Sussex Partnership NHS Foundation Trust

Issue 48

July 2019

Welcome to the July issue of

The Drugs & Therapeutics Newsletter

Featured in this issue:

The Pharmacy Team has pulled together all the electronic versions of medication related documents including patient information leaflets and prescribing guidance, into one area of the Trust's website www.sussexpartnership.nhs.uk/medication . Please have a look at the wide range of medication related documents now available.

Report and Learn

Lesson 1

A reported incident involved the prescribing of lorazepam IM in the wrong section of the drug chart; it was prescribed in the once only section instead of the rapid tranquillisation section. Consequently the physical observations were not completed putting the patient at risk. Lack of RT monitoring is an area that CQC have highlighted as a concern. It is crucial that rapid tranquillisation is prescribed in the correct section of the chart and monitored correctly as per the Trust policy. A copy of the monitoring form can found on https://www.sussexpartnership.nhs.uk/node/5472/attachment

Lesson 2

There have been several reported incidents of patients being given another patient's medication in error. This type of incident is not new and reflects a lack of vigilance when checking patient's identity. In one of the incidents the patient queried the medication and the patient was shown the wrong chart to confirm the medication was for them. In another incident the staff member had the patient 'pointed' out to them but got confused as the ward was very busy. When giving out medication **extreme care is required to confirm the patient's identity,** especially when the staff member does not know the patient. Use a photograph if available or confirm with another member of staff who can identify the patient visually. Verbal questioning confirming the patient's identity cannot be relied upon and should not be used.

For more information and data on medication incidents reported, refer to the incidents dashboard available from Ulysses or contact the Trust's Medication Safety Officer, Gus Fernandez, on spt.mso@nhs.net

If you require this document in an alternative format, i.e. easy read, large text, audio, Braille or a community language please contact the Pharmacy Team on 01243 623349 (Text Relay calls welcome)

Pipotiazine injection availability

A new supplier of pipotiazine injection has been identified, which for the next year or so will be an unlicensed import from France, but it is anticipated that it will become a licensed injection sometime in 2020, manufactured by the same French company, but branded with a UK supplier's logo, who will hold the licence. This means that the small number of patients we have been maintaining on pipotiazine, since it was discontinued, using the last of the Piportil stock, can continue on it long-term. We are also at this stage offering clinicians who had patients previously on pipotiazine injection, who would like to go back on it, the option of restarting it, now we have a long-term supply. If you are interested please speak to your mental health pharmacist.

The one drawback from the previous supplier is that the concentration of pipotiazine is half that of Piportil. The two ampoules available are pipotiazine 100mg/4ml and 25mg/ml. This may mean that any patient on a high dose may need to have the dose administered into two sites at each visit or the frequency of the injections adjusted. This will need to be a clinical decision made with the patient. A copy of the new suppliers SPC and more details about the manufacturer are available from Ray Lyon (ray.lyon@sussexpartnership.nhs.uk).

RCPsych statement on depression

Royal College Psychiatrists has issued recommendations setting out a range of actions to promote optimal use and management of antidepressants, including advising against general use for mild and sub-threshold symptoms among adults and providing advice on treatment discontinuation. Full details can be found on the following link

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps04_19---antidepressants-and-depression.pdf?sfvrsn=ddea9473_5

Antidepressant discontinuation: "go slow as you go low"

Given the current topical nature of the potential for withdrawal or discontinuation effects with antidepressants, and the recent publication of a paper in the Lancet Psychiatry by Dr Mark Horowitz and Prof David Taylor, this topic has been reviewed by the Mental Elf, highlighting tapering as a potential option to mitigate withdrawal effects.

The authors conclude that slowly reducing SSRIs (and potentially all antidepressants) allows for more time for the individual to adapt to a lower amount of serotonin. This in turn should reduce the severity of withdrawal / discontinuation symptoms. As such the authors recommend a pause between reducing the dose of medication.

It is important to note that not everyone will experience withdrawal from antidepressants and that that discontinuation effects are more likely in those individuals who have received high doses for prolonged periods of time. This may aid clinicians in identifying which patients may need extra care re: withdrawal when stopping antidepressants.

The authors suggest that the aid memoir for clinicians when tapering SSRIs should be "go slow as you go low" as the most significant discontinuation effects appeared to occur at the end of a reducing dose. Vitally, tapering (as with all prescribing) should be an individualised process, as there will likely be differences in withdrawal symptoms in different patients, e.g. dependant on dose, length of treatment course, previous withdrawal experiences.

If any generalities are to be made it would be that reducing the dose more slowly at the end of the tapering period and over a longer time period overall seems to be the safest option. It is also key to consider that a patient may have waited a long time to reduce their medication. As such good communication from the outset regarding expected treatment trajectory may prevent challenges around self-discontinuation of medication.

Relevant changes to summary of product characteristics (SPCs) and FDA warnings

Aripiprazole 7.5mg/mL solution for injection (Abilify®)

The SPC has been updated to advises aripiprazole may cause somnolence, postural hypotension, motor and sensory instability, which may lead to falls. Caution should be taken when treating patients at higher risk (consider lower start dose). Also, oculogyric crisis is listed as an adverse event.

Oxycodone products (OxyContin®, OxyNorm®, Longtec®, Shortec®)

SPCs updated to warn concomitant administration of oxycodone with serotonin agents, such as SSRIs or SNRIs, may cause serotonin toxicity (ST). Oxycodone should be used with caution and dose may need to be reduced in patients using these medications. Symptoms of ST are described.

FDA adds Boxed Warning for risk of rare but serious injuries caused by complex sleep behaviour (CSB) with eszopiclone, zaleplon, and zolpidem

66 cases, some fatal, including sleepwalking, sleep driving, and engaging in other activities while not fully awake have been reported over 26 years, thus use is contraindicated in patients who have previously experienced an episode of CSB with eszopiclone, zaleplon, and zolpidem.

Substance misuse testing kits (Alere® toxicology) – False positives

There have been reports that Alere test kits have given a false positive, which has been verified by the local pathology lab. A positive drug-screening test does not provide firm evidence of the presence of specific drugs. Many drugs belong to the same chemical family and cannot be differentiated using screening techniques. For example, the screening test may be targeted at detecting the use of morphine (present as a result of misusing heroin), but the test will also respond to codeine, which may be present in prescribed or over the counter medication. This effect is often referred to as cross-reactivity. In addition, a screening test cannot tell the difference between a legitimately prescribed drug versus one illegally obtained. Where legitimately prescribed drugs cross-react or have the potential to cross-react, it is impossible using screening tests alone to tell which was responsible for the positive test result. Despite these limitations, when properly used, screening tests give a very good indication of patterns of drug misuse.

In order to obtain the best possible results from screening test kits and to correctly interpret results, the following steps must be taken:

- Follow the manufacturer's instructions for the test kit. Any variation can lead to misinterpretation of results.
- Ensure the test kit is in date
- Ensure test kits are read under good lighting conditions.
- Ensure that staff using the test kits are properly trained.
- Ensure that any legitimately prescribed medication or medicines purchased is taken fully into account.

New chemicals are continually introduced and assessed. The pharmacy team have copies of the Alere Cross Reactivity Guide which has a list of medication and their known cross reactivity. Also the Alere product support team can be contacted on +44 (0)1235 443 291 or emailed toxeu.productsupport@alere.com.

Monitoring of patients prescribed lithium – POMH-UK re-audit

The Trust took part in this national re-audit last year (January to December 2018) and submitted data for 78 patients. The Trust results were:

Pre-treatment Lithium Tests

- 75% of patients had an **ECG** completed 6 months prior to starting lithium.
- 50% of patients had their **serum calcium** measured.
- 61% of patients had their **weight/BMI** measured.
- 89% of patients had their **urea & electrolytes** tested.
- 93% of patients had their **e-GFR** tested.
- 86% of patients completed a **full blood count** test
- 79% of patients had their **thyroid function** test

Lithium maintenance tests

- 39% of patients had their **serum calcium** tested every 6 months.
- 39% of patients had their **weight or BMI** measured during the last year.
- 64% of patients had their **serum lithium level** tested every 6 months
- 66% of patients had their **urea & electrolytes** tested every 6 months
- 70% of patients had their **e-GFR** tested every 6 months
- 50% of patients had their **thyroid function** tested every 6 months

The results have been discussed in the Drugs & Therapeutics Group and with senior medical staff as they have not improved from the previous audit and are putting our patients at risk. These results included patients prescribed lithium via their GP and the Trust. Communication of results and who has responsibility has been highlighted as areas for improvement; a solution of a Trust database of lithium monitoring is being explored.

Benzodiazepine and Hypnotic Prescribing

Benzodiazepine and Z-drug prescribing can create long-term problems for patients. Long-term use in exceptional circumstances may be warranted, but any such decision must be fully discussed with the patient, and carer if appropriate. GPs must been given clear reasons for the decision and this decision must be reviewed at regular intervals. The Trust's Formulary carries the following general guidance.

1. Benzodiazepine/hypnotics are not to be initiated when there is a history of any dependency or potential for abuse - either directly by the client or through onward sale.
2. The use and problems associated with benzodiazepines/hypnotics should be discussed fully with the patient, and the carer if appropriate. Patient leaflets on the subject are available.
3. No patient should be discharged from hospital on a benzodiazepine/hypnotic unless:
   - He or she was admitted on it **and it had not been initiated within a few weeks of admission**, or
   - Continued use is supported by the documented recommendation of a consultant psychiatrist.
4. Any patient discharged or initiated in the community on a short course of hypnotics/benzodiazepines must have this explained to them, emphasizing that they will not be getting a repeat from their GP. Prescribe enough to complete the course.
5. If the GP is expected to continue the prescribing of a new benzodiazepine/hypnotic then full information must be provided on why the medicine was started, whether the treatment is long term or short term and what information the patient or carer has been given.
6. Junior doctors only have authority to prescribe inpatients hypnotics/benzodiazepines for 48 hours (72 at weekend). Continued use to be supported by the consultant.
7. An inpatient admission should be seen as an opportunity to wean a patient off benzodiazepines/hypnotics if deemed clinically appropriate. **Gradual dose reductions are likely to be necessary.** Discontinuing benzodiazepines, particularly short acting ones, can however increase the risk of suicide.
8. Particular caution should be used when prescribing benzodiazepines/hypnotics for patients with personality disorders as the risk of misuse, non-adherence, disinhibition, paradoxical aggression and dependency may be greater than in other patient groups.

Trust pharmacists have the authority to discontinue inpatient 'prn' hypnotics if they have not been required within a two week period. Similarly, they may also discontinue inpatient 'prn' anxiolytics, after confirming there is no continuing need with nursing staff.

MHRA Medicines e-learning packages

The Medicines and Healthcare Products Regulatory Authority (MHRA) has developed several learning modules for clinical practitioners. These are self-directed learning packages, which are approved for continuing professional education (CPD). They outline the key risks of prescribing with these widely prescribed classes of medicines. Each module estimated completion time is between 1.5 – 3.5 hours (approx. 1 hour per CPD credit).

The current on line modules include:-

- Adverse drug reactions – 1 CPD credit
- Antipsychotics – 3.5 CPD credits
- Benzodiazepines – 2.5 CPD credits
- Opioids – 2 CPD credits
- Oral anticoagulants – 1.5 CPD credits
- Selective serotonin reuptake inhibitors (SSRIs) – 3 CDP credits

The modules can be accessed via: www.gov.uk/government/publications/e-learning-modules-medicines-and-medical-devices/e-learning-modules-medicines-and-medical-devices

Pregabalin and gabapentin - schedule 3 controlled drugs (CDs)

From 1st April 2019 pregabalin and gabapentin became schedule 3 CDs. This meant a change on how they are handled. This change in legal status has been done to increase the control on these two medicines that have increasingly been used as drugs of abuse. The differences between a schedule 3 and a schedule 2 CD (e.g. morphine, methadone), mean there is a lot less control, with the only requirement being that when the drug is prescribed on an outpatient prescription or for leave and discharge on the wards, full CD handwriting requirements are needed, as detailed in the BNF.

It has been brought to the Controlled Drugs Accountable Officer's attention that on one ward two prescribers failed to realize that they are now subject to full CD handwriting requirements and neither were the nurses involved.

Controlled Drugs Accountable Officer

Following one of the recommendations from the Shipman report, the Government has made it a legal responsibility that every NHS Trust has a Controlled Drugs Accountable Officer (CDAO) to ensure the safe handling and use of controlled drugs (CDs) in the Trust. This role is performed by Ray Lyon, Chief Pharmacist – Strategy. Many other organizations are also obliged to have their own CDAO including hospices and private hospitals. As part of his role the CDAO monitors all medication incidents reported that involve a CD. Occasionally the CDAO may have to personally investigate an incident and provide advice. Every quarter the CDAO is obliged to send in a detailed summary of any significant CD occurrence that has taken place within their organization in our case to the CDAOs for the NHS England Kent, Surrey & Sussex and Wessex localities, as we provide services in Hampshire, Kent and Sussex. In addition the total number of CD incidents completed is summarized and broken down into categories.

If any member of staff has concerns about the handling, prescribing or diversion of a controlled drug they are strongly encouraged to confidentially share their concerns with their line manager or directly with Ray Lyon. His email is address is ray.lyon@sussexpartnership.nhs.uk or he can be contacted on 07833 527412.

Anticoagulant medication

Prior to its move into NICE, the National Patient Safety Agency (NPSA) highlighted the risks associated with prescribing both oral anticoagulants and low molecular weight heparins (LMWHs). The Trust has a special pink chart for prescribing oral anticoagulants and guidelines for their safe use. Ward managers are reminded that if a patient is admitted or is initiated on oral anticoagulants, e.g. warfarin or LMWHs, all staff prescribing or administering the anticoagulant should be asked to read the Trust's guidelines. These guidelines are available on the Trust website. They can be accessed by clicking on:

www.sussexpartnership.nhs.uk/node/1450/attachment

Alternative supplier of Modecate® - UPDATE

A specialist import company have sourced a licensed alternative from Germany from a company called Neuraxpharm® that specializes in CNS medicines. They have two doses; a **100mg in 1mL** concentrate and a **25mg in 1mL** solution. Below are copies of the two patient information leaflets and a link to the company's website. The import company will be able to start importing stock once the current Sanofi supplies become exhausted. We have had confirmation that the new product is roughly **twice the price** of the Sanofi brand therefore it is pertinent to use the Sanofi brand for as long as it is available and when we switch it is used up first. **Please be aware that packaging will look different and be over labelled as we switch over.**


Fluphenazine Decanoate 100mgml (


Fluphenazine Decanoate 25mgml (F

https://www.neuraxpharm.de/en/

If you have a patient who would like to go back on fluphenazine decanoate injection or a new patient would like to try it; please contact your local pharmacy team to discuss supply and how to start/switch patients.

Drugs & Therapeutics Group update

1. The **Rapid Tranquillisation** e-learning module has been updated with changes following the latest review of the RT policy and is now available via MyLearning.

2. The use of **Valproate in Women of Child-bearing potential** monitoring and documentation requires improvement in this important high risk area. All senior medical staff have been communicated regarding compliance in this area.

3. Updated **anticoagulants guidelines** were approved and are available on line: www.sussexpartnership.nhs.uk/node/1450/attachment. The Pharmacy staff will hold DOAC cards when required for patients.

4. **Olanzapine long acting injection** guidance has been reviewed and includes trained non-nursing staff to carry out the observations, monitoring simplified and a simple agreement for patient to sign agreeing they understand the risks if they leave prior to the three hours of monitoring. The link for this guidance can be found on https://www.sussexpartnership.nhs.uk/node/1507/attachment

5. It was agreed to produce more robust guidelines for staff about meeting with **pharmaceutical company representatives** and receiving hospitality**.** These will be developed with input from medical, nursing and the APBI and will be in conjunction with the Trust's conflicts of interest declaration.

6. It was agreed that **clozapine 200mg tablets** be added to the formulary as slightly cheaper than 2x100mg tablets and will reduce the workload for pharmacy. The tablets are a different shape to the 100mg tablet.

Six psychotropics PGDs were updated with a change to the side effect frequencies. There is a nationally developed and approved **PGD for the shingles vaccine** being used in the prison health care services.

Fridge and Room Temperature Monitoring and related tips

Room temperature

If the ambient temperature exceeds 25°C for a short period during a heatwave and this results in the clinic room temperature rising above 25°C for a few days, this will not have an overall damaging effect on the medicines. If however, the temperature is recorded **above 25°C for more than 7 days in any 30 day period**, contact your pharmacy team as soon as possible for advice. Any actions taken should be recorded in the ward diary. If temperatures above 25°C are recorded for any other reason, the reason should be investigated immediately and the advice of the local pharmacy team sort.

Fridge temperatures

The effectiveness of refrigerated medicines cannot be guaranteed unless the medicine is stored at the correct temperature between +2°C and +8°C. It is therefore important that pharmaceutical fridge temperature is monitored correctly.

- **Read** the temperature and ensure it is between +2°C and +8°C
- **Record** the current, maximum and minimum temperatures daily
- **Reset** the thermometer after recording the temperatures (to restart monitoring for the next 24 hour period)
- **React** if there is a deviation in the temperature range +2°C to +8°C

Key points for fridge storage of medicines and vaccines

- Fridges used for storage must be a pharmaceutical (pharmacy) fridge
- Fridges should only be used to store medicines and vaccines (no food, drink or clinical specimens)
- The contents should be evenly distributed to allow air to circulate freely within the fridge
- There should be regular expiry date checks for stock stored in the fridge and any expired stock disposed of as per the Medicines Code.
- Medicines should be stored in their original packaging to retain information on batch numbers and expiry dates and to protect them from light and temperature changes.
- All prescription only medicines (POMs) must be stored under locked conditions.
- All fridges should be lockable or the fridge should be kept in a locked room ensuring appropriate access only.

Buprenorphine and fentanyl patches

The Care Quality Commission has published guidance on the safe use of buprenorphine and fentanyl patches, used for pain relief. These are not usually initiated by Trust prescribers, but we may have patients on the wards that are using them. The following advice is therefore relevant:

- Ensure only those CD transdermal patches intended for current use are applied, i.e. if administering a replacement patch, remove the previous patch as the patch will still be delivering some drug to the patient if left on, therefore overdosing them.
- Though rarely prescribed for Trust inpatients, when they are, please ensure these patches are prescribed appropriately and the wording, e.g. 'Replace every (? days)' is written in the additional information box (timings between patch switching varies so double check). In addition, prescribed omissions (X) should be recorded in the appropriate administration boxes at the time of prescribing to ensure the next patch is only applied on the appropriate day.
- Formally record the anatomical position of currently applied patches so that this information is readily available to inform future decisions and actions. **Always prescribe by brand for fentanyl patches** as the different brands last for different lengths of time. Ensure patients using CD transdermal patches have adequate prescriptions and supplies to minimise interruption and omission of therapy.
- The patch should be applied to; non-irritated, non-irradiated and non-hairy skin on the torso or upper arm. The replacement patch should be sited on a different area (avoid using the same area for at least 7 days) to minimize any irritation. The removed patch should be disposed of by folding the patch over so the sticky side are stuck together and then placing the folded patch in a sharps box.

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- Transdermal CD patches must be removed and replaced every 48 hours (2 days) to 7 days, depending on the brand; see the manufacturer's guidance (SPC). If the patches are left on for greater than the recommended timescale, patients can get breakthrough pain, but if replaced early, resources are being wasted.
- Consider that patients may exhibit symptoms of opioid withdrawal when a CD transdermal patch has been omitted. The cause of these symptoms may not be recognized and patients may be treated with benzodiazepines for these symptoms, rather than have opioid therapy for their analgesia re-instated, if necessary at a reduced dose.
- If administering these patches to anyone who comes into close contact with children, emphasis the severe risk to any child that accidently had a patch stuck to them. There has been a tragic case of a nursing mother inadvertently transferring her patch to her baby when it came unstuck during the night.

Risks of incorrect dosing of oral anti-cancer medicines

All healthcare staff involved in the use of oral anti-cancer medicines must be aware of the potentially fatal outcomes if incorrect doses of these medicines are prescribed or administered. Oral anti-cancer medicines are increasingly being used in hospitals and in the community. Risks are increased if non-specialist practitioners prescribe, dispense or administer these oral medicines and bypass the normal safeguards used for injectable anti-cancer medicines. Half of reported incidents concern the wrong dosage, frequency, quantity or duration of oral anti-cancer medicines.

Our doctors, nurses and pharmacists need to be aware that the prescribing, dispensing and administering of oral anti-cancer medicines should be carried out and monitored to the same standard as when dealing with injected cancer therapy. Though the use of oral cancer drugs in mental health units is minimal, the risks when prescribed are high and usage is likely to increase as more oral cancer drugs become available. National guidance requires that:

- Healthcare organizations prepare local policies and procedures that describe the safe use of these oral medicines - the Trust's Medicines Code reflects this advice.
- Treatment should only be initiated by a cancer specialist.
- All oral anti-cancer medicines should be prescribed only in the context of a written protocol and treatment plan including guidance on monitoring and the treatment of toxicity – copies of this will be available from the hospital initiating the treatment if the service user fails to bring a copy of their treatment plan in with them.
- FI doctors are not allowed to prescribe oral anti-cancer drugs.
- Staff dispensing oral anti-cancer medicines should be able to confirm that the prescribed dose is appropriate for the patient, and that the patient is aware of the required monitoring arrangements, by having access to information in the written protocol and treatment plan from the hospital where treatment is initiated and advice from a pharmacist with experience in cancer treatment in that hospital.

Full use should also be made of the initiating hospital's cancer specialist team to provide information for our staff, patients and carers to ensure the safe use of oral anti-cancer medicines when patients on them are admitted.

If you have any questions or comments about this edition or suggestions for future editions, please contact the co-editors:

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