Controlled Drug Factsheet 7

Dealing With Discrepancies

Standard operating procedures (SOP) should clearly define the action to be taken if a discrepancy arises including reporting to the CDAO via www.cdreporting.co.uk

If you identify a discrepancy between the balance of stock in the CD cabinet and that recorded in the CD register (CDR), ask yourself the following questions:

Too much stock

- Have you counted items returned from patients?
- Have you recorded all receipts?
- Are all the recorded quantities accurate?
- Have you recorded a prescription that has not yet been collected?
- Have you made duplicate entries?
- Has there been a dispensing error?

Too little stock

- Have you counted all expired stock?
- Have you counted all dispensed items awaiting collection?
- Have you recorded all prescriptions that have been collected?
- Have you made duplicate entries of receipts?
- Has there been a dispensing error?
- Has stock been returned to cabinet after dispensing?

If you resolve the discrepancy make a marginal note or footnote in the CDR, record any missed entries and correct the running balance.

Keep appropriate records of the action taken when discrepancies arise. This could be an entry in your CDR or cross referenced to an incident form.

Do not alter, score through or otherwise obliterate existing entries in the CDR.

If you are unable to identify the source of the discrepancy during your preliminary checks, inform the relevant GP, complete an incident form and undertake a formal internal investigation ideally within 48 hours. See Factsheet 10 for further action.

Too much stock should be treated with the same diligence as too little stock.

Contact the Medicines Management Team for advice: Clare Moody clare.moody@nhs.net 01480 387 114
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The cause of discrepancies is often due to failure to follow the agreed SOPs. The reason for not following SOPs should be explored. All learning should be shared with the team.

Dispensing Errors

If a discrepancy is identified to be the result of a dispensing error, or a patient reports a dispensing error, e.g. wrong product, quantity, take the following action:

- Contact patients to establish if they received the correct items. Bare in mind some patients may not be able or willing to help.
- Ask any patients who report / confirm errors to return the items to you for confirmation.
- Returned items should be quarantined and destroyed in the presence of an Authorised Witness (they are not "patient returns").
- Re-dispense, as necessary, from the original prescription. It is not appropriate to produce a new prescription.
- Investigate the cause of the error.
- Complete an incident form and raise as a significant event

Unexpected Pack Contents

If, when the tamper-evident seal is broken, the contents do not match that stated on the manufacturer's pack, e.g. product, quantity, take the following action:

- Wherever possible keep the pack and contents as evidence to present to the manufacturer / supplier and the dispense the CD from an alternative pack.
- Where this is not possible because patient care will be compromised, check with a GP that the contents are suitable for dispensing and then appropriately repackage them for the patient, keeping the original packaging for evidence and action. Make appropriate records in the CDR.
- Complete an incident report and contact MOT to discuss reporting the problem to the MHRA.

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