NHS England and NHS Improvement – North Midlands Controlled Drugs

Occurrence Summary Report Q3 (October– December 2021)

Introduction

In accordance with the Controlled Drugs Regulations designated bodies are required to submit to NHS England and NHS Improvement on a quarterly basis a controlled drug occurrence report. This document provides a summary of the occurrence reports submitted for Q3 (October – December 2021) and highlights the actions taken and learning from the incidents that occurred during this quarter.

Occurrence Overview Report for the period Q3 (October – December 2021)

Summary of occurrences, incidents, and concerns for the North Midlands Region:

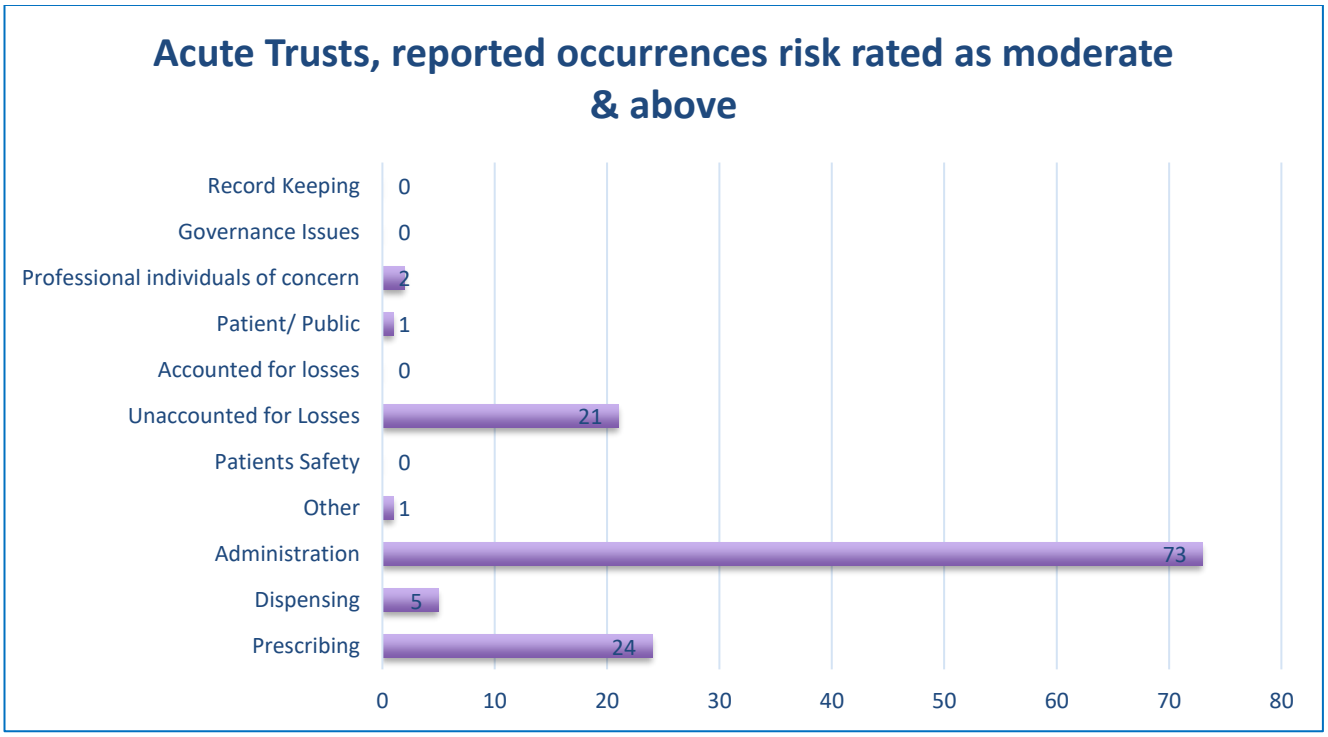
Category Type		Overall Occurrences	Low	Moderate	High	Extreme
Patient Related	Prescribing	70	42	6	22	0
	Dispensing	96	63	30	3	0
	Administration	163	82	11	70	0
	Other	41	38	1	2	0
Unaccounted for losses: such as theft and fraud (from the organisation), unexplained stock discrepancies, lost prescriptions / requisitions		122	73	49	0	0
Accounted for losses: such as spillages, breakages		59	59	0	0	0
Patient / public: such as fraud and theft (by patients / public), misrepresentation by patients		10	4	6	0	0
Professional individuals of concern: These are relevant individuals i.e. people who work in health or social care include a section to enter details of professional involved		4	1	2	1	0
Governance issues: such as CD safe custody, staff competence, audit, statutory requirements, SOPs		86	84	2	0	0
Patients Safety		29	29	0	0	0
Death		0	0	0	0	0
Record keeping		164	157	5	2	0
Total		844	632	112	100	0

Q3 Occurrence Reports – Rate of Response

Organisation Type	Number of Reports NOT received	Number of Nil reports
Ambulances (2 in total)	1	0
Private Healthcare Provider (38 in total)	35	0
Acute NHS Trust Hospitals (7 in total)	4	0
Non-Acute NHS Trust Hospitals (8 in total)	4	0
Pregnancy / Fertility Advisory Service (3 in total)	3	0
Hospices (11 in total)	8	0

NHS Acute Trusts

In 2021/22 during Q3 period there were 128 reported incidents(occurrences) from NHS Acute Trusts that were risk rated as moderate and above. The graph below breaks these down into categories:



The table below shows the total number of all occurrences, incidents and concerns reported by acute trusts for the North Midlands Region risk rated as Low, Moderate, High, and Extreme.

Category of Incident		Organisation Name				
		Chesterfield Royal Hospital NHS Foundation Trust	Nottingham University Hospitals NHS Trust	Sherwood Forest Hospitals NHS Foundation Trust	The University Hospitals of North Midlands NHS Trust	University Hospitals of Derby and Burton NHS Foundation Trust
Patient Related	Prescribing	6	27	9	16	7
	Dispensing	9	13	1	3	8
	Administration	9	76	13	21	18
	Other	0	8	1	1	10
Patients Safety		0	0	27		0
Unaccounted for Losses		16	18	0	8	10
Accounted for losses		3	15	2	4	21
Patient/ Public		0	0	2	0	0
Professional individuals of concern		0	1	0	0	1
Governance Issues		1	26	11	0	22
Record Keeping		11	36	50	34	37
Total		**45**	**220**	**116**	**87**	**134**

Q3 Learning from Acute Trusts

Prescribing

- Patient declared on admission that he was on regular pregabalin medication. upon screening the pharmacy was able to confirm that the patient was not actually on and had never been prescribed this medication. MDT reminded of need for accurate investigation requesting and prescribing
- Prescribing error identified by the Ward Pharmacist, informed Medical Doctor of the prescribing error, and requested the morphine sulphate oral solution to be re-prescribed with the correct maximum dose in mg. Generic shared learning for Anaesthetic and TC junior doctor teams, regarding good prescribing practice. Signposting of Trust acute pain guidelines.
- Incident occurred. No harm to patient. Discussed prescription with DR Not clear what original script showed as appears to have been altered. Possibilities are 1: Wrong dose prescribed 2: Poor handwriting. Dr Will reflect. Clinical practice, Communication with staff
- Patient was well and had no harmful aftereffects. lack of knowledge from our nursing colleagues re medication and breastfeeding. Clinical practice, Communication with staff, Staff education / Knowledge / Training
- incomplete drug prescription for butec - longtec prescribed and given by registered staff not realising previous butec patch was still in place from pre-admission. To ensure on admission that patients are checked for any transdermal patches in future. Communication with staff, Staff education / Knowledge / Training

- Patient had sedation withing the sedation policy guidelines, patient tolerance to the sedation led to the patient taking an extended period of recovery. Patient was given Flumazenil and sent home, there was a relatively short period of observation following the reversal agent being administered. Patient contacted the next day - he was fine, fit and well. Staff education / Knowledge / Training
- There was a combination of errors between the prescription of oromorph (when the patient was pre op) and post op when the patient was started on a Fentanyl infusion and the oromorph wasn't stopped. There was opportunity to correct this when the pain team came to review the patient, but this was still continued, and the day nurse also administered 1 dose of oromorph. Clinical practice, Communication with staff, Staff education / Knowledge / Training

Dispensing

- Several factors were involved in this incident, poor skill mix at the weekend, lack of attention to detail when labelling and dispensing a controlled drug, not following the Controlled drug policy by the labeller/ dispenser of checking the ascribe balance against the physical stock in the cupboard. Checker was multi-tasking at the time of checking and was distracted, causing them to miss the check of the strength on the dispensing label. The correct strength was dispensed to the patient and the correct strength was entered into the correct register. Communication with staff, Record keeping / Documentation

Administration

- Patient is prescribed gabapentin 900mg 3 x a day. On admission the patient self-administered 2700mg in one go claiming this is her normal routine. Educated patient that this medication should be spaced out through the day and not taken all together once a day. Dr assessed on unit to check for any adverse effects following patient taking medication. Patient on assessment unit, hadn't declared that she had any of her own medications with her to nursing staff.
- Medication hadn't been placed in patient's locker or locked in CD cupboard. Patient then took own meds and although nursing staff informed the patient of what they were giving her, she did not mention she had already taken it in the morning. In future when admitting a patient to the ward we should ask if the patient has their own medications with them and ensure they are locked in the appropriate place at this point. This would make sure there was no opportunity for patients to take their own medications unless the self-medicating form had been completed. Communication with patient
- Learning taken from incident and discussed at speciality QRS by pharmacist: Fentanyl and buprenorphine patches should be removed before MRI scan as can heat up and increase release of drug. This should be done by ward before scan and documented on patch chart. Importance of using patch monitoring chart as without evening check could have gone much longer without pain relief. Clinical practice, communication with staff

Unaccounted for Losses

- Use correct bung & appropriately sized oral syringes. Undertake end of bottle checks to avoid accumulation of underage.
- Scoping improvements to ward receipt of CDs that do not have safe storage requirements
- Issue believed to be a spillage that was not managed correctly
- It was never concluded whereabouts the Midazolam disappeared to, correct protocol followed and independently investigated.
- Oxycodone bottle remeasured, handover to the night and staff about missing ML of oxycodone. Management will monitor CD checks at night
- A thorough search of CD cupboard, clinic room floor and surrounding area the 2 missing Pregabalin were not found. There were no other discrepancies with any other Pregabalin of different strength. The missing tablets appear to have been lost from 2 loose slots in the tablets strip. This could have resulted in the tablets coming out of the strip without staff noticing and dropping onto the floor.

- CD's transferred to base ward and patient subsequently discharged therefore no evidence to investigate with. Nurse who signed in CD's can't remember who they signed them in with. Staff have been reminded of the importance of 2 nurse CD checks and this will be monitored by the NIC. Staff education / Knowledge / Training
- Appears that a dose was given and not recorded. Clinical practice
- Upon checking, the CDs, it was noted that there was a discrepancy in the amount of Oromorph left in the bottle after dispensing. Clinical practice, Communication with staff.
- signed out to patient documented in cd book all staff emailed to remind them what needs to be done.
- Use CD counting tray for solids.
- Use CD Liquid Top Tips

Accounted for losses

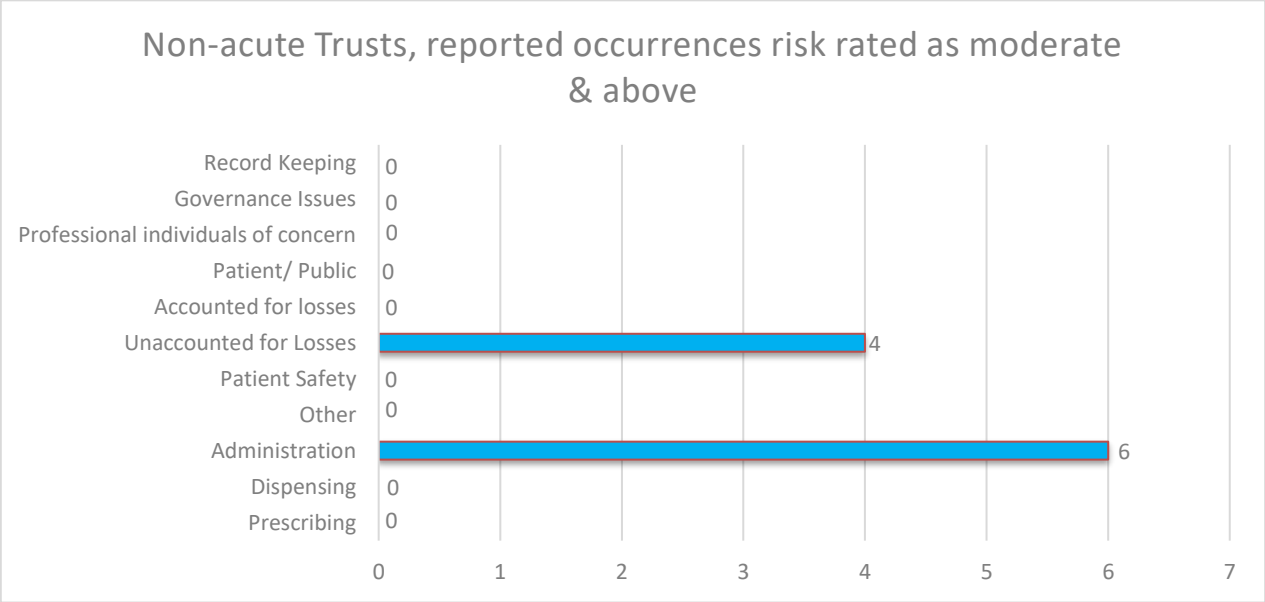
- Discrepancy initially found to be 9mls. After investigating found to be 4mls.Record keeping / Documentation
- Amps clearly broken during transport. Record keeping / Documentation

Governance

- CD returns had been on the log for a week and none had been removed. The technicians had been made aware by the ward pharmacist about the cd's on there and there were more CD's to be transferred. The ward technician cleared the CD returns. It had been agreed that the band 6 was going to be completing the CD returns, but due to staffing issues etc this hadn't been done. CD collection has been built into the rota. Communication with staff, staffing levels.
- Medication found on the ward in a pharmacy bag, however it was noted that the medication received had not been signed for by ward staff. Item had been delivered by a porter who had not waited for a nurse therefore left before staff could receipt item. Non-clinical practice, Record keeping / Documentation
- Staff signed in medications that day on other slips but did not see the medications in question. Therefore, the bag was not thoroughly checked by staff when signing in the CDs. Staff education / Knowledge / Training
- Staff signed in 2 boxes of oxycodone to the ward CD cupboard unaware that there were 3 boxes in the bag, and one was returned to pharmacy. Record keeping / Documentation, Staff education / Knowledge / Training
- Nurse involved got the morphine out of the Omnicell to administer to the patient for pain but then he settled. She kept it at the bedside in case it was needed but then forgot to replace in the Omnicell. She is aware of the correct procedure and storage for CDs and aware not to do this in future. Clinical practice
- The patient was transferred to another ward, but staff forgot to collect the bag of TTOs with CDs to go on transfer with the patient. Communication with patient, Communication with staff, Delivery of care, Record keeping / Documentation
- Deviation away from normal -pre COVID-19 practice. Similar incidents and practices have been noted and this demonstrates the importance of bedside checks which continue. Clinical practice
- Patient brought methadone with them to hospital and refused to hand it over to the nurses as it's a controlled drug, explained all the risks to the patient. Bronze informed and doctors aware. Patient had methadone prescribed on the drug chart. lessons learnt; To inform pharmacy and get advice for the medicine management. Communication with patient.
- Drawn up syringe of remifentanil left in a drug cupboard. No indication of date/time or who had drawn this up. Incorrect discarding of a controlled drug. Clinical practice, Equipment use.

NHS Non-Acute Trusts

In 2021/22 during Q3 period there were 10 reported incidents (occurrences) from Non -Acute Trusts that were risk rated as moderate and above. The graph below breaks these down into categories:



The table below shows the total number of all occurrences, incidents and concerns reported by Non-acute trusts for the North Midlands Region risk rated as Low, Moderate, High, and Extreme.

Category of Incident		Organisation Name						
		Derbyshire Community Health Services NHS Foundation Trust	Derbyshire Healthcare NHS Foundation Trust	Midlands Partnership Foundation Trust	North Staffordshire Combined Healthcare	Nottinghamshire Healthcare NHS Foundation Trust	Shropshire Community Health NHS Trust	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Patient Related	Prescribing	4	4	0	0		2	0
	Dispensing	3	0	1	0		2	0
	Administration	7	5	13	0		1	10
	Other	1	11	7	0		0	0
Patient Safety		0	1	0	0		1	0
Unaccounted for Losses		4	18	4	0		0	0
Accounted for losses		1	2	11	0		1	1
Patient/ Public		0	2	0	0		0	0
Professional individuals of concern		0	0	0	0		0	0
Governance Issues		6	5	6	0		3	0
Record Keeping		5	1	14	0		3	1
Total		**31**	**49**	**56**	**0**	**Not submitted**	**13**	**12**

Q3 Learning from Non-Acute Trusts

Patient related

Administration Errors:

- Action plan for nurse involved to include removal from administration, medication competencies, reflection, training on decision making and escalation.
- Came to light that a family member had been giving patient morphine along with home first staff. Staff reminded to communicate with family members and explain they will manage medication. Discourage more than one agency / family member to be involved in medicine administration to avoid errors. Information disseminated to team.
- Poor staff judgement regarding providing the patient with Diazepam and instructions not followed by escorting supporting staff member. Patients should not be sent to A&E with PRN medication. If necessary, A&E can provide medication.
- 300mg of Pregabalin had been administered twice during the day instead of the prescribed 100mg. Nurse involved to redo medication assessments and complete reflective account.
- Leaking syringe driver - Extra training to be provided and assessment of competencies as necessary. The trust is in the process of replacing all SD as issues previously identified.
- Zopiclone 7.5mg administered in error at 00:20 when patient had already received dose at 23:10. staff error; confusion over dates crossed over due to midnight. staff member to complete competency framework with manager.

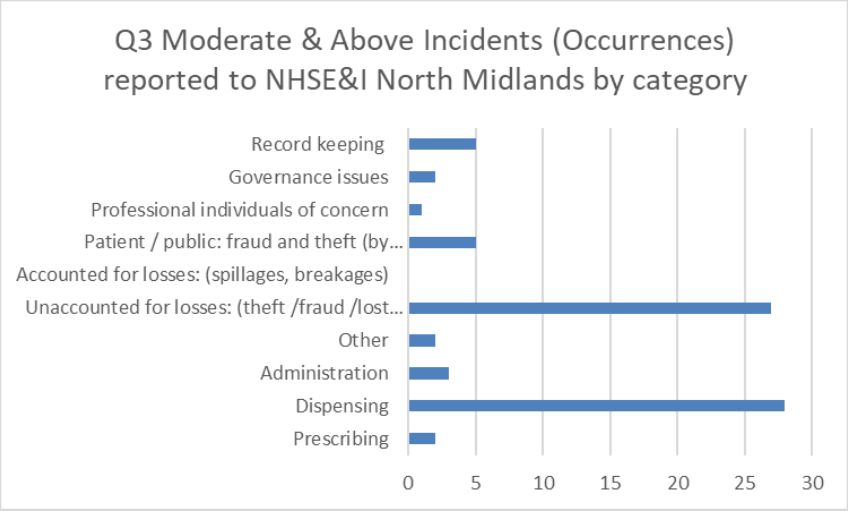
Unaccounted for Losses

Lost/ Stolen/ Missing CDs

- Contacted the dispensing pharmacy who confirmed CDs had not been returned. Informed some medications had been thrown out in the patient's dustbin. Internal investigations undertaken by care agency. Reminder provided to patient and care agency of the importance of storing CDs safely.
- CD audit carried out by pharmacy – identified loss. Processes reviewed and recommendations given. to all nurses to request they look through their diary contacts in case the medications were given but not documented. CD register updated.

NHS England and NHS Improvement – North Midlands Locality

In 2021/22 during Q3 period there were 75 reported incidents from NHS England and NHS Improvement that were risk rated moderate and above. The graph below breaks these down into categories:



The table below shows the total number of all**, incidents** reported to NHS England and Improvement North Midlands Region risk scored Low, Moderate, High, and Extreme.

Category Type		Low	Moderate	High	Extreme
Patient Related	Prescribing	3	2	0	0
	Dispensing	32	27	1	0
	Administration	1	3	0	0
	Other	3	1	1	0
Unaccounted for losses: such as theft and fraud (from the organisation), unexplained stock discrepancies, lost prescriptions / requisitions		28	27	0	0
Accounted for losses: such as spillages, breakages		10	0	0	0
Patient / public: such as fraud and theft (by patients / public), misrepresentation by patients		1	5	0	0
Professional individuals of concern: These are relevant individuals i.e. people who work in health or social care include a section to enter details of professional involved		1	1	0	0
Governance issues: such as CD safe custody, staff competence, audit, statutory requirements, SOPs		7	2	0	0
Record keeping		5	5	0	0
Total		91	73	2	0

Learning from incidents

Learning from Care Homes

Administration Error:

- Staff have learnt to check the notifications on the medication system for medications at a stock level of 10 or below, which will therefore prevent further incidents occurring.
- Staff to be more careful when giving controlled medications, and always follow the company's medication policy in CD administration. Staff to remember the Rights in Medication Administration. It is important for the staff to document and have someone witness when doing the stock count. Staff needs reminding of the importance of accurate documentation.
- To ensure MAR charts are double checked at the end of each medication round

Learning from Community Pharmacies

Unaccounted for Losses:

- When performing a balance check on methadone solution a double check must be made by a colleague.

Governance:

- The Superintendent Pharmacist has made all the team aware of the issue to try and prevent an incident like this from occurring in the future. It will also be brought up in the staff training day when a discussion of near misses and incidents will also be discussed. The COVID-19 pandemic has made it difficult to keep on top of the

destruction of medicines, due to the sheer increased workload and effects it has had on staff shortages, it has meant keeping CD medicines destroyed hasn't been a main priority, and this will have contributed to this error occurring. Going forward, if it is identified that there is a build-up of patient returns and expired controlled drugs, action should be taken as soon as possible to arrange for their destruction following SOP.
- Missed entries amended in the register to reflect receipt and supply. To always check any unusual drugs to verify that they are a CD. Share learning with locum pharmacist.
- Pharmacy to provide reassurance that this will not recur due to lack of locum knowledge

Dispensing Errors:
- The provisional pharmacist will be re-studying following failure to pass pre-registration exam.
- Controlled Drug SOP reviewed by staff
- This incident has served as a reminder of the importance of checking the issue date of all prescriptions & scanning ALL EPS tokens during the labelling process. This has been reinforced with all the dispensary team. It has also highlighted the need to resist the feeling of being rushed when dispensing prescriptions, wherever possible.
- to always do relevant checks and make colleagues involved
- 'LASA'; focus on one task regardless of how busy it can be, ensure greater care it taken when dealing with look/sound alike drugs, as these are more prone to mistakes.
- Owing slips should be checked to make sure the item and quantity are correct as part of checking protocol.
- To ensure missed doses are removed at the end of the day, and to check prescriptions carefully while handing out.
- The importance of segregating between Dispensed CDs (ready to check) and Ready to Collect CD in different cabinet. All pharmacist including relief to place Ready to collect CDs in clear bag with a bag label including patient name and address. - every pharmacy team member to get a final check by the pharmacist before handing over the CD item to the patient (enhancing patient safety). The importance of taking back any CD prescription back to the pharmacist to be entered out in the CD register immediately. The importance of all pharmacy team members to follow the handout. Every pharmacist including relief pharmacist to conduct a physical stock check when entering any CDs in or out of the register at a daily basis.
- Leave instructions for relief staff/locums on how to manage managed prescriptions.
- To be aware of handwritten prescriptions, and where a form is not known to contact the original prescriber to double check.
- Ensuring that whilst checking pharmacists are not disturbed.
- This incident has been an important reminder of the need to involve a second person in the dispensing process wherever possible. It has also acted as a reminder of not allowing the feeling of being rushed / under pressure & of checking the dates carefully on prescription - referring to an independent source of date confirmation, if necessary.
- Confirm details of patients against all scripts being handed out. Get patient collecting CD's to sign the back of prescriptions. Double checking name and address against each prescription when checking prescriptions.
- All blue prescriptions are being double checked by another dispenser before handout. Training in the pharmacy with the team so they are fully aware of issued raised and how to avoid further errors.
- Highlighted the need for two people to check dispensed CDs during the dispensing and checking processes regardless of which pharmacist is working in the branch.
- Careful selection of the bottle(s) from the CD cupboard, ensuring that the checks carried out before handout are adhered to as per the standard operating procedure.
- Take time to separate sugar-free and sugared more clearly, conduct one task at a time.
- Remain vigilant with all prescriptions for gabapentin and Pregabalin.

Fraudulent attempt to obtain CDs by patient:
- Always reach prescriber to verify prescription no items containing controlled drugs to be dispensed out of prescriber contactable time

Delivery Error:
- Ensure all paperwork accurately filled out for delivery and adequate Accuracy check to include paperwork plus medication.

- The pharmacy is to check medication and details prior to releasing any medication.
- Be extra careful with couriers and explain the importance of CDs as couriers are not always familiar with medication

Running Balance Issues:
- During busy periods these types mistakes are more likely to happen if not double checked.
- All colleagues will refresh their methadone dispensing knowledge as part of the updated CD SOPs by 10/12/2021. Store pharmacist re-briefed the whole team to ensure any spillages are reported to the responsible pharmacist. Incident to be reviewed in this month's patient safety review.
- Importance of checking quantities carefully. Importance of handling stock carefully and completing regular CD balance checks.
- Balance checked daily and if error is found it must be rectified the same day.
- Enter receipt and supply as soon as possible then store invoices in the CD invoice file Make sure supplies are entered in the register as the correct brand used.
- Make sure that the locum pharmacists are getting a double check when dispensing the methadone and make sure that the correct medicine is being dispensed.
- Double check balance for the previous day.

Lost or Missing Controlled Drugs:
- That more care needs to be taken when dispensing controlled drug prescriptions. Always double check.
- More regular checks needed on sugared methadone, even when not very often dispensed.

Lost or missing CD prescriptions:
- The pharmacy made an error and dispensed from an incorrect prescription, which affected the reduction regime of the client. The client has since been assessed and a new PGA completed to correct the error, so the original reduction can resume at the correct rate.

Prescribing Concern:
- To always check for previous supplies.

Policy deviation, affecting patient:
- We are seeing a trend for last minute cancelations from locums leading to partial closures (believe other multiples are seeing the same), and all Pharmacies will contact the locum 48 hours ahead of a shift to confirm their availability. All the pharmacy staff know to be aware who to contact and to follow emergency closure SOP that is in place.

GPhC inspection identified issue:
- SOP for “Controlled Drugs: Collection and Disposal of Patient Returns”. All members of staff have been retrained for all SOPs Also amended this SOP to include 7 days of limit to destroy all patient returned controlled drugs. As per SOP, everyone is aware to separate control drugs from patient returned medications and to keep in the control drug cabinet appropriately labelled “Patient returned stock- awaiting destruction”.

Learning from Drug & Alcohol Services

Lost or missing CD Prescriptions:
- Patient needs to find this prescription before the three day miss at the pharmacy. If it isn't found, then this would need to be reported as lost. Patient is now off script and couldn't find the script.

Lot or missing Controlled Drugs:
- Client learned that the safety of their medication is their responsibility and that the lockable box provided should have been used to prevent loss of medication.

Learning from GP practices/Dispensing Practices

Fraudulent attempt to obtain CDs by professional:

- The healthcare professional had used their own login to clinical systems to prescribe medicines including large quantities of controlled drugs and codeine for themselves. Ongoing investigation.

Patient and/or Public causing concern:

- Key that all clinicians need to follow high priority reminders

Learning from Prisons

No incidents submitted from Prison (non-designated bodies) to NHSE&I North Midlands in Q3 period

Learning from other non- designated organisations

Independent Sector Healthcare Providers: **Lost or missing Controlled Drugs**

- Application of policy by all staff needs review. Staff need reminding of seriousness of handling medication.

Patient Home: **Deliberate Overdose - no harm**

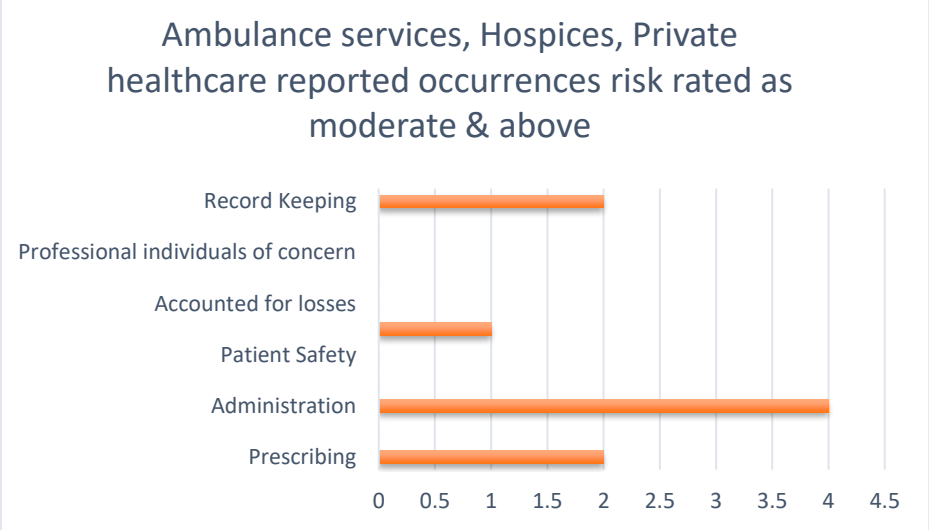
- Just below high dose opiate threshold over 120mg oral morphine equivalent. But multiple opiates Medication review coded regularly by GP but not face to face or anything detailed documented. Patients on long term opiates suitable for medication review with pharmacist.

Patient Home: **Illicit use by patient**

- To be discussed as a learning event in the practice. Going to look at an audit of return of just-in-case CD. Suggestion would be relevant authorities consider the published guidance for the destruction or retrieval of just in case drugs used elsewhere, e.g. NHS Tayside's guide. If return by relatives / next of kin not possible the following action could be taken - Registered Nurse with another member of the nursing team acting as a witness disposes of CD in an appropriate and safe manner within the patient's home or Registered Nurse could take CDs to community pharmacy. Another suggestion might require additional funding for a pharmacist or nurse and or police CD retrieval/ destruction team for a region. Relying on recently bereaved relatives to hand in or destroy just-in-case CD in all cases has a risk.

Ambulance Services, Hospices, Private Clinics/ Healthcare and Substance Misuse Services

In 2021/22 during Q3 period there were 9 reported incidents from Ambulance Services, Hospices, Private Clinics/ Healthcare and Substance Misuse Services that were risk rated as moderate and above. The graph below breaks these down into categories:



The table below shows the total number of all occurrences, incidents and concerns reported by all Ambulance Services, Hospices, Private Clinics/ Healthcare and Substance Misuse Services for the North Midlands Region risk rated as Low, Moderate, High, and Extreme.

Category	Organisation Type		
	Ambulance Trust	Hospice	Private Healthcare Provider
Accounted for losses	30	2	1
Administration	0	5	5
Dispensing	0	0	0
Governance issues	0	3	0
Other	0	2	3
Patient/ Public	0	0	0
Patients Safety	0	0	0
Prescribing	0	6	0
Professional individuals of concern	0	0	0
Record Keeping	26	7	3
Unaccounted for losses	0	1	0
Total	**56**	**26**	**12**

Hospices – Q3 Learning

Patient Related

Prescribing error - before reaching patient:

- Errors had already been highlighted and chart taken to GP for correction however GP had not amended errors. DN then asked for authorisation chart to be completed to ensure safe administration of drugs as areas of the chart were illegible. Palliative consultant reviewed chart at a home visit alongside DN and contacted GP surgery to update on amendments.

Administration error - patient taken:

- Importance of checking dose of prescribed medication against that being administered.
- Importance of full body check on admission and recording of placement of patches.

Prescribing error – patient taken:

- Importance of double-checking recommendation against prescription and challenging any discrepancies.

Unaccounted for Losses

Lost / stolen / missing drugs:

- Patch not found during routine check. Patient was prescribed Butrans patches, according to patch check charts the patch was on patients' right shoulder, however no patches were found. Staff involved to ensure they correctly inspect skin areas and patch prior to removing to ensure it correlates with patch for removal. Ensure all patch checks are completed at time specified on inspection chart.

Other

Recording Errors:

- Importance of clear checks on admission of patients and recording of CD's brought in
- Review denaturing process. Discuss with Pharmacy. Check stock levels daily.
- All medications must be labelled and can be identified as belong to which patient. The CD book for drugs awaiting to be denatured needs to be accurate.

Ambulance Trusts – Q3 Learning

Data from the Occurrence Reports submitted for Q3 by Ambulance Trust for the low risk rated incidents has not been pulled over on the CD reporting tool database, so details to capture any areas of learning is missing.

Private Healthcare Providers – Q3 Learning

Patient Related

Administration Error:

- PCA was set up in recovery with the wrong bolus dose. The dose was lower than what was prescribed: CCU to go over PCA use with recovery staff.
- Shortec 10mg was administered in place of Longtec 10mg: Long acting stickers and short acting stickers are on the boxes.
- Morphine and fentanyl were found to be out of date, some had been administered to patient(s): Theatre assumed pharmacy were date checking. New SOP implemented to ensure all drugs are date checked at the beginning of each list when the stock checks are carried out. Pharmacy to attended theatre team meeting to discuss issue and talk through the occurrence.

Discharge procedure error:

- Patients own controlled drugs were not given back on discharge: New member of staff that needed correct training on controlled drugs and the use of the stickers and magnets that had been implemented.

Recording Errors

- ODP left the site having failed to write in an Oxycodone that had been administered to the patient, this failure also lead to the anaesthetist not signing for the use and destruction of this drug in the controlled drug book: SOPs revisited by staff.
- Controlled drug given to patient written in the book on the wrong page: Importance of double-checking medications.

Learning from Nil Return Occurrence Reports

Sharing Good Practice in Controlled Drugs Management

- Audits, clinic checks, training for staff, medication competency assessment
- Pharmacy attend weekly to complete high-risk medication checks and review and audit medication and administration records.
- We have 2 nurses signing and checking in when CDs arrive. 2 Nurses check in the morning and in the evening on every shift, all CDs are counted and entered in the CD book. If it was suspected that a CD was missing on counting, then an incident form is completed, and a full investigation is carried out. Depending on the outcome of the investigation we Inform the hospital Manager and Pharmacist. Staff could be given further update on the management training of handling CD medication.
- Training for nurses on CD record keeping.
- Audits and sharing good practice with our teams.
- Audit of controlled drugs prescribing for the HFEA. Corrective action on signatures and dosing implemented.
- Installed patient own drug boxes in all patient rooms.