Reducing the risk of clozapine patient harm by correcting summary care records using a 'Continuous Quality Improvement' approach

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Background

Following the introduction of pharmacy-led clozapine clinics within Lincolnshire Partnership NHS Foundation Trust, pharmacy staff began carrying out medicines reconciliation for all patients. This identified that some summary care records (SCRs) did not list clozapine at all, showed additional antipsychotic medication prescribed by their GP and/or highlighted patients prescribed high dose combined antipsychotics (with no indication if this was intentional or not).

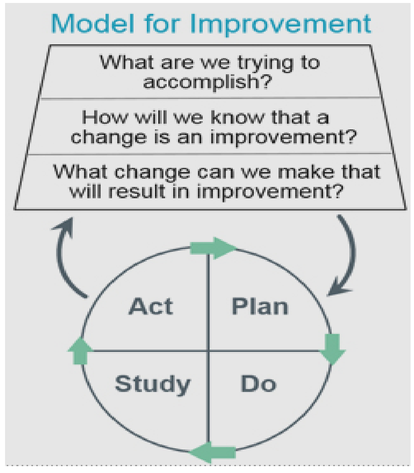
Given the strict monitoring and registration requirements for clozapine due to serious side effects and drug interactions, this was deemed a potential risk to patient care if GPs were not aware their patient's were taking clozapine. This potential risk was escalated to the Trust's DTC and Patient Safety & Experience Committee meetings and placed on the Trust corporate risk register. A Continuous Quality Improvement (CQI) approach was taken and initiated.

Aims & Objectives

This CQI initiative aimed to firstly determine the extent of disparity between secondary and primary-care patient records with regards to clozapine and plan the implementation of quality improvement interventions.

The objectives were to:

- Examine SCRs for clozapine patients in the Trust
- Identify other antipsychotics being prescribed by the GP
- Determine overall combined antipsychotic percentage
- Agree and perform change interventions.

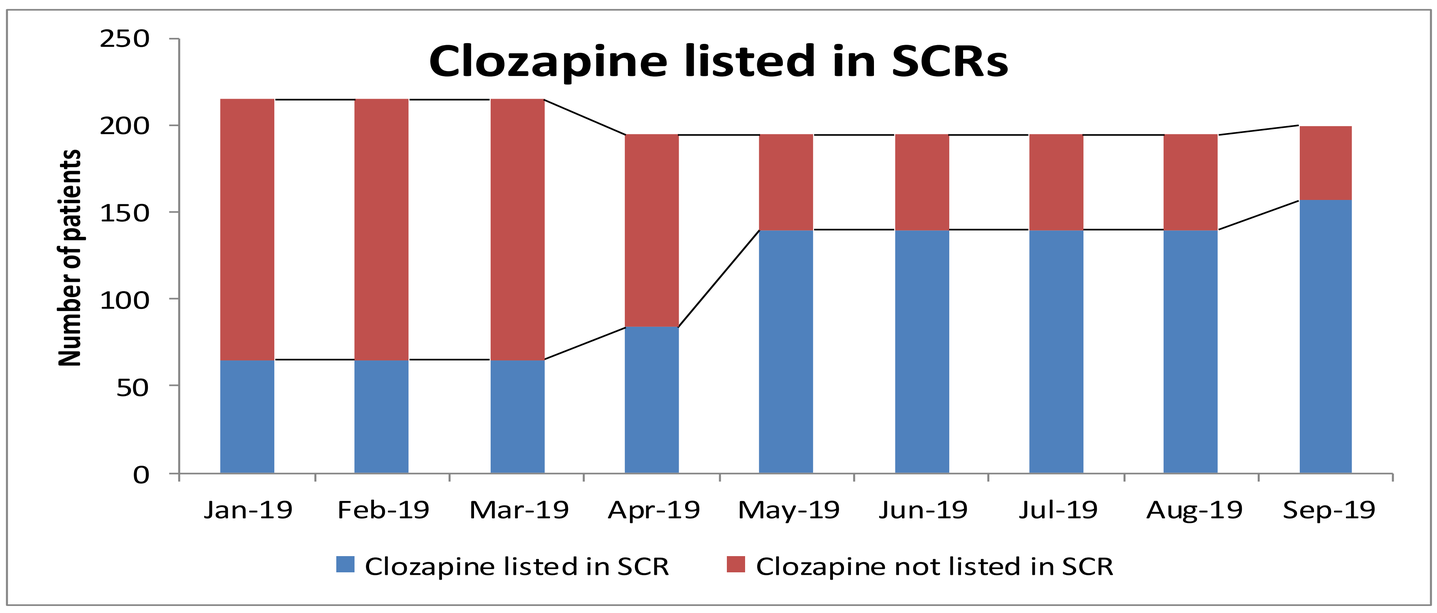


Methodology

A quantitative baseline audit (100% of SCRs should include clozapine) was performed by pharmacy staff on all clozapine patients along with which other antipsychotics were listed and a calculation of total daily antipsychotic percentage.

A driver diagram was developed. QI plans for change were agreed a part of this.

Models for improvement were tested via PDSA cycles. A communication tool was devised to provide written information exchange with GPs with recommendations for discrepancies to be corrected. This was followed by a re-audit and successive cycles of change interventions captured on a timeline.



QI interventions made:

- March 2019—Communication tool introduced - GP and consultant letters written, approved by DTC and CCGs and sent out to clinical leads.
- April 2019—Communication tool re-circulated—sent to all GPs and consultant psychiatrists and discussed with CCG leads.
- June 2019—Further communication and face to face discussions with CCG colleagues, pharmacists, consultants and at interface meetings prior to re-audit.

Discussion

At baseline audit, 70% of clozapine patient SCRs did not state that the patient was on clozapine. 21% were prescribed additional antipsychotics and of those, 35.6% were on high dose antipsychotic treatment (HDAT). It was not clear if the latter was intentional or not ; it was assumed not due to the lack of case note documentation and HDAT monitoring form completion.

Initial communications with GPs led to a 11% improvement in correct SCRs (from 30% to 41%) and a further 28% improvement at follow up (from 41% to 69%). There was no change in the number prescribed additional antipsychotics or over 100% (HDAT) as no real intervention was implemented to address this at the time.

Following face to face discussions at interface meetings, 78% of SCR listed clozapine.

- SCRs without clozapine listed poses a potential patient safety risk from GPs co-prescribing interacting medicines, both for physical health and other psychotropics, not recognising its serious side effects, such as constipation and blood dyscrasias, or understanding the need for regular physical health monitoring.
- The risk of patients being prescribed additional antipsychotics and unintentional HDAT can be significant and cause harm.
- Up to date, correct information should be available for all HCP's to access. Intervention and change relied on communication and prompting primary care colleagues. Communication sent out has had a positive impact on increasing number of summary care records having clozapine recorded. Further discussions about the importance of clozapine at various meetings across the county, internally and externally continued.

Considerations & Limitations

The relationship with patients and the clozapine clinic staff means they are more likely to be informed about changes to medication regimes directly from the patient; previously, due to little/no contact with this client group was had.
Between 6-8 SCRs were not accessible during the data collection periods. Inpatient SCR were not included.
It was not clear if those on additional antipsychotics were prescribed them by their GPs who were not aware the patient was taking clozapine.

Implementing changes to the SCRs was heavily dependent upon external non-Trust colleagues updating the SCRs and so updates were deemed to be slow.

Conclusions

The quality improvement work and interventions made by Pharmacy Staff through the use of communication tools and having discussions with primary care HCPs has significantly reduced the potential unintentional harm of people treated with clozapine in Lincolnshire, and ensured that SCRs are up to date. This will remain a continuous process.

This work has provided wider recognition of the potential risks to clozapine service users not having their clozapine treatment listed on their SCRs, such as being prescribed interacting medication by their GP, including additional antipsychotics, GPs not recognising the need for physical health monitoring and monitoring for potentially serious side effects.

It has also highlighted the risk of clozapine not being prescribed and therefore having to be re-titrated, if it is not listed on the SCR when a patient is admitted to an acute hospital.

Good communication and transfer of accurate medicines information is vital to keeping patient's safe and avoiding harm from medicines.

It is also evident that change to practice and implementing quality of care is challenging and slow across the primary-secondary care interface; something MH pharmacy staff can help to improve.

Action Plan/Next Steps:

Following the initiation of this CQI work, next steps are planned/already in progress by the Pharmacy Team:

→ Share and present the results to Trust medical staff and GPs.

→ Engage and share this issue with new GP practice pharmacists via the county-wide Clinical Pharmacy Network.

→ Routine use of the POMH-UK SCR tool with all discharges from hospital.

→ Work with clinical records and medical secretaries to ensure all medics have access to SCRs.

→ Review patients on other antipsychotics and HDAT and provide advice on ongoing treatment.

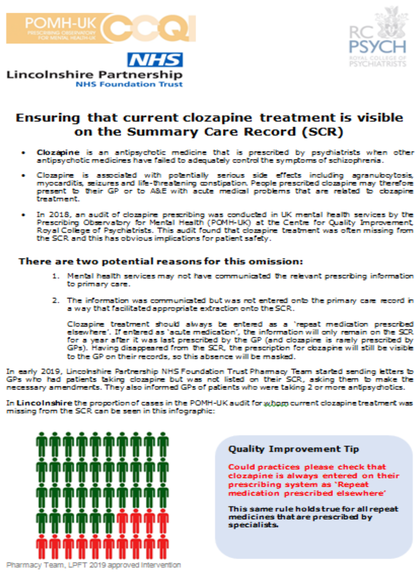
→ Changes to pharmacy SOPs to ensure good medicines information transfer.

→ Ensuring correspondences' such as discharge summaries, initiation and dose changes regarding clozapine are communicated via nhs.net to prevent faxes/postal letters being missed or lost.

→ Implementation of Transfer of Care Around Medicines via PharmOutcomes for improved medication discharge plans and correspondence with primary care healthcare professionals.

→ Establish improvement in SCR accuracy for patients on LAIs and women prescribed valproate.

→ Plan for joint CPD sessions with acute trust pharmacists to inform what to do when patients on clozapine are admitted to their wards and the need to continue treatment without a break.



POMH-UK CCQI

NHS Lincolnshire Partnership NHS Foundation Trust

RC PSYCH

Ensuring that current clozapine treatment is visible on the Summary Care Record (SCR)

- **Clozapine** is an antipsychotic medicine that is prescribed by psychiatrists when other antipsychotic medicines have failed to adequately control the symptoms of schizophrenia.
- Clozapine is associated with potentially serious side effects including agranulocytosis, myocarditis, seizures and life-threatening constipation. People prescribed clozapine may therefore present to their GP or to A&E with acute medical problems that are related to clozapine treatment.
- In 2018, an audit of clozapine prescribing was conducted in UK mental health services by the Prescribing Observatory for Mental Health (POMH-UK) at the Centre for Quality Improvement, Royal College of Psychiatrists. This audit found that clozapine treatment was often missing from the SCR and this has obvious implications for patient safety.

There are two potential reasons for this omission:

1. Mental health services may not have communicated the relevant prescribing information to primary care.
2. The information was communicated but was not entered onto the primary care record in a way that facilitated appropriate extraction onto the SCR.

   Clozapine treatment should always be entered as a 'repeat medication prescribed elsewhere'. If entered as 'acute medication', the information will only remain on the SCR for a year after it was last prescribed by the GP (and clozapine is rarely prescribed by GPs). Having disappeared from the SCR, the prescription for clozapine will still be visible to the GP on their records, so this absence will be masked.

In early 2019, Lincolnshire Partnership NHS Foundation Trust Pharmacy Team started sending letters to GPs who had patients taking clozapine but was not listed on their SCR, asking them to make the necessary amendments. They also informed GPs of patients who were taking 2 or more antipsychotics.

In **Lincolnshire** the proportion of cases in the POMH-UK audit for whom current clozapine treatment was missing from the SCR can be seen in this infographic:

Quality Improvement Tip

Could practices please check that clozapine is always entered on their prescribing system as 'Repeat medication prescribed elsewhere'

This same rule holds true for all repeat medicines that are prescribed by specialists.

Pharmacy Team, LPFT 2019 approved intervention

References:

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2. National Institute for Health and Care Excellence (2014). Psychosis and schizophrenia in adults: prevention and management. CG178. www.nice.org.uk
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