programme of training associated with the particular model of syringe driver in use. They must be familiar with the drugs and their compatibilities when mixed together in a syringe driver (unlicensed use).

12. DISPOSAL

Stock and Patient's own CDs:

This relates to all Schedule 2, 3 and 4 (Part 1) medicines.

Within SCHT settings, only a person specifically authorised (written authorisation) by the Accountable Officer may witness destruction of any controlled drugs, this is usually a member of the SCHT Medicines Management team. Both people will sign the entry in the controlled drug register. Within the prison setting, only the witness named within the Home Office License may witness the destruction of controlled drugs.

Within the RRU Wards based at SaTH, any CD requiring destruction will be undertaken by the SaTH pharmacy team. There are specific procedures covering this task which must be followed. In the event a CD leaves the ward with SaTH pharmacy staff, the CDAO for SaTH takes over the responsibility for ownership of the CD(s).

Only in exceptional circumstances may a registered HCP working in the community return a deceased patient's Controlled Drugs to a community pharmacy, e.g., there is a risk of abuse or diversion by remaining members of the household. Normally this would be the responsibility of the family since the medicines belonged to the patient. The clinical manager must be informed in advance so that a risk assessment can be made. A record must be in the deceased patient's notes and the HCP should also email the CDAO to this effect to notify them. The registered HCP must create a record of the transportation that includes the following:

a. the patient's name,
b. a list of the drugs (name of drug, strength, form and quantity) that are removed from the patient's home,
c. the signature of the patient's relative(s) as consent to their removal,
d. the name of the pharmacy they are taken to,
e. the signature of the pharmacist who receives them into his/her care for destruction,
f. The name of the HCP who transported the CD before handing it to the pharmacist at the community pharmacy as well as the HCP signature.

This record must be kept in the patient's record for auditing purposes.

In the event of a patient death where the patient had a syringe driver containing a controlled drug in situ, refer to the “Verification of Expected Adult Death Policy” for appropriate actions.

13. INCIDENT REPORTING - (ERRORS, LOSSES, SUSPECTED THEFT OR FRAUD)

Any incident involving a controlled drug, including temporary loss of CD cupboard keys must be reported via the Datix reporting system. Patient safety incidents or incidents involving an issue with safe and secure handling of CDs, will be investigated by the Medication Safety Officer (MSO) in conjunction with the CDAO. Where learning is required, this will be shared at the Medicines Safety Group as well as being disseminated throughout the Trust. Furthermore, learning can be shared across the System via the System Medicines Safety Group to ensure safety concerns are communicated to prevent similar instances occurring – this will occur using PSIRF in all instances, especially where themes are identified. This process is described in Medicines Policy Part 8: Policy and Procedure for Medication Incidents.

Where the service manager is supporting with the incident investigation and suspects or identifies that a staff member may have deliberately stolen a CD / other addictive medicine or certain addictive drugs that may not be identified as a CD (e.g. codeine, dihydrocodeine, diazepam etc) the Chief Pharmacist may take advice from the Security Advisor but will report the matter to the Director of Finance to decide on a referral to the police.

If a CD or certain addictive drug has been deliberately stolen using deception such as falsifying the medicines ordering or prescribing records or other stock records and fraud is suspected (e.g., false accounting, fraud by false representation, fraud by abuse of position) the Chief Pharmacist will report the matter to the Lead LCFS who will investigate further and decide on the way forward. If police powers are required, the Lead LCFS will liaise with the local police or via the specialist police team’s-controlled drugs liaison officer (CDLO) and will make the Director of Finance aware of the referral to the police.

14. ILLICIT DRUGS DISCOVERED ON SCHT PREMISES

Any issues concerning illicit substance misuse within the Trust must be reported to the Accountable Officer without delay.

The Security Advisor is responsible for advising on security in relation to this policy. The Security Advisor will liaise with the police as necessary upon being made aware of a suspected illicit substance being discovered on SCHT premises, except prison where there are alternative internal procedures.

If any suspected illicit substance or device for using illicit substances is discovered in plain sight on a SCHT site, the senior member of staff on duty will notify the service user that possession of the substance is illegal and in the presence of a witness ask that the substance is surrendered voluntarily.

The substance must be quarantined in the CD cupboard, a Datix record made, the clinical service manager informed and the Security Advisor and / or police informed so that they can retrieve or destroy. Staff will document the reasons for informing the police in the service user's case file.

Unless the service user gives their consent, and there is another staff member present, to witness the procedure, it is illegal to search a service user’s property. A search of a person without that person's permission could potentially lead to that staff member being charged with assault.

If the service user refuses to surrender a suspected illegal substance, then under no circumstances should staff exercise force to obtain this. The police should be called, and the Security Advisor should be contacted and remain in attendance until the police arrive. In an in-patient setting, if the service user expresses a desire to self-discharge at this point in time, then medical staff should be informed immediately.

It should also be remembered that the return of an illicit substance to a service user by a member of staff can be interpreted as supply of an illegal drug and thus lead to criminal charges being brought against the staff member.

It is the responsibility of the police to lead the investigation and decide upon the outcome.

Under no circumstances may a staff member destroy the illicit substance or device.

The Security Advisor will respond promptly when informed that a suspected illicit substance has been discovered on SCHT premises. The Security Advisor may be required to transport a suspected illicit substance to the police for safe disposal in accordance with the Misuse of Drugs Act (1971).

The Police will be requested to remove any quantity of suspected illicit substance deemed by the Security Advisor as too large or inappropriate for transportation to the police.

In the prison setting, the procedure would be for the appropriate prison officer to manage the illegal possession of substances or devices. Again, they must not destroy unless a Home Office approved witness or appropriately trained police officer is present. Appropriate CD procedures can be used for the purposes of destroying the illicit substance.

In a community setting where lone working may apply, for example during a home visit, no SCHT staff member should request that a service user surrenders a suspected illicit substance.

If the substance is volunteered by a service user for "disposal" or similar, then the service user should be advised to dispose of the substance themselves. Under no circumstances should any staff member of SCHT leave premises in possession of a suspected illegal substance.

A record of the advice given should be made in the service user's case file.

A discussion with the Security Advisor should occur as soon as possible following the visit to ascertain if an illegal act may need reporting to the police (for example, large

quantities of an illegal drug that may be considered as supplying, or cultivation of cannabis plants)

15. AUDIT AND MONITORING

On a regular cycle, the clinical pharmacists at each community hospitals, MIU's, dental services and special schools will conduct an audit against the standard operating procedure and policy before reconciling the physical drugs against the controlled drugs register. Any discrepancies will be reported to the CD Accountable Officer, and remedial action plans put into place, monitored by the clinical pharmacists and / or pharmacy technicians.

A copy of the audit document can be obtained from the Medicines Management Shared drive.

Prescribing of controlled drugs on FP10 by employees of Shropshire Community NHS Trust will be monitored by use of ePACT2 data.

16. REFERENCES

Misuse of Drugs Act 1971

Misuse of Drugs (Safe Custody) Regulations 1973

Misuse of Drug Regulations 2001

Misuse of Drugs (Safe Custody) (amendment) Regulations 2007

Misuse of Drugs (Amendment No2) Regulations 2012

The Health Act 2006

The Human Medicines Act 2012

The Controlled Drugs (Supervision of Management and Use) Regulations 2013

Specialist Pharmacy Services - Medicine administration by registered and non-registered staff – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Local policies:

McKinley T34 Syringe Pump adult care resource pack

Medicines policy Part 1: General Principles

Medicines Policy Part 6: Non-Medical Prescribing

Medicines Policy Part 8: Policy and Procedure for Medication Incidents

Severn Hospice Patient Specific Directions (Authority to Administer) Documentation: Information for healthcare professionals - Severn Hospice

17. CONSULTATION

The following people were consulted during the review of this policy:

Diane Kitching – Lead Pharmacist for Children, Young People, Families and Governance

Vicky Price – Lead Pharmacist for Community Hospitals and MIUs

Jas Sahota - Lead Pharmacist for Prison Services

Cheryl Rowley – Senior Pharmacy Technician

Lucy Manning – Medicines Safety Officer

Alun Gordon – Lead Local Counter Fraud Specialist

Ian Gingell - Local Security Management Specialist

Denis Kanu – Inclusion Pharmacist MPFT

Medicines Governance Group – Approved February 2024

18. OUTCOME MEASURES AND PROCESS FOR MONITORING COMPLIANCE AND EFFECTIVENESS

What key element(s) need(s) monitoring as per local approved policy or guidance?	**Who will lead on this aspect of monitoring?** **Name the lead and what is the role of the multidisciplinary team or others if any.**	**What tool will be used to monitor/check/ observe/asses/ inspect/ authenticate that everything is working according to this key element from the approved policy?**	**How often is the need to monitor each element?** **How often is the need complete a report?** **How often is the need to share the report ?**	**Who or what committee will the completed report go to and how will this be monitored.** **How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.**	**Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?**	**How will system or practice changes be implemented the lessons learned and how will these be shared.**
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Acting on recommendations and Lead(s)**	**Change in practice and lessons to be shared**
Reconciliation of physical CD stock with the CD register in community hospitals	Clinical pharmacists in community hospital	Direct comparison	A minimum of quarterly	The Medicines Management committee is expected to read and interrogate the report to identify deficiencies in the system and act	Medicines Management Governance Group will monitor progress of required actions and require them to be completed in	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the nursing team will be identified to

				upon them. CD discrepancies will also be reported via the Local Intelligence Network Occurrence reporting system.	the specified timeframe.	take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders via team meetings and via newsletters.
ePACT2 monitoring	Accountable Officer	ePACT2 data available for SCHT	A minimum of twice a year	Unusual prescribing will be challenged with the individual prescriber; reports made to Adult or Children's Safety Delivery Group by exception; reported to CDLIN as an "occurrence" in quarterly report	Safety Delivery Group. May be escalated to Quality and Safety Delivery Group	ePACT2 data discussed at team meetings and comparisons made with peer practitioners

19. APPENDIX 1A: CONTROLLED DRUG ORDER FORM FOR NAMED PATIENTS – FAIRVIEW TTOS ONLY

FAIRVIEW HEALTH LTD

Fairview Health Ltd
Unit 10, Rockhaven, Triangle Park,
Metz Way, Gloucester, GL1 1AJ

NHS
Shropshire Community Health
NHS Trust

Controlled Drug order form for named patients – TTOs only

Patient details			
Name			
Address			
DOB		NHS No	
Date requested		Date required by	

Please Note

- Fairview Health will NOT be able to accept faxed copies of this form
- The original form, signed by an Authorised Prescriber, must be sent out to Fairview Health Pharmacy for a supply to be made.
- This form **MUST BE** accompanied by a photocopy of the patient's medication chart
- This form must be used in conjunction with Shropshire Community Health NHS Trust controlled drug policy for prescribing

Medication request					
Drug name (BNF approved name)	Strength	Form	Dosage	Total quantity	
				In words	In figures
Comments:					

Prescriber details: Attention prescribers- Prescriptions valid only for 28 days from the date of prescribing

Prescriber's Name		Prescriber's Signature		Date Prescribed	
GMC No.		Prescriber's Address	**Whitchurch Community Hospital** Claypit Street, Whitchurch, Shropshire SY13 1NT		
Contact No.					

Version: 1.0

Created: 13/05/2023

APPENDIX 1B: CONTROLLED DRUG ORDER FORM FOR NAMED PATIENTS – SaTH PHARMACY TTOs ONLY:

The Shrewsbury and Telford Hospital NHS Trust

Shropshire Community Health NHS Trust

Controlled Drug order form for named patients – TTOs only

Patient details			
Name			
Address			
DOB		NHS No	
Date requested		Date required by	

Please Note

- Shrewsbury and Telford Hospital NHS Trust will NOT be able to accept faxed copies of this form
- The original form, signed by an Authorised Prescriber, must be sent to the Pharmacy department at Shrewsbury and Telford Hospital NHS Trust for a supply to be made.
- This form **MUST BE** clinically screened by SaTH pharmacy alongside the patient's medication chart.
- This form must be used in conjunction with Shropshire Community Health NHS Trust controlled drug policy for prescribing

Medication request					
Drug name (BNF approved name)	Strength	Form	Dosage	Total quantity	
				In words	In figures

Prescriber details: Attention prescribers- Prescriptions valid only for 28 days from the date of prescribing

Prescriber's Name		Prescriber's Signature		Date Prescribed	
GMC / Reg No.		Prescriber's Address	**RRU Ward Services** **Shropshire Community Health NHS Trust** **Based at Princess Royal Hospital** Apley Castle, Telford, TF1 6TF	Contact No.	

Pharmacy Section ONLY

Clinical check by Date:		Dispensed by Date:		Final Check by Date:	
Collected by (Name, Signature and Date):			Issued by (Name, Signature and Date):		

Version: 1.1

Created: 15/04/2024

20. APPENDIX 2: LIST OF CONTROLLED DRUGS REQUIREMENTS WITHIN SCHT

Schedule	Name of medicine	CD Cupboard storage required?	Enter into CD Register?	Requires destruction using DOOP?	Two Signatures required on administration?
2	Dexamfetamine	Yes	Yes	Yes	Yes
2	Diamorphine	Yes	Yes	Yes	Yes
2	Fentanyl	Yes	Yes	Yes	Yes
2	Lisdexamfetamine	Yes	Yes	Yes	Yes
2	Methadone	Yes	Yes	Yes	Yes
2	Morphine	Yes	Yes	Yes	Yes
2	Methylphenidate	Yes	Yes	Yes	Yes
2	Oxycodone	Yes	Yes	Yes	Yes
2	Pethidine	Yes	Yes	Yes	Yes
3	Buprenorphine	Yes	Yes	Yes	Yes
3	Gabapentin	No	No	Yes	Yes
3	Midazolam	Yes	Yes	Yes	Yes
3	Pregabalin	No	No	Yes	Yes
3	Phenobarbital	No	No	Yes	No
3	Temazepam	Yes	Yes	Yes	Yes
3	Tramadol	Yes	Yes	Yes	Yes
4	Chlordiazepoxide	No	No	Yes	No
4	Clobazam	No	No	Yes	No
4	Clonazepam	No	No	Yes	No
4	Diazepam	Yes	Yes	Yes	Yes
4	Lorazepam	No	No	Yes	No
4	Nitrazepam	No	No	Yes	No
4	Oxazepam	No	No	Yes	No
4	Zolpidem	Yes	Yes	Yes	Yes
4	Zopiclone	Yes	Yes	Yes	Yes
5	Oramorph	Yes	Yes	Yes	Yes

Exceptions:

- IDT Teams do not require two signatures for administration.
- **Zopiclone and Zolpidem** will be **exempt with respect to entry into a CD register at HMP Stoke Heath.**
- Gabapentin and Pregabalin **will require** entry into the CD register at HMP Stoke Heath.
- **Midazolam at Special Schools will not be subject to CD register requirements where it is the patient's own emergency supply.**
- **For RRU Wards on SaTH sites:** All schedules of controlled drug **must** be stored in the CD cupboard, ordered using the ward CD order book and recorded into the Ward CD register.