Controlled Drug Factsheet 12

Dispensing CDs

The act of dispensing itself is not defined in law – it is covered by "assemble and supply".

NEVER dispense a CD prescription that has not been signed by the prescriber.

Check the date on the prescription is not more than 28 days ago (S2, 3 and 4).

Check the prescription is not post dated.

Unless the prescription is computer generated check legal requirements:

- Patient name and address.
- Drug form, strength, quantity in words and figures.

Check that the instructions are sensible and suitable; "as directed" is insufficient.

Using the PRESCRIPTION select the correct product from the CD cabinet (S2 or 3) or shelf (S3, 4 or 5).

Confirm that you have selected the correct drug, brand, form, strength and quantity.

Caution: products with multiple modified release formulations and/or multiple strengths.

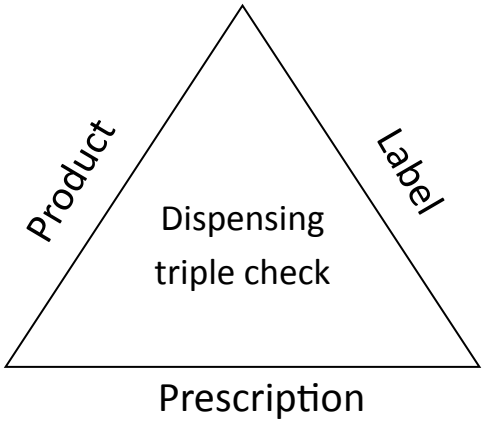
Check the expiry date.

Unless security sealed, where an original pack is being dispensed, open the pack and count the contents.

Confirm the label states the correct drug, brand, form, strength and quantity.

Confirm the label states the correct patient name.

Affix the label to the box taking care not to cover any text.



The Accuracy Check

If your practice pharmacist has performed a clinical check prior to you dispensing the prescription, an Accredited Checking Technician may perform the final check.

In all other circumstances, it is **highly recommended** that a GP or practice pharmacist performs the final check.

It is **highly recommended** that you do not perform the check if you dispensed the prescription.

Check in the same way that you would dispense. See left.

Record any errors detected in the dispensary near miss log.

Complete an incident form www.cdreporting.co.uk for any clinical errors detected.

Return the dispensed item to the CD cabinet, clearly segregated from your stock.

DO NOT make any entry in the CD register until the patient has collected their medication.

Contact the Medicines Management Team for advice: Clare Moody clare.moody@nhs.net 01480 387 114
Controlled Drug Accountable Officer: Dr Sarah Rann england.ea-CDAO@nhs.net

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

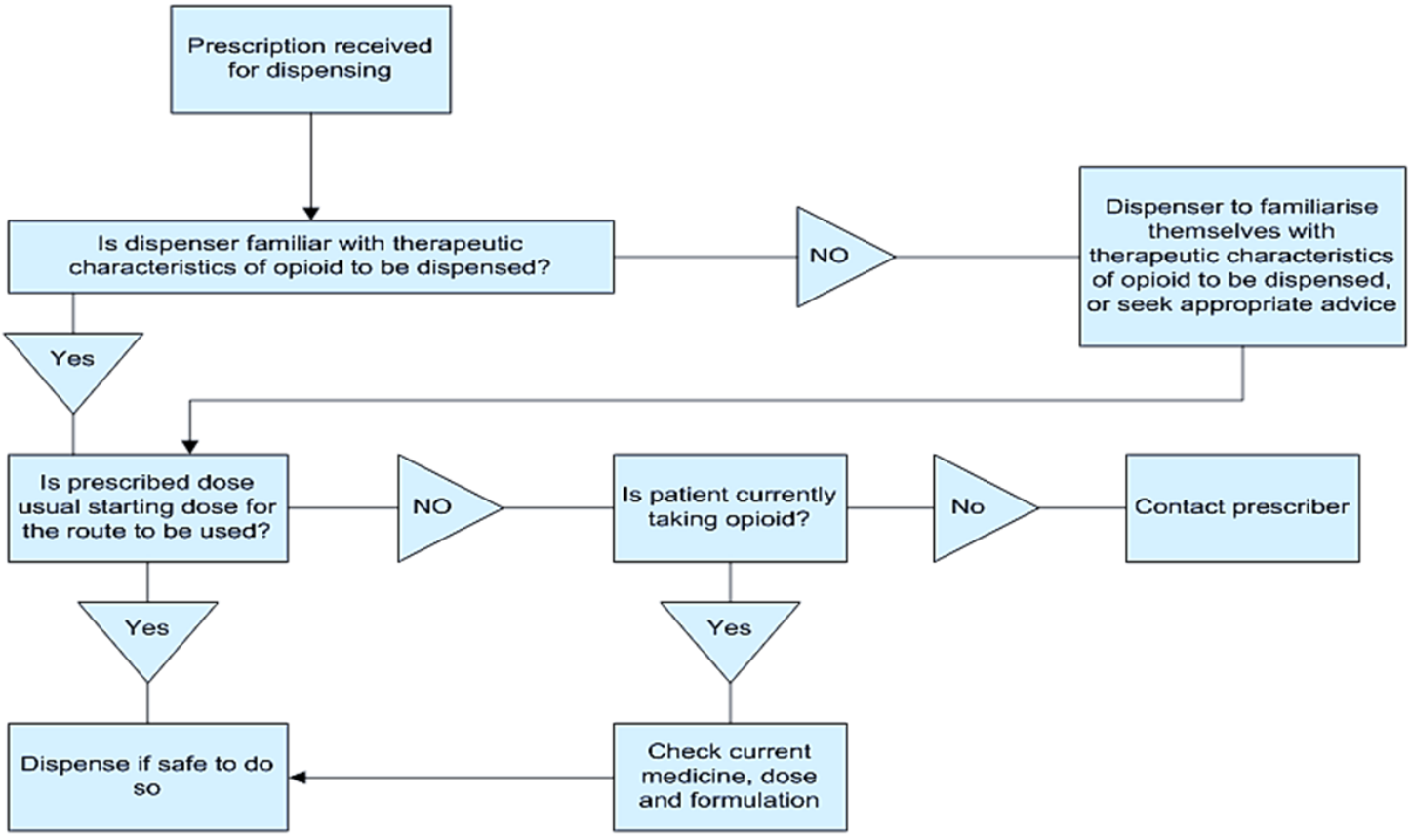
In July 2008 the **NPSA** published a **Rapid Response Report** Reducing dosing errors with opioid medicines.

This was in response to official reports of five deaths and over 4,200 dose-related patient safety incidents concerning opioid medicines up to June 2008.

When prescribing, dispensing or administering opioid medicines the healthcare practitioner or their clinical supervisor should:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient.
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient.
- Check the usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, and common side effects of that medicine and formulation.

As part of this report the NPSA published a dispensing algorithm:



As a dispenser, no one should expect you to have sufficient clinical knowledge to decide whether or not any prescription, in this context one for opioid medication - or indeed any other CD - is safe to be dispensed.

Even if the patient's dose is the same as the previous prescription, the rest of their medication regime or their clinical condition may have changed. Perhaps another drug acting on the central nervous system has been prescribed. Perhaps their kidney function has declined. There are many variables that may make a prescription for opioid medications harmful or fatal.