PRACTICE AND QUALITY
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NPSA Rapid Response Report: Reducing Dosing Errors with Opioid Medicines
RPSGB response

Background

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation.

The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy. The Society leads and supports the development of the profession within the context of public benefit. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

The Society has responsibility for a wide range of regulatory functions within the three countries of Great Britain that combine to assure competence and fitness to practise. These include controlled entry into the profession, education, registration, setting and enforcing professional standards, promoting good practice, providing support for improvement, dealing with misconduct and removal from the register.

The Society welcomes the opportunity to respond the the NPSA's consultation on the rapid response report on opioids.

General comments

Though each chart stressed knowledge of the pharmacology of an opiate, there have also been various issues around the actual drug formulation e.g.

- confusion between slow and instant release preparations
- patch formulations

These should also be highlighted in the bulletin.

The "check" of the previous dose and/or the appropriateness of the dose should be clearly documented somewhere. Otherwise a situation may arise whereby three different people will double check the same thing OR everyone assumes that someone has already checked the dose, which may have been previously missed.

It would also be helpful also include reference to DH documents around the safer management of Controlled Drugs.

If prescriber has already asked the questions and confirmed the dosage to be prescribed, is it not just duplication for the dispenser to ask the same questions of the patient / carer? Would it not be possible for the prescriber to endorse the prescription in some way to state that a recent dose and formulation has been confirmed and they wish the patient to have the medicine as stated on the prescription?

Currently, community pharmacists in particular, do not have access to patients' records. They, therefore, are unable to confirm 100% the dose and formulation of medication taken previously. In the majority of cases patients do use the same pharmacy and records of medication dispensed are kept as part of the patient's medication record (PMR). Quite often though, patient's who are taking opioid medication may be terminally ill and the nurse or carer would take the prescription to the pharmacy to be filled. They would not, necessarily always use the same pharmacy, depending on convenience in relation to where they themselves were.

A similar situation may occur during supply of opiates 'out of hours' where none of the healthcare professionals involved in prescribing, dispensing or administration of the opioid would have access to information about previously prescribed medicines and the patient or their carer may not be aware of exact doses or formulations.

It should be stated, at some point in the documentation that in palliative care there is no maximum dose of opioid painkiller as long as doses are increased gradually. Thus clinicians should be prepared, given appropriate expertise and experience, to work towards high doses if pain control is inadequate in palliative care patients. The BNF does not state maximum doses for many of the opiate analgesics.

It is helpful to include the NRLS data and the examples as this highlights some of the issues in relation to opioids. Incident 3, however, is not easy to understand as methadone is taken by drug addicts as part of rehabilitation programme and many people would not understand its use as a cough suppressant.

Scope

NPSA publications are useful for highlighting high-risk/high-consequence areas and to put high-risk/high-consequences areas of drug use on the map strategically, allowing the NHS to focus efforts and improvements on risky areas and ensuring buy in from other disciplines. This specific bulletin should really apply to all medicine.

There is some debate around the impact of such bulletins and what they are likely to achieve. The bulletin lists a number of very sensible issues that healthcare staff are already aware of and know they should be doing, in relation to opiates, however, incidents still occur even though prescribers already know how dangerous opiates can be.

It would be more helpful to receive practical advice on how to make things safer. Though we can appreciate the limitations on what can be achieved with one bulletin, we do feel that practical advice on improvement strategies would be more useful;

- General recommendations on how to safely administer opiates e.g.
  - What and how often to monitor the patient for
  - Who should be doing these checks?
  - How should checks be documented
- Limiting strengths stored in general wards
- Safe dose ranges and limits in the bulletin
- Advice on how to recognise the adverse effects of overdose and how to manage them

Though every hospital site will work differently, we feel that the bulletins need to give more specific advice.

Implementation
Who will be responsible for implementation and are there any available resources to implement all these alerts? Feedback from colleagues has highlighted issues around engaging doctors with previous NPSA alerts. In general, NPSA bulletins need to include specific, practical advice on how to achieve the recommendations.

Miscellaneous
There is some concern around the boxed information in the 'WHO pain ladder' section; junior doctors may think that a dose increase up to 50% for opiates is acceptable, which is not always the case.

This bulletin refers to non-emergency situations but does not address emergency situations; in an emergency staff would be expected to be even more careful.

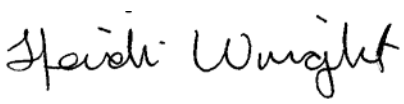
Flow Chart Specific comments
Prescribing Opioids - Suggest that opioids be replaced with 'drugs' as this bulletin highlights good practice for all drugs.

Dispensing Opioids
Opioids are mainly supplied as 'stock' in hospital, hence this chart does not directly apply to general opiate dispensing.

The appropriateness of drug therapy, subsequent pharmacological properties and the dose would normally be included in the Pharmacists clinical check of the prescription; who may not necessarily dispense the drug. Hence there is some concern around whether 'the dispenser' would be expected to be familiar with pharmacological properties of opioids.

We hope these comments will be taken into consideration, and would like to thank the NPSA for the opportunity to participate in the consultation. If you have any queries regarding the above, please do not hesitate to contact me.

Yours sincerely



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