Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

# Minutes of a Meeting of the AWP NHS Trust Medicines Optimisation Group (MOG)

Held on 25th May 2017, 09.30pm - 12.30pm, Conference Room, Jenner House

These minutes are **Approved**

| Members Present | |
|---|---|
| Rebecca Eastley, Chair (RE) | Prabhakaran Naveen (PN) |
| Valerie McElhinney (VMc) | Shirley Bickers (SB) |
| Lucie Ralph (LR) | Maria-Paloma Sequeiros (MPS) |
| Ellen Yankah (EY) | Philip Harding (PH) |
| Terri Turner (TT) | Sheirin Mehany (SM) |
| Jeremy Wallace (JW) | Chantelle Williams (GP Trainee) |
| **Staff In Attendance** | |
| Ben Watson (BW) – Consultant Psychiatrist, Specialist Drug and Alcohol Services | |
| Jonathan Hewitt (JH) – Consultant Psychiatrist, Older Adults, Callington Road Hospital | |
| **Apologies** | |
| Sherlie Arulanandam | Chris May |
| Jane Bolster (JB) | Christine Dean |
| Bill Bruce-Jones | Sarah Jones (pharm) |
| James Severs | |

## Declarations of Interest

None to declare

## MOG 2017/05/001 Minutes from last meeting 7th March 2017

Accepted as an accurate record

## MOG 2017/05/001 Action Log

**Action log updated.**

The following are still in progress:

- Controlled drugs procedure
- Prescribing for service users in the community
- Learning from medication incidents (lithium review at MIRG)
- Diabetes and insulin guidelines
- Vitamin D supplementation guidelines
- Safety matters briefing

**MOG/16/31 Diabetes and Insulin Guidance –** EY advised that update received from the group is that

Sarah Harding has received a copy of the draft national guidelines and is in the process of incorporating it into the procedure. It will be timetabled for MOG after it has been peer reviewed.
**MOG 16/12/005 Antimicrobial e-learning** – SB has completed the required documentation.

## MOG 2017/05/002 NMP Prescribing Authority Criteria

PH raised for discussion the withdrawal of NMP prescribing authority and wanted to know if the group is happy with the following criteria:
If an NMP has:

- not prescribed for over six months (this may be due to a changing role, limited opportunity within the team or the need for additional support)
- failed to attend minimum number of NMP forum meetings in a year (except in special circumstances agreed with the Non-Medical Prescribing Lead) or
- not effectively demonstrated that they have been actively using their prescribing skills and knowledge, then prescribing authority can be withdrawn.

It was discussed that there may be legitimate reasons why some NMPs cannot meet all the above. CPD is important and should be monitored. Failure to meet the above should however prompt a review/ discussion with the NMP concerned. RE advised that medics need to attend a minimum of 3 forums in a year and so that could apply to NMPs as well.

RE raised three issues with the policy document:

1. Is the patient consent written/ documented? PH responded that it is not currently documented but a leaflet is in development to address this
2. There is a section in the policy that states that it is common courtesy to inform the GP. This should be mandatory and not optional.
3. There are sections that appear to be inconsistent regarding supervision, this needs to be clarified and consistent throughout the document.

**Actions: PH to amend as discussed and amendments to be sent to RE for sign off and presentation to the Quality and Standards group for notification.**

## MOG 2017/05/003 Policies / Procedures / Guidelines

**a. Medicines policy**

VMc highlighted the additions that have been made:

1. Prescription security
2. Clinical trials
3. Medical gases (oxygen policy removed from Ourspace and the plan is to have three new oxygen/medical gas procedures to cover the various aspects)

**Policy ratified**

RE raised a question about what we do regarding out of hours leave medication requests. Currently, different practices. Some wards ring the on-call pharmacist for advice, some use Calne pharmacy on Saturday mornings, and some use FP10s. It was recommended that the practice be standardised and included in the medicines policy so that it is clear for all staff.

**Action: VMc to put together the options available for presentation at the next MOG.**

**b. Anaphylaxis guidelines –** not discussed, in draft.

**c. Alcohol detoxification guidelines –** not discussed, in draft.

**d. Procedure for the administration of medicines (Med 01)**

This procedure was reviewed last year; update minimal. Amendments include: ensuring service users are clearly identified before administering medication; delayed doses must be communicated to other members of the team and documented in the notes; where there are additional charts such as warfarin or clozapine titration charts in use, both the additional chart and the drug chart (DPAR) must be signed; covert administration taken out as covered by new covert procedure; if a service user requires controlled drugs (CDs) out of hours, s/he may be taken to a unit that stocks the required CD to have it administered there. Where there are issues, the on-call pharmacist must be contacted.

**Ratified - to be put on Ourspace**

**e. Procedure for the prescribing of medicines (Med 02)**

Issues raised on the cover sheet were discussed.

The statement: 'following outpatient attendance where medication is initiated or unchanged, prescribers are expected to arrange a supply which is at least sufficient to meet the immediate clinical need…' was discussed in some detail. JW raised the fact that sometimes it is better to allow the patient to use up the supply they already have, to make the dose required, until the GP issues a new script.

VMc advised that the new hospital contract changes will be discussed and any decisions made there that would impact current practice will be communicated.

Discussion around abbreviation for by the oral route – should it be 'o' or 'po'. 'po' preferred.

**Outcome: Ratified- to be put on Ourspace.**

**f. Procedure for the ordering, transporting, receiving and returning of medicines (Med 04)**

Various sections of the procedure require nursing input, such as the procedure for stock ordering by nurses. Inconsistencies relating to different teams and what they can order, e.g. nurses ordering 3days supply from wards vs. 7days in intensive teams; prns vs. no prns, also need reviewed. No nurse present at MOG.

**Action: nursing review required and then return to MOG in July [VMc/ JB]**

**g. Procedure for fridge temperature monitoring (Med 05)**

**Outcome: Ratified- to be put on Ourspace.**

RE advised that it would be good to have the summarised information on a poster on refrigerator doors to remind staff. TT mentioned that there are lots of posters on the units and it would be a case of putting it in a vantage point that will make it useful.

All units that hold medication in their clinic rooms must monitor the temperatures. The key is to monitor, take action and evidence the action taken. This is the Trust standard and what CQC or any inspector will be looking for.

**Actions:**

**SB to check the information that is currently available on the units regarding temperature monitoring and ensure it matches with the current guideline.**

**Lead pharmacists to feed back to units the importance of documenting and acting on out of range temperatures. [SB]**

SB raised the fact that there is no maintenance contract for servicing clinic fridges annually, to check they are working properly. SB had spoken to Avril Stallard who said there were difficulties as we don't have all the trust fridges on an inventory and there are several makes of fridge in use. This is getting better though as there is now a recommended make and models for all new fridges ordered and a trust list has started to be compiled.

**Action: RE to look into this**

**h. Procedures for oxygen –** not discussed, in draft

**i. Procedure for medicines storage (Med 14) –** no changes, presented for noting. Need to add small change relating to oxygen signage. Noted**.**

**Action: SB**

**j. Covert medicines procedure**

This is a new procedure aiming to unify practice across the Trust. This procedure makes a presumption that the Trust will support the off-label use of medication as follows, (Section2): Altering a medicine in

any manner not recommended by the manufacturer to facilitate covert administration, (e.g. crushing), renders the medicine use 'off-label', see section 5.2 below. If a prescriber follows all the associated guidance in this procedure, they do not need to complete a separate application for approval to use the medicine 'off-label'.

The procedure also considers the legal and pharmaceutical issues that arise from covert medicines administration, making clear the need for MDT consultation, proper documentation and the consideration of the service user's best interests.

RE raised concern about the point in the document that states that AWP staff should not recommend covert medication administration in community or care-home settings. MPS stated that this is something we do from time to time when the need arises, in the best interest of the service user, and it helps prevent hospital admissions that may not be necessary. Decision was made to clarify that point to advise that staff use the same principles/ safeguards as documented in this policy if recommending for service users in other care settings.

Another point was raised about the statement: 'The decision to administer a medication covertly should be a short-term measure only'. It is often carried on for as long as it is in the best interests of the service user. Statement to be changed to read: 'The decision to administer a medication covertly should not be considered routine, and should be *regularly reviewed and documented in a care plan*.'

**Ratified pending amendments**

**Actions: TT to make amendments and circulate via email to complete ratification**

**k. Naloxone PGD for use in SDAS –** update in draft. Expiry of existing PGD extended to end of July.

**Action: SB to complete paperwork to extend PGD expiry and bring update to MOG for noting in July**

**l. Hepatitis B vaccine PGD for use in SDAS –** update in draft. Expiry of existing PGD extended to end of July.

**Action: SB to complete paperwork to extend PGD expiry and bring update to MOG for noting in July**

**m. Physical health monitoring of psychotropic drugs**

SB presented a concise document with the monitoring requirements for the antipsychotics, mood stabilisers and antidepressants, based mostly on NICE guidelines. AWP clozapine guidelines recommend troponin levels. This has not been included in this document. SB to look into this further.

JW mentioned that the monitoring guideline does not state what measures to take if results are out of range. NP also commented that it is not clear whose responsibility it is to do what. VMc advised that both of these points are best addressed in the larger physical health document and that this is a short concise guide to replace what was previously on Ourspace and the external Trust web medicines and pharmacy pages.

**Ratified**

**Action: SB to look into whether troponin is to be added or not**

**n. Medicines management in 136 suites –** draft in progress.

It was recommended that treatment algorithms for managing behaviour and alcohol detoxification be included.

**Action: SB to email document round for ratification outside MOG**

**o. CAMHS rapid tranquillisation procedure (non-AWP procedure)**

This guideline has been submitted to MOG for approval to adopt, on a temporary basis following transfer of the Riverside Adolescent Unit (CAMHS) from North Bristol NHS Trust (NBT) to Avon and

Wiltshire Mental Health Partnership NHS Trust (AWP).

Contact with the Principal Pharmacist Medicines Management at North Bristol Trust (NBT), has confirmed that the document has not been ratified by their Medicines Governance Group in NBT. The guideline is still under review by NBT, although they are aware that the document has been in use on Riverside Adolescent Unit (RAU) and also in A&E at NBT for some time.

The current guidelines state that the ratifying committee was the Community Children's Health Partnership (CCHP) Governance Group. Dr Geoff Woodin has advised that this group was chaired by Jo Smith or Jane Schulte who now both work for Sirona.

Dr Woodin and Sue Leaman met recently to discuss the current guidelines. They are satisfied that the guidelines reflect the current clinical practice on the RAU. The only immediate change felt necessary following transfer of RAU to AWP, was that the NEWS observation chart would be used for recording patient observations as per AWP procedure, instead of using the record form in Appendix 3.

Dr Geoff Woodin, Dr Caroline Williams and Sue Leaman have arranged to meet on the 27th July to commence a more extensive review of the guidelines. Full review of the document is planned, for completion August 2017.

**Action: Clarity required on patient monitoring; papers presented contain an AWP draft dated June 2016 – RT Physical Health Observation (NEWS) Monitoring Requirements. SB to liaise with Sue Leaman and then circulate papers to MOG for approval via email.**

## MOG 2017/05/004 Formulary Application

### a. Oxazepam

Oxazepam was discussed at MOG in March but was not fully agreed because the titration charts for the high dose and very high dose regimes exceed the BNF max daily dose of 120mg and symptom trigged dosing was discussed as an alternative to fixed dose titration charts. Dr Ben Watson attended the meeting to discuss the charts and doses. BW explained that more complex patients are now being admitted, some with advanced liver cirrhosis, since the acute trusts no longer admit for alcohol detox. He also explained why they want to use oxazepam rather than lorazepam. One advantage is that the chlordiazepoxide to oxazepam dose ratio is 1:1 so the doses are the same in the titration charts.

On Acer unit, they are currently using chlordiazepoxide at lower doses for these patients. They would prefer to use oxazepam as there are no active metabolites and so it is safer in liver disease. Doses would be 20-50mg QDS. BW explained that admissions to Acer are planned and so a fixed regime that minimises withdrawal is the aim rather than a symptom triggered approach, as used in the acute trusts.

He stated that because oxazepam is not licensed to treat alcohol detoxification, the BNF max does not relate to alcohol detoxification, only to anxiety. Imposing a maximum dose on the use of benzodiazepines in this patient group can be dangerous. BW recommends senior doctor review routinely if the BNF max dose is exceeded, rather than impose a maximum dose.

He proposes to use oxazepam only in the specialist drug and alcohol service for service users with liver impairment as recommended by the Maudsley Prescribing and BAP guidelines. Oxazepam is also on the BNSSG formulary as second line treatment choice for specific patients with decompensated liver disease.

BW advised that the nature of the service is changing, with more detoxifications being carried out in the community. The charts will be used in the community, however, the very high dose chart is for Acer ward use only, so that adequate monitoring can be carried out, and liaison with the liver specialists if needed.

**Action: Ensure the very high dose charts are clearly labelled for use on Acer ward only.**

VMc raised concern about the doses of vitamin B co strong and Pabrinex on the chart – current national guidelines recommend different doses. Review of the Trust alcohol detoxification guideline is however underway and will effect these changes. The oxazepam charts have been approved for use as is. The vitamin supplementation information will be changed in line with current guidance, together with the chlordiazepoxide charts, when the alcohol detoxification guideline is ratified.

**Agreed oxazepam added to the formulary and oxazepam charts for use in SDAS**

### b. Levomepromazine

Dr Jonathan Hewitt presented a request to add levomepromazine to the AWP formulary. He proposes to use it in very low doses (e.g. initially 6.25mg BD and titrate very gradually) to manage agitation in severe dementia, where other conventional therapies have not worked. Levomepromazine is a neuroleptic with indications in psychiatry and general medicine, particularly in terminal care.

JH stated that levomepromazine was first suggested to him when he sought a second opinion from a palliative care physician in a case of an extremely severe end stage B.P.S.D. This drug provided another option where other treatments have not worked. Clinical experience has shown success in some cases, (it has been used for 10 service users since September 2015), and levomepromazine is favoured by nursing staff who have noticed a good effect. As with all medication in this population, the drug is reviewed regularly for evidence of efficacy and safety. If there is no response after a week it is stopped.

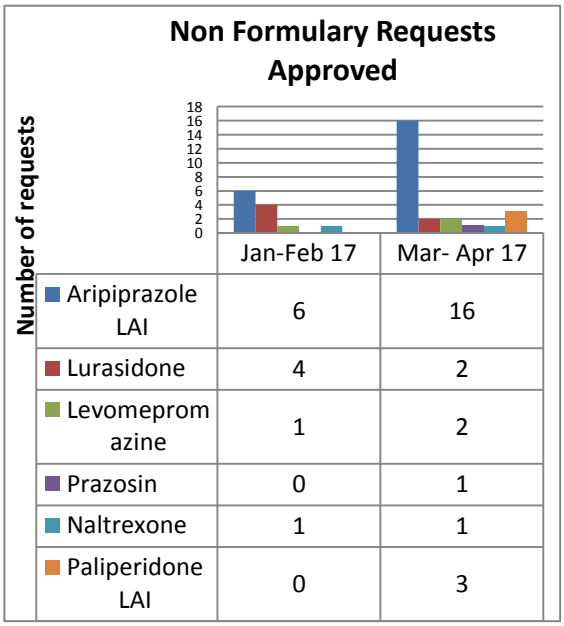
VMc raised a question as to why clomethiazole which is licensed for restlessness and agitation in the elderly, and used elsewhere, has not been tried. JW responded that he had no recent experience of using clomethiazole and now has more experience with levomepromazine.

**Agreed to be added to the list of approved medicines for off-label use - for review in 6 months' time. Report required for MOG, November 2017 [JW].**

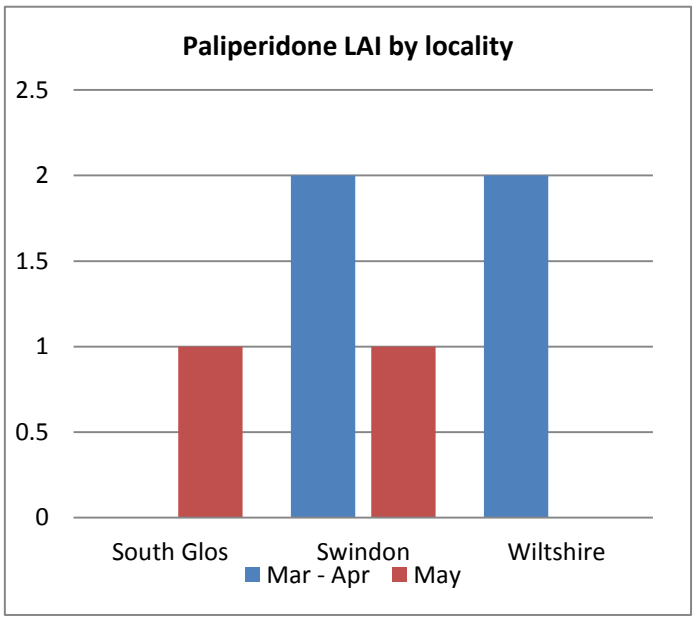
## MOG 2017/05/005 Antimicrobial Resistance (AR)

**Antimicrobial stewardship work plan –** ongoing by SB. Combined infection control and antimicrobial stewardship work plan now separated into 2 separate work plans.

## MOG 2017/05/006 Formulary Update




| | Jan-Feb 17 | Mar- Apr 17 |
|---|---|---|
| Aripiprazole LAI | 6 | 16 |
| Lurasidone | 4 | 2 |
| Levomepromazine | 1 | 2 |
| Prazosin | 0 | 1 |
| Naltrexone | 1 | 1 |
| Paliperidone LAI | 0 | 3 |




## MOG 2017/05/007 Feedback from the Medication Incident Review Group

### Clozapine SBAR

SB presented an SBAR which had arisen from the MIRG themed review that focussed on clozapine. The transfer of local blood results to ZTAS for clozapine monitoring is sometimes delayed. An incident occurred when the blood test sample was taken earlier than it was due. The results were red but this was not picked up by the pharmacy or clinical pharmacy team for about eight days. Because the sample was not labelled with the sticker to alert the lab that it was a sample for a service user on clozapine, the lab did not send the results to ZTAS. Also, because a medication supply was not yet due, pharmacy staff had no reason to look up the service user's blood results.

SB reported that the problem seems to be that local results are not always being uploaded to ZTAS in good time, or until such time as the pharmacy enters the results to confirm the clozapine can be

supplied. The gap between the sample date and the date the results are entered into ZTAS is longer than that recommended by ZTAS in some cases.

There are a number of recommendations to help avoid this incident recurring in the future. They include:

- Ensure the ZTAS sticky labels are used when samples are requested for clozapine FBCs. This indicates to the labs that the results need to be sent to ZTAS. The ZTAS PIN must be on the request and this is achieved by using the barcoded labels issued by Magna.
- The patient's NHS number clearly marked on the request form to avoid duplicate profiles in the lab systems – use ICE request form if possible.
- Ensure nurses taking the bloods know how to obtain the sticky labels from Magna labs.
- Contact details of the clinician requesting the test written on the request form, in case the lab needs to make contact, e.g. abnormal result.
- Clinical pharmacy teams to check that new blood test results are on ZTAS for inpatients even if a supply is not necessary

**Action: SB to produce a safety bulletin to highlight the issues and recommendations, and prepare a standard letter for service users to take to appointments, as a reminder for the person taking their bloods.**

## MOG 2017/05/008 Audit Update

a. **Antibiotic prescribing audit** (AWP-181) Overall risk ranking = 6

This was undertaken last year on the inpatient wards. Overall it shows good practice with a couple of areas having some room for improvement.

Recommendations and timescales:

1. Disseminate the learning from this audit to all prescribers

- Request through medical and/or academic leads that the audit report (along with the poster) is discussed at local meds management/prescriber meetings. (Aug 17)

2. Highlight to prescribers key considerations when prescribing antibiotics

- Plan to design a poster with key learning/reminders to be sent out with the audit report to highlight the key considerations and things to remember when prescribing an antibiotic (Jul 17)
- Review, update and re-issue the laminate ID sized cards with the antibiotic prescribing information (Aug 17)

The actions and risk score were agreed. Report approved for dissemination.

b. **Prescribing antipsychotics in dementia** (POMH 11c) Overall risk rating = 9

This is a national audit undertaken last year across the older adults inpatient wards and community teams.

The report is an AWP summary of the main results. There has been involvement from a consultant psychiatrist, pharmacist, and nurse consultant for dementia care in developing the recommendations and actions.

Recommendations and timescales:

Must ensure that non-pharmacological methods to manage behavioural symptoms of dementia are explored first, adequately trialed and clearly documented.

The use of antipsychotic medications is ‘a last resort’. The potential risks and benefits of commencing an antipsychotic medication must be fully examined and a discussion with the patient and/or carer prior to prescription takes place. Clear documentation of these actions, should always be accurately reflected in the healthcare record.

Active monitoring and documented review of associated physical risks must accompany a prescription to ensure ongoing clinical safety and effectiveness with appropriate discontinuation parameters in situ.

Summary of actions (with due dates)

To develop a patient/ carer leaflet for prescribing antipsychotics in dementia to be developed - June 2017

Once the leaflet has been developed, raise the awareness of it through communications to medical leads, education sessions and an Ourspace article - July 2017

Develop a pharmacy Ourspace page for antipsychotic prescribing in dementia (similar to the clozapine page) where the leaflet and other resources can be found - June 2017

Develop a checklist/aide memoir/flowchart (similar to the lithium procedure) to prompt documentation of key things when prescribing e.g. risks & benefits, underlying causes, medication reviews - June 2017

The group agreed the actions and risk score, report approved for dissemination.

## MOG 2017/05/009 Any Other Business

**a. Methohexitone for ECT report – SB to circulate report to MOG members**

b. **Management review of service user deaths/ end of life care -** meeting with BaNES modern matron and Sarah Jones (pharmacist). The meeting discussed availability of palliative care drugs and how these are best sourced to ensure no delays in treatment/care; the use of FP10s and supplies via community pharmacists may be quicker out of hours than via AWP pharmacy. The plan is to establish an Ourspace page to guide staff on options for obtaining medicines out-of-hours.

**c. Emergency (non-cardiac) drugs** – there have been delays in progressing the work relating to the emergency bags, which will contain the emergency drugs. Pharmacy staff will ensure availability of emergency drugs in inpatient units and confirm units have access to the medicines recommended on the Resuscitation Council's list for mental health units.

## MOG/16-12 / 11 Dates of Future Meetings

25th July 1.30 – 4.30, Conference room, Jenner House

26th September – 1.30 – 4.30, Conference room, Jenner House

28th November – 1.30 – 4.30, SR3 Jenner House