Methadone handout errors

REPORT

- Concerns have been raised about a number of handout errors, in which methadone has been supplied to the wrong patient. Such errors have the potential to cause significant harm.
- Medication Safety Officers (MSO) have highlighted increased risk on weekends when locums may need to rely on the team to help confirm the identity of a patient.

LEARN

- The root cause of handout errors is often over familiarity by the team. In such cases pharmacy colleagues may not perform the necessary checks because they believe they know and recognise the patient in question.
- Checks should always include:
  - Name
  - Address (where available)
  - Date of birth
- Where photo ID is not available, pharmacists should confirm how local Drug Action Teams identify patients.
- When dispensing methadone it is good practice to complete an additional check by asking the patient to confirm the volume or quantity that they are expecting to receive.

SHARE

- The issue of methadone handout errors has been raised in a number of Controlled Drugs newsletters.
- Details were shared with MSOs at the Community Pharmacy Patient Safety Group meeting. MSOs will disseminate learnings via their networks.
- Details were also published on the Pharmacy Safety website, shared with the Controlled Drugs Accountable Officers (CDAOs) for inclusion in monthly newsletters and will be shared with LPCs.

ACT

- Health care professionals and key workers should ensure patients are aware of the required identification checks that will take place prior to them receiving methadone. The acceptance of this as a norm, will support the reduction of errors as patients are prepared to show identification.
- MSOs have raised the issues with pharmacy teams and reminded them to always follow their company Standard Operating Procedures when supplying methadone, to ensure patients are correctly identified.
- Community Pharmacy Patient Safety Group will explore the opportunity to engage with researchers from the University of Bath, to consider processes to prevent errors.

REVIEW

- Community Pharmacy Patient Safety Group will monitor the the number of reported incidents and the impact of harm caused.