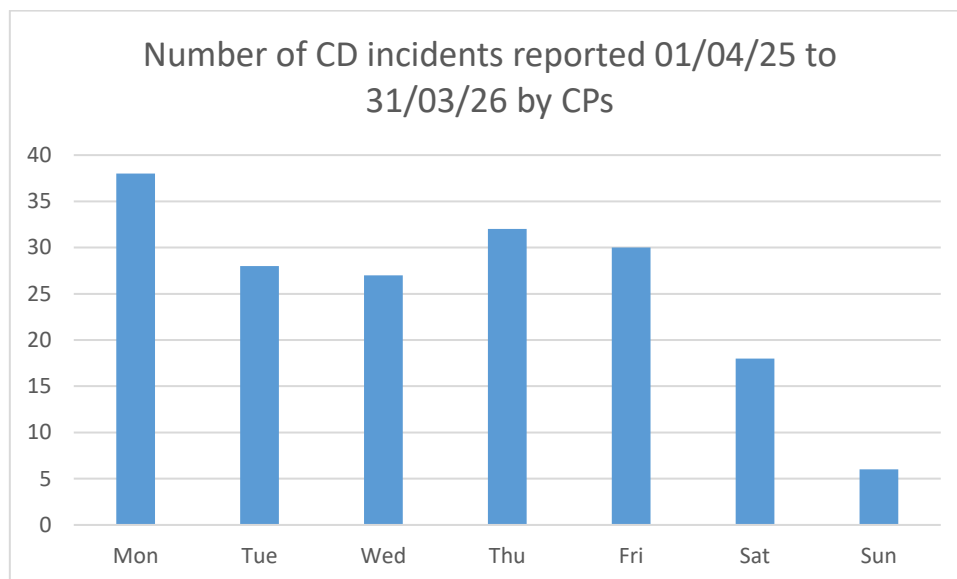


CD Incidents Reported by Community Pharmacies 1/4/25 – 31/3/26

The following trends have been identified following analysis of controlled drug incidents reported to NHS Grampian controlled drugs team from April 2025 to March 2026.



- Community pharmacies reported 179 controlled drug incidents between April 2025 and March 2026. This has decreased from 209 CD incidents reported in the previous 12 months.
- 67 community pharmacies submitted reports on CD events, frequency of reports received varied from 1 to 11.
- From April 2025 to March 2026 the medicines most commonly implicated in CD incidents were:
Methadone
Morphine
Methylphenidate
- The most common CD incidents reported from April 2025 to March 2026 were:
Dispensing errors
Handout errors
Unexplained loss/missing controlled drugs
- Dispensing errors were often attributed to supplying the incorrect quantity owing to pack size variations between manufacturers, e.g. pack of 30 supplied instead of the prescribed quantity of 28. On occasion, this was identified following a controlled drug check later. Community pharmacists are encouraged to reflect on their dispensing and checking processes to prevent such errors. A balance check of the controlled drug stock remaining after each item is dispensed is recommended. Completing the controlled drug register at the point of dispensing provides another opportunity to check that the quantity dispensed matches the amount prescribed.
- Community pharmacists are reminded that if a handout error occurs, both patients should be informed that their data has been shared with another patient. Handout errors result if the patient's identity is not confirmed prior to

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providing medication. Community pharmacists are requested to review their process for patient identification and ensure all staff are aware of the essential checks for **every** patient receiving prescribed medication

- When a pharmacy cannot account for a number of tablets following an investigation, it is often suggested that the missing medicines may have been accidentally discarded with, what is presumed to be empty packaging. In order to try and reduce this type of incident, it is recommended that all CD packets are torn up prior to being discarded and that the patient information leaflet is checked carefully to confirm that no medication is concealed within it.
- Such unexplained losses were commonly reported following assembly of dosette boxes, community pharmacists are advised to be particularly vigilant whilst disposing of packaging during this process.