NHS
Coventry and Warwickshire Partnership NHS Trust

Medicines Matters

Medicines Management

Spring 2024 (Volume 18 Issue 1)

Welcome to Medicines Matters! This bulletin is published regularly for all groups of staff working within the diverse range of services within Coventry & Warwickshire Partnership Trust. The bulletin aims to update staff on matters related to the Trust's Medicines Policy, and to highlight issues of current therapeutic interest. Electronic copies are available on the Trust internet. Underlined words are hyperlinks to relevant documents.

Current Therapeutic Interest

Drugs and Therapeutics Updates

The recent January Drugs and Therapeutics Meeting has seen the reapproval of two Medicines Manual Guidance (MMG) documents. This is a summary of the key changes for awareness:

- MMG3 - Procedure for verbal orders. This MMG now clearly states that this relates to verbal instructions by a medical prescriber to prescribe a drug in an emergency. This may be necessary in Trust areas where EPMA is not in use, and prescribing is undertaken on prescription stationery. In areas of the Trust with EPMA prescribing should occur directly onto the EPMA system, and verbal orders should not be necessary (more details in the MMG)
- MMG26 - Guidance & procedure for controlled drugs (CDs)

7.7 CD stock	Patient own and expired CDs should be stored separately and clearly identified within the CD cupboard.
9.4 Record Keeping	No cancellation or obliteration (including crossing through, over-writing) of any information on an entry in the record book should be made.
10 Ordering & Receipt	New wording to clarify this process. Please read carefully.
12 Daily CD Stock Check	New wording to detail this process. Please read carefully.
20 Transport	Now refers to importance of an audit trail for transported medicines.

There is new resource on the Medicines Management webpages - an updated **table comparing modified release methylphenidate products**. Proportions of immediate and modified release methylphenidate differ between brands; different products may not therefore have the same clinical effect. This table will help prescribers understand the differences and help support brand choice at treatment initiation or where a change is required in the event of medicines shortages.

- **Xaggitin XL** is a licensed and cost-effective product, and is an XL methylphenidate product of choice within CWPT
- **Meflynate XL** is a licensed and cost-effective product, which could be a considered treatment of choice in patients being initiated on methylphenidate. It is not bioequivalent to other XL methylphenidate preparations but has a similar release profile to Medikinet

Branded generics. In alignment with the Midland's Medicines Optimisation Regionwide Advisory Group, CWPT DOES NOT support the routine prescribing of category M branded generic medicines in primary care, except where legitimate clinical reasons exist. Generics are usually preferred as they are usually cheaper whilst being equally efficacious
Exclusions within our trust (where a change in blood level could affect symptom control) include the following medicines : Lithium, Methylphenidate, Antiepileptic Medicines.

Good Practice Points for Local Action

- **Clozapine supplies out of hours.**
  Following recent incidents where staff have needed to access clozapine out of hours, we would like to highlight the Trust protocol to access Clozapine Out of Hours that should be followed. This was written before the change from Lloyds to Rowlands but is still operational (read Rowlands in place of Lloyds). There is also a step by step algorithm in the Caludon/ St Michael's Dispensing Service Information Pack (Page 30)
- **MMG12 awareness—Pre-agreed medicines**
  Where this MMG is used to authorise non prescribed P (Pharmacy) or GSL (General Sales List Medicines) in respite areas/special schools. Staff following the guidance in 4.2 should be aware that these medicines may be transcribed onto the PRN section of the administration chart.

SPC Updates (Source EMC):

Keppra (levetiracetam) *Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS),* reported rarely with levetiracetam. Clinical manifestations **may develop 2-8 weeks** after starting treatment; typical symptoms are described.

Lyrica (pregabalin) patients treated with pregabalin should be monitored for signs and symptoms of pregabalin misuse, abuse or dependence, such as development of tolerance, dose escalation and drug-seeking behaviour.

Elvanse Adult (lisdexamfetamine) stimulants have been reported to exacerbate Tourette's syndrome (frequency unknown) therefore, clinical evaluation of Tourette's syndrome should precede use of stimulant medications.

Sodium valproate/ valproic acid Severe cutaneous adverse reactions such as Stevens-Johnson Syndrome, DRESS, erythema multiforme and angioedema, have been reported in association with valproate treatment. Patients should be informed about the signs and symptoms of serious skin manifestations and monitored closely. Treatment must be discontinued if they occur.

Concomitant treatment of **valproate and clozapine** may increase the risk of neutropenia and clozapine-induced myocarditis. If concomitant use is necessary, careful monitoring for both events is required.

In the Press -

- **ADHD in Adults** - A review and meta-analysis published in The Lancet has concluded that evidence points to *stimulants and atomoxetine being the only interventions with evidence of beneficial effects in terms of reducing ADHD core symptoms* in the short term, Medications for ADHD were not efficacious on additional relevant outcomes, such as quality of life, and evidence in the longer term is under investigated.
- **Comparative Effectiveness of Antipsychotic Treatment Strategies** for relapse prevention in first-episode schizophrenia in Finland: a population-based cohort study (n=3,000) found, at first psychosis relapse, *switching to clozapine was associated with a lower risk of second relapse* vs continuing any non-clozapine oral antipsychotic APD monotherapy (relapse rate 57.1% vs 73.2%, HR 0·66, 95% CI 0·49-0·89). Switching to another non-clozapine oral APD monotherapy was found to be approximately as unhelpful in preventing the next relapse as switching to antipsychotic non-use. It was concluded that this finding, with existing knowledge of decreased risk of mortality associated with clozapine, challenges current treatment guidelines recommending clozapine as a third-line treatment, resulting in treatment practices characterised by long delays to clozapine initiation.

- *For further information / comments / queries please contact the Medicines Management Team at Wayside House on 024 76536836*
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•**Turn over** for *Topic of the Month: Missed Dose Audit*

Topic of the month: Missed dose Audit 2024

Background
This audit was carried out on all prescriptions in the inpatient or rehabilitation wards (either paper charts or EPMA* records) for the 7 day period covering 8th October until 14th October 2024. *EPMA = Electronic Prescribing and Medicines Administration
For paper charts, a missed dose was counted if there was a blank administration box, or the administration box was annotated No Stock, O (omitted or other), S (sleeping) or A (absent from clinical area). A report was extracted from the EPMA system for the same time period. The reason codes on EPMA which correspond to a 'missed dose' are U (medication unavailable), N (nil by mouth), O (other clinical reason), A (patient absent), S (sleeping) and R (patient refused); in addition, there is a system generated reason 'Undefined' which equates to a 'blank' box on the paper form.

Blank boxes

There were 16 **blank** boxes on the paper charts (30 in 2023) and 320 (302 in 2023) **undefined** on the EPMA report resulting in a total 336 (1.05 per bed) missed doses—some of these were annotated as 'Discharged'

Potential reasons for blank boxes/ undefined doses:

- Staff not completing paper chart/ EPMA at time of administration
- Patients who have been discharged from the ward but not on EPMA will still appear as requiring medicines, these boxes could have been left blank and appeared as 'Undefined'. *There has since been an upgrade to resolve this issue*
- Patients who are 'on leave' have not had the paper chart or EPMA completed with a reason

Required Action:

- Administration boxes should **never** be left blank
- Take care to select the **correct code** when recording administration
- **Document** the reason if doses are not given as prescribed
- If a patient is absent from the ward document as **Absent** on the administration record

No stock

There were 223 doses missed and classed as 'stock unavailable' (119 in 2023). This equates to 0.69 doses per bed (0.44 in 2022) which is 87% increase on 2023.

26% of missed doses were attributed to food replacements which are not ordered via pharmacy. *The correct ordering route has now been communicated. Removing food replacements the missed doses from 'stock unavailable' is 0.53 per bed.*

222 missed doses were recorded for the wards using EPMA and only one on paper charts (Brooklands). Stock unavailable impacted 54 patients.

Reasons given included:

- Stock ordered
- Stock to be ordered
- Out of stock

Stock unavailable included: 19 doses of antibiotics, 25 doses of mental health medicines, 4 doses of analgesia, 73 doses of food replacements/ vitamins and 2 doses of Critical Medicines (anticoagulants)

Required Action:

- Ensure that the **stock list** and **emergency cupboard** lists are checked to ascertain if a medicine is available
- See the Dispensing Service Information Pack (including out of hours) for how to access medicines
- Medicines should be **ordered** in a timely fashion to avoid missed doses due to stock availability
- It is particularly important to ensure that medicines highlighted on the Critical Medicines List are not unintentionally missed

Asleep

76 (126 in 2023) does were 'missed' due patient sleeping, *since the 2023 Audit 'Sleeping' has been added to EPMA so all missed doses have been recorded under a specific reason rather than 'Other'.*
The majority of these doses were for the 8am (25 doses) or evening (8-10pm) (35 doses)

Required Action:

- If a patient is consistently asleep when a dose is due, the **timing of that dose should be reviewed**, particularly if it is a morning once only dose
- Consideration should be made regarding offering the dose later where appropriate

Omitted

141 doses were omitted with the category 'other' (214 in 2023), which did not fit into any of the other categories listed above. This is a 35% reduction on 2023, *this reduction can be attributed to the new omission code for sleeping and the link between Carenotes & EPMA when a patient is discharged.*
12 were recorded on paper charts and 129 on EPMA.

Reasons given included:

- On leave (13)
- Accepted alternate form (7)
- Discharged (17)
- Omitted for clinical reason (5) e.g. blood sugar levels.
- cumulative dose check locked out – these were for paracetamol; so EPMA had prevented a possible overdose (1)
- Omitted with no reason (135)

Required Action:

- Always **document** a reason for omission in the patient's notes

Refused

1578 doses were recorded as refused which 67% of all missed doses (5 doses/bed)

40% of all refused doses were at 8:00

Required Action:
Where a dose is refused consider and review the reason for the refusal.

- Is the **dose time** suitable for the patient?
- Does the patient have **concerns** about the medication?
- Does the patient need more **information** about the medication? See MMG35 for guidance to help inform and facilitate patient choice

- All clinical areas should ensure there is a **process to regularly check** for any outstanding blank boxes
- An **incident report** should be completed if a 'blank' box is found

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