

GP PAG BITES – Issue 3, August 2019

Bringing you snippets to share learning from the GP Performance Advisory Group meeting in the SW, where concerns raised about GPs are reviewed, including information from serious incidents, SEAs and complaints.

Take care when prescribing
concentrated formulations of
oxycodone

Incidents with on-line
prescription orders

Layman's terms vs medical
terminology

Information to share or remind:

1 - Take care when prescribing concentrated formulations of oxycodone

An incident report was reviewed in which concentrated oxycodone 10mg/ml oral solution was prescribed following receipt of a discharge summary stating, 'oxycodone liquid 10mg 4hrly prn'. The concentrate is seldom prescribed in primary care and the 5mg/5ml strength solution would normally be prescribed for this dose. Concentrated solutions can present a real risk of opioid overdose, as it can be difficult to measure the dose of concentrate accurately in millilitres. In cases where the strength of the preparation to be prescribed is unclear, it is advisable to confirm that the use of any oxycodone high strength or concentrate product is appropriate before prescribing. In this incident, that risk was exacerbated following advice from a local hospice clinician to 'increase the dose to 20ml prn' as they had assumed that the 5mg/5ml oral solution was being used. The error was spotted before a prescription for 20ml of concentrate was generated but it is important that when dose changes are made that these are always communicated as amount of drug in milligrams (mg) and never solely as volume of medicine (e.g. in millilitres). This type of incident is not restricted to oxycodone and so care must be taken when prescribing oral preparations with mg/ml dosages as the confusion around strengths of medication has also been an issue in prescribing paracetamol. As it is also common practice for non-clinicians to generate prescriptions, the prescriber must pay attention to mitigate this risk. The error was identified before the medication was dispensed.

2 - Incidents with on-line prescription orders

In keeping with the prescribing theme, cases have been discussed at PAG where patients have requested and received medications either via an on-line pharmacy, by requesting a repeat prescription and asking for the medications to be sent elsewhere or attending different GP practices to obtain medications. There will not necessarily be any involvement or awareness by their named GP and inevitably the patients are at risk of overdosing (intentionally or otherwise), sometimes fatally. On occasions, this has resulted in a coroner's Regulation 28 Prevention of Future Deaths report. Whilst the process is reliant on the honesty and integrity of the patient, which is difficult in circumstances with mental health issues and/or manipulative behaviours, it might be prudent to place alerts on the patient notes to highlight concerns. A system of notifying nearby practices might also mitigate any wider risk and further local information and CDAO contact details can be found at <https://www.england.nhs.uk/south/info-professional/safe-use-of-controlled-drugs/>

3 - Layman's terms vs medical terminology

PAG have reviewed a number of cases where there has been a misunderstanding of information by patients when medical terminology has been used. These have resulted in complaints and referral to PAG. Whilst it might seem arduous to repeat the same thing in different ways, if you are inclined to use medical terminology, please be mindful to also provide an explanation to a patient in layman's terms to ensure a full understanding by the patient. The GMC's 'Good Medical Practice' under Domain 3 states "*You must give patients the information they want or need to know in a way they can understand*" which clearly supports this view and helps to avoid any misunderstanding.