DHC prescription by GP to woman on methadone programme
16HDC00460, 26 June 2018

District health board ~ General practitioner ~ Methadone programme ~ Dihydrocodeine ~ Co-ordination of care ~ Right 4(5)

A woman with alcohol and drug dependence was enrolled on a methadone programme. She also enrolled at a medical practice and was prescribed dihydrocodeine (DHC) for chronic knee and back pain. The woman did not inform the general practitioner (GP) that she was on the methadone programme until 16 months later.

The GP contacted the methadone treatment service for advice on how best to treat the woman. The service provided no advice about her treatment at that time, and the practice continued to prescribe DHC regularly.

Medicines Control then informed the practice that a Restriction Notice in the name of the woman had been issued, and suggested that the practice might wish to be added as an authorised prescriber in conjunction with the service.

There was confusion over extending the Restriction Notice and the GP thought that the practice was authorised to prescribe DHC and that a plan to reduce the prescription was to be forthcoming from the service. The practice continued to prescribe DHC until finally the service instructed that all DHC prescribing was to cease immediately, and that any reduction would be managed by the service.

Findings

It was found that the standard of communication from the service to the medical practice was inconsistent and ambiguous. The service was criticised for its failure to follow up on the woman's referral to the pain clinic, and because the discussions held and the decisions made regarding the woman's care were not well documented or followed up in a timely manner.

In failing to ensure timely and clear instructions to the medical practice, the DHB was found to have breached Right 4(5).

Adverse comment was made about the GP continuing to prescribe DHC while there was uncertainty about the authorisation to do so.

Recommendations

It was recommended that the DHB provide a written apology to the woman. It was also recommended that the service conduct a random audit of clients covering the past 12 months to ensure that treatment assessments and reviews have been sent to clients' GPs. A further recommendation was made that the DHB, in consultation with the Director of Mental Health and the Ministry of Health Medicines Control, consider the introduction of an alert to GPs on the clinical records system.