Controlled Drugs Accountable Officer (CDAO) report to the Board of Directors

February 2017

J P Pratt, CD Accountable officer

Purpose of the report

To ensure that "safe management of controlled drugs" in maintained as an organisational priority.

To provide assurance on the systems and processes within SHSC that lead to the safe management of controlled drugs.

To describe the range of incidents reported to the CDAO over the past 12 months.

To update the BoD on the major concerns raised in last years (2015) report.

To highlight the recommendations from the CQC 2015 annual report on controlled drugs (published August 2016).

Background

In January 2000 Doctor Harold Shipman was convicted of the murder of 15 of his patients using the drugs diamorphine (heroin) and morphine. Reports also suggest that he may have used these drugs to kill many more of his patients, possibly around 250.

Following Shipman's conviction, the secretary of state for health asked Dame Janet Smith to lead an independent enquiry into the case and make recommendations to protect the public from harm by relevant people using controlled drugs.

Between 2002 and 2005 six reports were published under the chairmanship of Dame Janet Smith. These led to the legislative changes which were introduced in the 2007 Health Act to strengthen the governance arrangements surrounding the use of controlled drugs by "relevant people".

As part of the statutory requirements contained within the 2007 Health Act organisations such as NHS trusts were required to appoint a controlled drugs accountable officer (CDAO), who was responsible for the assurance of safe use of controlled drugs throughout the organisation. Other requirements included the sharing of information (or intelligence) across organisational boundaries and a duty to collaborate. Where there are strong grounds for concern a CDAO must share intelligence with other bodies such as the police, the NHS counter fraud service, the care quality commission (CQC) or registering bodies such as the General Medical Council, the Nursing and Midwifery Council, and the General Pharmaceutical Council.

In 2013 new legislation was introduced (The Controlled Drugs [Supervision of Management and Use] Regulations 2013) which brought the previous medicines and CD legislation in line with the NHS organisational changes. This legislation was put in place to ensure that the overriding aim of the CDAO continued to be to protect the public from harm in relation to controlled drug use by relevant people. The NHS England South Yorkshire and Bassetlaw area team CDAO is responsible for co-ordination the sharing of information through Local Intelligence Networks (LIN's). To support her in this task the Sheffield CCG head of pharmacy co-ordinates the functions of the Sheffield LIN.

Information concerning all incidents relating to controlled drugs is reported by the SHSC CDAO to the Sheffield LIN and the SHSC quality assurance department on a quarterly basis.

Controlled Drugs

In August 2012 the legislation covering medicines for human use was revised and consolidated into a new act – The HUMAN MEDICINES REGULATIONS 2012. This legislation updated the 1968 medicines act and incorporated various changes introduced by EU legislation together with all the updates and variations to the original act.

There is a degree of complexity surrounding the laws relating to medicines and CD's, but in general terms the main legislative points to note are:

The Misuse of Drugs Act 1971 (MDA 1971)
This act primarily covers the illegal use of drugs and provides a schedule system for classification of these drugs. This system of classification provides the courts with guidance on the maximum sentences to be imposed if this law is broken (Schedules A, B & C).

The Misuse of Drugs Regulations 2001 (MDR 2001) (and subsequent amendments)
Covers the medical use of those drugs listed within the MDA 1971. Within the context of MDR 2001 the classification system for the medical use these drugs defines the drugs by a different system of schedules (1, 2, 3, 4 & 5). Within this context these drugs are classified according to their likelihood of harm vs therapeutic benefit. With Schedule 1 drugs being the most tightly controlled in terms of prescribing, dispensing, storage & transportation and Schedule 5 having the least control. Schedule 4 also includes anabolic steroids.

The British National Formulary (BNF) gives details of the legal status of most of the medicines used in the UK. Although the full list of controlled drugs is currently under review, the Chief Pharmacist/CDAO would be expected to intervene in all cases where there may be a concern about the use of these drugs by relevant people. Further details can be found on the home office website http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-licences/controlled-drugs-list – including contact details for advice on whether or not a specific substance is a controlled drug. (DLCUCommsOfficer@homeoffice.gsi.gov.uk)

Management of Controlled Drugs (CD's)

Following the murderous activities of Harold Shipman in the 1990's it became clear that the systems and process of control that were in place at the time to govern the use of CD's were inadequate. Following the fourth report of the Shipman enquiry in 2004, the chairman Dame Janet Smith concluded that the governance arrangements for these drugs needed to be strengthened.

Many of her recommendations from the enquiry were incorporated into part three of the 2007 Health Act and statutory instrument No. 3148 The Controlled Drugs (Supervision of Management and Use) Regulations.

http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf

http://www.legislation.gov.uk/uksi/2006/3148/pdfs/uksi_20063148_en.pdf

One of the key changes introduced by the 2007 Health Act was the statutory requirement for NHS trusts (and other relevant bodies) to appoint an accountable officer for controlled drugs (CDAO).

In December 2015 further changes to legislation took place which enforced the use of new controlled stationary by anyone ordering stocks of controlled drugs. It appears that an unintended consequence of this legislation may result in a significant additional bureaucratic requirements for anyone receiving – or supplying controlled drugs outside of the legal entity of a NHS Trust. No exemption can be applied to NHS trusts such as SHSC where small quantities of controlled drugs are supplied to other NHS trusts and all NHS trusts are required to submit standard requisitions in order to transfer stocks of controlled drugs between themselves.

Statutory role of the controlled drugs accountable officer (CDAO)

The requirement for designated bodies to appoint a CDAO was made in the 2007 Health act and has been reiterated in subsequent legislation. The CDAO must ensure that his designated body has adequate arrangements for the safe and legal management and use of controlled drugs throughout the organisation.

The overriding concern of the CDAO is to protect the patients and public from harm due to controlled drugs by relevant people. There are a number of specific duties of the CDAO. Full details of the duties of the CDAO are laid down in Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (http://www.legislation.gov.uk/uksi/2013/373/part/2/made).

The CQC are required to hold a record of all CD accountable officer (and ensure all relevant organisations are registered with them. See http://www.cqc.org.uk/content/controlled-drugs-accountable-officers)

Duties of the CDAO include ensuring that:

- The organisation is following "adequate and up-to-date" standard operating procedures (SOP's).
- Appropriate arrangements for monitoring and auditing the management and use of controlled drugs.
- Systems exist to alert the accountable officer of any complaints or concerns involving the management or use of controlled drugs.
- The incident reporting system captures untoward incidents involving the management or use of controlled drugs.
- Appropriate arrangements in place for analysing and responding to untoward incidents involving the management or use of controlled drugs.
- Relevant individuals receive appropriate training in relation to controlled drugs.
- Arrangements are appropriate for monitoring and auditing the management and use of controlled drugs by relevant individuals and assessing their performance.
- The recording of any concerns raised in relation to the management or use of controlled drugs by a relevant individual.
- The assessment and investigating of any concerns raised regarding the management or use of controlled drugs by a relevant individual. The CDAO must determine whether these concerns should be shared with a responsible body.
- Appropriate action is taken to protect patients or members of the public in cases where concerns in relation to the management or use of controlled drugs by a relevant person appear to be well-founded.
- Appropriate arrangements for ensuring the proper sharing of information.

The designated body (board of directors) has a responsibility to ensure that they notify the CQC of the name of the CDAO and that s/he is a "fit, proper and suitably experienced person" who does not 'routinely supply, administer or dispose of controlled drugs as part of his or her duties'.

Notification to the CQC should be done through the relevant section of the CQC website (http://www.cqc.org.uk/content/controlled-drugs-accountable-officer-notifications) - Note this section is

password protected and the CQC must be contacted in advance for a password to enable on line notification.

The BoD can be assured that the CQC hold details (as at January 2017) of the CDAO for SHSC as follows:

TAH	Sheffield Health and Social Care NHS Foundation Trust	Peter	Pratt	0114 2718630	peter.pratt@shsc.nhs.uk

As part of their responsibilities the designated body must remove their CDAO from office if they no longer satisfy the conditions for appointment or if s/he is unfit to be an accountable officer.

If the CDAO neglects their duties either wilfully or through lack of competence the designated body must removed him/her from office and appoint an alternative CDAO. Designated bodies are also required to ensure that the CDAO is provided with the necessary funds and resources to carry out his responsibilities.

CD Recommendations of the Care Quality Commission (CQC)

The CQC scrutinise and report on how well NHS trusts and other agencies work together to ensure the sharing of intelligence/information on the safe management and use of controlled drugs by relevant people.

As part of this work the CQC publish their findings annually, together with recommendations on how the safe use and management of CDs can be improved. (See Appendix I)

In July 2016 the CQC published their latest (2015) annual report see

http://www.cqc.org.uk/sites/default/files/20160714_controlleddrugs2015_report.pdf

Only 3 recommendations were made by the CQC in 2015

1. NHS England CDAOs should agree on and collect consistent information on controlled drug-related issues to provide a national picture.

2. All CDAOs should support the NHS England CDAOs by providing information requested of them in a timely way so that the CD LINs function effectively and productively.

3. Local authorities, through their Public Health and Adult Social Care Directors, should engage with their CD LINs to share concerns about controlled drugs that relate to the services they commission – in particular, social care organisations and drug and alcohol services.

Only recommendation 2 above has direct relevance to the trust.

Assurance from last years CDAO report remains unchanged;

> *– SHSC CDAO attends the Sheffield arm of NHS England's LIN on a quarterly basis. All SHSC controlled drug incidents/occurrences are shared with member of the LIN. CDAO's from other local organisations also share their reports of occurrences/incidents within the LIN.*
>
> *Overall the sharing of information within the Sheffield arm or the LIN is good. There is regular attendance by the majority of CDAO's and intelligence shared amongst the wider LIN* membership.

Changes to the formatting of reports required by NHS England has resulted in some slight delays in submitting reports – but assurance remains i.e. the CDAO regularly attends the CDLIN and reports to through the LIN to NHS England's CDAO on a quarterly basis.

A number of legislation changes were made in the use and management of controlled drugs during 2015

Electronic prescribing of Schedules 2 and 3 controlled drugs is now permitted where the Electronic Prescription Service (EPS) is used. Note - EPS (electronic transfer of prescriptions between prescribers and community pharmacists) is not available within SHSC (as at January 2017).

Physiotherapist and podiatrist independent prescribers are able to prescribe a limited range of controlled drugs for the treatment of disease or injury.

Ketamine became a Schedule 2 controlled drug (with exemptions for specific health professionals under Patient Group Directions).

Standardised requisition forms for Schedules 2 and 3 controlled drugs became mandatory. (The Home Office has published additional guidance on the NHS BSA website following implementation queries.) – Note this guidance requires standardised ordering between legal entities e.g. supply of controlled drugs to/from Sheffield teaching hospitals and SHSC and between Sheffield Children's hospital and SHSC.

Update on Issues reported to the BoD in the previous annual CDAO report (2014- 2015)

1) Substance misuse in house electronic prescribing system – relates to initial concern raised in 2013 and again in 2014

Update 2016 - Verbal assurances have been given that the software issues highlighted in the previous report have been addressed. The role and involvement of the clinical safety officer and system for formal sign off of IT system developments software has been addressed by the Director of ICT. Approval for system changes must go through the trust clinical systems strategy group to ensure appropriate sign off from a clinical safety perspective.

The fixed term appointment (0.5WTE pharmacist) to work with the substance misuse team ends in March 2017. Unfortunately resources have not yet been found to enable this dedicated post to continue. Whilst it is recognised that this will weaken the dedicated medicines management support which is available to the substance misuse team, the pharmacy team will continue to provide a generic level of medicines optimisation support to the substance misuse service.

One Incident (118294) related to the substance misuse prescribing system was reported. This was described as a “technical bug” which meant the slow running of the system allowed duplicate prescriptions to be generated.

05/04/2016 (Incident number 118294) Staff member was made aware that the scripting system had generated two prescriptions for methadone 1in1 sugar free, 50nls. This was following a cancelled prescription.	2	08/04/2016	• Error identified as a technical ‘bug’ where the system slowed down allowing a replication of a prescription - prescribing module was subsequently fixed **Closed from Accountable Officer’s perspective** **CLOSED**

2) Delays in reporting/awareness concern (all incidents). There were, at times, significant delays between the occurrence of an incident and the CDAO being informed.

Update 2014 There has been a considerable improvement in this over the past year, and it is expected to improve further with the continued role out and refinement of the electronic incident reporting system throughout the trust.

Update 2015 Improvements in the timely reporting of CD incidents continue. The trust MSO continues to work with the risk department to improve the quality of reporting and learning from CD incidents.

Update 2016 The timeliness of reporting of incidents has improved – but the overall increase in the number of incidents has led to delays in fully investigating incidents. The interim Chief Pharmacist (in agreement with the CDAO) has agreed to update the SOP relating to the investigation of small discrepancies of schedule 3,4 & 5 controlled drugs in an attempt to create the capacity for timely investigation of incidents.

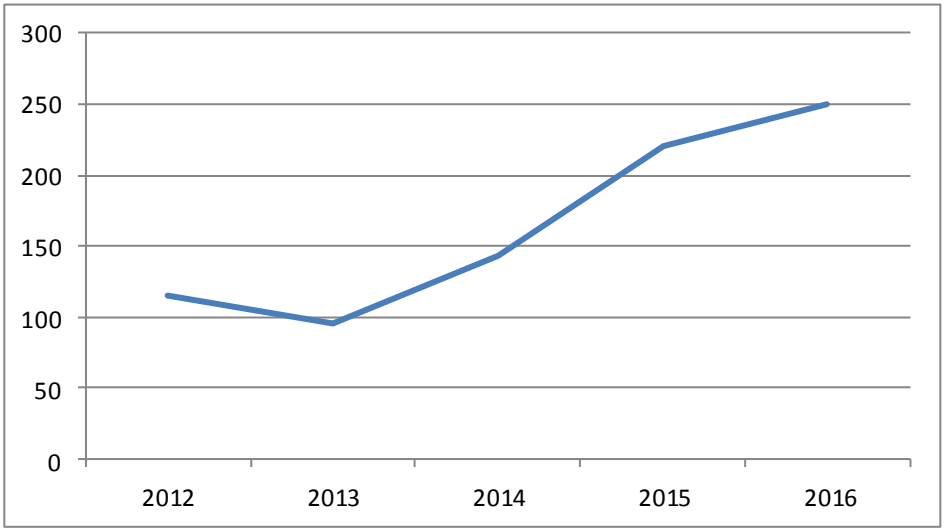
Incidents reported to the CDAO (October 2015- 2016)

	2016	2015	2014	2013	2012
Total CD incidents reported to CDAO	250	220	143	96	115
Incidents relating to schedule 2 CD's	22	29	18	23	22
Incidents relating to schedule 3 CD's	62	24	7	8	10
Incidents relating to schedule 4 CD's	153	154	97	55	60
Incident relating to schedule 5 CD's	2	3	2	3	1
Unscheduled or not listed because of other reasons e.g. multiple drugs/schedules	11	10	19	7	22

See Appendix II for summary of all incidents

A total of 250 incidents were reported to the CDAO throughout this period. All these incidents have been shared with the Sheffield arm of the NHS England South Yorkshire & Bassetlaw LIN and also with the SHSC Quality Assurance Group.

The annual trend in reported incidents involving all controlled drugs in shown below



Review and investigation of incidents

Almost all incidents were reported to the CDAO through the trust electronic incident reporting and management system – "safeguard". Occasionally the CDAO is informed directly through other routes such as the CDLIN or personal contact/intelligence. As soon as the CDAO is informed about an incident involving controlled drugs and relevant people, he makes a judgement about the potential seriousness of the issue and the need to protect people from harm.

In cases of known or suspected serious or major concern the CDAO will act immediately and inform the Chief Executive and Medical Director and where possible will put systems in place to prevent further harm. If the CDAO believes that there are strong grounds for major concern he will share information with other relevant bodies e.g. Local intelligence network (LIN), professional bodies, Police, Care Quality Commission (CQC), etc.

All reported CD incidents are subject to a brief initial assessment by the medicines safety officer (MSO) as a triaging process for the CDAO. A prioritised investigation is triggered if the CDAO suspects the incident may be a major concern.

In cases where the management investigation of a reported incident is considered insufficient, the MSO will try and interview the staff involved, their manager and any other relevant people in order to triangulate and verify information received. Details of individuals' behaviour in relation to relevant SOP's, their medicines related training and their involvement with other CD or medicines related incidents are all considered and recorded as part of the MSO investigation process.

The investigation/review continues until the CDAO is satisfied that there is a complete picture of what went wrong, why it went wrong and what action is necessary to prevent further occurrence. The incident is then classed as "closed" by the CDAO. In cases where there is insufficient information, or it was impractical to gather more details, the incident will be closed, but re-opened if further information comes to light through other incidents. Details of all incidents and subsequent investigation are held by the CDAO in both hard copy format as well as electronically within a spread sheet. The trust safeguarding system should also contain details of the incident, but as yet it has not been possible for this system to capture any associated information (e.g. copies of paper records).

Copies of the investigation reports are passed to the SHSC Risk Department when incidents are closed. Interrogation of the CDAO's incident Microsoft Excel spreadsheet enables patterns or themes to be identified which could highlight a major concern about a relevant individual and the risk of harm to people. See Appendix III for the data headings of information stored in relation to CD incidents.

Issues of serious or major concern (October 2015 – 2016)

None highlighted – but note emerging concern relating to controlled drug patches.

Of the 250 incidents reported in 2015 – 2016 none of these were considered to be of such serious or major concern as an" individual incident" by the CDAO to highlight in this report.

There remains an outstanding issue relating to the role of the clinical safety officer, but this is being addressed by the director of ICT through the trust clinical system strategy group.

The CDAO has previously highlighted the issue of capacity to support detailed investigation of incidents as a consequence of increased reporting (see 2013/4 report)

> *"If the number of incidents reported to the CDAO continues to rise at the same rate over the next year and we are unable to manage this through a more streamlined process within our existing resources, this will be flagged as a serious concern….. It is also important to note the impact of increased reporting creates a corresponding increased requirement for the capacity to investigate and manage the incident".*

Although the rate of reporting has continued to rise – this has not been flagged as a serious concern as the trust recently approved the pharmacy business to strengthen the pharmacy team by the appointment of additional members of staff, which will support the investigation and learning from medicines related incidents – including those involving controlled drugs.

Other issues (October 2015 – 2016)

Not all reported incidents concerned relevant people who were employees of the Trust. Some incidents involving schedule 2 drugs were "interface" issues. Details of these incidents were shared with NHS England's local CDAO and/or the relevant organisation's CDAO and the local arm of the LIN.

<u>Schedule 2 CD's</u>

Although the rise in the number of reported incidents/occurrences continues, it should be noted that there have been a reduction in the number of incidents that have been reported to be associated with schedule 2 drugs. One possible explanation may be the appointment of a dedicated pharmacist to work with the substance misuse team, but as yet, this has to remain a speculative factor as there is insufficient data to confirm a direct correlation.

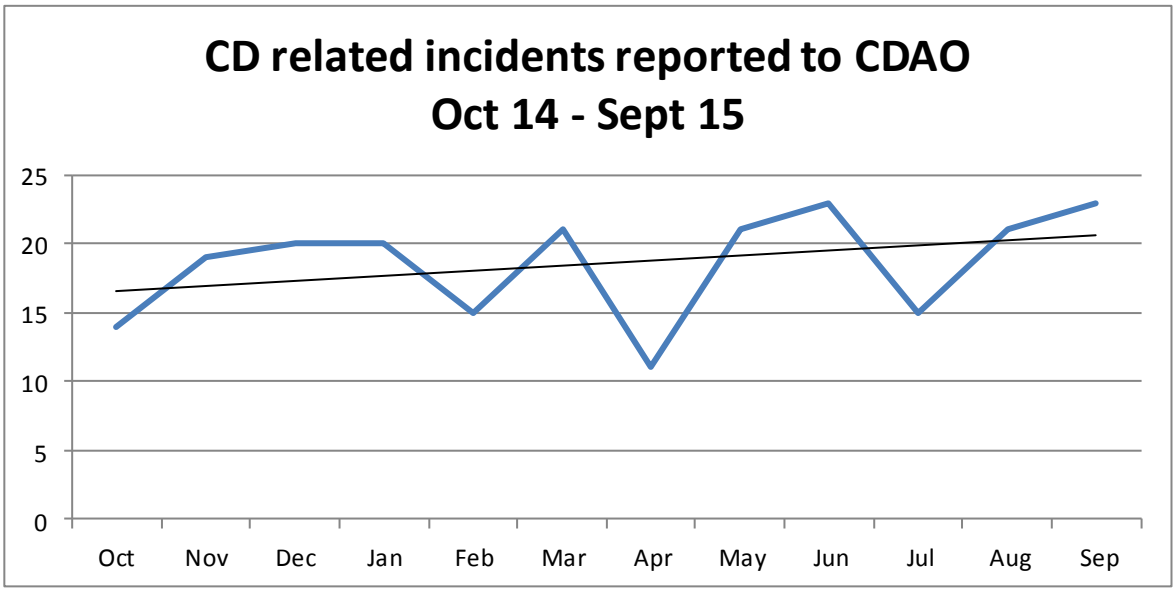
<u>Management of controlled drug patches</u>

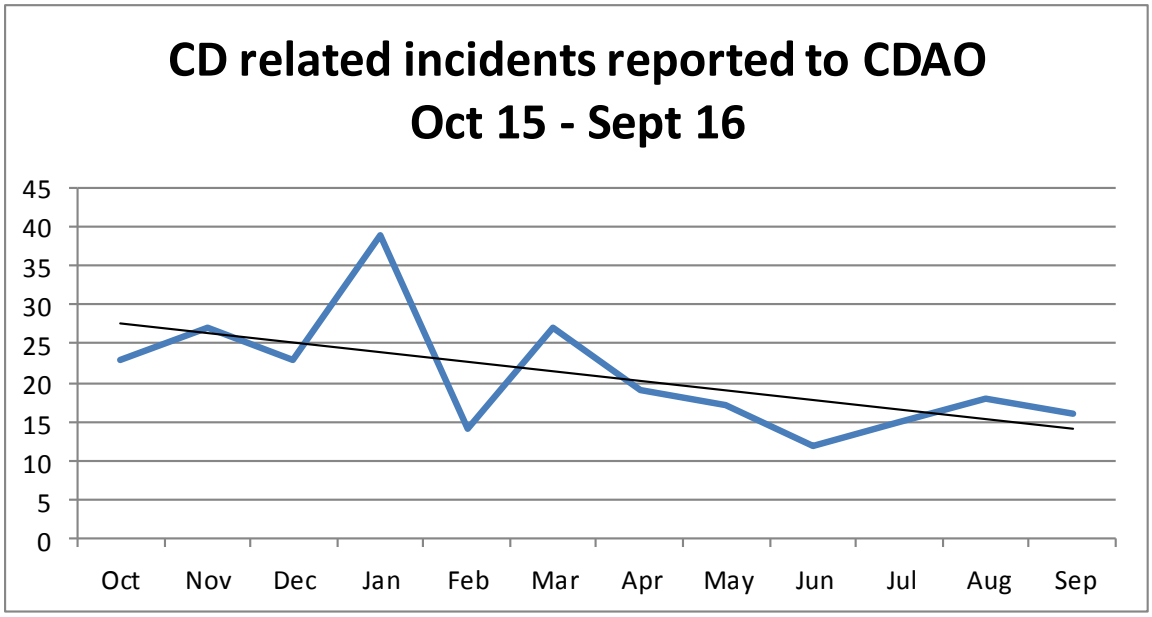
The possibility of an emerging theme relating to the management of controlled drug patches highlighted last year, appears to be confirmed. In 2016 there was a noticeable increase in the number of reports associated with schedule 3 controlled drugs (24 reports in 2015 which has increased to 62 in 2016). Of these 62 reports, over 50% relate to controlled drug patches (37 reports in all). The majority of these reports relate to patched "falling off", missing or duplicated (old patches not being removed) – one report related to a hole being found in the additional dressing placed on the patch to prevent removal (118537). Reports of "missing patches" could indicate service users pain was inadequately controlled.

Systems and processes within the trust to mitigate known risks associated with CD patches have been introduced over the past 18 months, but overall the number of reports appear to continue to increase. However it is also important to stress that this increased level of reporting may well be a consequence of the additional vigilance of the staff involve, rather than a reflection of an increased risk of harm to service users from the use of controlled drug patches *per se.*

The Interim Chief pharmacist has been asked to ensure a review the use of controlled drug patches has been submitted to the trust medicines optimisation committee by the end of March.

Patterns of reporting CD Incidents





Although the annualised number of reports has risen, further scrutiny of the monthly reports of CD incidents indicates that there has been a recent fall in the number of incidents reported to the CDAO. The reason for this apparent shift in trend is unclear and currently under investigation by the medicines safety officer

As noted in previous years, many incidents relate to incidents involving schedule 4 drugs. Of these, "stock balance discrepancies" account for 60 (40%) of the reports relating to schedule 4 controlled drugs.

Although finding the root cause for these minor discrepancies often remains elusive, each incident is investigated and the names of any members of staff involved are checked to see if they have been associated with any other medicine or CD related incident. Individual's medicines management training records are also checked to ensure that their training is up to date. Anyone who is found to be involved with several incidents is flagged for potential concern with their professional lead and line manager. Continued vigilance remains important as the possibility of stock discrepancies due to diversion by staff of small quantities of Schedule 3/4 medicines cannot be ruled out.

The Sheffield arm of the South Yorkshire & Bassetlaw LIN continued to function well.

Scrutiny and monitoring of the staff within Clover Group's use of CD's continues to be undertaken by NHS England South Yorkshire & Bassetlaw clinical support unit. This is done as part of their overall arrangements for the monitoring of CD's in general practice and primary care.

There are no obvious causes for concern about the management of controlled drugs by relevant people within clover group and the monitoring arrangements through NHS England will continue in line with the rest of the GP practices within the CCG.

Whilst there are no major incidents of concern to highlight to the board – the following areas should be noted

1) Controlled drug/opiod patches
2) Timeliness of investigations (adjustment of SOP to facilitate improvements currently in progress)
3) Incorrect administration of medicines

The interim Chief pharmacist has agreed to progress further work in these areas through the medicines safety officer and medicines safety committee who will review the medicines related SOP's, the medicines training and support programs to ensure these remain current and fit for purpose.

Conclusion

The overall the pattern of incidents involving CD's and relevant people within the Trust indicate that:

1) Safeguarding and information sharing across the local arm of the LIN appear to be continuing to work well

2) There has been an overall increase in the number of CD incidents are reported to the CDAO, particularly in relation to schedule 3 controlled drugs.

3) There are reasonable grounds for assurance that the CDAO was aware of and, where appropriate, acted on incidents in relation to controlled drugs and relevant people. However the timeliness of receiving details of investigation is a concern (SOP adjustment currently under review to address this)

4) The majority of Schedule 2 incidents relate to primary care interface issues.

5) The largest number of reports relate to schedule 4 controlled drugs (as in previous years). However the relative proportion of unnacounted discrepancies has reduced. This would support the adjustment of the SOP to ensure the timeliness of investigation.

6) Further work is indicated to support the safe use and administration of opioid patches

7) The reduction in schedule 2 reports may have been linked to the strengthened pharmacy presence within the substance misuse team, but further work would be required to confirm this association.

8) There may be an emerging issue of concern around the use of controlled drugs patches. The unit involved has made arrangements to switch to a different community pharmacy for medication supply. Further incidents involving patches will be scrutinised and additional measures put in place where indicated. The Trusts' decision to support Pharmacy's business case for a pharmacist to work within the older people's services will support this work.

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Appendix I

CQC Annual reports of controlled drugs - recommendations 2007 – 2014

CQC 2007 Summary of recommendations controlled drugs

Non-statutory prescribing drug services in community and inpatient (including residential) settings should be included in the list of responsible bodies so that they could become formal members of local intelligence networks.

Standards for Better Health (or any replacement) should introduce a separate standard or declaration for the safe management of controlled drugs, and this should be a registration requirement.

Healthcare professionals who prescribe or administer medicines to people living in care homes must ensure that the care home has a written record of the prescription and/or administration.

The recommendation (from the Healthcare Commission's Staffordshire Ambulance NHS Trust investigation report) that the Department of Health should liaise with the Home Office to clarify the circumstances in which NHS ambulance trusts require a licence to possess and supply controlled drugs to registered paramedics should be implemented as soon as possible.

Each trust board and independent healthcare designated body must have a mechanism for ensuring that the post of accountable officer remains appropriately filled at all times.

Controlled Drug Designated Bodies (CDDB's) must ensure that if their accountable officer has changed, they have notified the Healthcare Commission of all the appropriate details. A check should be made by the CDDB every quarter to ensure that the accountable officer recorded in the register is the current accountable officer.

Each trust must ensure that the chief executive and the board both know that the organisation is fulfilling its responsibilities in relation to controlled drugs, for example by arranging to receive quarterly reports from the accountable officer on controlled drug governance and activity.

Local Intelligence Networks should be reminded that the regulations allow information to be shared among responsible bodies and this cannot happen if the membership of the local intelligence network is too wide.

Local Intelligence Networks should be reminded that where primary care trusts have joined together for a local intelligence network, there needs to be clear leadership to ensure that intelligence is handled and stored appropriately.

Local Intelligence Networks should be reminded that their core function is to share information and build up a database of concerns.

Local Intelligence Networks should be reminded that where the safety of patients is a concern, there is a duty to share information, including, if necessary, sharing concerns about named professionals. There are parallels with child protection experience here.

Leadership and lines of responsibility should be clearly identified in local intelligence networks that serve more than one primary care trust.

Accountable officers in primary care trusts should remind GPs and private doctors that private prescriptions for controlled drugs must be written on the standard forms (FP10PCD).

CQC 2008 Summary of recommendations controlled drugs

Healthcare organisations should ensure that they have accountable officers in place at all times. They should have mechanisms to replace accountable officers immediately when they leave and notify the Care Quality Commission of the change.

A robust, workable method should be devised to ensure that 72-hour (three-day) fentanyl patches are applied at appropriate intervals to ensure that patients are not left in pain (because of too long an interval) and that the patches are not used wastefully (because of too short an interval).

PCT accountable officers should collaborate more effectively with other PCTs and national bodies to ensure that suitable numbers of authorised witnesses are available for destroying obsolete drugs. There should be a robust mechanism for recognising authorised witnesses, and healthcare professionals need to be made aware of the purpose of having authorised witnesses.

Local Intelligence Networks must make sure that all their designated bodies are kept up to date with the formation and leadership of the network, and that they know where to submit their reports. Networks should be reminded to keep their membership and working arrangements under review, and to keep everyone informed.

CQC 2009 Summary of recommendations controlled drugs

Chief executives and accountable officers should continue to keep the safe management of controlled drugs a high priority on their organisation's agenda.

The Royal Colleges should develop guidance on appropriate use of opioids and amphetamines for all sectors, to ensure best practice across all areas.

The Department of Health should revisit the requisition regulations and guidance to ensure that they capture and identify the purchase of controlled drugs by all individual doctors and healthcare professionals, in line with the original policy intent.

CQC 2010 Summary of recommendations controlled drugs

Chief executives and accountable officers should continue to keep the safe management of controlled drugs a high priority on their organisation's agenda during the reorganisation of the NHS to ensure that the gains in safety made over the past four years are not lost.

Chief executives and accountable officers should ensure that CD LINS have robust working arrangements and are fit for purpose and adequately prepared for the transition.

Non-designated bodies should also participate in the information-sharing process to ensure that intelligence gathering is thorough and complete, capturing information from all sources for example; community pharmacists, the Ministry of Defence, care homes, substance misuse services and new provider services.

All professionals and providers of care, whether practising in the NHS or independent sector, should take account of best practice guidance that is published by relevant professional bodies and agencies. All sectors should be made aware of the document, *Drug misuse and dependence: UK guidelines on clinical management* and that it applies across all sectors.

CQC 2011 Summary of recommendations controlled drugs

Designated body organisations should ensure that they notify CQC promptly when the controlled drugs accountable officer for their organisation changes, to ensure that this is not overlooked in a period of change. The newly appointed accountable officer must also make contact with the accountable officer leading the CD LIN.

The Responsible Officer (RO) and the controlled drugs accountable officer should work collaboratively on areas of mutual concern to ensure that the processes for oversight of controlled drugs are suitably robust.

Controlled drugs accountable officers should ensure that they have systems in place to assure the safe prescribing and administration of controlled drugs in all situations where controlled drugs are used.

Medicines safety, risk and clinical governance groups must always include the controlled drugs accountable officer when incidents involving controlled drugs are reported, so that opportunities for local and national learning are not missed.

Controlled drugs accountable officers should ensure that suitable systems are in place to ensure the safe and effective use of transdermal fentanyl patches. This should include ongoing education of all staff involved in prescribing, dispensing, administering and disposing of transdermal fentanyl patches.

The use of methylphenidate and dexamfetamine should be monitored carefully to ensure that they are being prescribed appropriately in all sectors.

The use of a standard Controlled Drug Requisition Form (FP10 CDF) should be encouraged more actively.

CQC 2012 Summary of recommendations controlled drugs

Health and social care professionals must ensure they know how to contact their local controlled drugs accountable officer (CDAO) and know the mechanism for reporting controlled drug concerns.

CDAOs need to ensure they are following our [CQC] guidance to update contact details promptly to ensure the CDAO register is accurate.

Effective systems developed at the local level for secure gathering, sharing and recording of intelligence should be preserved and transferred into the new NHS structure.

CDAOs, clinical commissioning groups and controlled drugs leads must be mindful of their continuing responsibilities for good governance and safe use of controlled drugs to ensure on-going monitoring and vigilance.

Looking forward to 2013, we must incorporate providers' governance arrangements for controlled drugs into its inspection model for primary medical services.

CQC 2013 Summary of recommendations controlled drugs

NHS England controlled drug accountable officers must be adequately resourced to carry out their roles and responsibilities with regard to controlled drugs.

NHS England controlled drug accountable officers must be clear about their responsibilities for controlled drug governance arrangements and strengthen their relationships with clinical commissioning groups (CCGs) and commissioning support units (CSUs) so that these organisations are clear as to how they can support them.

NHS England controlled drug accountable officers should consider organising learning events for controlled drug accountable officer colleagues and controlled drug leads, to enable them to share learning and best practice.

NHS England controlled drug accountable officers should consider extending membership of the controlled drug local intelligence network to other relevant local organisations (such as social enterprise organisations or community interest companies) either on a permanent or 'as required' basis.

A formal process should be put in place by NHS England controlled drug accountable officers to ensure controlled drug concerns and good practice are shared nationally where appropriate.

Healthcare providers must determine whether they are required to appoint a controlled drug accountable officer or whether they meet the criteria for an exemption.

The Care Quality Commission should summarise the key messages from the Controlled Drugs National Group meetings and circulate them to NHS England controlled drug accountable officers to pass on to members of their controlled drug local intelligence networks.

CQC 2014 Summary of recommendations controlled drugs

Recommendation for all controlled drug accountable officers Controlled drug accountable officers should share organisational learning from controlled drug-related incidents with their CD LINs (local intelligence network) and, where possible, develop links with their Medication Safety Officers (MSOs) to maximise these opportunities for learning. – **Note this recommendation is relevant to SHSC**

Recommendation for CQC - CQC should make information available to small organisations to advise them of the exemption provision in the regulations for the need to appoint a controlled drug accountable officer.

Recommendations for NHS England lead controlled drug accountable officers

• NHS England lead controlled drug accountable officers should use the changes to the regional structure from April 2015 as an opportunity to work more collaboratively so that there is greater national consistency of approach to delivering their controlled drug responsibilities.

• NHS England lead controlled drug accountable officers should engage with and formalise the support of clinical commissioning groups (CCGs) so that monitoring controlled drug prescription activity is a higher priority.

• NHS England lead controlled drug accountable officers should determine how best to engage with social care organisations in their area and should encourage local authorities to be engaged in controlled drug local intelligence networks (CD LINs).

Recommendations for NHS England

• NHS England should provide guidance for occurrence reporting so that organisations understand what they need to report to the CD LIN.

Appendix II

SHSC Occurrence Report – Controlled Drugs Concerns Reported Between Oct 2015 – Sept 2016

Description of concern	Schedule	Date aware	Actions taken
29/12/2014 (Incident number 107506) Service notified of the death of a patient. Cause of Death: 1) Cardio Respiratory Depression and 1b) Methadone Overdose Conclusion: Drug Related Death	2	11/01/2016	• No prescribing or medicines related concerns identified with the client • No actions recommended or identified by the Coroners inquest **Closed from Accountable Officer's perspective** **CLOSED**
02/04/2015 (Incident number 109463) Coroner's Office informed the Trust that a client had been found dead at their home address on 01/04/2015.	illicit	03/11/2015	• No further actions required from Coroners office • Policy for frequency of reviewing / assessing patients to be looked at • Death primarily caused by illicit drug use and underlying physical health problems • No prescribing concerns identified following the incident review **Closed from Accountable Officer's perspective** **CLOSED**
16/06/2015 (Incident number 111278) Coroner's Office informed the Trust that a client had died in hospital on 24/02/2015. Last prescribed medication from the Trust for this client was August 2014. Client declined re-referral made by the GP in October 2014. Following monitoring, the client was known to use crack cocaine regularly.	illicit	03/11/2015	• No prescribing concerns identified within the SHSC Trust incident review • No further actions required requested from the Coroner's inquest **Closed from Accountable Officer's perspective** **CLOSED**
07/07/2015 (Incident number 111758) Service notified of the death of a patient. Cause of Death: 1a) Heroin Toxicity, Methadone and Cocaine use Conclusion: Alcohol / Drug Related Death	illicit	11/01/2016	• No prescribing concerns identified within the service • No actions identified or recommended post inquest **Closed from Accountable Officer's perspective** **CLOSED**
14/07/2015 (Incident number 111932) Trust informed that a client was found hanged in the woods on 10/07/2015. The Cause of Death: 1a) Hanging and Inquest Conclusion - Narrative Inc Took Own Life: Client had a long history of mental illness.		12/11/2015	• No controlled drug prescribing concerns identified from the incident review **Closed from Accountable Officer's perspective** **CLOSED**
21/08/2015 (Incident number 112793) During nightly benzodiazepine stock check it was discovered that 1x5mg diazepam was unaccounted for.	4	04/01/2016	• Awaiting investigation
25/08/2015 (Incident number 112917) Service notified of the death of a patient. Cause of Death: 1a) Methadone Toxicity &	2 & 4	11/01/2016	• No prescribing or care concerns identified in relation to the clients death • Client had a range of complex physical health

Diazepam use and 2) Ischaemic heart disease **Conclusion: Drug related death**			problems on top of poly substance misuse from the age of 24 **Closed from Accountable Officer's perspective** **CLOSED**
01/09/2015 (Incident number 113153) Service notified of the death of a patient. Cause of Death: 1a) Methadone Toxicity & alcohol intoxication and 2) Hepatitis C induced cirrhosis of the liver. Conclusion: Drug/alcohol related death	2	11/02/2016	• Client prescribed methadone 50mg daily (supervised) – 2 days take home on Friday • Was under hepatic clinic – to consider Hep C treatment if off alcohol • No concerns with prescribing practice identified **Closed from Accountable Officer's perspective** **CLOSED**
09/09/2015 (Incident number 113396) Controlled drugs stock check showed several discrepancies: 4x10mg chlordiazepoxide, 2x500mcg clonazepam, 2x5mg diazepam & 2x1mg lorazepam.	4	05/10/2015	• Staff nurses reminded to document all dispensed benzodiazepines in the controlled drugs register • Stock checks are occurring on a regular basis • Weekly discrepancy chart to be completed to review dose unit discrepancies by wards – to be completed by early December **Closed from Accountable Officer's perspective** **CLOSED**
10/09/2015 (Incident number 114764) GP not updated with medication changes for patient. GP was due to prescribe new dosage. Medication: methylphenidate	2	05/11/2015	• Consultant reminded of importance of timely correspondence with the GP regarding medication changes – considered to be an isolated incident due to particular circumstances **Closed from Accountable Officer's perspective** **CLOSED**
30/09/2015 (Incident number 113923) During the period 15/09/15 to 01/10/15, the following medication had been missed due to the client being asleep: Temazepam 20mg/10mls missed 12 x doses Also 12 doses each of haloperidol 2mg/2mls & olanzapine 5mg. 13 doses of paracetamol 1mg. 4 doses of trazodone 50mg/5mls.	3	05/10/2015	• Pharmacy assessment took place at this unit and following up with the clinical director • Ward rounds are to be increased twice weekly to aid medication reviews and raise concerns • Nurse manager will quality check drug cards and bring the issue of medication management and following of protocols to staff supervision • Local Medicines Policy had been updated but this didn't match current practice – policy to be circulated and shared with staff • A deputy ward manager has been appointed to undertake audits and checks to ensure internal procedures are followed • Staffing resources to be reviewed **Closed from Accountable Officer's perspective** **CLOSED**
01/10/2015 (Incident number 113935) During the period 19/09/15 to 01/10/15, the following medication had been missed due to the client being asleep: Temazepam 20mg missed 4 x doses Diazepam 5mg missed 4 x doses	3 & 4	05/10/2015	• Pharmacy assessment took place at this unit and followed up with the clinical director • Incident reviewed with all staff and discussed individually in supervision • Monthly staff meetings implemented • Observation sheet has been implemented and

Also 4 doses each of olanzapine 7.5mg & aripiprazole 30mg.			incorporated in to the local medicine policy • Capacity staffing issues identified • Training department reviewing staff that have undertaken Medicines Management training **Closed from Accountable Officer's perspective** **CLOSED**
02/10/2015 (Incident number 113950) Patient was administered 2mg diazepam instead of 5mg on two consecutive nights.	4	05/10/2015	• Prescription reviewed and changed to reflect appropriate tablet strength on JAC • Incident shared with pharmacist and technician to reflect on tablet strength modifications on prescriptions **Closed from Accountable Officer's perspective** **CLOSED**
03/10/2015 (Incident number 113986) Patient had missed his prescribed medication due to sleeping. Drug cardex indicates a series of recording codes for drugs not used and reasons why. No record in nursing notes by nurse in charge. Temazepam 20mg/10mls Paracetamol 1g Haloperidol 2mg/2ml Olanzapine 5mg	3	06/10/2015	• This was one of 3 incidents involving significant periods of missed doses of medication. Whilst no specific harm identified to client regarding missed doses – concern has promptly been raised at directorate level and the need to address the identified trend and systematic failures on the ward • Electronic prescribing to be initiated asap **Closed from Accountable Officer's perspective** **CLOSED**
06/10/2015 (Incident number 114145) Stock check revealed 1x3.75mg tablet of zopiclone unaccounted for.	4	06/10/2015	• Staff encouraged to be more vigilant with recording administered / wasted benzodiazepines in the register • Continue with daily stock checks **Closed from Accountable Officer's perspective** **CLOSED**
06/10/2015 (Incident number 114768) The community chemist didn't have enough stock of lorazepam medication for a client. The client missed their 0.5mg morning dose and 1mg teatime dose.	4	05/11/2015	• Incident reviewed with staff at the unit – increased vigilance needed with ordering medication in light of dose changes and stocks running low • Monitor for further incidents **Closed from Accountable Officer's perspective** **CLOSED**
07/10/2015 (Incident number 114051) Whilst staff were completing a benzodiazepine check, a patient rushed in to the clinic room and snatched some tablets (lorazepam) from the cupboard before rushing back to her room to ingest them. Stock check confirmed that 2x1mg lorazepam tablets were missing. See incident 114070	4	07/10/2015	• Regular medication withheld – physical observations taken • Incident discussed in Pharmacy meeting – ward technicians are to ensure they lock themselves in the clinic room whilst doing the ward stock check (SOP to be reviewed) • Demonstration and reiteration of personal safety alarms shown and staff reminded to take with them on the wards **Closed from Accountable Officer's perspective** **CLOSED**

07/10/2015 (Incident number 114070) Ward technician was conducting a ward top-up in the clinic room, therefore the medication cupboard doors were unlocked and open, when a client entered the clinic room and grabbed a part box of lorazepam. The client then proceeded to open the box and take the tablets. Ward technician was unable to stop the client but managed to call for help. See incident 114051	4	08/10/2015	• Regular medication withheld – physical observations taken • Incident discussed in Pharmacy meeting – ward technicians are to ensure they lock themselves in the clinic room whilst doing the ward stock check (SOP to be reviewed) • Demonstration and reiteration of personal safety alarms shown and staff reminded to take with them on the wards **Closed from Accountable Officer's perspective** **CLOSED**
12/10/2015 (Incident number 114187) Staff nurse administered a patients regular evening medication of 1000mcg clonazepam but when staff nurse checked this exceeded the BNF limits, having 4500mcg within a 24hr period. Limits exceeded by 500mcg.	4	20/10/2015	• Supervision undertaken with staff nurse • Incident shared with e-prescribing technician to review and feedback to JAC regarding identifying between regular and prn doses
13/10/2015 (Incident number 114189) Benzodiazepine stock check showed a discrepancy of -1x10mg chlordiazepoxide capsule.	4	13/10/2015	• Daily stock checks to continue • Vigilance with recording to be encouraged • Regular medication withheld – physical observations taken • Incident discussed in Pharmacy meeting – ward technicians are to ensure they lock themselves in the clinic room whilst doing the ward stock check (SOP to be reviewed) • Demonstration and reiteration of personal safety alarms shown and staff reminded to take with them on the wards **Closed from Accountable Officer's perspective** **CLOSED**
13/10/2015 (Incident number 114190) During daily stock check, 1x500mg clonazepam tablet was found to be unaccounted for.	4	13/10/2015	• Ward continuing with daily stock checks • No trend of significant stock discrepancies identified **Closed from Accountable Officer's perspective** **CLOSED**
14/10/2015 (Incident number 114265) Stock check revealed there was 1x1mg lorazepam tablet missing.	4	15/10/2015	• Daily stock checks to continue on the ward • Staff member aware of incident and need for vigilance during administration **Closed from Accountable Officer's perspective** **CLOSED**
17/10/2015 (Incident number 114355) Benzodiazepine stock check showed a discrepancy of -1x5mg diazepam tablet and +1 clonazepam tablet.	4	28/10/2015	• Staff reminded of diligence needed with the SOP • Ward continuing with daily stock checks **Closed from Accountable Officer's perspective** **CLOSED**
18/10/2015 (Incident number 114362) 1 x 0.5mg "suboxatine" tablet missing. Discovered during controlled drugs count.	3	19/10/2015	• Ward manager and deputies contacted to review controlled drugs register for pattern of single signature administrations

			• Ward to circulate the directorate approved SOP to nursing staff • Incident discussed at ward business meeting
19/10/2015 (Incident number 114374) Benzodiazepine stock check indicated that there is 1 tablet of diazepam 5mg missing.	4	04/12/2015	• Ward continuing with daily stock checks • Questionnaire added to stock balance discrepancies in December 2015 – currently being piloted on this ward **Closed from Accountable Officer's perspective** **CLOSED**
20/10/2015 (Incident number 114445) 2mg lorazepam was charted in error. 2mg lorazepam IM was actually administered and was not charted.	4	05/11/2015	• Staff reminded care needed at the point of administration charting • No concerning patterns of administration incidents identified **Closed from Accountable Officer's perspective** **CLOSED**
21/10/2015 (Incident number 114453) Client accidentally taken the wrong medication (1x0.5mg clonazepam) on the morning of 21/10/15. Usually takes this at night time.	4	23/10/2015	• Unit to review ways to manage / prevent in future
21/10/15 (Incident number 114456) Nurse from the ward telephone Pharmacy to report that there was a record of 7x morphine sulphate amps recorded in the CD book but not in the cupboard. Pharmacy records show 7 ampoules were returned to Pharmacy on 25/10/15 and subsequently destroyed.	2	30/10/2015	• Staff reminded to sign the controlled drugs register when removing controlled drugs for destruction in Pharmacy **Closed from Accountable Officer's perspective** **CLOSED**
21/10/2015 (Incident number 114482) Staff member administered IM 2mg lorazepam but forgot to chart it.	4	23/10/2015	• No administration / charting incident identified in this case • No concerns identified with nursing practice for this staff member • Supervision with staff member and consideration to undertaking an administration medicines assessment • Staff to ensure service user's medication is handed over each shift, e.g. IM medication, which side it was given on, who was present, etc **Closed from Accountable Officer's perspective** **CLOSED**
22/10/2015 (Incident number 114563) It was noted on reflection by the dispenser that a service user received 20 doses of tramadol on his leave prescription but was only required 10 doses. The pharmacist retrieved the prescription and noted the doctor had requested 20 tablets. However, only 10 tablets was actually needed given the dosing of 100mg SR tramadol BD for 5 days.	3	27/10/2015	• Incident discussed in governance – while the incident occurred, it was recognised that this staff member was found to identify more 'near misses' in comparison to colleagues • Incident shared with line management • SOP was reviewed and was fit for purpose **Closed from Accountable Officer's perspective** **CLOSED**
22/10/2015 (Incident number 114580) The service was contacted by a GP surgery to inform that a client had requested a repeat	2	28/10/2015	• Prescription was reviewed by SHSC service – dose increased to 90ml daily and changed to

prescription of methadone. Our service also prescribed this medication. The client had been prescribed 12 weeks worth of methadone (210mg per week) since at least June 2015. This was on a green prescription, without supervision or chemist details. The client had also collected 84x5mg methadone tablets in June 2015.			daily supervised • Increased monitoring of client • Incident shared with area team and Sheffield CCG • All methadone / buprenorphine patients to be referred to SHSC service – GPs informed they should no longer offer this service • GP practice has taken this incident very seriously and has undertaken reviews on a number of patients and made changes to their systems **Closed from Accountable Officer's perspective** **CLOSED**
25/10/2015 (Incident number 114537) When checking lorazepam quantity, there appeared to be 2 x 1mg tablets missing. This was traced back to 2 mg lorazepam being administered on 25/0/15 to client SH. This was not logged in benzodiazepine book.	4	26/10/2015	• Ward continuing with daily stock checks which picked up on the discrepancy • Monitor for further incidents
26/10/2015 (Incident number 114538) Upon checking if matrifen patch was in situ, it was observed not to be.	3	26/10/2015	• Staff reminded to carry out all daily checks around the management of patches as directed in the local guidelines • Patch to be applied to residents back in future in line with the updated local guidelines • Management to follow this up with responsible staff member
26/10/2015 (Incident number 114543) Patient needed his depot antipsychotic medication (1mg lorazepam IM & 20mg flupentixol deconate IM) but walked away from staff, pushing past repeatedly. Staff attempted to escort him to a more low-stimulus area where the depot could be administered. The patient became resistive, pushing against staff with increased force. The patient was restrained and IM medication was administered.	4	26/10/2015	• No prescribing / administration issues identified following this incident • Incident logged to capture administration of injections in nursing corridor which was not the expected practice but was deemed clinically necessary at this time **Closed from Accountable Officer's perspective** **CLOSED**
28/10/2015 (Incident number 114576) When completing controlled drug audit, 1x1mg lorazepam could not be accounted for.	4	28/10/2015	• Pilot of stock discrepancy incident review now started on another ward • Ward continuing with daily checks at night **Closed from Accountable Officer's perspective** **CLOSED**
30/10/2015 (Incident number 114614) Labelled zopiclone x14 tablets but only put in x7 tablets.	4	09/12/2015	• Pprescription returned for amending • Daily stock checks to continue • Accuracy checking SOP reviewed and discussed in staff meeting – remains the discretion of the checker to count the quantity in a box **Closed from Accountable Officer's perspective** **CLOSED**
30/10/2015 (Incident number 114640) Administered PRN Lorazepam 2mg in 2hr period,	4	02/11/2015	• Staff to be vigilant with medication and time interval needed between doses

rather than 4. Immediately informed medics with no further action required, other than observe. Patient not naive to benzodiazepines.			
02/11/2015 (Incident number 114655) Service informed by community pharmacist that a client had passed away at home. Coroner's inquest outcome: Cause of death – heroin and methadone toxicity Conclusion – drug related death	2	24/05/2016	• No concern identified from methadone prescribing from the service • No further action requested by Coroner **Closed from Accountable Officer's perspective** **CLOSED**
03/11/2015 (Incident number 114728) On the stock check on 04/11/2015 it was discovered that we had 17 x diazepam 2mg tablets more than we should have. After investigation it was found that on 03/11/2015 a full pack was sent to a unit, which only had 11 tablets in it.	4	10/11/2015	• Staff reminded to be vigilant with medication returned to the correct part of the shelf and also to ensure part packs are marked with a large cross to identify part packs **Closed from Accountable Officer's perspective** **CLOSED**
03/11/2015 (Incident number 114729) Whilst investigating a stock discrepancy we became aware that leave medication for a service user had been ordered and dispensed on consecutive days (03/11 & 04/11). After discussion with the ward it was explained that the first lot of medication had been received without a label so was assumed to be for stock. The dispenser, accuracy checker and bagger-up all insist they saw a label on the container and a trace on JAC showed a TTA label had been generated. However, ward staff were similarly certain that there was no label on the container.	4	10/11/2015	• Ward staff reminded of the need to check audit trails for medicines and alert senior staff / Pharmacy if there is a failure with the trail **Closed from Accountable Officer's perspective** **CLOSED**
04/11/2015 (Incident number 114725) Wrong medication was handed over to a service user on discharge from the unit. Support worker contacted to collect medication from the service user. Current practice is to automatically hold and supervise medication for all step-down service users for the first 7 days.	4	04/11/2015	• Manager to retrain both staff members using the unit's competency assessment tool • Manager to review the local medicines policy with specific reference to custody of medication, staff supervision and looking at removing this practice / option unless exceptional circumstances
04/11/2015 (Incident number 114796) During morning checks it was noted that a client had only one buprenorphine patch on their back when there should have been two (1x5mcg & 1x10mcg). The 5mcg was in position. However, the client's dosage was being increased from 15mcg to 20mcg so the patch was replaced with a 20mcg patch. The missing10mcg patch was not found.	3	06/11/2015	• Considered to be a patch failure – this has become fairly common at this unit • Good evidence of body map in place and daily checks picked up on the missing patch
05/11/2015 (Incident number 114756) During home visit, service user was seen with a white tablet in their hand. They were asked to put it in their pocket and hand it over when back on the ward. When arrived back on the ward the tablet wasn't to be found. The service user said they had thrown in down the sink. Tablet was believed to be diazepam.	4	05/11/2015	• Family member was requested to bring all medicines currently at home to be disposed of • Updated DRAM and collaborative care plan • Home visits to be facilitated by psychologist and another member of staff • Risk assessments to be carried out prior to leave and post leave **Closed from Accountable Officer's perspective** **CLOSED**

07/11/2015 (Incident number 115076) Client was not given their morning dose of 1x250mg naproxen and 2x50mg tramadol.	3	18/11/2015	• Care needed administering medication before moving on to the next task **Closed from Accountable Officer's perspective** **CLOSED**
08/11/2015 (Incident number 114826) Found that a client's patch was not in place.	3	09/11/2015	• Patch missing from body the following day after administration – checking process identified as an issue • Unit to continue with daily check
08/11/2015 (Incident number 114827) Found that a client's patch was not in place.	3	09/11/2015	• Ward to continue with daily checks to ensure patches remain in place • Processes currently being embedded on the unit and procedures waiting for signing off
09/11/2015 (Incident number 114869) A service user was about to go on leave but it was noted that there was no leave medication for them. There was no one available to prescribe the leave medication until the next day. After discussion with a pharmacist the service user was given the remains of their previous leave medication (lorazepem & diazepam).	4	10/11/2015	• Team to ensure that leave is arranged in advance to allow time for leave medication to be written up and ordered • Prescriptions to be written to capture the appropriate period of leave needed **Closed from Accountable Officer's perspective** **CLOSED**
12/11/2015 (Incident number 114929) During night shift checks of benzodiazepine medication it was found that the stock of 1mg lorazepam was 2x tablets short. Unable to find the missing tablets.	4	13/11/2015	• Communicate with the staff regarding waste / dropped tablets and the recording of the benzodiazepines **Closed from Accountable Officer's perspective** **CLOSED**
13/11/2015 (Incident number 114979) Client was asleep until 10am. Staff member went to do a routine check on his buprenorphine patch but it was not there. After searching it was found on the floor.	3	15/11/2015	• Unit continuing with routine daily checking that patches are in place – in line with body map
13/11/2015 (Incident number 114989) Staff member found a medication pot in the clinic room with what appeared to be 2 lorazepam 1mg tablets in it.	4	04/01/2016	• Awaiting investigation
15/11/2015 (Incident number 115092) Client came to the office and informed staff that he had taken all his prescribed medication. Medication included zopiclone.	4	19/11/2015	• Discussed as a team, at no point were staff concerned about any change in client's presentation and he had spent all his time with staff and in communal areas • Client's stays were put on hold until a review meeting with him and his care co-ordinator happens • At review meeting the client will have a contract to follow and will jeopardise any further stays if he is unable to adhere to it
18/11/2015 (Incident number 115081) Client was not on JAC so staff member was unable to administer their medication. On-call doctor was contacted but said they were too busy. Another on-call doctor was contacted later but was given the same response.	4	19/11/2015	• Developer working on the system to stop transfers which shouldn't happen • Pharmacy e-prescribing technician reviewing JAC options

20/11/2015 (Incident number 115127) Service user disclosed to support work that she had taken 56 tramadol 50mg. Service user disclosed this information at 22:45 stating that she had taken the tablets at 21:45. She stated that she had had these tablets since admission. Physical observations were taken. Advice was sought from the on-call doctor. An ambulance was called and she was taken to A&E.	3	23/11/2015	• Updated documentation of risks undertaken • To date, an review on the incident had not been done – Medicines Safety Officer to discuss with Assistant Clinical Director
21/11/2015 (Incident number 115164) Telephone call received from chemist to say they had given a client 2x8mg buprenorphine (supervised) instead of 1x8mg.	3	23/11/2015	• Incident shared with Sheffield CCG for review • No prescribing concerns identified within the Trust • Buprenorphine description / route to be added to prescriptions **Closed from Accountable Officer's perspective** **CLOSED**
24/11/2015 (Incident number 115194) Client was sat in the lounge most part of the evening and was found holding his buprenorphine patch which he'd removed from his back.	3	24/11/2015	• Continue to apply patch in a place which is hard to reach & remove • Nursing staff to continue to check daily that patch is in place • Review with GP to see if any alternatives to this patch
25/11/2015 (Incident number 115200) Nightly controlled drugs check found there was 1 less 1mg lorazepam than stated in the book.	4	04/01/2016	• Preceptorship nurse was having difficulty administering medication due to high clinical activity
26/11/2016 (Incident number 115247) Discrepancy with zopiclone 3.75mg. 19 recorded but only 18 present on count.	4	04/01/2016	• Linked to incident 115200 • Incident under review
26/11/2015 (Incident number 115249) Service user disclosed to staff that she had stockpiled lorazepam medication and hidden this in the communal female bathroom. Upon investigation, there was found to be 1x1mg lorazepam tablet wrapped in tissue and placed inside a syringe which had been put in a basket on the shelf. No further medication found following search of toilet and bedroom.	4	26/11/2015	• Risks captured on DRAM **Closed from Accountable Officer's perspective** **CLOSED**
26/11/2015 (Incident number 115260) Support workers found a Matrifen patch stuck to the sheets whilst washing a client.	3	26/11/2015	• Unit continuing with routine daily checking that patches are in place – in line with body map
26/11/2015 (Incident number 115285) During the technician check, the ward were informed that diazepam 5mg was short by 1 tablet.	4	27/11/2015	• Ward to continue with daily stock check with 2 members of staff • Staff to ensure that they sign and document any benzodiazepines that are administered **Closed from Accountable Officer's perspective** **CLOSED**
26/11/2016 (Incident number 115328) Service advised of the death of a client. Coroner's inquest outcome: Cause of death – drug (methadone) toxicity	2	24/06/2016	• No prescribing concerns identified • No further action requested by Coroner

Conclusion – alcohol/drug related death			**Closed from Accountable Officer's perspective** **CLOSED**
28/11/2015 (Incident number 115311) A resident's Matrifen patch could not be found when checked this morning. The on-call GP was contacted and advised applying another one.	3	30/11/2015	• Procedures reviewed to stipulate application of patch to the back – processes to continue to be embedded with staff
01/12/2015 (Incident number 115379) Upon doing the 18:00 medication round, it was apparent that prescribed suboxone 8/2mg for a patient had not been administered. When Staff nurses came to administer this, it was found that half of the dose had been given at 08:25 (1 tablet as oppose to 2), and recorded as such in the controlled meds book. No documentation of reasons for half dose given could be found on Insight or JAC, however it appears that it was the last of this box.	3	02/12/2015	• Incident reviewed in supervision with staff member • Pharmacy e-prescribing technician to review functionality for part regular doses (if out of stock or patient only accepted part doses) • Review of controlled drugs administration process as SOP doesn't capture standardised practice for part administration
02/12/2015 (Incident number 115383) Controlled drug check completed. Lorazepam 1mg tablets found to be different from stock book. 52 in book and only 51 in stock drug cupboard. Full check of service users JAC records for the ward and no one issued with lorazepam in the last 72 hours. No drugs signed out to other wards.	4	02/12/2015	• Staff reminded to ensure that they document any waste / disposed of medication • Ward staff to continue to ensure that nightly stock checks are completed **Closed from Accountable Officer's perspective** **CLOSED**
03/12/2015 (Incident number 115396) Documented that 100mls/100mg of methadone sugar free oral solution remaining, when attempting to administer 60mls/60mg only 25mls/25mg remaining in the bottle. 75mls/mg unaccounted for.	2	03/12/2015	• Balance stock check was done and identified that there was also a discrepancy with the balance of methadone 1mg/ml – visual inspection showed there was approximately 100ml extra to what was documented – overall shortfall would be 25mls which is considered within acceptable limits from a 500ml bottle • Stock discrepancy likely to have been caused by a patient being given sugar free when prescribed original • Staff reminded to inform senior staff of controlled drugs stock discrepancies promptly to allow early investigation **Closed from Accountable Officer's perspective** **CLOSED**
07/12/2015 (Incident number 115469) Patient became extremely agitated and violent following the decision to continue seclusion. Decision was made to administer IM lorazepam. 4mg administered but intended dose 2mg. JAC computer in the clinic room takes a long time to become active and had not become so during the time the medication was being prepared.	4	08/12/2015	• Patient's physical observations were monitored when safe to do so • There is a need to ensure the JAC computer activates quickly – this delay has been reported to IT on previous occasions but remains slow with obvious risk to patient's
09/12/2015 (Incident number 115531) Matrifen patch had fallen off a client whilst they were showering.	3	09/12/2015	• Monitoring of patches daily to continue • Patches to be applied to out-of-reach areas
10/12/2015 (Incident number 115636) Spot check conducted on medicines. Controlled drugs record checked and identified that historically 77 diazepam tablets were received into the unit and 75 were returned, meaning that	4	11/12/2015	• Feedback given to nurses in the team – offered additional supervision and training

2 were not accounted for.			
11/12/2015 (Incident number 115599) Client's buprenorphine patch was missing when staff member checked. Unable to find it.	3	11/12/2015	• New patch applied on 11th December and documented on Body Map • Unit to continue with daily checks to monitor patch adhesion • Staff reminded to document appropriately on the body map and follow care plan / new SOP to apply to out-of-reach areas
11/12/2015 (Incident number 116103) Service informed of patient death. Cause of Death; 1a Hanging, 2 Heroin toxicity and methadone use.	2	29/07/2016	• No prescribing concerns identified • Last prescription issued for methadone was in April 2016 – unknown source of methadone that was listed in the Coroners report • No actions for the Trust identified by the inquest • Inquest conclusion was suicide **Closed from Accountable Officer's perspective** **CLOSED**
12/12/2015 (Incident number 115711) Client had been administered prn lorazepam 2mg orally on several occasions, despite being prescribed and charted as intramuscular.	4	14/12/2015	• IM lorazepam prescription now stopped • Staff concerned to receive a Medication with Respect assessment
13/12/2015 (Incident number 115671) Staff were assisting a client with washing and changing when they found the buprenorphine patch was stuck to the bed sheet.	3	14/12/2015	• Unit to continue with daily checks to monitor patch adhesion • Procedure for patches to be applied to out-of-reach areas to be disseminated to staff
14/12/2015 (Incident number 115684) Diazepam 2mg found to be down by 1 tablet during stock check.	4	04/01/2016	• Unknown reason for discrepancy • Ward to continue with daily stock checks
15/12/2015 (Incident number 115793) Pharmacy top-up box had not been unpacked from the delivery on 11/12/15. No medication was missing but the box contained diazepam and lorazepam.	4	17/12/2015	• Staff reminded to be vigilant and unpack the blue top-up box on the date it is delivered **Closed from Accountable Officer's perspective** **CLOSED**
16/12/2015 (Incident number 115788) Service informed by community pharmacy that a client had been dispensed 100mgs methadone (supervised) that morning but returned to the pharmacy later that day and was dispensed another 100mg methadone. Service was unable to contact the client. Emergency services were contacted.	2	17/12/2015	• Incident shared with Sheffield CCG • Consultant raised concern regarding initial lack of concern or responsibility from the community pharmacy – reassurance given over review process • Plans for management clearly documented on Insight and the client was reviewed the following day with a plan for a reduced dose and 7 days supervised prescription at a different chemist **Closed from Accountable Officer's perspective** **CLOSED**
16/12/2015 (Incident number 115800) Service user was due to be discharged from the ward. Discharge prescription indicated that 14 days were to be supplied of buprenorphine, diazepam and zopiclone. Pharmacist had noted on the system that 4 days supply of	3 & 4	17/12/2015	• Appropriate intervention and involvement of the ward pharmacist prevented excess medication being issued on discharge • Ward to keep a copy of the discharge prescription with controlled drugs on them and aware how to find the discharge information on

buprenorphine was to be provided. There was only 7 days of diazepam and zopiclone. The discharge prescription was not the latest version that was on the ward and this was sent to Pharmacy.			Insight
19/12/2015 (Incident number 115860) Upon entry of the clinic room, it was apparent that there was an unopened pharmacy bag. When this was checked there was a box of Buprenorphine inside which was delivered the previous day 18/12/15.	3	21/12/2015	• Staff member reminded of procedure during the incident review • All medication was checked and accounted for and entered in the register the following morning
20/12/2015 (Incident number 115871) Benzodiazepine stock check completed. Lorazepam minus 1 tablet & diazepam minus 1x5mg tablet.	4	04/01/2016	• Awaiting investigation
20/12/2015 (Incident number 115880) Error with eprescribing system. Client had been administered 5mg haloperidol and 1mg lorazepam IM a 15:00hrs. Later, the system showed that 3mg haloperidol and another 2mg lorazepam IM had also been administered – this was incorrect.	4	04/01/2016	• Awaiting investigation
22/12/2015 (Incident number 115915) When replacing the buprenorphine patch of a client, it was noticed that the previous patch applied on 19/12/15 was not in situ. The client was examined but it could not be located. Further patch applied today as prescribed.	3	22/12/2015	• Unit to continue with daily checks to monitor patch adhesion
22/12/2015 (Incident number 115955) Pharmacy technician check of controlled drugs noted there was 1x2g diazepam tablet more that was logged in the book.	4	04/01/2016	• Awaiting investigation
22/12/2015 (Incident number 116066) Client brought into the service some out of date medication: rectal diazepam.	4	30/12/2015	• The clients parents were contacted and advised that the medication would not be returned with the client and would be disposed of • Medication assessed and disposed of appropriately **Closed from Accountable Officer's perspective** **CLOSED**
23/12/2015 (Incident number 116293) Client's mother phoned the unit to check where prescription was as she had requested it on 18.12.15 and it had still not arrived. Staff member said he would speak to consultant on 24.12.15 to arrange for another script. This was sent by taxi to clients address, the client's mother had requested this script be sent to her address which is different from the normal one. This information was not passed on to secretary. The client's mother collected script from wrong address but the chemist would not dispense it as it was not correct script for a controlled drug. This resulted in another script being sent by taxi, which was still incorrect and a GP next to the chemist completed it and it was eventually dispensed.	2	07/01/2016	• The two previous prescriptions were issued but didn't reach their intended destination – incident not logged until complaint from clients mother arrived • Written protocol to support admin staff to be written to encompass safe delivery and receipt of prescriptions via taxi and a template to communicate prescribing to the GP • No significant concerns around safeguarding about the clients mother and the potential for seeking extra medication and using inappropriately • Incident shared with NHS Sheffield Accountable Officer about pharmacies recording serial numbers of destroyed / returned prescriptions but there were no

			considered actions necessary to record serial numbers of prescriptions destroyed **Closed from Accountable Officer's perspective** **CLOSED**
24/12/2015 (Incident number 115970) Patient was offered prn oral lorazepam due to agitation and distress, refused on 3 separate occasions. IM 2mg lorazepam administered under restraint by staff.	4	29/12/2015	• Incident logged as a restraint – not classed as a medication incident • Care needed with capturing incidents on the safeguarding system • No concerns of medication prescribing or administration identified **Closed from Accountable Officer's perspective** **CLOSED**
26/12/2015 (Incident number 116025) Patient was not reviewed overnight when admitted to the ward due to being asleep. The patient subsequently when into alcohol withdrawal having been a functional alcoholic. Prescribed chlordiazepoxide.	4	29/12/2015	• Noted good culture of doctor to report incidents – requested her to encourage practice within junior doctors committee
27/12/2015 (Incident number 116014) Client was re-admitted to the ward. Reported to have been self medicating with diazepam 5mg tablets which were given to him on discharge 2 days earlier. Bloods not checked by A&E prior to coming to the ward. Potentially delaying any treatment needed for adverse effects caused by the overdose.	4	27/01/2016	• Unknown reason for no blood test results being on ICE • No prescribing concerns identified (limited supply of diazepam issued at discharge – 1/52 GP not to continue) **Closed from Accountable Officer's perspective** **CLOSED**
27/12/2015 (Incident number 116020) Whilst undressing a client ready for bed, staff noticed that their matrifen patch was missing. Unable to locate it.	3	29/12/2015	• Continue to embed daily check of patch adhesion • Positioning of patch to continue to out-of-reach areasProtocol in place to complete daily checks to ensure patch is in situ – to continue to embed process • Patch applied to client's chest – SOP amended subsequently to apply to 'out of reach' areas • Staff also complete Boots 'patch application record' • All staff aware of handover sheet that client has patch and to be aware of this during all personal care procedures
27/12/2015 (Incident number 116066) Client brought into the service rectal diazepam that was out of date.	4	30/12/2015	• Medication assessed and disposed of appropriately **Closed from Accountable Officer's perspective** **CLOSED**
29/12/2015 (Incident number 116052) Client was taking overnight leave to his flat. He left the ward on the 28th of December and was due to return on Thursday the 31st of December. He returned to the ward at 10:30am after experiencing anxiety whilst out. On his return he handed in his leave medication, it was noted that he had taken too many of his tablets. Doctor informed. Observations taken every 2 hours.	4	29/12/2015	• Overnight leave was suspended • Staff monitored physical state – no concerns • Client fully reviewed at multi disciplinary meeting including discussion if accommodation remains appropriate **Closed from Accountable Officer's perspective**

			CLOSED
30/12/2015 (Incident number 116090) Client requested night time medication of clonazepam but refused when staff tried to give to him as he stated he didn't like to take tablets.	4	31/12/2015	• Ward manager to review incident reporting threshold with staff • No concerns in practice identified and no other relevant actions identified **Closed from Accountable Officer's perspective** **CLOSED**
30/12/2015 (Incident number 116141) Staff unable to find matrifen patch on a client. It was assumed that the patch had become detached from the client's body and a replacement patch was applied. Two days later the original patch was found on the client.	3	04/01/2016	• Ensure staff are vigilant when completing body maps and checking patches remain in place – guidance given and procedures reiterated to all staff • Staff to ensure only one body map in place
01/01/2016 (Incident number 116118) Client was administered 5mg diazepam instead of 2mg.	4	04/01/2016	• Medicines Safety Officer to follow up with ward manager as no incident review
02/01/2016 (Incident number 116128) Completed benzodiazepine checks, -1 clonazepam tablet and -1 chlordiazepoxide tablet.	4	27/01/2016	• All records checked but unable to account for discrepancy • Ward to continue with daily checks
02/01/2016 (Incident number 116130) Delivery of 3x ampoules of lorazepam 4mg/1ml from 12th November was not logged in the controlled drugs book. This was not noted until 2nd Jan 2016.	4	04/01/2016	• Daily stock checks in place by nursing staff – this did not previously include less familiar items such as the lorazepam amps • Technician to check fridge as part of the top-up process **Closed from Accountable Officer's perspective** **CLOSED**
02/01/2016 (Incident number 116140) Client did not receive her 08:00hrs omeprazole and diazepam as it was unclear if she had already had them. They were therefore omitted as a precaution.	4	04/01/2016	• Medication to be administered with another member of nursing staff • Clarification of preceptorship process to be undertaken – competency to administer medication
03/01/2016 (Incident number 116149) Completed stock check. Minus 1x clonazepam tablet and minus 2x5mg diazepam tablets.	4	04/01/2016	• All records checked – unable to identify discrepancies
05/01/2016 (Incident number 116270) When pharmacy technician conducted a stock check on 5th Jan on the ward, a discrepancy of lorazepam 1mg x 1 tablet was identified.	4	06/01/2016	• Ward to continue with daily check • Ward technician to continue to monitor stock as part of top-up process
07/01/2016 (Incident number 116289) A client's patch could not be found when staff went to check. It was confirmed later by staff who had conducted the client's personal care that they found it.	3	07/01/2016	• Unit to continue with daily checks as per policy to ensure patch remains in place • Continue to complete body map as per policy • Monitor for further occurrences • Medicines Safety Officer following up ongoing incidents with unit manager
08/01/2016 (Incident number 116549) Checking process identified a stock discrepancy of morphine solution (10mg/5ml). Register stated	4	08/01/2016	• Considered human error – the assumption made that the stock was already entered in the register

200ml but there was actually 500ml.			**Closed from Accountable Officer's perspective** **CLOSED**
09/01/2016 (Incident number 116330) Benzodiazepine stock check showed a discrepancy of -2x10mg chlordiazepoxide.	4	11/01/2016	• Awaiting investigation
10/01/2016 (Incident number 116522) When staff were getting a matrifen patch ready for a client they struggled to find the last patch. They later found it on the client's chest. The body map had not been filled in when it was previously changed.	3	20/01/2016	• Staff reminded to complete the body map
11/01/2016 (Incident number 116365) On admission it was noted when counting a client's medication that her family had not sent in any lorazepam. The family were contacted who brought in the medication the next day.	4	14/01/2016	• Unit aware of process to obtain medication out of hours • No further actions identified **Closed from Accountable Officer's perspective** **CLOSED**
11/01/2016 (Incident number 116368) Client declined regular clonazepam tablets. Staff checked and the client was actually prescribed clonazepam sugar free solution. On call doctor contacted who amended the electronic prescription.	4	14/01/2016	• Diligence needed with the prescribing and administration of clonazepam due to the differences in strengths expressed for different formulations • Issue discussed in Pharmacy – manufacturers label was listed as 0.5mg/ml – in light of no other incident concerns identified, the description was to remain the same and match the manufacturers • Medicines Safety Officer to follow up timelines of incident reporting with the ward team **Closed from Accountable Officer's perspective** **CLOSED**
11/01/2016 (Incident number 116394) Client disclosed to staff that she was self medicating with morphine that she brought from home whilst on leave.	2	14/01/2016	• Risk management discussed on the ward – agreed to search client on return from home leave in future • Increase awareness within nursing team about recognising client's distress around waiting for pain relief • Therapeutic intervention and emotional support provided
12/01/2016 (Incident number 116409) Client was administered was administered 7.5mg zopiclone instead of 3.75mg.	4	14/01/2016	• Awaiting investigation
13/01/2016 (Incident number 116408) During benzodiazepine stock check, found clonazepam were down by 1 tablet.	4	14/01/2016	• Awaiting investigation
13/01/2016 (Incident number 116459) Pharmacist wrongly endorsed a chart for a client. Methylphenidate 2mg instead of circadin. The client was also on methylphenidate 10mg twice a day.	2	14/01/2016	• Incident reviewed in supervision – no known trends of this nature • Prompt self reporting of the incident noted once identified • Care needed when undertaking the task • Pharmacist following up with wider medicine management issues at this unit

			Closed from Accountable Officer's perspective **CLOSED**
14/01/2016 (Incident number 116456) A client's methadone was increased from 60mg to 65mg and as the client had moved home, the dispensing chemist was changed. However, the new chemist had dispensed the next day's methadone today in error. This means the client had received 60mg from the old chemist and 65mg from the new one (total of 125mg).	2	14/01/2016	• No actions identified within the prescribing service • Incident shared with Sheffield CCG **Closed from Accountable Officer's perspective** **CLOSED**
14/01/2016 (Incident number 116463) Staff nurse gave a patient 10mg temazepam, should have been 7.5mg zopiclone.	3 & 4	15/01/2016	• Prescription checked but wrong hypnotic selected – clinical activity considered as the cause of the incident • Ward monitoring for further incidents of this nature
16/01/2016 (Incident number 116478) Client was given 5mg lorazepam in error. Correct dose prescribed is 4mg in 24hrs).	4	18/01/2016	• Diligence needed at the point of administration • Medicines Safety Officer awaiting review by ward team
17/01/2016 (Incident number 116574) During SOP check on nights lorazepam 1mg tablet could not be accounted for. The balance should have been 185 but there were only 184.	4	21/01/2016	• Ward staff to continue with daily stock checks **Closed from Accountable Officer's perspective** **CLOSED**
18/01/2016 (Incident number 116510) Staff gave a client his matrifen patch a day early by mistake.	3	19/01/2016	• Amendment of MAR chart post incident to reflect the new administration dates
21/01/2016 (Incident number 116581) Whilst staff were conducting a client's personal they noticed that his buprenorphine patch was missing.	3	21/01/2016	• Continue with current protocol of daily checks and documenting patch remains in place • Continue documenting placement of patch on body maps • Patch failure – no documented batch number identified in incident report – not fed back to manufacturers
23/01/2016 (Incident number 116619) During SOP check of controlled medications it was noted that there was 1x 5mg diazepam and 1x 10mg chlordiazepoxide less than the stock balance.	4	25/01/2016	• Ward to continue with daily stock checks
26/01/2016 (Incident number 116661) Patient was administered 10mg of zolpidem instead of nitrazepam.	4	26/01/2016	• Diligence needed at point of administration
27/01/2016 (Incident number 116702) Staff member found a buprenorphine patch on the bedroom floor of a client. The client was checked and confirmed that it was his missing patch.	3	27/01/2016	• Flexi nursing staff to be informed of SOP for checking the patches are still in situ • Medicines Safety Officer following up with the unit re induction process of agency staff and checking processes • Continue to document on body map
28/01/2016 (Incident number 116953) Staff were unable to locate a client's matrifen patch which had been placed on 25/01/2016. A new patch was administered.	3	11/02/2016	• To embed process of daily check of patch positioning (unclear why not happening) – Medicines Safety Officer to follow up with unit manager

28/01/2016 (Incident number 116955) While attending to a client to administer a new matrifen patch, staff were unable to locate the previous patch which was administered on 25/01/2016.	3	11/02/2016	• Continue to embed the need for daily checks required as part of the SOPs
31/01/2016 (Incident number 117540) Client was administered 1mg lorazepam instead of 2mg diazepam in error.	4	07/03/2016	• Awaiting investigation
01/02/2016 (Incident number 116775) Staff observed a client take a tablet which was reported to be trazodone. When belongings were searched, staff found empty blister packs for lorazepam and trazodone.	4	04/02/2016	• On-call medic was informed – evening dose of trazodone omitted • Inadequate review – Medicines Safety Officer to discuss with the ward • Unclear if client took own medication
02/02/2016 (Incident number 116963) Staff went to apply the matrifen patch as prescribed to a client but were unable to locate the patch applied on 30/01/2016.	3	11/02/2016	• Awaiting investigation
03/02/2016 (Incident number 117613) Client's father reported that a staff member dispensed medication at 08:00hrs and omitted to dispense 2mg diazepam.	4	09/03/2016	• Awaiting investigation
06/02/2016 (Incident number 116873) While assisting a client with personal care, staff noticed the client's buprenorphine patch was missing.	3	07/02/2016	• Qualified nurses to continue to observe daily each resident patch and document on Insight • Qualified nurses to continue to document on the body chart the removal of old patches and the application of new patches
14/02/2016 (Incident number 117038) There was a discrepancy in the controlled drugs count on 13/02/2016. There should have been 13 temazepam tablets in stock but there were only 12.	3	19/02/2016	• Awaiting investigation
14/02/2016 (Incident number 117043) Staff noticed that a client's Butrans 5mcg patch was not in situ. Full body assessment completed and patch not found.	3	15/02/2016	• Qualified nurses to continue to daily observe patch and document on Insight
14/02/2016 (Incident number 117228) On checking a client's medication it was noticed that the 21:00hrs medication was missing. A thorough check found that the 08:00hrs medication had not been given. Medication included: Diazepam 2mg & 4mg.	4	22/02/2016	• Challenging environment in this area identified as the main contributory factor • A greater need to distract / manage the other clients during the administration process was emphasised and shared with the staff
17/02/2016 (Incident number 117101) During night shift benzodiazepine check it was noted that there was one less tablet in the 10mg diazepam stock. Diazepam 5mg was one tablet up. Possibility that a patient received the wrong strength of diazepam.	4	17/02/2016	• Diligence needed at the point of admission
18/02/2016 (Incident number 117180) Staff member noticed a client's Butrans 10mcg patch was found on the sofa he was sat on. Patch was removed and destroyed.	3	19/02/2016	• Further embedding needed to capture patch batch number if patch comes off / medication failure

21/02/2016 (Incident number 117225) Patient was very distressed and was administered 1mg lorazepam instead of the 0.5mg lorazepam as prescribed.	4	21/02/2016	• Awaiting investigation
24/02/2016 (Incident number 117428) Zopiclone 7.5mg tablet found to be missing when checked by Pharmacy technician.	4	01/03/2016	• Awaiting investigation
25/02/2016 (Incident number 117316) Whilst completing SOP controlled drugs check it was noted that 1x2mg diazepam tablet was unaccounted for. None had been charted as administered or documented in the controlled drugs book.	4	25/02/2016	• Awaiting investigation
28/02/2016 (Incident number 117394) Whilst checking when a client was next due their prn clonazepam it appeared that they had been administered 4 prn doses of 500mcg clonazepam, the last in the 24 hours being administered at 20:46hrs. Client is prescribed 3x500mcg prn in 24 hours.	4	29/02/2016	• No action identified from a prescribing or administration perspective • Medicines Safety Officer requested ward to review incidents in timely manner • Incident logged to capture that the treatment plan was insufficient for the prescription **Closed from Accountable Officer's perspective** **CLOSED**
29/02/2016 (Incident number 117575) Client was given 2mg diazepam at 13:00hrs in error. Service was advised not to give the 20:00hrs medication and continue as normal the next day.	4	08/03/2016	• Two supervised drug administrations undertaken • Avoid medication not in the Biodose MDS system unless unavoidable • Greater need for care / vigilance at the point of administration **Closed from Accountable Officer's perspective** **CLOSED**
03/03/2016 (Incident number 117456) During controlled drugs stock check it was noted that 3x10mg diazepam tablets and 1x5mg diazepam tablets were unaccounted for.	4	03/03/2016	• Awaiting investigation
03/03/2016 (Incident number 117461) Client took their child to A&E after they potentially ingested buprenorphine and was found to be drowsy. The client reported that they earlier dropped their buprenorphine medication on the floor at home but couldn't find it, then later found the tablet part consumed.	3	03/03/2016	• Supervision practice reviewed with the community pharmacy • Locked box in use – further advice about storage in place • Daily supervision in place (remains to have medication at home in locked box over weekend) • Clients Risk Profile updated • To review if further issues highlighted from safeguarding process **Closed from Accountable Officer's perspective** **CLOSED**
07/03/2016 (Incident number 117528) Client reported to the service that they had taken 74 dihydrocodeine tablets over the weekend. Advised to go to A&E.	5	08/03/2016	• Awaiting investigation

09/03/2016 (Incident number 117635) Client was administered 5mg diazepam at 15:39hrs and although it was recorded in the controlled drugs book it wasn't charted on JAC. Another staff member then administered 5mg diazepam to the same client at 17:45hrs.	4	09/03/2016	• Awaiting investigation
11/03/2016 (Incident number 117664) 100ml diazepam bottle not recorded in the controlled drugs book (2mg/5ml).	4	14/03/2016	• Awaiting investigation
12/03/2016 Incident number 117671) Client's parents expressed concern over the client not receiving the correct medication. On looking at the medication card, prn medication of temazepam & paracetamol not signed for or documented as given, temazepam not signed out of the controlled drugs book.	3	14/03/2016	• Incident discussed with staff nurse involved – reassurances regarding medicines management training to be attended (provided through flexi manager) • Nurse in question has not been booked at this unit since the incident • Deputy manager has liaised with the service users family **Closed from Accountable Officer's perspective** **CLOSED**
12/03/2016 (Incident number 117901) Client was given 3x diazepam tablets instead of 2 during the 16:00hrs medication round. Contributory factors - medication not in nomad; some medication changed doses Environment factors – family members bringing dogs.	4	23/03/2016	• Staff to manage supported living environment and in this case to limit distractions by removing the dogs during administration • No trends of incidents identified for member of staff **Closed from Accountable Officer's perspective** **CLOSED**
12/03/2016 (Incident number 117951) Two buprenorphine patches were observed on a client – one of which was in an inappropriate place.	3	24/03/2016	• Staff reminded to complete documentation of the body map and not to apply to the breast area • Staff to ensure a patch is removed prior to applying a new one
15/03/2016 (Incident number 117716) Routine benzodiazepine count showed the 2x500mcg clonazepam tablets could not be accounted for.	4	15/03/2016	• Awaiting investigation
20/03/2016 (Incident number 117839) Client requested their prn codeine 30mg which was administered. When signing off on JAC, staff nurse noticed that it had only been five hours since the client had the previous dose and that six hours should be left between doses.	5	21/03/2016	• Prescription reviewed and frequency altered to 4 hourly
20/03/2016 (Incident number 117855) During controlled drug audit, 3x4mg/ml lorazepam ampoules were found in the fridge. These were not logged in the controlled drugs book.	4	21/03/2016	• All controlled drugs were moved during the ward relocation except for the drug fridge contents • No weekly audits were completed from 16/12/2015 – Medicines Safety Officer to discuss with the team
21/03/2016 (Incident number 117856) Whilst carrying out medication round, found that according to the recording in the controlled drugs book there was a shortfall of 1xtramadol capsule.	3	21/03/2016	• Tramadol not intended to be monitored in CD record book – not part of the SOP for hypnotics / benzodiazepines

22/03/2016 (Incident number 117874) Client received prn at 02:05hrs but staff member later realised this administration hadn't saved on the JAC system. Medication included: clonazepam & zopiclone	4	23/03/2016	• No duplicate dose identified following incident review • JAC not added to capture administered doses • Monitor for further incidents of this nature – no problems reported or identified currently **Closed from Accountable Officer's perspective** **CLOSED**
23/03/2016 (Incident number 117916) Benzodiazepine check was done during the night shift. Staff noted that 2x10mg chlordiazepoxide tablets were missing.	4	23/03/2016	• Awaiting investigation
23/03/2016 (Incident number 117930) Staff were unable to find a matrifen patch on a client which had been applied on 20/03/2016.	3	24/03/2016	• Awaiting investigation
23/03/2016 (Incident number 117944) Returned medication in Pharmacy was being processed and 26 doses of concerta XL (methylphenidate) was found in a sealed envelope.	2	24/03/2016	• Audit trail of medication documentation to be reviewed • Patients own medication, issued by community pharmacy, should be returned to the community pharmacy • Ward to discuss with SHSC Pharmacy if they need to send medication to SHSC Pharmacy – issue to be added to community guidelines in Medicines Management policy
24/03/2016 (Incident number 117961) Client's 5mg diazepam was dispensed at 16:00hrs after checking the system to see what she had in the last 24 hours. On signing for it in the benzodiazepine book it was discovered that she had been given 5mg at13:20hrs which was not charted.	4	29/03/2016	• Awaiting investigation
24/03/2016 (Incident number 117979) Evening dose of clonazepam 1mg had not been signed for on the drug card or entered in the ward controlled drugs book.	4	25/03/2016	• Medicines Safety Officer following up with the ward
25/03/2016 (Incident number 118057) On-call SHO prescribed 2mg tds of diazepam for 4 day. Client was given 5mg diazepam in error.	4	30/03/2016	• Awaiting investigation
26/03/2016 (Incident number 117995) 1x500mcg clonazepam was found missing whilst completing benzodiazepine stock check.	4	29/03/2016	• 7 small stock discrepancies identified over this quarter • Medicines Safety Officer following up with the ward and directorate
28/03/2016 (Incident number 118034) On completion of SOP check the count of diazepam 2mg was found to be 1 (one) down.	4	28/03/2016	• No trend of stock discrepancies identified for this ward • Ward continuing with daily stock checks
30/03/2016 (Incident number 118068) Lorazepam 1mg could not be accounted for during stock reconciliation and top-up.	4	30/03/2016	• Approximately 2 stock discrepancies per month for this ward • Medicines Safety Officer following up with the ward and directorate

30/03/2016 (Incident number 118076) The unit medication fridge had been running at too high a temperature. When the engineer attended, he took away the fridge. The unit don't have a drugs fridge. Medication from the fridge included Lorazepam IM which would only be stable for 24 hours.	4	30/03/2016	• Awaiting investigation
05/04/2016 (Incident number 118294) Staff member was made aware that the scripting system had generated two prescriptions for methadone 1in1 sugar free, 50nls. This was following a cancelled prescription.	2	08/04/2016	• Error identified as a technical 'bug' where the system slowed down allowing a replication of a prescription - prescribing module was subsequently fixed **Closed from Accountable Officer's perspective** **CLOSED**
06/04/2016 (Incident number 118206) Balance of 5mg diazepam wan incorrect, there was one tablet unaccounted for.	4	04/05/2016	• Medicines Safety Officer following up with ward manager / ward pharmacist and inpatient directorate – timeliness of reporting needed to capture learning from the incident **Closed from Accountable Officer's perspective** **CLOSED**
06/04/2016 (Incident number 118255) A clients prescription for 60mls methadone had not been received by the chemist when the client attended. On-call doctor was contacted and a new prescription was generated. Member of staff took this directly to the chemist and met with the client there.	2	07/04/2016	• Prescription was confirmed as being delivered to the optical department instead of the pharmacy • No dose of methadone was missed – a prescription for that days dose was generated by the on-call doctor • Issued discussed with the taxi company • Service is reviewing it's process for sending prescriptions by taxi **Closed from Accountable Officer's perspective** **CLOSED**
07/04/2016 (Incident number 118257) During benzodiazepine check, 2x10mg chlordiazepoxide capsules were unaccounted for. Diazepam 2mg in 5ml liquid, stock balance was 138mls but actual balance was 106mls. Some of this will be due to wastage.	4	07/04/2016	• SOP for benzodiazepines stock check to be reviewed and changed if necessary – Medicines Safety Officer following up on this • Timely review of incidents required to support the ward in managing discrepancies **Closed from Accountable Officer's perspective** **CLOSED**
07/04/2016 (Incident number 118295) Staff member was made aware that there had been an error on the prescribing system. The system had generated 2 prescriptions for the same drug following the system being dropped into cancellation mode.	?	08/04/2016	• Error identified as a technical 'bug' where the system slowed down allowing a replication of a prescription - prescribing module was subsequently fixed **Closed from Accountable Officer's perspective** **CLOSED**
14/04/2016 (Incident number 118427) During nightly stock check of benzodiazepines it was noted that 1x500mcg clonazepam was unaccounted for.	4	14/04/2016	• Ward to continue with daily checks of stock balance on the night shift • Staff reminded of the importance of documenting all administrations / dropped or refused doses **Closed from Accountable Officer's perspective** **CLOSED**

15/04/2016 (Incident number 118447) When completing stock check of benzodiazepines the clonazepam total was minus 1x500mcg tablet.	4	15/04/2016	• Timeliness of incident reviews to be embedded with ward team • No significant trend of stock discrepancies identified during this quarter **Closed from Accountable Officer's perspective** **CLOSED**
16/04/2016 (Incident number 118465) When staff were checking that a client's matrifen patch they found that it was missing. Bedroom was searched but couldn't find it.	3	18/04/2016	• There are known issues with patches that senior staff are aware about • Daily checks have been put in place as the most practical solution • Pharmacy to continue monitoring for further incidents
17/04/2016 (Incident number 118482) Whilst preparing to administer 2mg diazepam to a client, staff members counted the amount of 2mg diazepam and discovered that there was 1x2mg more that written in the controlled drugs book. 5mg diazepam was counted and there was an extra tablet. After checking the records it would seem that a client had been given 5mg in the morning instead of 2mg.	4	18/04/2016	• Another qualified nurse was hired after this incident so that there are two qualified members of staff to administer and check medication before it is given • Inadequate staffing levels appear to be the main reason for the error and management were aware of problem and risks associated with that **Closed from Accountable Officer's perspective** **CLOSED**
18/04/2016 (Incident number 118489) On going the benzodiazepine check there was 5mg diazepam unaccounted for.	4	28/04/2016	• Reason for stock discrepancy not identified – timeliness of incident reviews to be shared with the ward, pharmacist and directorate **Closed from Accountable Officer's perspective** **CLOSED**
19/04/2016 (Incident number 118523) Whilst completing controlled drugs stock check found there were only 37x1mg lorazepam tablets when there should have been 38.	4	20/04/2016	• Weekly stock check to be undertaken on a Friday • Discussed with staff via the ward meetings **Closed from Accountable Officer's perspective** **CLOSED**
19/04/2016 (Incident number 118526) Whilst checking the controlled drugs it was noted that the diazepam in both 2mg & 5mg were one tablet short.	4	20/04/2016	• New staff to be informed of benzodiazepine procedures • Member of staff had been subsequently informed of the procedure to undertake • Documented stock check to take place on a weekly basis on a Friday evening • Medication incidents to be reviewed in a timely manner to capture the learning and reflection of the incident **Closed from Accountable Officer's perspective** **CLOSED**
20/04/2016 (Incident number 118537) Whilst attending to a client, staff noticed that the matrifen patch was 'missing' but the tegaderm film had a small round hole cut in it where the patch should have been. Staff were unable to find the patch.	3	20/04/2016	• Incident has been reviewed with the team – staff to check patches are in place each shift and document on Insight and MAR chart • Use of tegaderm dressing to stop patches falling off (although not recommended by manufacturer) & dates written on patch when applied – not part of current SOPs but issues

Staff had reported previously that they had found 2 patches on this client but the previous day only had one patch correctly positioned as per the body map. The patch was removed a new one applied, witnessed as per the policy by 2 qualified nurses.			regarding management of patch adhesion being reviewed
21/04/2016 (Incident number 118577) Whilst Pharmacy were completing a routine drugs check they alerted staff that there was 1x5mg diazepam tablet missing.	4	21/04/2016	• Nursing stock check frequency reviewed with the team – to be embedded as a regular daily check
21/04/2016 (Incident number 118634) Medication dispensed on the ward incorrectly. Client was given 2mh (5ml) instead of 5mg (12.5ml). This also occurred on 22/04/2016.	4	25/04/2016	• Unable to identify if there was a competency or calculations issued following review – nurse moved to another Trust • Incident may be linked to a small number of incidents where the strength of drug was administered as opposed to the dose **Closed from Accountable Officer's perspective** **CLOSED**
23/04/2016 (Incident number 118647) Patients medication was ordered from NGH out of hours and collected using the incorrect requisition form. Staff member realised when they returned to the ward that they should have used the controlled drugs requisition. Medication was methadone.	2	25/04/2016	• No Medicines Optimisation Training undertaken – followed up with ward deputy manager to ensure this is updated • SOPs shared with the ward – ward to review process for sharing of SOPs with new staff starting on the ward • Prompt self reporting of the incident noted • No stock discrepancies but the use of the wrong requisition book led to the page number not matching the CD requisition book **Closed from Accountable Officer's perspective** **CLOSED**
24/04/2016 (Incident number 118688) 32mg of suboxone prescribed on JAC by admitting doctor, picked up in ward MDT the following day. 32mg had been charted by nursing staff on JAC, however, Insight prescribing screen indicated dosing to be 12mg daily. Junior doctor chased medicines reconciliation- confirmed dosing with the service as 12mg. On checking the controlled drugs book it appears only 2mg suboxone was ordered from 'out of hour's, and 4 of the 2mg given.	3	28/04/2016	• Incident shared and reflected on post incident – learning to include risk of prescribing duplicate prescriptions (dose already prescribed in the community for 24th April) • Dose description altered on JAC for both suboxone strengths (expressed as mgs) • Controlled drugs prescribing SOP to be reviewed
25/04/2016 (Incident number 118846) Client was given and extra dose of diazepam for 3 days in error due to a misunderstanding of dosages. Linked to incident 119158	4	03/05/2016	• Incident shared with Sheffield CCG – no further incident investigation being undertaken • Communication of medicines changes and the process of MAR chart amendments to be reviewed in the relevant medicines policy • Unit staff are to follow procedure / admin codes as per MAR chart – the use of 'X' was not an approved code • Staff informed to contact the prescriber directly in the case of any queries about the treatment plan • To monitor for further incidents involving MDS systems

26/04/2016 (Incident number 118698) Phone call received from patient's mother that patient had taken an overdose of unknown quantities whilst at home. Ambulance called to attend patients address. Medication: zopiclone	4	05/05/2016	• No safeguarding alerts or prescribing alerts identified • Client was re-admitted to the community team **Closed from Accountable Officer's perspective** **CLOSED**
26/04/2016 (Incident number 118700) Whilst conducting a stock check of controlled drugs staff found that there was 1x2mg diazepam extra and 1x5mg diazepam short. When the entries in the controlled drugs book were checked, the stock was correct.	4	27/04/2016	• Linked to incident 118526 where medication wasn't recorded in the register by the same staff member • No concerns with competency identified – this was a recording error • Ward to continue to embed inpatient procedures **Closed from Accountable Officer's perspective** **CLOSED**
26/04/2016 (Incident number 118772) Changes to a patients medication regime were made without a face to face assessment. Patient had all her diazepam stopped - was on 25mg daily. Prescribed clonazepam regular and prn.	4	03/05/2016	• Incident contributed to by medics striking and access to doctors **Closed from Accountable Officer's perspective** **CLOSED**
27/04/2016 (Incident number 118725) Staff went to replace a clients fentanyl patch as prescribed. The previous patch was not in situ and could not be found.	3	03/05/2016	• Previous incidents at this unit have been reviewed and discussed with management • Daily checks are in place as a practical solution which will help staff to identify a lost patch promptly for action
28/04/2016 (Incident number 118751) Service user had been dispensed her medication and took most of what was in the medicine tot before adding a small amount of water. She took a small sip then poured the remainder down the drain. It was difficult to assess how much of the prescribed dose she actually had.	4	29/04/2016	• Appropriate action was taken post administration • Not considered to be a medication incident (logged as incorrect dose) **Closed from Accountable Officer's perspective** **CLOSED**
29/04/2016 (Incident number 118769) Telephone call received from the pharmacist at the community chemist explaining that a client had called them about her prescription from the GP. She then arrived by taxi in a rush and the pharmacist accidentally dispensed 90mg methadone that was due the day after. Client had already taken 90mg methadone at home earlier that morning.	2	29/04/2016	• Incident shared with CCG Accountable Officer for review with dispensing pharmacy
04/05/2016 (Incident number 119158) Client was prescribed diazepam by the GP. Dosage was increased from 10mg daily to 15mg daily. Staff misunderstood the level of increase and administered an additional 10mg diazepam for 11 days.	4	17/05/2016	• Incident shared with Sheffield CCG – confirmed community pharmacy procedures were followed – no further investigation being undertaken • Communication of medicine changes and the process of MAR chart amendments to be reviewed in the disabilities medicines policy and amended appropriately • Unit managers to be reminded to contact the prescriber directly in the case of any queries about the treatment plan • To monitor for further incidents of this nature

			Closed from Accountable Officer's perspective **CLOSED**
05/05/2016 (Incident number 118846) Client was administered more diazepam than prescribed. Was changed from 5mg diazepam twice a day to 10mg in the morning, 5mg at lunchtime and 10mg at night (25mg in total). Due to misunderstanding of dosages, client received and extra 5mg for the past 3 days.	4	05/05/2016	• Incident shared with Sheffield CCG – confirmed community pharmacy procedures were followed – no further investigation being undertaken • Communication of medicine changes and the process of MAR chart amendments to be reviewed in the disabilities medicines policy and amended appropriately • Unit managers to be reminded to contact the prescriber directly in the case of any queries about the treatment plan • To monitor for further incidents of this nature **Closed from Accountable Officer's perspective** **CLOSED**
05/05/2016 (Incident number 119962) Service received a telephone call from a community pharmacy in relation to a prescription provided to a patient the previous day. The pharmacy were of the opinion that the script had been tampered with. The script was for 9 tablets of 2mg diazepam and a number 3 had been inserted in front of the number 9.	4	22/06/2016	• Incident followed up with client • Warning added to Insight and letter written to GP • Incident shared with SHSC security officer and with CCG accountable officer **Closed from Accountable Officer's perspective** **CLOSED**
09/05/2016 (Incident number 119004) Staff unable to locate old matrifen patch to replace for a new one. New patch put in place as prescribed on prescription sheets.	3	10/05/2016	• Dating of patches and use of occlusive tegaderm dressings were thought to have been put in place to prevent recurrent issues of missing patches • Process to continue to be embedded with staff (need to monitor adhesion on a daily basis)
12/05/2016 (Incident number 119068) Client was refusing oral medication but agreed to accept IM lorazepam. When preparing the lorazepam for administration, staff nurse diluted it with water only realising later that this brand did not need diluting.	4	13/05/2016	• Due to supply problems, lorazepam injections were imported – these did not require dilution for IM injection – information leaflet was issued at the time • No imported IM lorazepam in use currently
15/05/2016 (Incident number 119088) Medication stock checked and found that 10mls of clonazepam liquid is short. 300mls documented in the controlled drugs book however only 290mls visible in the bottle.	4	16/05/2016	• Not considered a significant discrepancy from a 150ml bottle • Benzodiazepine / hypnotic SOP to be reviewed to capture expectations for liquids • Directorate to clarify process for visual / actual monitoring **Closed from Accountable Officer's perspective** **CLOSED**
15/05/2016 (Incident number 119100) Staff nurse went to apply a new pain relief patch to a client and observed that the old patch was missing.	3	16/05/2016	• Staff informed to check the patch every morning shift
21/05/2016 (Incident number 119268) During night shift stock check of controlled drugs there were 2 discrepancies in the benzodiazepine stock:	4	23/05/2016	• Medicines Safety Officer to follow up the use of the stock questionnaire to capture the investigation of stock discrepancies at the time • SOP was not followed at this time – stock not

1x1mg lorazepam tablet missing 8x4mg/1ml IM lorazepam ampoules extra			entered in the benzodiazepine register **Closed from Accountable Officer's perspective** **CLOSED**
23/05/2016 (Incident number 119303) Controlled drugs check found 4x500mcg clonazepam tablets to be missing.	4	23/05/2016	• Medicines Safety Officer to share as an example of an untimely review • The review does not capture the reasons for the stock discrepancy – this is a recurrent issue within the inpatient adult acute wards • Shared as the inpatient governance meeting in September **Closed from Accountable Officer's perspective** **CLOSED**
24/05/2016 (Incident number 119384) Service was informed by community pharmacist that they had dispensed 7 days of medication in error. Client is prescribed 10mg buprenorphine and 12mg diazepam which they usually collect three times per week.	3 & 4	26/05/2016	• No prescribing issues identified from the service contributing to the incident • GP was informed and an updated prescription was generated to bring the supply back in line • To re-open if further issues are identified from the CCG **Closed from Accountable Officer's perspective** **CLOSED**
25/05/2016 (Incident number 119346) During benzodiazepine check on the night shift, staff nurse counted an extra 2 clonazepam tablets.	4	25/05/2016	• Vigilance needed with benzodiazepines • Staff to document any wasted / refused medication • Continue with daily stock checks which were evidenced in the records books **Closed from Accountable Officer's perspective** **CLOSED**
28/05/2016 (Incident number 119437) Benzodiazepine check found 1x1mg lorazepam tablet was missing.	4	31/05/2016	• Staff encouraged to be vigilant with record keeping • Continue with daily stock checks **Closed from Accountable Officer's perspective** **CLOSED**
31/05/2016 (Incident number 119490) Client was not administered their morning dose of diazepam.	4	01/06/2016	• Greater time to be taken during the administration process • JAC system planned for roll out
03/06/2016 (Incident number 119592) Service reported that their midazolam liquid had expired and had some lorazepam amps that needed returned as they had no fridge. The service later advised that they had sent this medication back to Pharmacy via the delivery driver however, upon return the driver confirmed he had just been given a requisition for midazolam.	4	06/06/2016	• New fridge ordered • No medication missing – assumptions were made as to where the midazolam was and incident form completed prematurely having been found stored appropriately **Closed from Accountable Officer's perspective** **CLOSED**
05/06/2016 (Incident number 119569) Benzodiazepine check found a discrepancy of 25.5mls liquid diazepam.	4	06/06/2016	• SOP for liquids to be clarified – expectations for stock check to be added

06/06/2016 (Incident number 119585) Client requested prn lorazepam at 02:31hrs. However, was administered 7.5mg zopiclone in error. The client had requested and was administered prn zopiclone at the earlier time of 22:31hrs.	4	06/06/2016	• On-call doctor was contacted promptly following identification
09/06/2016 (Incident number 119790) Weekend leave script for a client was dispensed without the original prescription due to time constraints.	3	10/08/2016	• Midazolam issues discussed in Pharmacy governance and discussed in peer review – reminded of the need for controlled drugs prescriptions for schedule 3 drugs • Process for taxi deliveries added
10/06/2016 (Incident number 119687) The temperature of the drugs fridge recorded at 11.6oC in morning, 10.3oC in afternoon and 12.7oC at 10pm. Pharmacy was contacted who advised the Lorazepam vials can still be used.	4	22/06/2016	• Ward to continue with daily monitoring of fridge temperatures • New fridge ordered and in place 14/06/2016 **Closed from Accountable Officer's perspective** **CLOSED**
10/06/2016 (Incident number 119718) 1mg Lorazepam tablet unaccounted for on Benzodiazepine checks.	4	13/06/2016	• Discussed in ward meeting for staff to capture the initial investigation at the time of the incident • Medicines Safety Officer to follow up the use / roll-out of the questionnaire on the incident system with Risk department **Closed from Accountable Officer's perspective** **CLOSED**
22/06/2016 (Incident number 120367) Whilst checking stock control sheets for medication, realised they didn't match the drugs in the cupboard; -1 lorazepam & -3 diazepam tablets.	4	27/06/2016	• Staff to continue to do stock check every morning • Management to review medication / documentation on a monthly basis • Directorate aware of the concerns from family / staff – safeguarding meeting planned
26/06/2016 (Incident number 120055) Client was contacted and informed that staff would be visiting. On arrival, staff found the client in bed (front door was open having given staff access via buzzer system). Client reported to have taken a mixed overdose which included diazepam.	4	27/06/2016	• Small quantities of medication prescribed by the team • Consultant reviewed and communicated the overdose to the GP **Closed from Accountable Officer's perspective** **CLOSED**
27/06/2016 (Incident number 120103) Community pharmacist reported that they had given a client an extra days supply of methadone in error.	2	27/06/2016	• No prescribing concerns identified from the service • Re-open incident if any other issues relevant to the service are identified from the CCG **Closed from Accountable Officer's perspective** **CLOSED**
30/06/2016 (Incident number 120183) Whilst undertaking benzodiazepine stock check found 1x10mg diazepam tablet missing.	4	30/06/2016	• Daily stock checks to continue • Discussed during ward meeting to remind staff of the need for documentation, particularly if dropped or refused • Reviewing if diazepam to be removed from the ward stock list

01/07/2016 (Incident number 120203) During controlled drugs check, found the stock of clonazepam was minus 2 tablets. No clonazepam was given during the shift to account for this deficit.	4	01/07/2016	• Staff reminded to log any medication which was refused and disposed of • Ward to continue to monitor and report any discrepancies **Closed from Accountable Officer's perspective** **CLOSED**
02/07/2016 (Incident number 120244) Client was given another clients medication by mistake.	?	28/07/2016	• Nursing staff informed of incident and reminded of administration policy • On discussion with the manager it appears that 'runners' are used sometimes, particularly in situations where patients may be agitated and don't take their medication from a certain individual – although not in common practice, 'runners' must be supervised administering the medication • Staff member booked for medicines management training in November 2016
04/07/2016 (Incident number 120290) Controlled drugs check found clonazepam 500mcg did not balance.	4	05/07/2016	• Incident reviewed with member of staff and was identified as a recording issue
04/07/20416 (Incident number 120296) Various recording errors found for administered clonazepam and lorazepam.	4	06/07/2016	• Supervision undertaken – nurse aware of SOP and to concentrate on administration task alone • Care needed to record on both the drug card and the benzodiazepine register • Staff member booked for medicines management training in January 2017 **Closed from Accountable Officer's perspective** **CLOSED**
06/07/2016 (Incident number 120329) It was discussed, planned, documented and handed over verbally that client would be prescribed prn temazepam 10mg for 2 nights, however, in error prn diazepam 10mg was prescribed.	4	07/07/2016	• Vigilance from nursing staff prevented the incorrect medication being administered • On-call doctor amended the prescription to the correct temazepam
07/07/2016 (Incident number 120380) While staff were assisting a client with personal care they noted that the pain relief patch was not in place. Patch could not be located.	3	11/07/2016	• There have been numerous incidents involving this client's patches and it's unclear whether he is removing them himself – management are aware of recurring incidents • Staff continue to check patches are in place **Closed from Accountable Officer's perspective** **CLOSED**
07/07/2016 (Incident number 120387) Whilst administering a client's evening medication, staff noticed that the morning dose of diazepam 5mg had not been given or signed for on the drug card or in the controlled drugs book.	4	08/07/2016	• Staff names to be captured in the incident review • Staff wear tabards during the administration process but managing the unpredictable behaviour was difficult to manager • Process for recording administration was known but task got missed as a result of the disruption • JAC to be implemented in January 2017 **Closed from Accountable Officer's perspective**

			CLOSED
07/07/2016 (Incident number 120558) Midazolam was dispensed from a drug card without a CD prescription.	3	15/07/2016	• Retrospective cd prescription sent on 14/07/2016 to cover the supply • The need to ensure legal requirements are met was discussed with member of staff during supervision • Fact sheet has been developed and circulated to raise awareness of clinical / licensing differences between products
08/07/2016 (Incident number 120419) Client was administered 20mg temazepam instead of 10mg diazepam.	3	11/07/2016	• Ongoing investigation
08/07/2016 (Incident number 120518) Midazolam buccal liquid 10mg/2ml (Buccolam) was dispensed instead of 10mg/1ml (Epistatus).	3	13/07/2016	• Confusion about different products and CD requirements were the root cause – this was discussed with the pharmacists and in governance
14/07/2016 (Incident number 120562) 0.5mg lorazepam tablet was missing from the count but found the next day on the floor. It was correctly disposed of.	4	18/07/2016	• Care needed with small/half tablets at the point of administration • No significant actions needed
20/07/2016 (Incident number 120646) 3 x lorazepam tablets were missing during benzodiazepine check.	4	10/08/2016	• Incident discussed with management team to monitor the benzodiazepine books • Nursing staff to be reminded of the procedure regarding benzodiazepine recording • No significant trend of stock discrepancies identified for this area **Closed from Accountable Officer's perspective** **CLOSED**
28/07/2016 (Incident number 120922) Following the ward meeting, it was noted by the pharmacist that 2mg lorazepam had been administered to a client on 4 occasions since being stopped on 07/07/2016.	4	29/07/2016	• Greater vigilance needed when administering medication • Ward to continue with two qualified nurses checking and signing for medication • One to one staff meetings discussing reflective practice and medicines management • Weekly audit to commence by ward management team • CQC inspection highlighted the clinic room/office was not fit for purpose – action plan to be put in place **Closed from Accountable Officer's perspective** **CLOSED**
29/07/2016 (Incident number 120933) During nightly controlled drugs stock check, staff found the count of lorazepam 1mg was down by one tablet.	4	29/07/2016	• Ward to continue with daily controlled drugs checks to pick up any discrepancies • Medicines Safety Officer to continue to monitor incident reports for this ward **Closed from Accountable Officer's perspective** **CLOSED**

29/07/2016 (Incident number 120951) Service was informed that a patient had taken all their diazepam and zopiclone from the Nomad system. Ambulance was called and the client was taken to A&E. Linked to incident 120195	4	29/07/2016	• Team to review patient's sleep and anxiety to avoid another overdose • Locked box to be used temporarily until more suitable options are available – NOMAD to be stored in this and medication to be administered on a daily basis **Closed from Accountable Officer's perspective** **CLOSED**
29/07/2016 (Incident number 120962) When counting temazepam before administering to a client, staff noticed that there was one less tablet. Nurse contacted to check if the night time medication had been given – it had.	3	03/08/2016	• Management are monitoring stock balances carefully • Nurses are carrying out weekly controlled drug checks
29/07/2016 (Incident number 121026) Whilst checking a client's medication, found that a box of lorazepam 1mg x28 was labelled to another patient (from another ward). Pharmacy was contacted and collected the medication, replacing it with the correctly labelled medication.	4	02/08/2016	• Previously returned medication was added to the wrong shelf inadvertently – SOP has been updated to prevent the risk of packs with labels being sent out as ward stock • Incident and SOP review discussed with staff **Closed from Accountable Officer's perspective** **CLOSED**
31/07/2016 (Incident number 120985) On administering a clients pain patch it was noticed that the previous patch was missing. Linked to incidents 121484 & 121120	3	01/08/2016	• Staff are using Micropore tape to reduce the risk of the patch coming off as per the Trust guidelines on administration of medication at this unit – however, the use of occlusive dressings is not recommended and referred to in the manufacturers guidelines • Management are alert to incidents and checking for trends in staff • Continuing staff supervision when patch is applied and maintain patch towards centre of back to prevent tempering **Closed from Accountable Officer's perspective** **CLOSED**
01/08/2016 (Incident number 121067) Community pharmacist left a message with the service informing them that a client had missed their Friday 29th collection of methadone but was given a dose on the following Monday. Client was contacted and reported to have a spare bottle that she used over the weekend.	2	03/08/2016	• Incident shared with CCG Accountable Officer Support • Client 'safe and well' check undertaken • Prescribing label was amended following this incident to have the additional statement on the prescription: consult the prescriber if 3 or more consecutive days of a prescription have been missed **Closed from Accountable Officer's perspective** **CLOSED**
04/08/2016 (Incident number 121092) When checking controlled drugs the stock balance was incorrect, there was one less lorazepam 1mg tablet than recorded in the book. Unable to identify where the discrepancy had come from.	4	05/08/2016	• Staff have been reminded to document on both JAC and the benzodiazepine book if tablets were refused and disposed of • Daily checks are being completed and not recent concerns or incidents **Closed from Accountable Officer's perspective** **CLOSED**

06/08/2016 (Incident number 121120) Service user was found not to have his pain patch in the middle of his back as per the body chart and MAR chart.	3	08/08/2016	• Nursing staff to continue daily checks to make sure patch is in place • Staff to apply patch towards centre of back as client may be able to remove it independently **Closed from Accountable Officer's perspective** **CLOSED**
08/08/2016 (Incident number 121186) Client was administered and extra dose of zopiclone 7.5mg in error.	4	09/08/2016	• Ongoing investigation
09/08/2016 (Incident number 121183) Discrepancies identified during nightly benzodiazepine check: 3x10mg chlordiazepoxide capsules 1x7.5mg zopiclone tablets	4	09/08/2016	• Ward to continue with daily stock check • Medicines Safety Officer to monitor for trends **Closed from Accountable Officer's perspective** **CLOSED**
10/08/2016 (Incident number 121229) Clients methadone was thrown away by family member leaving them 5 days short. Chemist should have dispensed the methadone in daily dose bottles as per the prescription but had dispensed in one bottle. Original script was cancelled and a new one supplied, however, when the client when to the chemist they had given her methadone from the new script plus 6 days as per the cancelled script.	2	12/08/2016	• Ongoing investigation
11/08/2016 (Incident number 121582) Ward requested buprenorphine (generic) 8mgs/l tabs but branded Subutex 8mg s/l tabs were dispensed but labelled as generic brand.	3	24/08/2016	• Discussed at staff meeting as a general reminder to all staff to be vigilant when dispensing and checking controlled drugs so that the correct brand/generic brand is supplied
15/08/2016 (Incident number 121328) Whilst client was being helped with daily personal care, staff noticed that the pain patch was missing. It was found stuck in the bed linen.	3	01/09/2016	• Patches have been known to detach occasionally and staff should be vigilant with checks to ensure they are in-situ – there is evidence that patch checks have been carried out almost daily **Closed from Accountable Officer's perspective** **CLOSED**
17/08/2016 (Incident number 121410) Client was given morning dose of tablets in a medicine pot that looked to have a white medication spilt on it.	4	17/08/2016	• Care / vigilance needed when administering medication • No trends identified • No additional action plans identified **Closed from Accountable Officer's perspective** **CLOSED**
17/08/2016 (Incident number 121413) Clients clonazepam was not cancelled on the medication chart. Clonazepam was still being administered by nursing staff.	4	18/08/2016	• Ongoing investigation
19/08/2016 (Incident number 121493) Service contacted by Pharmacy to inform staff regarding fridge temperature. Maximum reading between 8th and11th August was 15oC. Medication needed to be returned to Pharmacy for destruction. Some other medication required	4	22/08/2016	• Continue monitoring fridge temperatures daily to ensure it remains at suitable temperature • Management to monitor for further fridge incidents and consider contacting manufacturer for fridge servicing if incident occurs again

the expiry date amending.			
19/08/2016 (Incident number 121473) Client dropped their medication (diazepam) on the floor and proceeded to take the next days medication (Sunday). This would leave the client without medication on Sunday. Client would not let staff member look for the dropped medication to dispose of if.	4	22/08/2016	• Although dropped accidentally, the team should consider documenting which medications were missed and a clear action plan with the new dosette box in another incident occurs **Closed from Accountable Officer's perspective** **CLOSED**
20/08/2016 (Incident number 121484) Staff observed that a client's pain patch was missing whilst attending to personal care.	3	22/08/2016	• Management are alert to incidents and checking for trends in staff • Two members of staff in place when patch is applied and patch applied towards centre of back to prevent patient removing it • Patient specific plan implemented to monitor patch in place on a daily basis **Closed from Accountable Officer's perspective** **CLOSED**
23/08/2016 (Incident number 121546) Whilst completing discharge paperwork, staff member noticed that client was still prescribed regular lorazepam 1mg x3 daily. This was to have been reduced and stopped by discharge.	4	23/08/2016	• Incident shared with pharmacists and discussed in peer review • Reviewed with ward doctors as documentation of treatment plan needed to be captured **Closed from Accountable Officer's perspective** **CLOSED**
30/08/2016 (Incident number 121792) There was a problem with prescribing chlordiazepoxide regime on the JAC system. No doses of chlordiaxepoxide were missed and the care of the patient was not affected.	4	02/09/2016	• Pharmacists have been informed of JAC issues through clinical meeting and in-patient directorate meeting • Awareness of issue has been communicated to prescribers – prior to discontinuation to contact Pharmacy and JAC to analyse the prescription **Closed from Accountable Officer's perspective** **CLOSED**
31/08/2016 (Incident number 121790) 1x2mg diazepam tablet missing during routine check of benzodiazepines.	4	02/09/2016	• Discussed with ward to include benzodiazepine check after ward round so the discrepancy is picked up earlier however, this may not be possible at present due to heavy workloads and time constraints – this option can be considered again if there are further incidents **Closed from Accountable Officer's perspective** **CLOSED**
01/09/2016 (Incident number 121765) 1x1mg lorazepam tablet was noted as missing during night shift stock check of benzodiazepines.	4	01/09/2016	• Issue has been raised with the nurses and discussed procedure, documentation and vigilance with staff members **Closed from Accountable Officer's perspective** **CLOSED**
03/09/2016 (Incident number 121934) Drug discrepancies in benzodiazepines log book: 2x1mg lorazepam tablets 1x7.5mg zopiclone tablet	4	08/09/2016	• Issue of procedure, documentation and vigilance was raised with staff nurses • Discrepancy issue discussed at meeting • Deputy ward manager aware of incidents on

			ward and is monitoring the situation **Closed from Accountable Officer's perspective** **CLOSED**
08/09/2016 (Incident number 121983) Alcohol detox started but patient was refusing chlordiazepoxide. In light of refusal and no evidence of alcohol withdrawal, the doctor called and reported that he was unable to discontinue on JAC. There was a risk of doses being given if patient started to accept in future.	4	12/09/2016	• Ongoing investigation
10/09/2016 (Incident number 122010) Client's matrifen patch was changed the day before it was due.	3	12/09/2016	• Nurses to check patch administration dates carefully and consider when the last patch was applied and when new patch due
11/09/2016 (Incident number 122038) During benzodiazepine check, staff found that the ward stock was missing 1x2mg diazepam tablet.	4	19/09/2016	• Ward to continue with benzodiazepine checks **Closed from Accountable Officer's perspective** **CLOSED**
12/09/2016 (Incident number 122039) During stock check of benzodiazepines it was noted that 2x500mcg clonazepam tablets were missing.	4	13/09/2016	• Continued management of incidents by management and encourage vigilance with logging refused medication on both JAC and in the benzodiazepine stock book • Management are aware of previous incidents and monitoring for any trends **Closed from Accountable Officer's perspective** **CLOSED**
15/09/2016 (Incident number 122117) Client entered the clinic room and got hold of a packet of lorazepam and took 2 tablets whilst staff were attending to another client (who had requested the door be left open).	4	15/09/2016	• Incident discussed with nursing staff during meeting – as client preferred to pop out her own tablets, the nurses would cut one or two tablets from the blister packs to give to her • Staff have been reminded to close the clinic doors to ensure only one client is in the room at a time **Closed from Accountable Officer's perspective** **CLOSED**
16/09/2016 (Incident number 122142) Service users patch was missing when staff checked.	3	19/09/2016	• Daily checks are in place and are documented on the drug card • Patient specific plan in place to check patches each shift **Closed from Accountable Officer's perspective** **CLOSED**
17/09/2016 (Incident number 122152) Client requested prn lorazepam and was administered in sealed packet as per the plan. The client walked off with the medication, staff did not witness if the client took the tablets.	4	17/09/2016	• Nursing staff had taken action from the previous incident (122117) to restrict client's access to medication by only cutting out a small amount of tablets to take and being more vigilant • Staff to continue to be vigilant as per the current plan, but to strive to fully witness the ingestion of medication **Closed from Accountable Officer's perspective** **CLOSED**

19/09/2016 (Incident number 122193) Client hadn't had their pain patch applied on the due date therefore missing a dose.	3	20/09/2016	• Nurses reminded that all medication on admission to the unit needs to be transferred across to a drug card – this is so there is a clear record of medication administration and then these are needed to be administered
19/09/2016 (Incident number 122202) Client had missed 4 days of medication. They hadn't attended their appointment on 15th and didn't visit the chemist to collect their medication until 19th.	3	20/09/2016	• Following the incident, additional details were added to the prescription to highlight the need to contact the prescriber if 3 or more days were missed • The chemist was closed on Sat/Sun (17th & 18th) which contributed to the generation of the prescription collection plan and access to medication having missed a supply on the Friday – changing the chemist was considered to enable collection over the weekend **Closed from Accountable Officer's perspective** **CLOSED**
27/09/2016 (Incident number 122341 Client did not receive their lunch time dose of diazepam.	4	28/09/2019	• Staff to input on JAC 'client on leave' when clients are out for the afternoon to avoid confusion • Handover book recently started
28/09/2016 (Incident number 122361) During planned home visit, client disclosed to support worker that he had taken 14 temazepam tablets and later disclosed he'd taken a number of other tablets. Ambulance was called and client taken to A&E.	3	29/09/2016	• Staff remain vigilant of possible overdose risks in clients • A locked box was organised for the patient after the A&E admission and overdose • Risk assessments have been updated and passed on to the teams involved with client's care **Closed from Accountable Officer's perspective** **CLOSED**

Appendix III

CD incidents Data headings available for review/interrogation within the CDAO incident spreadsheet

Report No	Enables incident to be linked to risk /safeguarding database
Incident Type	Highlights serious/major concern
CD Schedule	Lists schedule 2,3,4,4anabolic 5,or unknown
Incident Date	Date incident occurred
Incident Location	Incident Location
Date Received in Risk	Date incident report received in the risk dept
Date Received in Pharmacy	Date incident report received in the in pharmacy department/CDAO aware.
Person Reporting Incident	Name of the person reporting the Incident
Principal Person Involved	Name of the person Involved in the incident
Others Directly Involved in Incident-1	Names of others involved in the incident
Others Directly Involved in Incident-2	Names of others involved in the incident
Witness-1	Names of people who may hold additional information
Witness-2	Names of people who may hold additional information
Cause Group	Free text cause – not limited to pre defined causes
Cause 1	Free text cause – not limited to pre defined causes
Cause 2	Free text cause – not limited to pre defined causes
Prescribing Doctor / Practitioner	Name of prescriber
Consultant / GP	Name of Consultant / GP
Description of Concern	Free text Description of Concern
Contributory Factors / Action Taken / Outcomes	Contributory Factors / Action Taken / Outcomes
Recommendations	Recommendations to prevent recurrence/further harm
Follow-Up / Comments	Additional information that may only come to light after implementing recommendations
Further Action / Comments from Pharmacy Dept	Pharmacy specific additional information that may only come to light after implementing recommendations
Status	Flagged when closed