

Capturing mental health clinician perspectives on strategies to address medication safety

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Queensland at a glance

- 2007/08 approx. 55,000 hospitalisations for mental and behavioural disorders in QLD¹
 - > 1400 inpatient beds²
- Mental Health Services (MHS) provided 374,000 days of inpatient care²
- >2,000 staff delivered over 1.1m occasions of service within community based services²
- PBS funding medicines approx. \$136m¹

¹Queensland Government. *The Health of Queenslanders 2010: third report of the Chief Health Officer*. QLD Government, Brisbane, 2010.

²Queensland Government . *Queensland Plan for Mental Health 207-2014*. QLD Government, Brisbane, 2008.

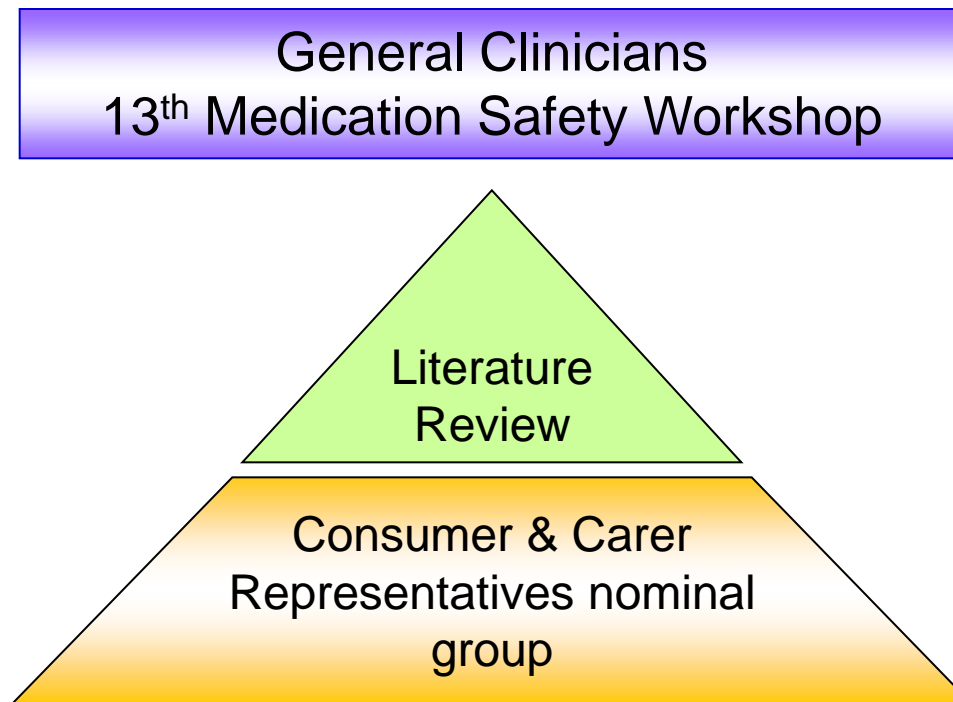
Background

- Reducing adverse drug events is a priority in The National Safety Priorities in Mental Health: a national plan for reducing harm
- How to achieve this in QLD MHS was unclear?
- Partnership between Medication Services QLD & QLD Mental Health Alcohol and Other Drugs Directorate
 - Formation of the Mental Health Medication Integration Project (2009)

Overall project aims

- Provide direction on implementation of strategies to
 - reduce adverse drug events and
 - support safe and quality use of medicines
- to improve patient safety in mental health services in Queensland

Overall project methodology



Mental Health Clinicians
'grass roots'
5 nominal groups

Mental Health Clinicians
Medication Safety
Workshop

Aim

- Identify current issues facing clinicians in delivering quality use of medicines in acute & community mental health services (MHS)
 - project focus on systems and health service perspectives
 - evidence based medicines outside project scope

Literature review - methodology

- Descriptive literature review
 - identify current knowledge base regarding mental health medication safety
 - search of databases e.g. CINAHL, Medline & PsychINFO
 - internet 'Google' search engine
 - current QLD Health documents

Areas of review

- Mental health & recovery
- Overview of medication safety
- Mental health medication safety
- Psychotropic medicines
 - Prescribing issues
 - Non adherence
 - Polypharmacy
 - PRNs
 - Monitoring protocols
- Target groups
 - Rural & remote
 - Aboriginal & Torres Strait Islander People
 - Dual Diagnoses
 - Child & youth mental health
- Continuity in medication management
- Clinical pharmacy services
- Mental health & workforce

Overall results

- Medication safety in mental health (MH) is under researched compared to physical health
- Most studies are inpatient focused
 - mainly relate to prescribing
- Studies are process based, rather than outcome based
- Limited systematic study of causes of medication errors in MH

QLD Mental Health clinicians

- Focus groups - 58 participants + 10 sites
 - senior medical, nursing & pharmacy staff
- Nominal groups - 36 participants + 5 sites
 - ‘grass roots’ clinicians
- Focus question ...
“In the delivery of mental health services what are the problems, concerns, or needs related to the safe and effective use of medication”

Focus group - methodology

- Participants remained in one group to brainstorm issues
- Facilitator sought responses from the floor
- Issues sorted into 7 themes by workshop facilitators and confirmed with groups
- Participants divided into 7 groups
 - further exploration of issues

Focus groups - results

- Common themes
 - incident reporting
 - medication administration
 - medication prescriptions
 - health care professionals education
 - discharge processes
 - adherence issues
 - physical/environmental factors

Focus groups - issues

- **Incident reporting**
 - Need for greater identification of incidents
 - Tool for reporting – not user friendly
- **Medication administration**
 - Poor legibility & clarity of drug orders
 - Lack of patient identification (acute & community)

Focus groups - issues

- **Discharge processes**
 - Lack of communication between all providers
 - Delays in discharge scripts; lack of doctors
- **Adherence issues**
 - Enforced treatment; disempowered consumers
 - Complicated dosing regimes
- **Physical /environmental factors**
 - Lack of physical space (poor cupboard space)
 - Need to restrict unqualified staff entry into MHS

Focus groups - issues

- **Prescribing**

- Lack of rationale of drug choice
- Imprecise PRN orders;
do not include indications

- **Clinician education**

- Lack of time/poor attendance
- Education is fragmented
(often only delivered by 'drug companies')

Nominal group - methodology

- Initial individual brainstorm
- Recorded individual issues
- Feedback of issues to main group to generate statements
- Statements rated on overall importance & achievability (1 low → 5 high)
- Post group sessions
 - overall statements consolidated → total of 182
 - content analysis into common clusters/themes

Issues - nominal groups

1. Quality of documentation; inadequate documentation practices

- Doses not being signed for by nursing staff
- Changes in notes; not written in medication chart
- Accuracy of documentation

2. Gap in competencies, lack of knowledge &/or application of knowledge

- Medicines being consistently prescribed above recommended doses without clear documentation
- Lack of medication knowledge by clinicians
- Need for adequate PRN/consistent regimes

Issues - nominal groups

3. Workforce & skill mix not meeting current service needs

- Mental health pharmacist (lack of)
- Allied health supervising medications in the community
- None/ limited side effects monitoring

4. Poor infrastructure & structure/access

- Distance & coverage
- Storage of benzodiazepines
- Availability & cost of medicines

Issues - Nominal groups

5. Lack of standardised guidelines & protocols

- Imprest – no guidance
- Clozapine – esp. prescribing & monitoring
- Inconsistent medication guidelines

6. Discontinuity of care

- Consumer movements into other districts
- Community pharmacies
- Multiple prescribers → failure of communication of issues/changes/cessations

Issues – Nominal groups

7. Psychosocial impacts on consumers & families

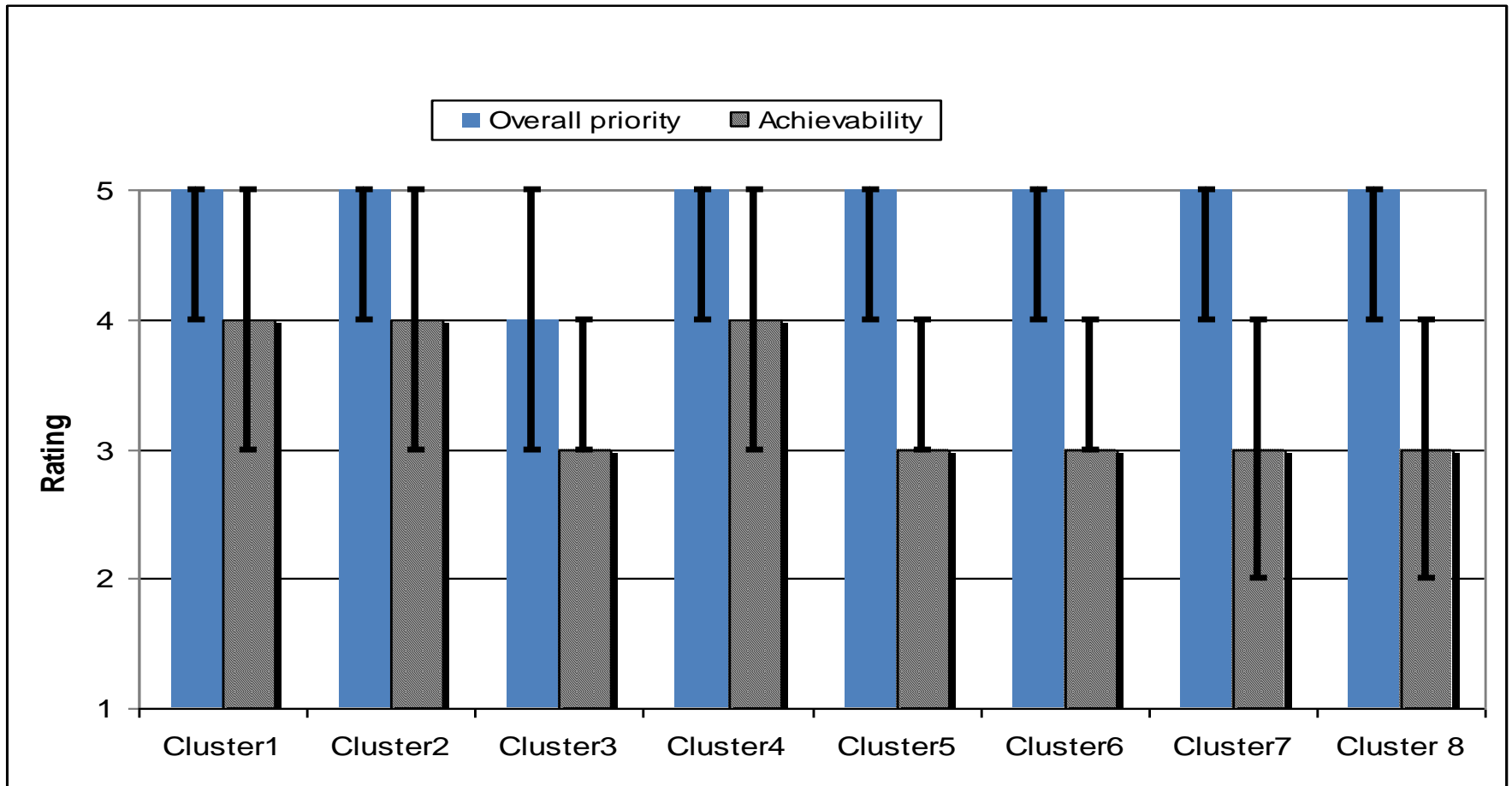
- Non-Compliance by the consumer
- Doctor shopping; MHS not informed
- Storage of medications in 'high risk' clients' home
- Consumers do not feel they are in partnership with their doctor, when deciding on treatment
- Poor/lack of demonstrated documentation around decision making of medication and education
- Poor/lack of psycho education regarding medication is given to consumers and carers

Issues – Nominal groups

8. Staff processes

- Poor/lack of identification & reporting of errors
- Failure to consult with senior colleagues
- Administration of medications in community
i.e. home visits
- Transcribing of medication charts
- Poor/lack of 'formal' patient identification
- Poor/lack of review & monitoring of PRNs
- Administering more medication than prescribed
purposely incl. liquids and depots
- Poor/lack monitoring effect/review of medication

Priority & Achievability Ratings



Cluster 1 – Quality of Documentation

Cluster 2 – Gaps in Competencies

Cluster 3 – Work and Skill Mix

Cluster 4 – Infrastructure and Structure Access

Cluster 5 – Guidelines and Protocols

Cluster 6 – Staff Process

Cluster 7 – Continuity of Care

Cluster 8 – Psychosocial Impacts on Consumers and Families

Common threads

- Poor communication
- Discontinuity of care
- Lack of education – clinicians and consumers
- Lack of clinical pharmacy services
- Need for standardised policies, procedures and work processes



The way forward

- These issues will be incorporated into a statewide framework
- “Medication management in Queensland Mental Health Services – scoping study of quality use of medicines in Queensland Mental Health Services (draft) 2010”**

Recommendations in brief

- Ensure standardised procedures for the correct identification of consumers are across all QLD Health mental health environments
- Incorporate a dedicated medication section in the clinical records (paper and electronic) for collection & transfer of complete & accurate medicines-related information
- Implementing state-wide policies & protocols for medication management of psychotropic medicines in QLD MHS

Recommendations in brief

- Enhance medicines-related skills of clinicians by implementing education & training programs
- Increase skills of clinicians to minimise medication risks by incorporating the Medication Risk Awareness Training Package for Nurses
- Improve prescribing skills of medical officers and non-medical prescribers by incorporating the National Prescribing Service (NPS) curriculum

Recommendations in brief

- Improve treatment services for consumers with a dual diagnosis (substance use) by developing & implementing treatment strategies
- Increase clinicians' knowledge of medication policy & rules for funding & access to medicines by the development of written materials
- Improve continuity of medication management for community based MHS by developing a tool to document a current medication list

Recommendations in brief

- Optimise delivery of clinical pharmacy services in acute & community based MHS by undertaking a pharmacy workforce analysis
- Ensure pharmacists provide appropriate services by developing & implementing a structured competency development program
- Enhance clinical governance for QLD MHS medication management by implementing an evaluation /performance monitoring system

Recommendations in brief

- Ensure strong clinical governance for safe & quality use of medicines through effective operation of the Queensland Psychotropic Medication Advisory Committee (QPMAC) under the auspices of the Executive Director of Mental Health

Conclusion

- Concepts such as ‘medication safety’ and ‘medication management’ are not widely recognised within MHS
- Medicines are a first line treatment for mental illness & mental disorders, yet recognition of their impact and potential for harm is still limited
- Quality use of medicines is a high priority for improvement & development within QLD MHS

Thank you