Think Medicines!

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

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Safety

Safer Use of Controlled Drugs - Recommendations for preventing harms from the use of methadone

The CQC have issued guidance to reduce the harms associated with methadone

During the period 31st May 2011 to 31st May 2013, nationally, 3,307 methadone related patient safety incidents were reported to the National Reporting and Learning System (NRLS). This included 359 incident of actual harm to patients. 45 of these incidents resulted in moderate or severe harm and 2 resulted in death.

An additional search of NRLS for the same period identified a further six deaths and three severe harm incidents related to medication errors involving only methadone.

Published data from submitted coroner's reports for England and Wales in 2012 identified 85 deaths from accidental poisoning with methadone.

In early 2014, UK news media reported the death of a child from accidental ingestion of methadone.

Clinical practitioners who **prescribe, dispense or administer** methadone should check the following:

- They are competent to prescribe, dispense or administer in the context of use.
- The methadone dose is safe for those who may be opioid/ opiate naïve as a consequence of intentional/unintentional withdrawal or initiation of treatment.
- Methadone prescribed by the substance misuse service should be added to the patient's other medication record. GPs should refer patients to the local substance misuse service who usually retain prescribing responsibility due to specialist nature of treatment. GPs prescribing for drug addiction should hold RCGP level 2 certificate.
- Do not produce additional methadone scripts for patients under the care of substance misuse service.
- Supervised consumption is available at local authority contracted pharmacies and used to ensure compliance while preventing diversion; and allowing for individual progression to recovery and self-management.
- Liaise with the local substance misuse service if you have concerns about someone receiving treatment.
- The correct formulation has been prescribed, dispensed and administered and that a x10 error is not possible due to confusion between the 1mg/mL and 10mg/mL concentrate.
- High strength products are flagged on ScriptSwitch®. Good practice to only prescribe 1mg/ml products.
- If recommended by palliative care or pain specialists, please ensure sufficient information about dosing is received.

Counsel patients to keep all medicines including controlled drugs out of the sight and reach of children. Be aware of resident and visiting children.

Ensure methadone is dispensed with child resistant closures.

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The concurrent use of methadone with other opioid(s)/opiate(s) and/or respiratory depressants, e.g. alcohol, sedatives, can result in a cumulative respiratory depressant effect leading to serious patient harm. Clinicians should review these medicines and avoid their use if possible; and if prescribed, patients should be made aware of potential interactions.

Those who prescribe, dispense, administer or **take methadone** are fully aware of the consequence and potential for harm if:

- The drug is taken to excess (in any context);
- Combined with alcohol, and other drugs; and
- Is given to someone with insufficient tolerance to the dose.

Advice for healthcare professionals:

- Counsel patients about the harms associated with methadone.
- Ensure you are aware which of your patients are receiving treatment with methadone so respiratory depressants are not prescribed inadvertently.
- Have a dedicated practitioner who sees, and responds to queries from, patients receiving treatment for substance misuse.
- If you have concerns about someone receiving treatment liaise with the local substance misuse service

Training Resources

Royal College of General Practitioners Certificate in the Management of Drug Misuse Part 2 (training offered annually, applications for 2016 are now closed).

http://www.rcgp.org.uk/learning/substance-misuse-and-associated-health-landing-page/rcgp-certificate-in-the-management-of-drug-misuse-part-2.aspx

The Faculty of Pain Medicine of the Royal College of Anaesthetists has a new resource to support the safe and rational use of opioid medicines by prescribers and patients.

http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

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