Do assertive outreach patients with schizophrenia receive adequate cardiovascular risk monitoring as per NICE guidance?

J. Payne
Sherwood Forest Hospitals, King’s Mill Hospital, Mansfield

People with schizophrenia have been demonstrated to have a higher incidence of cardiovascular disease and type 2 diabetes. This finding has been linked to patients having a poorer diet, smoking more and exercising less than the general population. Second-generation antipsychotics also have adverse metabolic effects that contribute to the risk.

It is therefore essential that regular monitoring of cardiovascular risk is carried out for patients with schizophrenia. This area was chosen for audit as per the National Institute for Health and Clinical Excellence updated schizophrenia guidelines in March 2009.

OBJECTIVES
1. To determine whether annual cardiovascular risk assessments are conducted in schizophrenia patients under the care of the Nottinghamshire Healthcare NHS Trust Assertive Outreach (AO) Team, in accordance with the NICE guideline for schizophrenia (and consequently the NICE lipid modification guideline to which it refers)
2. To determine whether the results of such cardiovascular risk monitoring are documented in the patients’ secondary care notes as per the NICE schizophrenia guideline
3. If shortfalls are identified, to explore methods for improving cardiovascular risk monitoring

METHOD
Data were collated between October 2009 and December 2009 by accessing and systematically checking patients’ notes in both primary and secondary care. This was done by pharmacists working within the North Nottinghamshire Primary Care Trust and Sherwood Forest NHS Trust, respectively. A questionnaire was also completed by each member of the AO team to assess their understanding of cardiovascular risk monitoring and highlight any training needs.

RESULTS
The rate of cardiovascular risk monitoring varied between 35% and 70%. Fewer than 30% of patients had information recorded in their secondary care notes. The responses to the questionnaire found potential barriers to routine physical health monitoring. For example, only 33% of AO team members were confident at interpreting monitoring results and only 50% knew what physical health parameters needed to be measured for their patients.

DISCUSSION
The low rates of cardiovascular risk monitoring could be attributed to the fact that AO patients are difficult to engage.

The greater levels of monitoring seen for non-invasive parameters may be due to the fact that patients are more willing to consent to them. Because the rate of parameter documentation in secondary care notes is considerably less than the rate of monitoring, it is clear that improvements need to be made in communication between primary care and AO in secondary care.

To conclude, although the audits objectives were met, improvements need to be made to ensure that schizophrenia patients receive annual cardiovascular risk monitoring.

REFERENCES

2011 CONFERENCE AND CALL FOR ABSTRACTS
The annual International Conference of the College of Mental Health Pharmacy is to be held at the Hinckley Island Hotel, Leicestershire, from 30 September to 2 October 2011. The event will include sessions and interactive workshops on leading-edge mental health pharmacy practice, as well as a joint session with the British Association for Psychopharmacology.

ABSTRACTS The CMHP is now accepting applications for oral or poster presentations in the following categories: original research, service developments; audits. The call for abstracts closes on 5 May 2011.

AWARDS The applications for the CMHP Travel Award and the CMHP Preregistration and CMHP Undergraduate Bursary Award are also open; closing date 30 May 2011. Further information about the conference and submission of abstracts will be available at www.cmhp.org.uk from 14th March 2011.
The prophylactic use of Pabrinex during alcohol detoxification treatment

Faiza Benaouda
St Charles Hospital, Central North West London NHS Trust

Wernicke’s encephalopathy (WE) is common (>1%) and associated with alcohol dependence (>80%). The initiation of alcohol detoxification (AD) may precipitate the onset of WE, since it has been reported to cause a large reduction of thiamine stores in patients. The trust’s AD policy recommends a prophylactic Pabrinex intramuscular (IM) course for all inpatients undergoing AD. Concerns have been raised across the trust with regards to the effective and routine use of Pabrinex during AD.

AIM AND OBJECTIVES
The aim of the audit was to assess the quality of WE prevention during inpatient AD in order to identify the limiting factors for the implementation of the trust’s guidelines. The objectives were to assess: (1) the route of the prophylactic thiamine replenishment therapy used, (2) the duration and initiation of the Pabrinex IM course, and (3) the continuation oral supplementation therapy.

METHOD
The audit included all inpatients undergoing AD within the trust (six mental health units (MHUs) and one substance misuse unit (SMU)), between 5 and 31 January 2010. The audit standards were: (1) Pabrinex IM injection should be administered on day 1 of the AD to all inpatients undergoing AD, (2) it should be continued for three to five days, unless contraindicated; and (3) it should be followed by oral supplementation (vitamin B compound and thiamine).

RESULTS
At the SMU, standard 1 was adhered to at a high percentage (94%). However, the adherence to this standard at the MHU was very low (20% at MHU1 and 0% at MHU2). Interestingly, all the participants received oral supplementation of thiamine alone or in combination with vitamin B complex. At MHU1, Pabrinex was initiated on day 4 of the AD regimen, whereas it was started on day 1 in all the cases at the SMU. At both sites, IM Pabrinex was continued for five days and in 94% of the cases, Pabrinex IM therapy was followed by oral supplementation using a combination of thiamine and vitamin B strong compound.

DISCUSSION AND CONCLUSION
In spite of the limitations of the audit, the obtained data clearly indicated that the adherence of the MHUs to the trust’s policy regarding the prophylactic use of Pabrinex IM injection was poor. Analysis of the audit results identified numerous reasons, including consultants being reluctant to prescribe Pabrinex, the trust guidelines not being sufficiently directive, concerns about the risk of anaphylactic shock, and patient refusal (which accounted for 7.5% only). Accordingly, it was suggested to increase awareness regarding the trust guidelines on the prophylactic use of Pabrinex within the medical team and to highlight the benefit to risk ratio profile of Pabrinex IM injection (one report of associated anaphylactic reaction for every 5 million pairs sold vs >1% risk of developing WE1). With respect to the trust’s guidelines document, it was proposed to include a treatment flowchart in order to clarify the thiamine prophylactic treatment steps for inpatient AD further. It was also suggested to reaudit six months following the implementation of the action plan to cover a longer period.
a formulation could go forward to market targeting genetic markers identified to cause or make someone susceptible to neurological or psychiatric illness.

REFERENCES

CMHP UNDERGRADUATE AWARD
RUNNER UP
An audit on the use of hypnotics in patients on acute wards

Taran Nayyar*, John Marriott*, Brian Hebron*
*Aston Pharmacy School, Aston University, Birmingham B4 7ET;
†City Hospital, Birmingham B18 7QH

Insomnia is one of the most common medical complaints observed by the general population, and untreated can negatively affect quality of life particularly among hospital inpatients. NICE guidance recommends the use of non-pharmacological interventions before initiating drug therapy. With no evidence to distinguish between efficacy, hypnotics with the lowest purchase cost are recommended as first-line treatment.

AIM AND OBJECTIVES
This audit aimed to discover whether hypnotics were prescribed for inpatients at City Hospital in Birmingham within their licensed indications and in line with current NICE guidance. The specific objectives were: to identify whether insomnia was correctly documented in patient notes, to assess whether non-pharmacological measures were used prior to hypnotics, and to assess whether hypnotics were prescribed within licensed dose ranges.

METHOD
A data collection form was designed and piloted on three patients at City Hospital, before being clarified and used on acute medical and surgical wards. The form was designed to discover whether insomnia and non-pharmacological approaches to deal with insomnia were documented in patient notes. The drug name, strength and frequency of administration were also noted, including whether the drug was on the trust’s formulary. Simultaneous prescribing of other sedating drugs was recorded where appropriate. Zopiclone was the trust’s lowest purchase cost and formulary hypnotic.

RESULTS
Eleven patients were identified at the end of the four-week data collection period, which included three at Sandwell Hospital, another hospital at the trust. Seven patients were prescribed zopiclone, all within the licensed dose range and all as prn medicines. None of the patients had documented non-pharmacological measures and three patients had insomnia documented in their notes, although this was based on their drug history.

DISCUSSION AND CONCLUSION
Leaflet guides on non-pharmacological strategies for use by patients and healthcare professionals were designed and recommended for implementation on wards, due to the poor adherence to this objective. Although formulary prescribing was good (64%) the standard for this and all criteria were set at 100%. The only standard met was that relating to prescribing within licensed dose ranges. Interpretation of the results was limited by the small population size and consequently it was deemed necessary to propose a reaudit in six months, to be conducted over a longer period to complete the audit cycle.

REFERENCES

ORAL PRESENTATION AWARDS
FIRST PRIZE
Knowledge and perceptions of qualified and student teachers towards ADHD and the role of medication

G. Akram*, A. H. Thomson*, A. C. Boyter*, M. McLarty*
*Institute of Pharmacy and *Department of Education, University of Strathclyde

Some 5% of school-aged children are thought to have attention deficit hyperactivity disorder (ADHD). School teachers are often charged with containing ADHD behaviours. Recent Scottish Intercollegiate Guidelines Network guidance recommends that teachers become more closely involved in the diagnostic and/or treatment process. This assumes that they have a sound knowledge of the disorder and its treatment.

Analyses of teacher training programmes at Scottish universities revealed that none of them offer courses that cover the diagnosis and medical treatment of ADHD. Teachers are therefore left to access ADHD information by their own means, including use of “the media, friends and parents of children with ADHD.” The potential for misinformation, culminating in incorrect or inappropriate feedback to the clinician, is exacerbated by this situation.

AIMS
To determine and compare the knowledge and attitudes of qualified and student teachers towards ADHD and its treatment. The nature of information resources was also investigated.

METHOD
A self-administered questionnaire was developed using items from validated questionnaires used in similar studies and distributed among teachers attending undergraduate and postgraduate courses at the University of Strathclyde. Knowledge was determined by True/False/Don’t know responses to 15 statements related to general issues about ADHD, followed by 18 medication specific statements. Beliefs and attitudes were identified by a five-point Likert scale response to 12 statements.

RESULTS
Sixty-eight questionnaires were returned by 43 qualified teachers (response rate = 92%) and 25 student teachers (78%). Forty-four individuals had taught a child with ADHD and 25 had received formal training about the condition. The mean number of correct responses to 15 ADHD knowledge statements was 5.1 (SD 2.3) for qualified teachers and 5.4 (standard deviation [SD] 2.5) for student teachers. On medication specific issues, student teachers had a greater number of correct responses (mean 3.6 [SD 3.4] compared with 3.3 [SD 2.8]) but this difference was not statistically significant (P=0.64). There was general agreement that teachers should be aware of medication side effects, and that they should be more closely involved in monitoring a child’s response to medication. The most popular sources for information about the disorder were found to be “other
colleagues" (87%) and the internet (86%). Knowledge and use of previously evaluated high-quality ADHD websites was low — eg, only 11 respondents were aware of ADDISS (the national Attention Deficit Disorder Information and Support Service) and only 10 were aware of Mind’s ADHD website.

**DISCUSSION AND CONCLUSION**

Teachers lack knowledge of the basic concepts of ADHD and also seem ignorant about the cognitive and adverse effects of ADHD medication. The potential for inadvertently attributing improvements or relapses in the child’s functioning to the medication or the disorder are therefore high. This is a particularly worrying since all the qualified teachers were designated “support teachers” with responsibility for children with “additional support needs” and so should be better informed than their unqualified counterparts. This suggests that there is an unmet need in the education and training of teachers. Moreover, there appears to be a reluctance for information on “other colleagues”, who may be similarly misinformed, and the internet. Unfortunately, awareness of government health or education-based websites was low, again compromising the quality of information accessed by teachers.

The training of school teachers in medication-associated issues appears to be an area ripe for pharmacist involvement. Training need not be limited to advising on the physical effects of medication but could address other medication-specific issues such as administration, storage and misuse.

**REFERENCES**


**ORAL PRESENTATION AWARD**

**Runner Up**

**How to improve medication safety using pharmacists’ interventions**

P. Brown, E. Street, S. Lennon, J. Mills
Manchester Mental Health and Social Care Trust

Although mental health is the third highest reporter of medication incidents as reported by the National Patient Safety Agency, it is well known that there remains under-reporting of medication incidents particularly in community settings. Within Manchester Mental Health and Social Care Trust, medicines incidents were predominantly reported by inpatient nursing staff. Interventions made by pharmacists were not routinely captured on the trust’s web-based incident reporting system, DATIX.

**AIMS**

To improve reporting of medication incidents using pharmacist interventions and to improve learning and feedback thus improving patient safety.

**METHOD**

Using an amended “pharmacy intervention” form, all interventions made by the pharmacists and technicians were reported through DATIX and analysed alongside medication errors. These were reviewed and recategorized by the chief pharmacist to medication incidents or improving quality of care. Medication incidents were recategorised as per NPSA classification.

**RESULTS**

Medication incident reporting increased dramatically. The trust now has the second highest level of reports for a mental health trust with reporting by all staff groups in all areas. Changes to systems include a new medicines card, nurse competency assessment, non-registered practitioner training, reviewed in-house medical training and a medicines nurse.

Feedback to ensure lessons are learnt is through locality incident scrutiny meetings, mandatory training, e-learning and newsletters. 50% of incidents are due to prescribing errors versus 12% for the equivalent NPSA cluster. Two one-day consultant training sessions highlighted these errors. The team can identify high risk medicines and practices (eg, insulin, sodium valproate, olanzapine, clozapine and methadone) and ensure changes to processes and systems support. The increased reporting has additionally allowed monitoring of pharmacy services, yellow card reporting, adherence to antibiotic policies, NPSA alerts and issue of lithium patient packs following on from the recent patient safety alert.” The team won the 2010 Patient Safety Awards for a “system wide, sustainable change in practice that truly improves patient safety”.

**DISCUSSION AND CONCLUSION**

Submitting pharmacy interventions has dramatically increased the levels of medication incidents reported. Analysing and learning from this has led to changes to training, practice and competency assessment systems. Improvements in practice such as protected medication time, incident learning forums, link nurses and learning boards on wards are now in place. The system is now used as a quality management system also to provide assurance for external validation of services such as by monitoring medicines reconciliation. By monitoring the implementation of NPSA alerts, for example, the trust can show it is improving patient safety.

**REFERENCES**


**POSTER PRESENTATION AWARDS**

**A. SERVICE DEVELOPMENT: Award Winner**

**Developing a prescribing trigger tool to guide pharmaceutical care planning on psychiatric wards**

A. Tinto, S. Hopker, K. Cullen, R. Tindall, S. Stevens, J. Sohal
Bradford District Care Trust

Global trigger tools have been devised to measure adverse drug events in a range of care settings including mental health. Rather than retrospectively look for harm when it has already occurred, I wished to introduce a system that highlighted certain prescribing events, thereby embedding in the organisation a clear and proactive process that would both aid ward pharmacists carrying out their clinical duties and facilitate closer multidisciplinary working.

**AIM AND OBJECTIVES**

The aim was to develop and audit the use of a prescribing trigger tool to guide pharmaceutical care planning on psychiatric wards. The objectives were to encourage clear and consistent documenting of care plans, expected outcomes of the rationale, any risks or expected benefits that should be anticipated, whether additional monitoring is required and clear timescales for review when a treatment is expected to be for a limited period.
**DISCUSSION AND CONCLUSION**

The results are set out in Tables 1 and 2 (above).

**REFERENCES**


**POSTER PRESENTATION AWARDS**

**A. SERVICE DEVELOPMENT: RUNNER UP**

Prescribing support pharmacists support appropriate benzodiazepine and “Z” drug reduction 2008/2009 — experiences from North Glasgow

Chris Johnson, Anne Thomson  
Prescribing Support Pharmacists, North Glasgow Community Health and Care Partnership

North Glasgow Community Health and Care Partnership (CHCP) provides primary care services within an urban area with high deprivation. In a 12-month period (2006/07) data obtained from Prescribing and Information System for Scotland (PRISMS) highlighted benzodiazepine and “Z-hypnotics” (B&Zs) prescribing increase of 6.7% defined daily doses (DDD) per 1,000 patients. The Committee on the Safety of Medicines advises that benzodiazepines are indicated for short-term use.1 Two practices were identified as higher than average B&Z prescribers. Both practices had experienced prescribing support pharmacists (prescriber and non-prescriber). It was agreed within these practices to reduce inappropriate B&Z prescribing.

**AIM**

To reduce inappropriate prescribing of B&Z drugs without compromising patient care.

**OBJECTIVES**

- Gather baseline information on B&Z prescribing
- Agree a practice policy for B&Z prescribing
- Provide practice education and resources
- Improve “housekeeping” of B&Z prescriptions
- Identify patients suitable for review and withdrawal in a general practice setting
- Monitor prescribing data using PRISMS

**METHOD**

The pharmacists performed baseline General Practice Administration System Scotland (GPASS) practice computer searches (2008) identifying patients prescribed regular B&Z prescriptions in the previous 12 weeks. A subgroup of regular B&Zs patients were further audited to gain insight into prescribing patterns. The results were presented to the practice teams. An action plan and practice policy were then agreed. Support materials were provided: educational memory aides for staff, patient information leaflets informing of B&Z use and review, and posters displayed in waiting areas and consultation rooms stating that routine initiation of B&Zs would no longer take place. Patients who regularly ordered B&Zs and were suitable for withdrawal were invited for review. Access to repeat prescriptions were restricted until patients were reviewed. Individual patient specific B&Z reduction schedules were ensured the sequence of recognising and actioning them is consistently documented.

**Table 1. Results by trigger point type and medication origin**

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<th>o</th>
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<tr>
<td>Totals</td>
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<td>104</td>
<td>32</td>
<td>55</td>
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</table>

| Key: | ad = admitted on this medication, pm = triggered by prescription of pm, ptr = poor treatment response, ao = already on trigger medication, o = other |

**Table 2. Results by ward type**

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<td>-</td>
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<td>-</td>
<td>-</td>
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<td>1</td>
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<td>General adult (male)</td>
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<td>8</td>
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</table>
agreed and recorded in patients’ clinical notes. Pharmacists and GPs reviewed patients supporting appropriate dose reduction/withdrawal.

RESULTS

See Table 1 (above). A B&Z prescribing policy was agreed by both practice teams. From PRISMS, practice prescribing trends decreased by 32.0% and 22.3% DDDs per 1,000 patients.

CONCLUSION

B&Z reduction or cessation was achieved for most patients reviewed, demonstrating that pharmacists can be effective at enabling reductions in B&Z prescribing by working closely with practice teams adopting a multi-strand approach, including education and “hands on” support.

REFERENCES


POSTER PRESENTATION AWARDS

B. RESEARCH: Award Winner

A survey of medication documentation in written communication to GPs

H. C. Stanniland

Lakeside Mental Health Trust, West London Mental Health Trust, Twickenham Road

Good communication across interfaces has been highlighted as essential to patient safety.1 During routine visits to community teams, errors were noticed in some letters to patients’ GPs on their electronic patient record (a notes database not linked to electronic prescribing).

AIMS AND OBJECTIVES

To assess the medicines information on communications to patients’ GPs within the local area. As there is no trust guidance on communication of medicine information to GPs standards were based on the trust discharge medication prescription as follows: 100% of letters should specify the names of the medicines, dose and frequency, the date of next review, whether there were changes and the rationale for those changes; 100% of the medicines information provided should be accurate.

METHODS/STUDY DESIGN

The clinical documentation folders were examined on the electronic patient notes database not linked to electronic prescribing). The clinical documentation folders were examined on the electronic patient record (a notes database not linked to electronic prescribing).

RESULTS

- 579 letters were examined from 14 wards/teams
- There were 191 errors identified including: 57 omitted details, 41 incorrect formulations, 40 wrongly-spelt names, 18 wrong doses and eight wrong names
- Examples of errors: risperidone Consta doses of 27.5mg and 57.5mg, depot listed as Depixol (should have been zuclopenthixol [Clopixol]), discharge summary listed flupentixol 400mg 2/52 (should have been 40mg 2/52)

DISCUSSION AND CONCLUSION

Medication details were incomplete in 18% of the communications. In addition, there were errors, which were brought to the attention of the patients’ consultants. This could have led to patients receiving incorrect prescriptions from their GPs. Therefore, the required standards were not met. The following was recommended:

- Use standard formats for letters to prompt necessary information
- Ensure these issues are raised at staff induction and supervision
- Junior doctors should have their letters checked for accuracy
- Clinical staff who use secretaries should check returned work for accuracy

REFERENCES


POSTER PRESENTATION AWARDS

B. RESEARCH: Runner Up

Naturalistic evaluation and audit database of agomelatine (NEVADA): clinical outcome at 14 months

A. Sparshatt*, D. S. Baldwin†, S. Bazire‡, P. M. Haddad||, E. Weston§, R. H. McAllister Williams*, D. Taylor¶

* Kings College London; †Clinical Neurosciences Division, University of Southampton School of Medicine, Hampshire Partnership NHS Foundation Trust; ||Norfolk and Waveney Mental Health NHS Foundation Trust; ¶Greater Manchester West Mental Health NHS Foundation Trust; §Institute of Neuroscience, Newcastle University; ¶ Kings College London, South London and Maudsley NHS Foundation Trust

Agomelatine is a recently licensed antidepressant drug with a novel mode of action. Agomelatine exerts agonist activity at melatonergic MT1 and

<table>
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<th>Patients</th>
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<tr>
<td>Patients inappropriate for withdrawal at present</td>
<td>442</td>
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<tr>
<td>Patients invited for review</td>
<td>207</td>
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<tr>
<td>Review outcomes: Stopped</td>
<td>74 (35.7%)</td>
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<tr>
<td>Reduced</td>
<td>63 (30.4%)</td>
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<td>Increased</td>
<td>4 (1.9%)</td>
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</table>

Table 1. Changes in B&Z prescribing

Figure 1. Quality of medicine information

Were the above details provided?
MT2 receptors and antagonist activity at 5HT2c receptors. Published data suggest a preferable side effect profile compared with other licensed antidepressants. While trial data and local experience may provide guidance as to agomelatine’s clinical value, naturalistic reports from a wider clinical environment may determine its ultimate place in treatment. The NEVADA programme is a naturalistic UK-wide two-year evaluation designed to provide a national picture of the clinical value of agomelatine. Here we report data collected at 14 months.

Aims
To collect outcome data that can inform decision making regarding agomelatine in the treatment of depression, and to identify appropriate patient groups for whom treatment with agomelatine may be particularly beneficial.

Objectives
To develop a secure live database to collect data from various centres across the UK. Demographic and treatment outcome data will be collected for all patients prescribed agomelatine.

Method
Secondary care centres from across the UK were approached to participate in the NEVADA service development study. Following local approvals, staff were trained on the use of the database and provided with access. Data were collected for all patients prescribed agomelatine following an independent prescribing decision. Data were collected at treatment initiation, and at Weeks 4, 8 and 12.

Results
After 14 months of data collection, 12 centres were enrolled in the study, and 89 reports were collected. The study cohort was aged between 19 and 75, 91% had an ICD-10 diagnosis of severe and/or recurrent depression and 57% of patients had experienced three or more prior episodes of depression. At the time of agomelatine initiation, 96% had received at least one antidepressant in the current depressive episode, and 58% of patients were suffering an episode lasting over twelve months. At 14 months, 58 patients had either completed 12 weeks of agomelatine treatment or discontinued their treatment prior to the 12-week study period. Sixty per cent of those with complete data sets continued on treatment at 12 weeks. Of those who discontinued, 61% discontinued due to lack of efficacy, and 26% due to an adverse event.

The adverse events believed by the prescribers to be possibly associated with treatment (13 adverse events, 9 patients) were diarrhoea (n=2), increased aggression and irritability (n=1), cold-like symptoms (n=1), sleep disturbance (n=1), taste disturbance (n=1), susceptibility to the sun (n=2), sedation (n=3), hyperphagia (n=1) and weight gain (n=1).

Discussion and Conclusion
Treatment discontinuation within 12 weeks of agomelatine treatment was 40%; the majority of these discontinuations were due to lack of efficacy. This study suggests agomelatine is often prescribed for patients who are among the most ill and possibly suffering a treatment-resistant depression. Despite such severity of illness, 60% remained on treatment at week 12. Agomelatine may also be beneficial in the treatment of less severely ill patients who have not failed to respond to other antidepressants. Similar data from less severely ill patients are required to inform if the drug is efficacious in such patient groups.

Acknowledgement
Funded by an unrestricted research grant from Servier Laboratories Ltd. Please note this represents work in progress.

References

Poster Presentation Awards
C. Audits/Surveys: Award Winner

Compliance with the trust’s high dose antipsychotic policy in patients receiving regular treatment

Vanessa Redmond
Central & North West London NHS Foundation Trust

There is no convincing evidence that doses of antipsychotic drugs higher than the recommended doses are more clinically effective than standard doses. Regular high-dose prescribing is used in clinical practice for treatment-resistant schizophrenia when all other evidence-based options have been used or are deemed inappropriate. Risks are associated with prescribing and as a result should be closely monitored.

Method
Data were collected by ward pharmacists across four acute wards, two psychiatric intensive care wards and two rehabilitation wards (total 118 beds) during a four-week period for those receiving regular high-dosing. These wards were selected because they are most likely to have the highest prevalence of regular high-dose prescribing. Data were obtained from drug charts and medical notes.

Objectives
In 100% of cases of prescribing regular high-dose antipsychotics:
1. Prescribing should be discussed with the patient and documented in the medical notes
2. The rationale for prescribing should be documented in the notes
3. A trust high-dose antipsychotic form should be completed
4. An electrocardiogram (ECG) should be done at baseline, after initiation, dose escalation and then three-monthly as per CNWL high-dose antipsychotic policy (see Table 1, below)
5. Baseline bloods (U&Es, full blood count, liver function tests, lipids, glucose, prolactin, creatinine, phosphokinase, physical observations (blood pressure, pulse, temperature, body mass index) should be taken
6. A progress review is documented in the notes at least every three months

Results
Twenty-five patients were identified as being prescribed regular high-dose antipsychotics.

Nineteen of the 25 patients had the rationale for prescribing a high dose antipsychotic policy in their notes, 17 had a documented discussion about being informed about the decision to prescribe; 18 had a trust high-dose antipsychotic form completed. Only 13 of the patients had a progress review every three months documented in the medical notes.

Discussion
As the results show, none of the audit criteria was met to a 100% level. Limitations of the audit were that the results were dependent on clear

| Table 1. Electrocardiogram (ECG) monitoring requirements |
|-------------|-----------------|-----------------|-----------------|
|             | Yes | ECG requirements | Not known | N/A |
| At baseline | 19  | 1               | 5             | 0   |
| Post initiation | 2  | 12              | 11            | 0   |
| Dose escalation | 3  | 11              | 4             | 7   |
| One-to-three months | 13 | 6               | 1             | 5   |

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Safety, accountability and legal compliance: a new prescription chart for psychiatry

A. R. Dunne, J. Begley
Pharmacy Department, University Hospital, Galway, Ireland

West Galway Psychiatric Services have used the same style of prescription chart since the 1970s. Use of the charts has been reviewed and the decision made to introduce a new chart for the department. The current chart is in use across inpatient and outpatient services. It was decided to review the use of charts for adult acute inpatients initially, with the potential for roll-out across the community and long-stay services in the near future.

AIM AND OBJECTIVES
The aim was to update the prescription chart, incorporating safety features that are in common use in general hospitals and other departments of psychiatry.

Objectives included:

- Audit the use of the current chart
- Look at designs used in the neighbouring general hospital and other psychiatric departments in Ireland and worldwide
- Consider safety and legal standards
- Design a new chart
- Audit the use of the new chart to continually improve the design

METHOD
An audit of the current charts was undertaken to determine legibility and completeness of information. Copies of charts from several different hospitals were reviewed, along with the Australian national drug chart. Irish safety standards for healthcare documents were considered. A decision was made to base our new chart on one that is used in our neighbouring general hospital, but to tailor the chart to suit psychiatric inpatients in our acute and long-stay units.

The new chart was introduced following a period of staff training and familiarisation. The audit was then repeated once the new charts had been introduced and in use for two months.

RESULTS AND DISCUSSION
The use of the current prescription charts was audited in April 2010. The new chart design was introduced on 1 June 2010 for all adult inpatients. A repeat of the audit in July 2010 gave the results set out in Table 1 (above).

The introduction of the new chart improved several elements that contribute to improved safety when prescribing and administering medication. Legibility of drug name, clarity of drug dose and recording of patient’s allergy status were among the elements showing improvement.

A fault in the new charts was discovered in that directions for when required medicines were now not being completed in the majority (61.4%) of cases (51/83). This will be addressed immediately through staff training and also in a rewording of the next version of the chart.

Another element that needs to be improved is the way that nurses sign when a drug is administered. The new chart has a new set of codes which nurses should use if a drug is withheld. Not all nursing staff were using these codes correctly and this will be addressed with staff training.

The introduction of the new prescription chart to the department of psychiatry in West Galway has gone some way to improve the safety of the use of medicines in the department. It has also increased accountability and highlighted the benefit of the pharmacist as part of the clinical team. This audit is part of a continuing review of the prescription charts — a second version will be designed as a result of the audit and evaluation of daily use of the document. It is intended that the new prescription style will be adapted to suit the needs of the community mental health teams and local day hospital.

REFERENCES

Table 1. Summary of results

<table>
<thead>
<tr>
<th>Element of prescription</th>
<th>Original chart</th>
<th>New chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressograph/patient name readable</td>
<td>39 (96%)</td>
<td>31 (87%)</td>
</tr>
<tr>
<td>Full name of consultant on prescription</td>
<td>36 (90%)</td>
<td>21 (66%)</td>
</tr>
<tr>
<td>Drug allergy/sensitivity box completed</td>
<td>5 (13%)</td>
<td>10 (31%)</td>
</tr>
<tr>
<td>Date prescription started</td>
<td>18 (45%)</td>
<td>27 (84%)</td>
</tr>
<tr>
<td>Chart number completed (ie, chart 1 of 2)</td>
<td>5 (13%)</td>
<td>22 (69%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHEN REQUIRED OR STAT MEDICINES</th>
<th>Number (%) of correct prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element of each drug prescribed</td>
<td>(n=167) (n=144)</td>
</tr>
<tr>
<td>Drug name</td>
<td>144 (86%)</td>
</tr>
<tr>
<td>Drug dose</td>
<td>157 (94%)</td>
</tr>
<tr>
<td>Prescriber’s signature</td>
<td>161 (96%)</td>
</tr>
<tr>
<td>Date</td>
<td>153 (92%)</td>
</tr>
<tr>
<td>Route</td>
<td>162 (97%)</td>
</tr>
<tr>
<td>Directions</td>
<td>157 (94%)</td>
</tr>
<tr>
<td>RPN (nurse) signature on admin</td>
<td>161 (96%)</td>
</tr>
<tr>
<td>Time of dose</td>
<td>129 (77%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REGULAR MEDICINES</th>
<th>Number (%) of correct prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element of each drug prescribed</td>
<td>(n=40) (n=32)</td>
</tr>
<tr>
<td>Chart number completed (ie, chart 1 of 2)</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>Drug allergy/sensitivity box completed</td>
<td>5 (13%)</td>
</tr>
<tr>
<td>Full name of consultant on prescription</td>
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</tr>
<tr>
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<td>18 (45%)</td>
</tr>
<tr>
<td>Chart number completed (ie, chart 1 of 2)</td>
<td>5 (13%)</td>
</tr>
</tbody>
</table>
The use of these agents in elderly patients with dementia is associated with pharmacological interventions, and only produce short-term improvement. Antipsychotic drugs. These agents are no more effective than many non-difficult to manage. These are commonly managed using atypical of dementia (BPSD) will often occur alongside cognitive deficits and can be effect in order to make the best use of limited resources.

**Aims and Objectives**
This project aimed to use a number of indicators to analyse the use of atypical antipsychotics in care homes and identify any associations between these and the characteristics of the homes. The main objective was to develop a method that could be used to predict which care homes are likely to have a high rate of atypical antipsychotic usage.

**Methods/Study Design**
Anonymised details of the medication dispensed by the pharmacy in a six-month period were transferred into a Microsoft Access database. This was used to produce a range of outputs, which were subjected to statistical analysis using PSPP. Similarly-aged patients living in their own homes were used to enable the determination relative risk. Data on the care home characteristics were obtained from the Care Quality Commission (CQC).

**Results**
Usable data were obtained for 13 care homes; 486 patients were in the care homes included in the study. Of these, 113 were prescribed an antipsychotic medicine, and 100 received an antipsychotic drug for more than three months. Average antipsychotic equivalent doses (expressed as mg haloperidol/risperidone) varied from 0.4mg/day to 2.0mg/day (mean 0.86mg/day). Higher scores reflected a greater level of antipsychotic use in the care home. The relative risk of a care home resident being prescribed an antipsychotic medication compared to a community resident is 13.84, (CI 5.17 – 37.05; p=0.05; AR 0.23) and of that antipsychotic being continued for three months is 12.25 (CI 4.56 – 32.86; p=0.05; AR 0.20). The analysis has not identified any statistically significant associations between any of the prescribing indicators and any of the care home characteristics identified.

**Discussion and Conclusions**
The sample size was too small to produce any significant results. The CQC inspection scores showed little variation between homes. Although the study failed to identify any associations between the characteristics of the care homes and the use of atypical antipsychotics, it has identified a methodology that could be adapted to provide a meaningful comparison of the usage of antipsychotics between different care homes.

**References**

**Poster Presentations**
**Evaluation of near patient testing for patients receiving clozapine**
Steve Buckley
Cheshire and Wirral Partnership NHS Foundation Trust (CWP)

To improve efficiency and patient experience, near patient testing with the Novartis/Sysmex Point of Care Haematological Instrument (POCHi) system was trialled in two locations. This study looked at the implementation of change directly affecting service users and nursing staff.

**Aims and Objectives**
To survey the perspectives of patients and staff regarding the use of POCHi, in order to ascertain the value of expanding the service across the trust.

**Method**
In order to evaluate the pilot study, staff and patients were asked to complete satisfaction survey forms. Patients in attendance at the two clinics were asked to complete the questionnaire, and to hand back to the pharmacy team once completed. Response rate was high at 92%. Nursing staff were also given the questionnaire by hand, but asked to return via internal post, to promote anonymity. The response rate was much lower at 50%.

**Results**
The response to the questionnaire is summarised in Table 1.

<table>
<thead>
<tr>
<th>Table 1. Questionnaire responses</th>
<th>Percentage of responders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients satisfied with old system</td>
<td>86%</td>
</tr>
<tr>
<td>Patients thought new system was an improvement</td>
<td>100%</td>
</tr>
<tr>
<td>Patients thought it was better to have a pharmacist involved in the clinic</td>
<td>100%</td>
</tr>
<tr>
<td>Patients had physical parameters / side effects checked under old system</td>
<td>89%</td>
</tr>
<tr>
<td>Patients had physical parameters / side effects checked under new system</td>
<td>86%</td>
</tr>
<tr>
<td>Patients thought that POCHi should be rolled out to all clozapine clinics within the trust</td>
<td>100%</td>
</tr>
<tr>
<td>Nursing staff felt POCHi improved patient care</td>
<td>100%</td>
</tr>
</tbody>
</table>
DISCUSSION AND CONCLUSION

The key advantages from feedback of patients were:

- the ability to collect medication shortly after having blood analysed
- the involvement of a pharmacist at the clinics
- the extent of monitoring of physical health and side effects was similar under both systems.

After initial reservations regarding near patient testing, nursing staff believe it has improved patient care.

Pharmacy staff were key to implementing the service improvement and were well received by patients as part of the clozapine clinic team.

In conclusion, patients, nursing staff and the pharmacy team all felt that there was an improvement in the provision of clozapine and this new service should be offered to all patients within the trust.

REFERENCES

1 Cheshire & Wirral Partnership NHS Foundation Trust. Point of care haematological analysis policy (MP17). Chester: CWP; 2009

Antibiotic audit, January 2009 to March 2010

Jennifer Southern
Cheshire and Wirral Partnership NHS Foundation Trust

The Infection Prevention and Control (IPC) Group works jointly with the Medicines Management Group (MMG) at Cheshire and Wirral Partnership NHS Foundation Trust (CWP) to implement and monitor standards of prescribing of antibiotics within the Trust. Appropriate antibiotic prescribing is important to treat infections effectively and reduce the risk of adverse drug reactions.

AIMS AND OBJECTIVES

- To identify compliance with the prescribing guidelines for antibiotics laid out in the CWP Medicines Policy1 and the trust-wide IPC Operational Policy2.
- Where compliance is poor, to implement an action plan and re-audit.

METHOD

A point prevalence study of all antibiotic prescribing was carried out across CWP in January 2009 and repeated in November 2009 and March 2010.

RESULTS

The results are set out in Table 1.

DISCUSSION AND CONCLUSION

The greater number of antibiotics prescribed in November 2009 may be due to new wards opening or it being a winter month. Some aspects of antibiotic prescribing were good but there was not 100% compliance with audit standards across thetrust. Following the January 2009 audit, the medicines management training was updated to emphasise the importance of complying with the antibiotic prescribing recommendations which were developed to meet the Department of Health requirements.2,3

Despite this, allergies were less well documented in November 2009. With further input from the clinical pharmacy team this improved to 100% in the March 2010 audit. No patients were prescribed an antibiotic to which they had an allergy whether this had been documented on the chart or not.

From the results of the audits it is apparent that the recommendations still need emphasising. The audit will continue to be completed twice yearly, and will be expanded to include Clostridium difficile rates. The MMG and IPC Group will prepare an action plan for the clinical services to disseminate.

REFERENCES

1 CWP MP1 Medicines Policy.
2 CWP IPC Trust-wide Infection Prevention and Control Operational Policy.

A medicine reconciliation audit

Nichola Yates
Cheshire and Wirral Partnership NHS Foundation Trust

In December 2007, the NPSA in conjunction with NICE produced guidance on medicines reconciliation on admission to hospital1. Following the introduction of the Cheshire and Wirral Partnership NHS Foundation Trust (CWP) Clinical Pharmacy Team, a baseline audit of medicines reconciliation as defined in NICE guidelines2 was undertaken in August 2009 and reaudited in February 2010. This was to enable the team to review current practices and to implement a policy with realistic standards, guidelines and responsibilities for clinical staff.

AIMS AND OBJECTIVES

To assess adherence to the NICE/NPSA and CWP policy2 standards for medicines reconciliation.

METHOD

Data was collected by clinical pharmacy technicians over a two-week period as a baseline in August 2009 before rolling out the pharmacy ward service. The audit was then repeated in February 2010 after the Clinical Pharmacy Team made up of pharmacists and technicians was in place. The audits were performed for all inpatients on the same four adult acute mental health wards using an audit tool based on the NICE/NPSA template1 and CWP standards.

RESULTS

The results are set out in Table 1.

DISCUSSION

The overall results indicate that 100% compliance with set standards was not achieved. Since the implementation of the clinical pharmacy team the number of patients receiving medicine reconciliation on admission was

<table>
<thead>
<tr>
<th>Table 1. Compliance with recommended criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criterion audited</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Allergy documented</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Stop date indicated</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Indication given on chart</td>
</tr>
<tr>
<td>Indication given in notes</td>
</tr>
<tr>
<td>Formulary choice: drug, dose, duration</td>
</tr>
<tr>
<td>Microbiology advice</td>
</tr>
<tr>
<td>if “no” to above</td>
</tr>
</tbody>
</table>

Microbiology advice Yes 3 of 6 (50%) 3 of 9 (53.3%) 1 of 3

Microbiology advice if “no” to above Yes 3 of 6 (50%) 3 of 9 (53.3%) 1 of 3
Table 1. Levels of compliance with recommended standards

<table>
<thead>
<tr>
<th>Standard recorded</th>
<th>Category</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy status</td>
<td></td>
<td>50%</td>
<td>90%</td>
</tr>
<tr>
<td>Admission date</td>
<td></td>
<td>45%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage receiving medicines reconciliation in total</td>
<td></td>
<td>59%</td>
<td>100%</td>
</tr>
<tr>
<td>Time elapsed before medicines reconciliation</td>
<td>&lt;24 hours</td>
<td>24%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>24–72 hours</td>
<td>7%</td>
<td>31%</td>
</tr>
<tr>
<td></td>
<td>&gt;72 hours</td>
<td>89%</td>
<td>9%</td>
</tr>
<tr>
<td>Who undertook medicines reconciliation</td>
<td>Clinical pharmacy team</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Other clinical staff</td>
<td>28%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>72%</td>
<td>0%</td>
</tr>
<tr>
<td>Time taken for pharmacist involvement</td>
<td>24 hours</td>
<td>9%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>24–72 hours</td>
<td>0%</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>&gt;72 hours</td>
<td>91%</td>
<td>24%</td>
</tr>
<tr>
<td>Errors found</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Errors breakdown</td>
<td>Route</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Timing</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Frequency</td>
<td>22%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Dosage</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Legibility</td>
<td>61%</td>
<td>76%</td>
</tr>
</tbody>
</table>

Aims and objectives
This audit aimed to compare current practice at Leeds Partnership Foundation Trust with the NICE guidance.

Methods
This is a qualitative audit. Data was collected by medical students from one Community Mental Health Team (CMHT) due to the time involved in hand searching notes. Demographic data, including co-morbidities, and information on current drugs and doses prescribed was collected for patients with a diagnosis of BPD.

Results
Data was collected from 59 patients from the CMHT. Of these, 82% were female and most (44%) were aged between 36 and 45; 61% had co-morbid diagnoses, most commonly affective disorders. Of the 23 patients (39%) with no co-morbidities, 92% were on at least one psychotropic medication and 18 (78%) were on medium- to long-term antipsychotic medication. Two were prescribed doses > BNF maximum. Thirteen (37%) were prescribed an antidepressant, most commonly a selective serotonin reuptake inhibitor (SSRI). This was much higher — 29 (81%) — in those with co-morbid conditions. Three (8%) were prescribed a mood stabiliser. In the total sample, 21% were prescribed long term benzodiazepines; 17% were long-term hypnotics, most commonly zopiclone.

Discussion and conclusion
In accordance with previously published studies the utilisation of medication in BPD was high. The results show that current practice does not accord with NICE guidance. However, prescribing in BPD is a complex issue, the strong emotional inferences BPD patients attribute towards the act of prescribing and the medication itself can thwart attempts at medication reduction. There are some who criticise the NICE guidance itself.

Reviewers were forced to look at undersized and over-short trials, and it could be argued they drew conclusions from lack of evidence rather than evidence the drugs did not work.

Implications for practice: Efforts should be made to reduce medication where possible as evidence for use is weak. Pharmacists could assist in this process by questioning medication use in those with BPD and helping with review.

Audit of prescribing in borderline personality disorder

J. Raynsford, A. Roylance, A. Brodie, C. Ross, M. Assis

Borderline personality disorder (BPD) is characterised by a pervasive pattern of instability of interpersonal relationships, unstable self-image, emotional lability, and marked impulsivity. Polypharmacy is often used in an attempt to control symptoms, most information on this comes from the US. The evidence base for medication is poor. Recent NICE guidance stated that drug treatment specifically for BPD or for the individual symptoms or behaviour associated with the disorder should not be used. Although the utility of short-term treatment for crisis was acknowledged, the guidance also stated that antipsychotics should not be used for medium- and long-term treatment. Drug treatments for co-morbidities were advocated.

An audit of cardiovascular risk factor monitoring in a acute adult inpatient mental health wards at Auckland Hospital, New Zealand

C. L. Young, G. Boo
Auckland Hospital New Zealand

Severe mental illness has been associated with reduced life expectancy and poor physical health, of which cardiovascular disease is a significant cause of morbidity and mortality. Given the increased risk of cardiovascular disease in these patients, one might expect regular recordings of associated
aim to determine whether individual five-year absolute cardiovascular risk can be calculated from the cardiovascular risk monitoring that occurs during an admission to the acute adult mental health unit at ADHB from 1 July to 31 December 2008.

results
From the 284 patients admitted over the six-month period from 1 July to 31 December 2008, 100 patients were randomly selected to be included in the sample, with a total of 109 admissions (nine patients were admitted twice in the six-month period). A majority of patients had a diagnosis of schizophrenia or schizoaffective disorder (64%), 23% bipolar affective disorder, 12% depression and 1% unknown diagnosis. The mean age was 38 years (range, 18–73 years).

Adjusted individual five-year cardiovascular risk was able to be calculated in 57% of admissions and in 60% of patients admitted. In this sample, 11% of patients had a known co-morbidity associated with increased cardiovascular risk.

Discussion and conclusion
The main finding of this audit was that only 60% of patients in this sample had sufficient monitoring to enable calculation of adjusted individual five-year absolute cardiovascular risk. Routine monitoring of cardiovascular risk factors does not occur in the acute adult inpatient units at Auckland Hospital and it is not known if this has led to worse outcomes for those not monitored adequately. Despite significant evidence associating severe mental illnesses and cardiovascular disease, physical health monitoring is still sub-optimal. Without early adequate monitoring patients’ physical health issues cannot be identified, treated appropriately to avoid increased cardiovascular morbidity and mortality.

Aims and objectives
To introduce a standardised method for depot administration throughout the Trust which will improve patient safety, outcomes, prevent adverse events and help improve physical health monitoring of service users.

Methods/study design
All patients receiving depot medications were included although only patients attending depot clinics were interviewed. Interviews were conducted with range of stakeholders including:
- Service users and carers
- GPs and practice nurses
- Team managers within organisation
- Nurses responsible for administering depot medication
- Doctors responsible for prescribing of depots
- Mental health pharmacists.

To maximize the involvement of all professionals and service users who have depot medication, a “Transforming Care” event was held, which enabled all to contribute to the mapping process of the “depot journey”. Compliance rates were analysed using data collected from the clinics throughout the trust and an audit of the use of long-acting neuroleptics in clinical practice in one locality was also conducted alongside this study. The data from this audit has been incorporated into the study to further inform the learning and implementation of new way of working.

Results
- Compliance rates - 88% - 100% across the trust
- No standardisation of documentation found particularly in relation to physical health
- Differing environments, range of professionals, available equipment in clinics impact on level of care provided
- 94% of patients interviewed rated the level of service they received as “high”
- 86% of patients preferred to receive their depot medication at clinic rather than in their homes

Discussion and conclusion
The results clearly demonstrated that there is a lack of consistency across the trust in relation to how we prescribe, administer and monitor depot medication. However, patients interviewed preferred to attend a clinic to receive their medication. A thorough literature search and liaison with other trusts demonstrated that many do not have formalised standards based on best evidence based practice with which depot services should be managed.

The Medicines Management Team have now developed a core group of Standard Operating Procedures which cover the ordering, delivery, prescribing, administration, and continued monitoring of depot medicines. These standards reflect national guidance and recommendations (NICE, POMH-UK, NMC, and UKPPG). This work is linked to a trust community services review which is looking at how to operationalise these procedures. A business case is being developed with the aim of developing nurse led clinics incorporating non-medical prescribing. This will further facilitate improved monitoring and review of patients receiving depots and enable the development of the gold standard service we hoped to achieve.
An audit of the medication prescribed to patients with borderline personality disorder

K. W. Liu, C. Paton
Oxleas Foundation NHS Trust

The National Institute for Health and Clinical Excellence (NICE) produced a clinical guideline for the management of borderline personality disorder (BPD) in 2009. There are few UK data relating to prescribing practice in this patient group.

AIMS AND OBJECTIVES

Aim: To audit prescribing in patients with BPD in accordance with two of the key recommendations in the NICE BPD guidance: (1) drug treatment should not be used for the individual symptoms or behaviours associated BPD; (2) drugs that are toxic in overdose should be avoided.

Objectives: To obtain a baseline picture of current prescribing for people with BPD by clinicians in Oxleas NHS Foundation Trust.

METHODS/STUDY DESIGN

The trust’s electronic patient record system (RIO) was used to produce a list of patients with a diagnosis of BPD who were in contact with trust clinicians as of December 2009. Data were collected for every 10th case. Patients with a co-morbid diagnosis of bipolar disorder and schizophrenia were excluded from the audit. Data collected included: co-morbid diagnosis and current psychotropic medication including dose, route of administration, duration and reason for use.

RESULTS

Of 758 patients identified as having a diagnosis of BPD, 76 constituted our sample. Eight (11%) patients had a co-morbid diagnosis of bipolar disorder and 9 (12%) schizophrenia, leaving a final sample of 59 patients.

(1) Drug treatment should not be used for the individual symptoms or behaviours associated BPD. There were 52 instances of a psychotropic drug being prescribed for the manifestations of BPD alone, 44 as described in Figure 1, and a further eight in the nine patients with no co-morbid diagnosis.

(2) Drugs that are toxic in overdose should be avoided. Three patients were on medications which were relatively unsafe in overdose (two tricyclics, one lithium).

DISCUSSION AND CONCLUSION

A large number of patients with a diagnosis of BPD are currently in contact with trust services, only a minority of whom have no co-morbid psychiatric diagnosis. Antidepressants, antipsychotic and mood stabilising drugs were prescribed for patients who did not have diagnosed depression, psychotic illness or bipolar illness, respectively, and a very small proportion of patients were prescribed drugs that are toxic in overdose. Such prescribing is not consistent with the recommendations in the NICE guideline for the management of BPD. It is important to note that the NICE recommendations were based on the absence of evidence rather than evidence of absence.

Since data collection for this audit was completed, two further systematic reviews1,2 have been published that reach different conclusions, tentatively supporting the use of psychotropic drugs for individual symptom clusters in BPD.

RECOMMENDATIONS

The audit findings against the NICE recommendations will be presented to local clinicians along with the findings from the two new systematic reviews. Given that there are no UK data to compare our findings with, the audit is to be conducted in two other mental health trusts, and prescribing practice will be compared across these settings.

Limitations of this audit include the accuracy of recording of diagnosis and prescribing data on RIO.

REFERENCES


Multidisciplinary Med-ed

R. McAskill

The Care Quality Commission survey of mental health acute inpatient services1 found many patients felt they were not given understandable information about their care and treatment and 48% thought that potential side effects of medicines prescribed were not explained in a way they could understand. The National Institute for Health and Clinical Excellence Clinical Guideline 82, Schizophrenia,2 recommends that treatments should be explained clearly and simply and the benefits and risks of treatments should be discussed along with other treatment options. Previous trust pharmacy department attempts to establish medication education (Med-ed) sessions for inpatients were never sustained. An inpatient secondment of a consultant psychologist gave an opportunity for pharmacy to work together with psychology, a service user and ward staff to develop Med-ed sessions for inpatients and embed them in the ward culture.

AIMS AND OBJECTIVES

- To develop Med-ed sessions giving inpatients an opportunity to discuss their medication and other treatment options, increase their knowledge about medication and to signpost them to sources of further information.
- To evaluate these sessions to see if they meet the needs of the inpatients.

METHODS/STUDY DESIGN

A multidisciplinary group developed the Med-ed sessions on antipsychotics, antidepressants, mood stabilisers, anxiolytics and hypnotics. A one-off session was presented to inpatients who volunteered to give feedback before the session contents and delivery were finalised. The sessions were introduced by a service user who also discussed the group framework. The pharmacist delivered the session on medication and answered questions. The psychologist gave a brief outline of evidence based psychological therapies relating to the topic. The presenters gave signposting information on treatments and community support groups.

The psychologist developed a questionnaire to evaluate the views of inpatients. This consisted of statements allowing feedback using a five-point Likert scale and the option of giving suggestions on improving the sessions. The evaluation took place over three months and consisted of 12 weekly sessions.

RESULTS

The results of the evaluation (n=30) showed that inpatients agreed that the sessions had increased their knowledge about medication in a way they felt was useful to them. Information presented was easily understandable and the timing of the sessions was about right. Inpatients indicated that signposting information needed further development to meet their needs. Inpatients valued interactions and discussions with other inpatients and those running the sessions.

DISCUSSION AND CONCLUSION

The Med-ed sessions succeeded in providing inpatients with information about their medication and other treatments in a format they could understand and find useful. As a result of the evaluation, the multidisciplinary team has updated the session contents, evaluation
questionnaire, provided further support to ward staff in getting patients to the sessions, developed signposting information and improved advertising of the sessions.

REFERENCES

A completed audit cycle of rapid tranquillisation incidents

G. Newton, M. Ashfaq, A. Dyer, T. Myatt, I. Stirton Cook, D. Watson
5 Boroughs Partnership NHS Foundation Trust

Rapid tranquillisation (RT) is the use of oral and/or parenteral psychotropic medication to control agitated, threatening or destructive psychotic symptoms. NICE1 requires all episodes of rapid tranquillisation to be audited to ensure that practice meet current trust policy.

Baseline audit results are available from 2008. This poster shows results from the second completed audit cycle in 2009.

AIMS AND OBJECTIVES
To repeat the RT audit against the criteria and standards agreed in the trust’s Rapid Tranquillisation Policy.

METHOD
A data collection form was developed and piloted using the trust’s Rapid Tranquillisation Policy criteria.

All episodes of rapid tranquillisation are reported using the trust’s incident reporting system. Each incident report prompts the locality pharmacist to review the documentation of the episode of RT and complete an audit form.

CRITERIA AND STANDARDS
The criteria are given in the results table; the standard for all criteria is 100%.

RESULTS
The results are set out in Table 1.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Summary results</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate checks prior to the service user’s admissions</td>
<td>Pass</td>
<td>Pass</td>
</tr>
<tr>
<td>Adequate review and assessment at admission</td>
<td>Fail</td>
<td>Fail</td>
</tr>
<tr>
<td>Adequate preparation as behaviour escalates</td>
<td>Fail</td>
<td>Pass</td>
</tr>
<tr>
<td>Review and assessment at the point of deciding to use medication</td>
<td>Pass</td>
<td>Pass</td>
</tr>
<tr>
<td>Adequate monitoring for adverse effects</td>
<td>Fail</td>
<td>Pass</td>
</tr>
<tr>
<td>Appropriate and effective management of side effects</td>
<td>Fail</td>
<td>Pass</td>
</tr>
<tr>
<td>Inclusive and adequate debrief for service user and professionals involved</td>
<td>Fail</td>
<td>Fail</td>
</tr>
</tbody>
</table>

DISCUSSION
In the summary data, two of the seven criteria were maintained, three improved from a fail to a pass and two remained as fails. This shows an overall improvement in the quality of documentation of rapid tranquillisation episodes.

The key areas of concern that remain are at the points of admission (about the assessment(s) undertaken and the review of previous episodes of rapid tranquillisation, the drugs previously used, the responses achieved, and the treatment plan for this admission) and at the point of debrief (for the service user and the staff) following the episode of rapid tranquillisation. In each case the defect is not necessarily in clinical practice but rather the lack of documentation showing that the Policy criteria have been followed.

RECOMMENDATIONS
- Maintain ongoing audit cycle
- Develop and implement update action plan reflecting latest audit results

CONCLUSIONS
The trust has achieved an improvement in the quality of documentation of their rapid tranquillisation episodes, there is further work required to ensure improving standards and adequate compliance with the trust’s policy.

REFERENCES

Spreading the word: developing a link practitioner network

D. Marriott, C. Sullivan, K. Hartley, J. Whitefoot, T. Campbell
Devon Partnership NHS Trust

Devon Partnership NHS Trust is a specialist mental health trust with inpatient units for adults, older adults, learning difficulties, forensic and specialist services. It covers a large geographical area and the supply of medicines is provided by three separate acute trusts under SLA. The functional and geographically diverse of the inpatient units, combined with separate acute trust providers, presents a challenge to ensuring consistent, high standards of medicines management.

The Medicines Management Team (MMT) decided that the best approach to managing this challenge was to develop a link practitioner scheme. This multidisciplinary approach emphasises that “medicines management is everybody’s business”, not just the role of the MMT.1,2

AIM AND OBJECTIVES
To set up an effective Medicines Management Link Practitioner (MMLP) network across inpatient units of Devon Partnership NHS Trust to

(a) Empower front line nursing staff to inform the MM policies and procedures and ensure that all specialties in the trust are represented in working parties.
(b) Embed the MM policies and procedures into practice at ward level
(c) Provide a network for spreading best practice between DPT units
(d) Strengthen medicines governance arrangements

METHOD
(a) August 2009: Ward managers provided with a role description and asked to identify interested persons for role of MMLP
(b) October 2009: Launched scheme with a trust-wide induction day. Regular email communications were established, supported by individual ward visits from MMT
Raising the profile of the medicines management team by facilitating an awareness day for trust staff

J. Woodward, J. Shelmerdine, L. Prescott
5 Boroughs Partnership NHS Foundation Trust

Following the publication of “Talking about medicines”, substantial investments were made by 5 Boroughs Partnership NHS Foundation Trust into the expansion of its clinical pharmacy services. It was decided to hold annual Medicines Management Awareness Days for trust staff, to raise awareness of the new team and its members. The first awareness day took place in January 2009 and the second in May 2010.

AIMS AND OBJECTIVES

The aim of the day was to raise awareness of the Medicines Management Team and its work. The objectives were as follows:

- To deliver a series of short presentations on the work currently being undertaken
- To hold a series of interactive workshops in which clinical staff were invited to participate and share ideas on current work and ideas for future projects
- To gather feedback from the day which could be used to generate ideas for future work and also shape future awareness days

RESULTS

All 20 inpatient units have an MMLP currently; Seventeen of the 20 had an activity check by MMT within six to nine months of the induction day.

The headline results were:

- Presence of out-of-date stock on ward – 13/17
- Housekeeping sheets in use – 8/17
- Documentation of daily fridge check – 10/17
- Use of glitch book – 7/17
- Resource file available – 5/17

CONCLUSION

The MMLPs have proved to be invaluable to help spread the medicines management message. They act as a strong link between clinical staff and the MMT and act vital in the safe introduction of new MM initiatives.

The collaboration between the MMLPs and the MMT has been particularly useful in fulfilling the new registration requirements of the Care Quality Commission, but there is still a lot of work to be done to raise awareness of the importance of handling medicines safely.

REFERENCES


Table 1. Feedback from 2009/2010 awareness days

<table>
<thead>
<tr>
<th>Comments from 2009/2010 awareness days</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>The day was relevant to my job role</td>
<td>47/32</td>
<td>11/10</td>
<td>0/2</td>
<td>0/1</td>
<td>0/0</td>
<td>58/45</td>
</tr>
<tr>
<td>The session was well delivered</td>
<td>51/36</td>
<td>7/8</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td>58/44</td>
</tr>
<tr>
<td>The material in the sessions was</td>
<td>40/33</td>
<td>15/13</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td>55/46</td>
</tr>
<tr>
<td>Coverage of the topic was</td>
<td>45/37</td>
<td>9/7</td>
<td>1/7</td>
<td>0/0</td>
<td>0/0</td>
<td>55/44</td>
</tr>
<tr>
<td>I am more aware of available</td>
<td>51/32</td>
<td>6/13</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td>55/45</td>
</tr>
<tr>
<td>Information regarding medicines</td>
<td>42/28</td>
<td>16/15</td>
<td>0/1</td>
<td>0/0</td>
<td>0/0</td>
<td>58/44</td>
</tr>
<tr>
<td>I have a greater understanding of</td>
<td>47/31</td>
<td>11/14</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td>58/45</td>
</tr>
<tr>
<td>medicines management as a concept</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recommend attendance</td>
<td>52/34</td>
<td>6/10</td>
<td>2/1</td>
<td>0/0</td>
<td>0/0</td>
<td>60/45</td>
</tr>
</tbody>
</table>

METHOD

The event was held at the Trust Education Centre. The day consisted of two half-day sessions with places for 40 delegates at each. The sessions consisted of six 10-minute presentations followed by a series of interactive workshops. Feedback forms were completed by the delegates who were also given a certificate of attendance.

RESULTS

The feedback is summarised in Table 1.

DISCUSSION

Following the first awareness day, to which registered doctors and nurses were invited, comments were made that the sessions would be useful for other healthcare professionals. The following year invitations were extended to all trust staff. However, some staff, particularly healthcare assistants, found the day less relevant to their job role as their involvement in medication issues is limited.

CONCLUSION

Both awareness days have been a huge success in raising the profile of the team and were greatly appreciated by the majority of staff who attended. Following the first awareness day the team gathered useful information on future projects, which are now under way. Additional training has been provided as requested and the following awareness day was structured according to the comments received.

REFERENCES