Avon and Wiltshire Mental Health Partnership NHS Trust

Minutes of a meeting of the AWP Medicines Optimisation Group (MOG) Held on 25th July 2017, 13:30 – 16:30pm, Conference Room, Jenner House

These minutes are Approved

Members present

Rebecca Eastley, Chair (RE)	Prabhakaran Naveen (PN)
Sarah Jones (pharm) (SJ)	Maria-Paloma Sequeiros (MPS)
Valerie McElhinney (VMc)	Philip Harding (PH)
Lucie Ralph (LR)	Sheirin Mehany (SM)
Jeremy Wallace (JW)	Jane Bolster (JB)
Wendy Cashmore (WC)	Elena Ely (EE)

Apologies

Sherlie Arulanandam	Shirley Bickers
James Severs	Theresa Tattan (role taken by Claire Taylor)
James Eldred	Peter Wood
Phil Harding	Suzanne Webb (role taken by Wendy Cashmore)

Declarations of interest

None to declare

MOG 2017/07/001 Minutes of the previous meeting for approval

Minutes from 25th May 2017 accepted as an accurate record

MOG 2017/07/002 Actions update

Amended copy of NMP prescribing authority: RE to take to Q&S for noting (Action: RE)

Action log to be updated with actions closed and moved on (Action: SJ)

Work on NICE guideline for psychosis and schizophrenia in young people to be moved to NMP led working group

Issue of moving Safety Matters Briefing to MLE to be discussed with Wendy Kelvin (Action: RE)

MOG 2017/07/003 Emergency (non-cardiac) drugs

VMc reported that the long term solution for access to emergency drugs remains the provision of purpose made bags (this work is being led by James Severs) but in the interim the pharmacy team have ensured the availability of the agreed non-cardiac emergency drugs on the inpatient wards following discussion with JS.

MOG 2017/07/004 - Policies/Procedures/Guidelines

a. Procedures for oxygen

Very limited time for MOG members to review prior to the meeting. This update is an interim version to reflect the new BTS (British Thoracic Society) guidelines and is closely based on their suggested procedure template.

In the medium term, JS plans for the content to be split in to three or four complementary procedures to make the content easier for staff to follow.

Agreed that the procedure will be recirculated to members and any comments should be returned to Sally Squire (lead author) by Wednesday 2nd August which will also give JS a chance to comment on this version.

b. Procedure for the emergency treatment of anaphylactic reactions

The procedure needs to be very clear on which staff can administer adrenaline.

The flow charts should be bespoke to AWP and include the doses which are administered via the EpiPen device.

Need confirmation that the time period for repeating a dose (5 minutes) is as per national guidance.

Check whether Riverside, STEPS or Bellbrook unit would use a Junior EpiPen (and that they stock them if required). If they are not used in our units the reference to the Junior device should be removed.

The question was raised as to what access community services should have to EpiPens when administering depot medication. It was agreed that whenever 'first exposure' to a depot medicine occurs, adrenaline should be available. Members of the group said that they did not think this was universally the case in community team bases, therefore a bigger piece of scoping work would be required to implement this action.

Any additional comments should be sent to JS and the whole procedure will be returned to MOG in September for approval.

c. Covert medicines procedure clarification

TT has revised the Covert Medicines procedure following the comments from the previous MOG. SJ asked MOG to consider one particular statement included at the request of Mark Dean: that episodes of covert medicines administration should be referred to the Safeguarding team. This represents a significant departure from current practice and the current statement in the procedure is ambiguous as to whether the Safeguarding team have to grant approval before the covert medicines administration is commenced.

The meeting discussed the benefits of having a Trust-wide view of how many episodes of covert administration occur, but questioned whether the Safeguarding or MHA/MCA teams are best placed to do this role. There are already significant checks built in to the procedure before covert administration is commenced. Recording via the incident system (as with rapid tranquilisation) could be another option.

Action: RE to discuss with Mark Dean to agree most appropriate action

d. Naloxone PGD

Noted by MOG

e. Hepatitis B vaccine PGD

Noted by MOG

f. Influenza vaccine PGD

Noted by MOG

g. Appendix to procedure for fridge and room temperature monitoring

Summary poster approved to be appended to the temperature monitoring procedure.

The meeting briefly discussed the issue of a lack of centralised maintenance contract for medicine fridges. RE requested that this issue should be tabled at the Design Authority Group (DAG). **Action: JB**

h. CAMHS rapid tranquillisation procedure

AWP has been asked to adopt the rapid tranquilisation procedure currently in use at the Riverside Unit, (with the inclusion of the AWP NEWS monitoring). Unfortunately the document was not available to the meeting but will be circulated to the group for approval by email.

The clinicians at Riverside are meeting this week to undertake a fuller review of the procedure and this should be ready for submission to the September MOG.

i. Alcohol detoxification guideline

LR presented the updated version of the alcohol detoxification guideline which she and Richard Edwards have worked on and she is taking forward following his retirement. The update was undertaken in part as a response to the audit which highlighted some gaps in meeting best practice. The update was reviewed by the meeting, three revisions/clarifications were requested:

- A reference to the risks of **not** treating withdrawal/detox in the groups where caution was advised, in particular pregnant women. Additional sources of advice could perhaps be cited for these more complex cases.
- LR highlighted that advice on how to administer Pabrinex injection less painfully was to be added.
- VMc raised that Section 9 included a general recommendation to give six months of oral thiamine after detox when it would generally only be necessary when drinking continued or there was insufficient dietary intake. The SDAS clinicians would be asked to clarify this point.

Action: LR to liaise with Tim Williams to make amendments. Amended version to be circulated for approval

j. Clozapine procedure amendment

SJ requested that a minor amendment to the clozapine procedure was made to recommend that the clozapine transfer form should be used for transfers between community teams as well as transfers from inpatient to community care. This follows successful adoption of this practice in some areas of Wiltshire and in Swindon. This was agreed by the meeting.

Action: SJ to amend procedure

MOG 2017/07/005 Missed doses report

JB presented an update on the missed doses audit work which has been developed on the inpatient units following inconsistent completion of previous tools.

A new tool designed with LR and accessed via Ourspace has been in use since May. It originally collected data on every missed dose, but this was very time consuming and has since been refined. Over 1,600 missed doses were reported in May and this reduced in June, although completion rates also reduced. This translates as over 200 missed doses per week

on some units. Various issues have been highlighted as a result of this work:

- There is no guideline on how often or how late a service user should be approached again if they initially refuse a dose of medication
- Timings of doses can contribute to regularly missed medication (for example when service users are sleeping) and nursing staff are encouraged to be proactive in approaching prescribers about this
- The work has also raised again the need to work with pharmacy and prescribers to identify a 'critical medicines list'
- Although L for 'leave' can be recorded when service users have access to medication via another provider or their dispensed leave medicines, there are also incidences where leave from the ward does lead to missed medication.

JB is scrutinising the weekly report to identify other common patterns or particular units where there may be an issue and will feedback to teams. There is also facility for more detailed investigations to be undertaken where necessary.

MOG 2017/07/006 - Formulary applications

None received

MOG 2017/07/007 - Antimicrobial resistance

Standing item – updated workplan to be tabled at the next meeting

MOG 2017/07/008 - Formulary Update

a. Non formulary drug requests report

Twenty six non-formulary requests have been received so far for June and July. Just over half of these were for paliperidone long acting injection, with lurasidone and aripiprazole long acting injection being the next most common items. SJ noted that the process for applications is still not fully embedded in all areas, and because it relies on email chains, it is not always efficient. She is considering alternative ways to administer the system.

Drug spend data from the last 12-months was also reviewed. Spend on aripiprazole and paliperidone long-acting injection has been reasonably stable. The significant spend on melatonin on FP10-HP prescriptions was noted and SJ reported the pharmacy team were considering more cost-effective supply routes for melatonin. Some consultants raised that because GPs won't prescribe melatonin in many areas, there is not only a cost pressure from the drug, but also having to retain this group of service users on AWP case loads when they could otherwise be discharged.

Action: SJ to prepare SBAR on melatonin prescribing for September MOG

b. Updated formulary format

SJ presented a suggestion for a revised format of the formulary, stripping out much of the detail in the current version (some of which is hard to keep up-to-date). RE asked if an electronic format would be easier to update, but although this has been discussed with IT before, they don't have any capacity to work on this at the moment. It is a NICE requirement that the formulary is available externally as well as internally. The meeting approved the new format.

Action: SJ to upload to Ourspace and ask web team to upload to external pages

MOG 2017/05/009 - Feedback from the Medication Incident Review Group

No meetings in July or August.

MOG 2017/07/010 – Audit Update

LR presented a brief audit update noting that there had been delays in reports being received from some of the national audits, including rapid tranquilisation and high dose antipsychotic prescribing. The next POMH-UK audit will be on prescribing in bipolar.

MOG 2017/07/011 – NICE update

SJ briefly reported the relevant medicines content in newly published NICE guidelines

QS153 Multimorbidity

Quality statement 4 states: *Adults having a review of their medicines and other treatments for multimorbidity discuss whether any can be stopped or changed.* This is relevant to AWP prescribers reviewing medicines for service users who may have one or more other chronic health conditions

QS154 Violent and aggressive behaviours in people with mental health problems

Statement 1 People in contact with mental health services who have been violent or aggressive are supported to identify triggers and early warning signs for these behaviours.

Statement 2 People in contact with mental health services who have been violent or aggressive are supported to identify successful de-escalation techniques and make advance statements about the use of restrictive interventions.

Statement 3 People with a mental health problem who are manually restrained have their physical health monitored during and after restraint.

Statement 4 People with a mental health problem who are given rapid tranquillisation have side effects, vital signs, hydration level and consciousness monitored after the intervention.

Statement 5 People with a mental health problem who experience restraint, rapid tranquillisation or seclusion are involved in an immediate post-incident debrief.

NG71 Parkinson's disease in adults

Section 1.5 gives recommendations for the pharmacological management of non-motor symptoms including depression, psychotic symptoms (quetiapine and clozapine specifically recommended) and Parkinson's disease dementia.

RE asked whether the trust has a clear route for the dissemination of new and updated NICE guidelines, and the meeting concluded there was not a effective system in place for this.
Action: RE to refer this issue to PW to review

MOG 2017/07/012 - Any Other Business

a. Olanzapine price increase

SJ reported that due to the ending of a national contract, there is a significant price increase in the prices of 2.5mg and 5mg olanzapine from less than £1 per pack to £20 or more per pack. The pharmacy procurement team are assessing the best response and are monitoring the price. If the increased price is maintained, then advice to prescribers may need to be issued.

b. Changes to oral nutritional supplements routinely kept on wards

SJ reported a recommendation from the head of dietetics Christian Lee to rationalise the oral nutritional supplements kept on wards, and pharmacy have actioned this.

c. Discontinuation of fluphenazine

VMc updated the meeting about the forthcoming discontinuation of fluphenazine (Modecate®) at the end of 2018. Pharmacy will be issuing advice about possible alternatives and how swaps might be managed. This discontinuation may create an additional cost pressure if significant numbers of service users are swapped to paliperidone or aripiprazole long acting injections.

d. Traffic-light status of melatonin and memantine

MPS raised the difficulties in getting GPs in S. Glos to take on prescribing of melatonin and memantine. SJ explained the traffic light status of medicines are set at joint formulary groups where primary and secondary care are represented. We can make a submission for a traffic-light status to be changed, but this has to be done for each formulary individually and can be time consuming. The AWP pharmacy team currently has limited capacity to lead on applications to alter traffic-light status.

Melatonin is currently red in the BNSSG formulary area (which includes S. Glos)

Memantine is amber in the BNSSG formulary so GPs should be willing to take on prescribing after secondary care initiation, although in practice this is not always the case.

As noted above, melatonin prescribing will be reviewed at the next MOG.

Dates of next meetings

26th September 2017 | 13.30 to 16:30 | Conference room, Jenner House

28th November 2017 | 13.30 to 16:30 | To be notified