

The evolution of a statewide Depot Administration Record

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...in the beginning...

- Implementation of standardised medication chart in QLD 2003
- 2006 a need for standard chart for prescribing and administration of depot identified
 - locally developed injection cards used across QLD

2006

INJECTION CARD

ADULT MENTAL HEALTH
STONES CORNER

Prescriptions must be printed in ink,
no erasures or white-out permitted.

DOCTOR
CASE MANAGER
PATIENT IDENTIFICATION LABEL
NAME
ADDRESS
PHONE NO.
FILE NO. D.O.B.

CHANGE OF ADDRESS:

ADVERSE DRUG REACTIONS	DRUG	MTH/YR	NATURE OF REACTION

PRESCRIPTION: Once only drugs

DATE	TIME	DRUG	DOSE	ROUTE	DOCTOR	GIVEN BY	TIME GIVEN

PRESCRIPTION *

DATE	INJECTION TYPE	DOSAGE	DURATION	SIGNATURE	CEASED - SIG/DATE
22/9/04	Flupentixol	60mg	7/52	<i>[Signature]</i>	A. Nibyan
14/11/04	Zuclopentixol	300mg	7/52	<i>[Signature]</i>	A. Nibyan
26/11/04	Flupentixol	60mg	2/52	<i>[Signature]</i>	
14.09.05	Consta	25mg	3/52	<i>[Signature]</i>	
4/11/05	Consta	50mg	3/52	<i>[Signature]</i>	

* Maximum duration of any prescription is six (6) months.

ADMINISTRATION RECORD

Name: *[Signature]* Doctor: *[Signature]*

DATE	DOSE	SITE	DRUG	SIG
23/11/04	Last given	WAAFU	13/9/04	
23/9/04	60mg	IM	Flupentixol	<i>[Signature]</i>
21/10/04	60mg	IM	Flupentixol	<i>[Signature]</i>
16/11/04	300mg	RA	Clapixal	<i>[Signature]</i>
26/11/04	60mg	IM	Flupentixol	<i>[Signature]</i>
01/12/04	60mg	RA	Flupentixol	<i>[Signature]</i>
24/12/05	given	in	inpt unit	

[Handwritten note: R to home in hospital despite previous comp.]

DATE	DOSE	SITE	DRUG	SIG
02.02.06	50mg	RA	Consta	<i>[Signature]</i>
16.02.06	50mg	RA	Consta	<i>[Signature]</i>
27/2/06	50mg	RA	Consta	<i>[Signature]</i>

MSQ process to develop standardised forms/ tools

- Identify problem/gap
- Evidence gathering
- Expert working party
- Pre & post evaluation
- Education, implementation guidelines & tools
- Change management & issues register

2007 - 2009

Modification

- Home visit safety status
 - dot alert system removed

Queensland Government
Community Mental Health Service
ORAL MEDICATION & DEPOT ADMINISTRATION

Facility: _____

Attach ADR Sticker

All reported Adverse Drug Reactions (ADR)
 All known Unknown, as assessed by a qualified person.
 Drug (or other) Reaction/Code Results

URN: _____ (Affix patient identification label here and overhead)
 Family name: _____ NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT
 Given names: _____
 Address: _____
 Date of birth: _____ Sex: M F

For Prescriber to Print Patient Name and Check Label Correct

Community Mental Health Team:
 Case Manager: _____ Extension: _____
 Consultant: _____ Contact number: _____

Months: 11 3 11 9 12
 Date: _____
 Weight: _____ kg _____ kg _____ kg _____ kg
 Height: _____ cm _____ cm _____ cm _____ cm

Home Visit Safety Status
 Note any issues impacting on the level of caution that must be exercised by staff when visiting consumers. A consumer's safety status should be reviewed at each formal clinical review, not less than every 90 days, and documented in the consumer's clinical record.
 Note of the consumer:
 A. May not be visited at home under any circumstances.
 B. May be visited at home by two staff.
 C. May be visited by one staff member with caution pending current mental state.

Test Dose Injections or Once Only Medications

Date	Medication and form (use generic name)	Route	Dose	Prescriber's signature	Print name	Date given	Time given	Given by	Pharmacy

Patient's Current Medications
 Prescribed, over the counter, complementary. Yes No H. Administration list (specify):

Medication	Dose & frequency	Duration	Medication	Dose & frequency	Duration

GP: _____ Community Pharmacy: _____
 Documented by: _____ (Date) Medicines usually administered by: _____

NOT FOR ADMINISTRATION

Retrospectroscope...learnings

- Limited implementation strategies
 - tabled at Mental Health Network meeting
 - official launch at statewide Medication Safety Workshop
 - factsheet distributed to all mental health services

2010 - trigger for change

- Clinical audit pilot completed by Mental Health Alcohol & Other Drugs Directorate (MHAODD)
 - Highlighted a number of issues
 - several clinics had not implemented form
 - sections of the form not being utilised
 - medication orders not reviewed every 90 days
- Funding provided for MSQ to complete review of the OM&DA chart

Aim

- To undertake a review of the Oral Medication & Depot Administration chart to identify issues and areas for improvement in format and content

Methodology

- Stage 1 - Phone survey
- Stage 2 - Chart Audit
- Stage 3 - Statewide user group

Stage 1- Phone survey

- 11 community mental health services contacted
- Questions:
 - Are you using the chart?
 - If not, what chart are you using?
 - Do you have any issues with OM&DA chart?

Phone survey results

- 2 services using locally developed form
- Test dose/oral medication section not used
- Home visit safety status not used
 - duplication of information
- Current medication section
 - unsure of currency of information
- Medication order and administration section
 - inadequate space

Stage 2 – Chart audit

- May 2010 a retrospective audit completed at 3 CHS
 - 116 consumer's OM&DA charts
 - 2 CMHs using OM&DA chart (Sites A&B)
 - 1 CMHs using local chart (Site C)

Utilisation of chart sections

	Sites A & B n = 66 charts	Site C n = 48 charts
Test Dose or 'Once Only' used	7.5%	N/A
CMH team info. recorded	18%	81%
Home visit safety status	9%	N/A
Girth recorded	0	0
Weight recorded	0	40%
Current medication list documented	7.5%	N/A

ADR's, route and frequency

	Sites A & B n = 66 charts	Site C n = 48 charts
ADR documentation complete	4.5%	8.3%
Similar class of medication prescribed	0%	0%
Route Unclear	3.2%	6.3%
Route Missing	0%	16.7%
Frequency Unclear	91.3%	91.7%
Frequency Missing	0.8%	0%

Note: use of methods from National Inpatient Medication Chart Audit

Audit - other issues

- Original chart did not match current work practices
- Sections of the chart rarely or never used
 - Home safety status section
 - Pharmacy comments section
 - Due date of drug

Stage 3 – User Group

- A Statewide user group convened
 - representatives from 7 CMH services
 - 13 nurses and a 1 psychiatrist
 - representatives from Clinical Forms Design
- Presented with feedback from the phone survey, audit results, and issues register
- ‘Lively’ discussion prior to reaching consensus

User group consensus

Exclusions

- Home visit safety status
- Health team details
- Girth
- Current medication list
- Test dose injection and once only medications
- Name - OM&DA

Inclusions

- Height
- Consumer Integrated Mental Health Application alert
- “mg” and “IM” pre-printed
- Prompt for 3 month review
- Name – Depot Administration Record

Pre statewide release

- Wider stakeholder consultation
 - mental health pharmacists
 - site visits to several local CHS clinics
 - Mental Health Directors of Nursing (DON) forum
 - QLD Psychotropic Medication Advisory Committee (QPMAC)
- Testing of the record
 - doctors and nurses at the 2 CHS
 - no issues with the form were identified
- Review and update of implementation tools included:
 - user-guide
 - PowerPoint® presentation
 - fact sheet

Comparison of strategies used

2006

- MSQ project officer (generalist RN)
- Usergroup membership - 1 MHS (3 clinics)
- Tabled at Statewide Mental Health Network meeting
- Official launch at statewide Medication Safety Workshop
- Factsheet distributed to all mental health services

2010

- Mental health nurse seconded for project
- Usergroup membership - 11 MHSs
- Local and statewide consultation
 - Mental Health Nursing Directors
 - Queensland Psychotropic Medication Advisory Committee
- Mental Health Medication Safety Workshop
- Factsheet distributed to all mental health services

Use to date

- Phone survey of 11 CHS
 - All sites have implemented the depot administration record
 - Staff find it a user friendly form
 - To date no issues identified by users

In summary

- Lessons learned
 - Need to engage relevant clinicians
 - Form needs to reflect and support work practice
 - Need effective and resourced implementation strategy
- Ongoing education and marketing is required to increase uptake of the record
- Post implementation evaluation is required

Acknowledgements

Mental Health Alcohol and Other Drugs
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