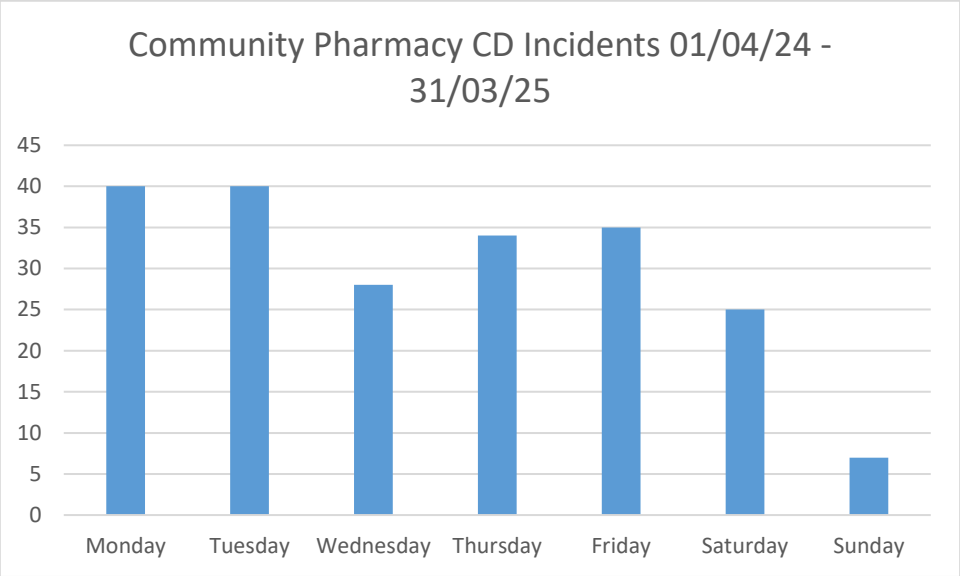
The following trends have been identified following analysis of controlled drug incidents reported to NHS Grampian controlled drugs team from April 1st 2024 to March 31st 2025.

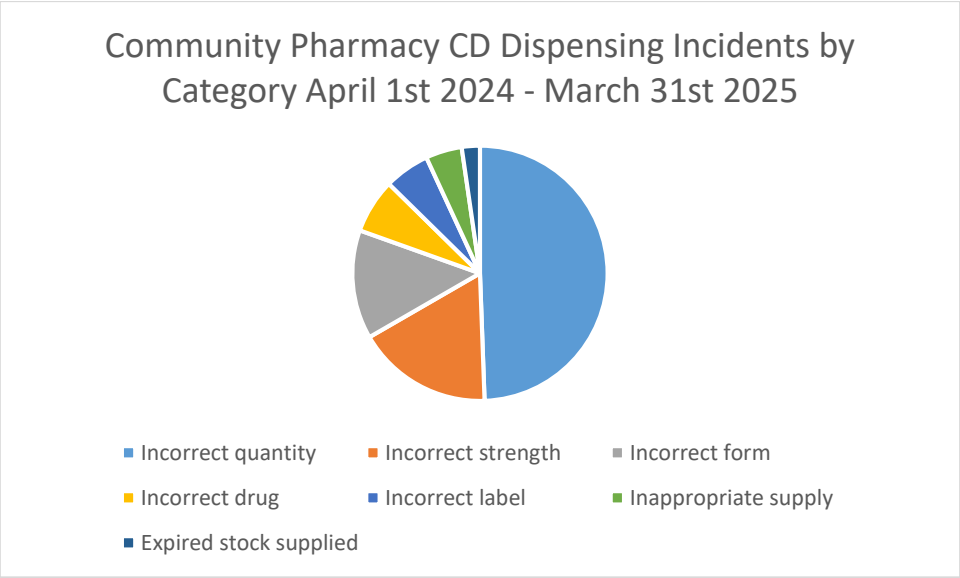


Community pharmacies reported 209 controlled drug incidents from April 2024 to March 2025. Previous year April 2023 to March 2024 saw 140 controlled drug incidents reported. For both periods, the three drugs most commonly involved were:

1. Methadone
2. Methylphenidate
3. Morphine

The top three incidents reported were:

2024/2025	2023/2024
1. Dispensing errors	1. Dispensing errors
2. Theft/fraud/actual/potential	2. Handout error
3. Unexplained loss	3. Misbalance



A comprehensive review of the controlled drug **dispensing errors** revealed that the majority resulted due to an error in the quantity supplied to patients. On occasion this was identified following a controlled drug check at a later date. Community pharmacists are encouraged to reflect on their dispensing and checking process to prevent such errors occurring. A balance check of the controlled drug stock remaining after each item is dispensed is recommended. Please also be vigilant when dispensing original packs as they often contain 30 as opposed to 28 solid oral dosage forms and this is frequently cited as the source of the error. Dispensing the incorrect strength and formulation are the second and third most frequently reported cause of dispensing errors respectively. Community pharmacists are requested to review their storage arrangements for controlled drugs to ensure there is adequate segregation of different strengths and formulations to minimise the risk of selecting the wrong product.

An increase in reports of **theft/fraud/actual/potential** are associated with increased reports of transient patients attempting to obtain a supply of controlled drugs via emergency supply pathways.

Reports of **unexplained loss/missing controlled drugs** are often thought to be attributed to packaging inadvertently being placed in the bin when it is not empty. As above, verifying that the physical balance remaining in the controlled drugs cupboard is correct after each item is dispensed should alert staff of a potential loss. Community pharmacists should also reflect on how they dispose of controlled drugs packaging and consider whether there is an opportunity for another member of staff to confirm that the packaging is empty and there are no small strips of foil contained in the patient information leaflet.