



National Mental Health
Development Unit

C · M · H · P
College of Mental Health Pharmacy
Incorporating UK Psychiatric Pharmacy Group

Getting the Medicines Right 2

**Medicines Management in Mental Health
Crisis Resolution and Home Treatment Teams**



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Foreword

We welcome the publication of this vital document. In 2009 the National Mental Health Development Unit sponsored and published the first *Getting the Medicines Right* report which focused on medicines management systems in adult and older adult acute mental health wards. This second document focuses on the medicines management arrangements for crisis resolution and home treatment teams (CRHTs).

The main findings of the research undertaken as a part of this project are that:

- Medicines Management has evolved organically around perceived clinical needs and staffing arrangements in CRHTs in England.
- Many aspects of Medicines Management that have been developed as essential in-patient functions have not been fully replicated or implemented by CRHTs.

In the current economic climate, avoiding the need for admission to a psychiatric hospital is an important outcome. Better management of medicines will culminate in a number of beneficial outcomes; provide an effective clinical approach to the use of treatments that have a good evidence base; tackle interventions around concordance, improve medicine safety, reduce waste in the NHS, and offer a significant contribution to cost improvement targets. All of this is achieved with the person being maintained at home rather than admitted to hospital.

A strength of *Getting the Medicines Right 2* is that it has been written and co- managed jointly by representatives from both the nursing and pharmacy professions. Such joint working needs to occur within CRHTs and we welcome the recognition of the need for greater pharmacy input to CRHTs.

Reassuringly, where medicine management is viewed as a critical aspect of CRHT functioning, the study has found evidence of good practice. Examples are provided within the body of this report so that CRHTs are able to consider implementing a range of improvements in their own service areas.



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Executive Summary

The development of Crisis Resolution and Home Treatment (CRHT) Services has been a critical factor in the modernisation of Mental Health Services in the UK. The Department of Health set out its agenda for change in 1998, emphasising the need to offer care and treatment in the least restrictive environment including the provision of alternatives to psychiatric admission.

In 2007 the Healthcare Commission (now the Care Quality Commission) in its review *Talking about medicines* made a wide range of recommendations about the management of medicines by Trusts providing Mental Health Services. It identified 10 focus areas for medicines management and in addition raised concerns about the lack of pharmacy input to community teams of all kinds.

Nurses account for the majority of the workforce in some CRHT teams; they often do not have direct access to pharmacy or medical colleagues. In these instances, nurses carry a great deal of clinical and practical responsibility in what are often complicated clinical situations. The lack of consistency around access to medical and pharmacy colleagues has culminated in a wide variety of practice in England. Although the effect of this upon patient safety and mental health recovery has not been specifically evaluated in this study there was great inconsistency of practice. This is influenced by several factors including experience and seniority of staff, 24 hour access to prescribers, involvement of pharmacy staff and overall fidelity to CRHT model standards.

Little work has been conducted to explore what elements of medicines management schemes work best in crisis intervention and home treatment teams. This document follows an extensive review undertaken by a research team of current practice and provides:

- an evaluation of medicines management approaches used by crisis intervention and home treatment teams
- recommendations for best practice for medicines management schemes for by crisis intervention and home treatment teams
- key messages from service users and carers organisations, and
- a model framework for better medicines management on by crisis intervention and home treatment teams.



Key findings regarding Medicines Management Schemes in Crisis Resolution and Home Treatment teams

Where medicines management schemes were most successful, the following key components were present:

- **Leadership** – a lead clinician was clearly in charge at local level to drive the medicines management agenda.
- **Team working** – the knowledge and skills of medical, nursing and pharmacy staff are essential for successful medicines management in CRHT teams.
- **Resources** – the dedicated input of medical and pharmacy staff is needed to complement nursing staff to achieve the appropriate skill mix.

CRHT medicine management services should be reviewed to assess whether they are tailored to meet the needs of the patients, not merely developed in response to the changing service.

The following aspects of medicines management schemes are most likely to lead to successful use of medicines by CRHT teams:

Aspect of medicines management	Findings from evaluation	Recommendations
Responsibility for medicines management within CRHT	No consistency between evaluated teams. Medicines management was not recognised as part of the role of a crisis team in some teams.	A nominated individual within the CRHT should be responsible for driving the medicines management agenda.
Recording prescribing information about medicines (medicine charts)	Where prescribing information was recorded, paper and/or electronic systems were used. In-patient charts were used by some teams. There were no consistent procedures for the maintenance and recording of prescribing or administration of medicines	Medicine charts should be used by all CRHT teams. The use of medicine charts (electronic or hard copies) should allow clinical audit of prescribing, dispensing and administration for all patients. It would also ensure an overview of all medicines that the patient is taking.
Medicines reconciliation on admission – Systems & processes to ensure that medicines being taken by the patient correspond to those intended	The variety in staffing has resulted in a wide range of standards. Teams that do not have access to pharmacy or medical colleagues do not undertake medicines reconciliation regularly.	This is a requirement from NICE/NPSA on mental health acute wards, but also needs to be a routine part of Care Co-ordination and admission to CRHT and other mental health teams. A nominated lead should oversee the process and audit it. Individual practitioners are responsible for documenting appropriately. This should involve a pharmacist.
Access to a prescriber	Prescriptions were written variously via dedicated medical staffing, on-call rota, GPs, A+E, out-of hours GP service.	CRHTs should have 24-hour access to a medical prescriber (preferably a psychiatrist). For medical advice relating to the prescription of medicines and care CRHTs should have 24-hour access to a consultant psychiatrist.

Aspect of medicines management	Findings from evaluation	Recommendations
Non-medical prescribing	Whilst some clinicians had non-medical prescriber (NMP) qualifications, the application was minimal. There are several perceived barriers to successful implementation of NMP.	A mental-health focussed NMP course needs to be designed. Individual trusts need to consider using NMPs in their CRHTs, and invest accordingly in their training. Trusts with existing NMPs need to support the development of qualified NMPs in CRHTs to optimise their potential.
De facto prescribing	It was widespread custom and practice for non-medical staff to advise and instruct GPs on choice and dose of psychotropic medicines, otherwise known as "De Facto prescribing".	Where appropriate, NMP and patient group directions (PGDs) should be utilised more widely to reduce the need for de facto prescribing. All prescribing advice given by telephone should be clearly documented.
Access to and use of Patient Group Directions (PGDs)	PGDs were rarely used by the CRHTs in this survey, due to perceived extra bureaucracy.	PGDs have the potential to facilitate quick and appropriate access to supportive medicines. Further support and training should be developed to encourage nurses to use them, within their acknowledged limitations.
Access to medicine supplies.	Where CRHT teams were located with access to a pharmacy supplies of medicines were easier to obtain. For immediate access to supportive medicines, pre-packs were often used.	Immediate access to supportive medicines is an essential component of CRHT team work. The full resources of a pharmacy that is able to meet the needs of a CRHT team should be available.
Medicines dispensing	Medicines often need to be re-dispensed due to changes in dose or amount to be left with the patient. Where there is no easy access to a pharmacy, this is undertaken in a variety of ways depending on staff and training.	All medicines should be dispensed with correct directions and in appropriate containers to meet legal standards. Ideally all dispensing should be undertaken by pharmacy. However if pharmacy services are routinely unable to provide dispensing services in a timely manner local protocols need to be developed to enable nursing staff to re-dispense medicines safely.
Medicine administration	In some CRHT situations, patients are unable to self-administer medicines. Various staff members assist with the administration of medicines.	Administration of medicines should be undertaken by qualified nursing staff only. Where non-qualified nursing staff assist patients to self-administer, this should be supported by local protocols and training.
Training of staff about medicines management	There was little evidence of formal medicines management training in CRHT teams. Where there was direct pharmacy involvement, medicines management had a higher profile.	A nominated individual within the CRHT who is driving the medicines management agenda should ensure that all staff are trained to Nursing and Midwifery Council (NMC) standards in the clinical, practical and legal use of medicines. This should be delivered alongside the pharmacy department, through local or regional training schemes for all disciplines in the CRHT.
Managing medicines concordance and suicide risk	Poor medicines concordance was managed in a variety of ways, mainly by observing medicines administration. There was an understanding of suicide risk but not of poisoning.	Training in health belief models should be developed to enable CRHT teams to explore poor concordance more thoroughly. The CRHT medicines management lead should ensure that all CRHT staff have access to suicide risk training.
Involvement of carers in medicines management.	Carers are often involved in storage, collection, and administration of medicines.	Leadership from the CRHT is required to develop training packages for carers who are involved in managing medicines for people in crisis. They should have direct access to the clinical pharmacist for the CRHT.
Pharmacy input to CRHTs	Very few teams had a dedicated pharmacy member.	CRHTs should appoint pharmacy staff as full team members to assist, direct and deliver the clinical and medicines supply needs of the teams.

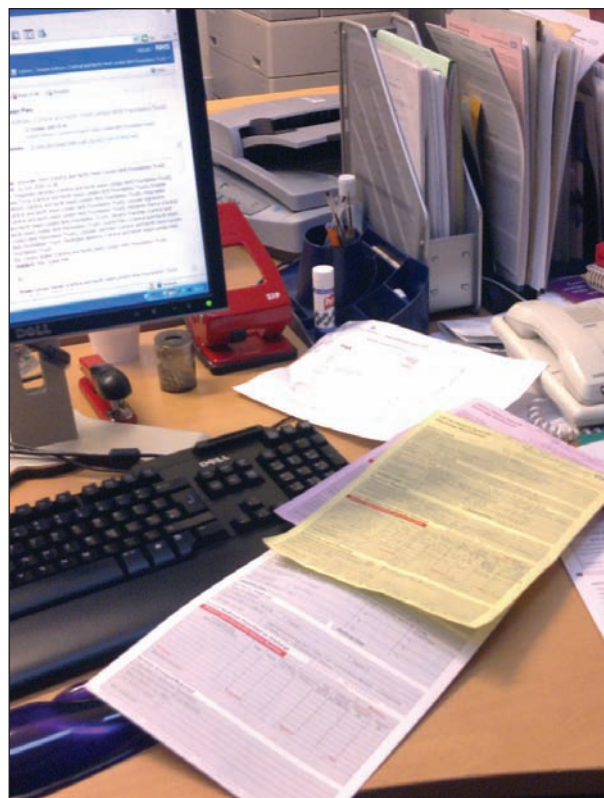


Introduction

Medicines management has been defined as “A system of processes and behaviours that determines how medicines are used by patients and by healthcare services”. (NPC, April 2001). It includes all aspects of the supply and use of medicines, as well as advice and information given. The core aims of medicines management are to deliver the right medicine to the right patient at the right time.

In 2001, the Audit Commission published *A Spoonful of Sugar – Medicines Management in NHS Hospitals* which highlighted that medicines management is central to the quality of healthcare, and underpins many of the specific objectives set out in the NHS Plan. The Audit Commission adopted the term ‘Medicines Management’ to encompass the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to produce informed and desired outcomes of patient care.

In 2007, the Healthcare Commission published *Talking about Medicines: The management of medicines in trusts providing mental health services* (HC 2007) which highlighted that managing medicines safely, effectively and efficiently is vital for delivering high quality, value for money care that is focused on the person using services. It made a number of recommendations to mental health Trusts within ten priority areas.



- 1) Involving people in decisions and management of their medicines
- 2) Ensuring appropriate and effective use of medicines in people's care
- 3) Efficiently and effectively providing and administering medicines
- 4) Promoting multi-disciplinary team working to provide seamless care
- 5) Co-ordinating care with other service providers
- 6) Governing use of medicines
- 7) Choosing and prescribing medicines
- 8) Ensuring staff are competent to work with medicines
- 9) Accurately recording and reporting on use of medicines
- 10) Supplying and managing medicines in the Trust

It recommended that Trusts should include clinical pharmacy support in CRHT teams and pharmacy support levels should be bought in line with corresponding inpatient units. However a survey undertaken in England in 2006 (Branford et al. 2006) indicated that very few CRHT teams had such pharmacy support.

The Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) has issued standards for the “Accreditation for Inpatient Mental Health Services” (AIMS). Although there is not a specific set of standards for CRHTs, when considering the medicines management activities and standards desired in CRHTs it would be useful to refer to those for inpatient wards for working-age adults (*refer to Appendix 1*).

The development of CRHT services has been a critical factor in the modernisation of Mental Health Services in the UK. The Department



of Health set out its agenda for change in 1998, emphasising the need to offer care and treatment in the least restrictive environment including the provision of alternatives to psychiatric admission. There was a commitment within the NHS Plan in 2000, to establish over 300 CRHTs which would enable service users to have access to CRHT teams at any time.

The service model of CRHT in the UK is not new and has been in existence in the USA and Australia since the 1980s, and is based on the following principles:

- Service available 24 hours a day, 365 days a year.
- Provide care and treatment to people in their own home, by a mobile and responsive workforce.
- Provide an alternative to hospital admission.
- Gatekeep inpatient beds.
- Provide intensive support, visiting up to 2-3 times per day during an acute phase of a crisis.
- CRHT will remain involved until the crisis is resolved.
- Multidisciplinary working.

The Mental Health Policy Implementation Guide (2007) recommended the standard CRHT would cover a population of 150,000 and have a caseload of 20-30 service users on Home Based Treatment. A standard team of 14 was recommended for a caseload of 25 people requiring home treatment at any one time. It also recommended that medical staff are active members of the team, and that the medical on call rota should allow a senior psychiatrist to undertake home visits 24 hours a day.

CRHT services have radically changed the experience of mental health crisis and have had a significant impact on the number of people who are admitted to hospital (Glover

et al, 2006; Johnson et al 2005; Keown et al, 2007). For the person in crisis, being maintained in their own community can lead to new and helpful ways of coping, reduces the stigma attached to mental illness and protects the integrity of family and community relationships. However the CRHTs vary widely in staffing, funding and impact on bed occupancy (Audit Commission 2010).

The development of CRHTs means that they are often managing complex patients in the community who require intensive pharmacological treatment and often have changing and complex medicines needs. These requirements have often been addressed through local trust or team protocols and procedures, with little wider or national guidance on medicines management in this setting. Due to the lack of clear guidelines there are a variety of possible medicines management scenarios; patients might have responsibility for all aspects of their medicines (e.g. safe storage, ordering, self-administration); it is also possible that some or all of this responsibility is taken over by the CRHT. Typically, CRHTs do not take responsibility for patients' physical health medicines.

Little work has been conducted to explore which medicines management schemes work best in CRHTs. This document follows an extensive review undertaken by a research team of current practice and provides an evaluation of medicines management approaches used by CRHTs.

This was undertaken by:

■ Questionnaire

- To obtain a broad picture of medicines management a questionnaire was distributed to all CRHT teams in England, to be filled in by a nurse, doctor or pharmacist.
- 51 questionnaires were returned from CRHT teams representing 36 different trusts (62%).

■ Focus Groups

- A focus group was attended by 10 people from 5 different CRHT teams within the Northumberland Tyne and Wear (NTW) Trust. (2 consultant psychiatrists, 1 nurse consultant, 2 team managers, 2 pharmacists, 1 social worker, 1 clinician, 1 nurse prescriber)

■ Semi-structured telephone interviews

- Semi-structured telephone interviews were conducted with 35 CRHT workers from a range of disciplines (nursing, medical and pharmacy).
- Respondents were encouraged to describe areas that they felt were examples of good or poor practice.

■ Structured interviews with carers

- Twenty semi-structured interviews were conducted with people who were registered carers for people with mental health problems
- Registered carers were encouraged to discuss any particular areas of medicines management in more detail or develop new related topics.



Key medicines management activities

Several key medicines management activities were identified from the research project, they include the following:

- Medicines reconciliation
- Accessing a prescriber
- Accessing supplies of medicines
- Dispensing and administration
- Recording of prescribing information
- De facto prescribing
- Managing adherence and suicide/self-harm risk
- Carer involvement in managing medicines.

Medicines Reconciliation

Rationale:

Medicines errors pose a threat of harm to hospital inpatients (and therefore also to CRHT patients), leading to increased morbidity, mortality and economic burden to health services (NICE/NPSA 2007). Errors occur most commonly on transfer between care settings and particularly at the time of admission. International guidelines recommend that medicines reconciliation should be undertaken within 24 hours of admission (WHO, 2007).

The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. Details to be recorded include the name of the medicine(s), dosage, frequency, and route of administration (NICE/NPSA 2007).

The image shows the cover of a NICE patient safety guidance document. At the top right is the NHS logo and the text 'National Institute for Health and Clinical Excellence' and 'National Patient Safety Agency'. On the left, there is a box with the following information: 'Action deadline for the Safety Alert Broadcast System (SABS)', 'Category: ACTION', 'For action by: pharmacists', 'Deadline (action 1.1 underway): 12 January 2008', and 'Deadline (action 1.1 complete): 12 December 2008'. Below this, it says 'Issue date: December 2007' and 'Alert reference: NICE/NPSA/2007/PSG001'. The main title is 'Technical patient safety solutions for medicines reconciliation on admission of adults to hospital'. A summary box states: 'The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. Details to be recorded include the name of the medicine(s), dosage, frequency, and route of administration. Establishing these details may involve discussion with the patient and/or carers and the use of records from primary care. This does not include medicines review.' The document is divided into sections: 1 Action, 2 Other interventions evaluated, and 3 The patient safety problem of harm. Section 1.1 states that all healthcare organizations that admit adult inpatients should put policies in place for medicines reconciliation on admission. Section 1.2 lists requirements for standardised systems for collecting and documenting information about current medications, policies for medicines reconciliation on admission, and involvement of pharmacists. Section 2 lists potential interventions like package for medicines reconciliation and IT-based information transfer initiatives. Section 3.1 notes that medication errors pose a threat of harm to hospital inpatients, leading to increased morbidity and economic burden. Section 3.2 mentions two recent literature reviews reporting unintentional variations of 35-70% between medications patients were taking before admission and their prescriptions on admission. At the bottom, it says 'NICE patient safety guidance 1' and 'This guidance represents the view of the Institute and the NPSA, which was arrived at after careful consideration of the available evidence. Healthcare professionals are requested to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.' and 'NICE patient safety guidance addresses how to improve the safety of patients in the NHS in England and Wales.'

Although prescribing responsibility for medicines may be shared with other teams and services, a full knowledge of medicines is required by each prescriber to aid diagnosis and form an appropriate treatment plan. To obtain details of all current medicines it may be necessary to contact multiple services from primary and secondary care.

Evidence base:

Medicines reconciliation is a national requirement on mental health acute wards. All healthcare organisations that admit adult inpatients should make sure that they have policies in place for medicines reconciliation on admission. This includes mental health units, and applies to elective and emergency admissions (NICE/NPSA, 2007).

Getting the Medicines Right (NMH DU, 2009) recommended that medicines reconciliation forms a routine part of admission to crisis teams. CRHT teams were not included in the recommendations of NICE/NPSA circular or the *Assuring Medication Safety at Transitions* WHO report (2007).

Survey findings:

Medicines reconciliation was undertaken in a variety of ways by the teams involved in this study; verbal information was obtained from the referrer/patient/general practitioner (GP), and written information was obtained from the GP and other services involved. Only one team routinely involves a member of the pharmacy department in this process. Medicines reconciliation was most often undertaken by nursing staff, often at triage. Where funding was available, a pharmacy technician was able to assist in the process.

When explored further about possible risks and benefits of medicines reconciliation, few of the teams thought of it as being an important part of the assessment of someone in mental health crisis. Concern was expressed about undertaking additional administrative processes, especially when contacting multiple services. The value of medicines reconciliation was also questioned; when presented with a long list of physical health medicines that were unfamiliar to mental health staff it was assumed that somebody else would manage this part of a person's care.

Risks:

Safe and effective prescribing requires an accurate picture of all medicines; inaccurate records may result in risk of harm from the omission of a patient's regular medicines or the effects of pharmacokinetic or pharmacodynamic interactions.

Recommendations:

Complete knowledge of current medicines as assessed through the medicines reconciliation process is a fundamental part of assessment during a mental health crisis, and recommended by national guidelines (NICE/NPSA 2007).

When a patient is accepted for care by the CRHT, a written list of a patient's current medicines should be obtained as soon as practical, usually from the GP.

Outside of working hours verbal information should be sought until written information is obtainable. Interpretation of current medicines requires a detailed knowledge of the medicines themselves and their interactions with each other and illness.

Each CRHT should formally agree a local medicines reconciliation process, and this should involve a pharmacist.

Best practice example:

At triage, the referrer is asked where the patient usually obtains their medicines (i.e. which GP). Patient identifiers are then emailed to a pharmacy technician who requests a medicines summary from the GP immediately or the next working day, and inputs this data to an electronic notes system. The list of medicines and allergy status are then accessible by all prescribers who wish to prescribe for that patient. The information is also reviewed by a pharmacist, and any queries or concerns can be addressed quickly.

Accessing a prescriber

Rationale:

Access to supportive and regular medicines requires timely access to a prescriber. Like wards, as a 24-hour service, CRHTs often need to access a prescriber to review a patients' pharmaceutical care, to initiate a new medicine or amend a current prescription outside of regular working hours. This may be to prevent unintentional non-concordance (e.g. patient has run out of regular medicines), or due to change in circumstance (e.g. a newly referred patient outside of regular working hours). In such circumstances a doctor is the most appropriate prescriber, as other medical skills are required, and a non-medical prescriber may not be skilled to undertake these additional tasks.

Survey findings:

The survey identified particular problems related to accessing someone to write a prescription; this variation was partly explained by a lack of dedicated medical cover for many CRHTs. The impact of this was delayed access to medicines, which has the potential to exacerbate the crisis and reduce the possibility of successful home treatment.

For teams without direct access to a prescriber, several options exist to obtain a prescription or authorisation to dispense; indirect contact with a prescriber (usually via the telephone); the use of patient group directions (PGDs); the use of pre-packs of supportive medicine; prescribing by another team (e.g. another mental health team or out of hours GP). For some services, responsibility for prescribing remained with the GP despite input from a psychiatrist into the crisis team. Very few crisis teams took responsibility for prescribing physical health medicines during a crisis, resulting in dual prescribing. One risk of dual prescribing is a lack of clarity about prescribing responsibility.

In particular benzodiazepines were reported to have been over-prescribed. Where prescribing responsibility remained completely with the GP, CRHTs often provided advice and guidance regarding choice of medicine (de facto prescribing). Out-of-hours, prescriptions can be accessed via local on-call psychiatrists, A&E departments and out of hours GP services. All of these options can result in treatment delay, and possibly exacerbate the crisis.

Accessing medicines via patient group directions (PGDs)

Supportive medicines are often used to reduce distress and agitation in an acute psychiatric crisis. One quick route to accessing supportive medicines may be via the use of PGDs (for further details refer to Appendix 2) or locally arranged protocols to provide small amounts of pre-packed medicine. Whilst it may not be suitable to produce PGDs for all psychotropic medicines, appropriate use may improve access and consequently patient care. There was little evidence of widespread use of PGDs in CRHTs (some services had not heard of PGDs). There were no obvious reasons for not using PGDs, but anecdotally they were described as overly bureaucratic, and the benefits of them did not justify the training required.

Risks:

Delayed access to supportive medicines can exacerbate a crisis and result in hospital admission.

A known risk of dual prescribing is a lack of clarity about prescribing responsibility. In particular benzodiazepines were reported to have been over-prescribed. Patients in crisis might assume that both prescribers are aware of each other's role and inadvertently overdose or take a harmful amount of medicines.

Recommendations:

CRHT teams should have 24-hour access to a medical prescriber (ideally a psychiatrist).

Prescribing responsibility should be clearly defined and communicated to all prescribers.

Best practice example:

Teams that had direct access to a psychiatrist related fewest problems. One inner-city team has 2 full-time consultants as well as junior medical staff.

Practice example:

An in-house PGD training package for staff which included side effect profiles, pharmacology treatment options and medico-legal aspects, was facilitated by a nurse consultant. This resulted in a good uptake and appropriate use of PGDs, and over a short space of time staff grew more confident about their use.

Accessing medicine supplies

Rationale:

Access to supportive and regular medicines is dependent on access to a pharmacy service for supply. Like wards, as a 24-hour service, CRHTs often need to access a prescription and medicine supplies outside of regular working hours. This may be to prevent unintentional non-concordance (e.g. patient has run out of regular medicine), or due to change in circumstance (e.g. a newly referred patient outside of regular working hours). It is often necessary to access supportive medicines to aid an assessment or to treat anxiety related to the crisis.

Survey findings:

Once a prescription or authorisation to dispense is obtained, accessing the medicines can be via a number of routes. The survey identified particular problems related to accessing supplies of the prescribed medicines, although a range of different methods were used. The variation in process was partly explained by a lack of dedicated pharmacy services to many CRHTs, or no arrangements for supplies outside of regular working hours. Medicines supply arrangements included using a hospital pharmacy, a community pharmacy, a hospital ward, or the medicines may be stored on-site in the CRHT base. During working hours, hospital pharmacies that are co-located provide easy access to medicines for the CRHT and are a good solution. Another option used by several CRHTs was to develop good working relationships with community pharmacies, which were willing to co-operate flexibly with the various demands of the CRHT. Two important advantages of developing a relationship with community pharmacy are that their opening hours are longer than most hospital pharmacies, and it may provide continuity of care for the patient when they are discharged from CRHT care.

There were a few teams which did not have any access to their own storage of medicines, but utilised A&E departments or shared facilities with inpatient units. The range of medicines was very similar in CRHTs that did have storage/access to emergency medicines. Therefore whether they used prescribers or PGDs CRHT staff direct access to medicines for their patients was still the limiting step in the process.



Example of supportive medicines used by CRHTs:

Benzodiazepines	Hypnotics	Other
Diazepam Lorazepam Temazepam	Zopiclone Zolpidem	Procyclidine

Risks:

Poor and delayed access to appropriate medicines has the potential to exacerbate the crisis and reduce the possibility of successful home treatment.

Recommendations:

Teams should have access to a dispensing service that can meet the requirements of the CRHT in a timely manner.

Teams should ensure systems and training are established to facilitate rapid access to supportive medicines that do not require a prescriber (e.g. pre-packs, PGDs, non-medical prescribing).

Best practice example:

CRHT teams that were co-located with a hospital pharmacy were often able to have medicines dispensed in ways that suited each individual patient (e.g. daily dispensing, use of a medipack). This is of course also possible through community pharmacies, and in some circumstances CRHT teams had developed close working relationships with community pharmacies that allowed them to fax prescriptions and avoid queuing.

Practice example:

Some CRHT teams have developed local protocols that allow nurses to dispense small amounts from a limited range of medicines. The medicines involved are supportive (e.g. diazepam, lorazepam, olanzapine) and the amount dispensed is usually enough until the pharmacy opens.

Dispensing and administration of medicines

Rationale:

The dispensing and administration of medicines are distinct and separate processes. These processes can be described as follows:

- **Dispensing:** The process of providing specific medicines for an individual that follows the written instruction of a prescriber.
- **Secondary dispensing:** The process of using medicines that have already been dispensed and re-packaging it for an individual.
- **Administration:** The process of giving an individual dose of medicine to a person that is to be taken immediately. This usually follows the written or verbal instruction of a prescriber.

The terms dispensing and administration are sometimes incorrectly used interchangeably. In hospitals and other areas of primary care the professions that undertake these tasks are usually clearly defined; dispensing should be undertaken by pharmacy staff and administration should be undertaken by nursing staff. In CRHTs, with the current variations in team arrangements both of these roles are undertaken by a variety of clinical staff. Undertaking tasks outside of the normal professional field of expertise carries inherent risks. The immediacy and 24-hour nature of CRHT work with the current variations in team arrangements means that such practices do occur.

CRHTs also need to clarify those staff able to undertake roles that stop short of handling the medicines themselves but support the patient with practical tasks in the handling of their own medicines; e.g. collecting prescriptions from pharmacy, prompting (a verbal reminder to the person to take their medicines) or encouraging the person with the taking of their own medicines.

Survey findings:

Medicine dispensing by pharmacy or the CRHT and secondary dispensing

Secondary dispensing is not a formally agreed or defined process. In fact the legal basis of secondary dispensing is unclear, and although it is highly likely that most CRHTs undertake secondary dispensing, some were reluctant to discuss it. Some CRHTs had developed local protocols that allowed nurses to dispense small amounts from a stock supply of medicines. The medicines involved are supportive (e.g. diazepam, lorazepam) and the amount dispensed is usually enough until the pharmacy opens. Secondary dispensing has been used where patients have large quantities of medicines in their home and there is concern about the patients' safety regarding potential overdose. In such circumstances the large volumes of

medicines have been removed (with the patients' consent) from the patients' care, and only one or two days' worth of the patients' own medicines are re-dispensed and left with them. Secondary dispensing is also sometimes used if the dose of a medicine is changed and the printed instructions on the label are no longer accurate. Since the original packaging is removed the CRHT staff must ensure that the patient is left with clear instructions on how to take the remaining medicine, and that the dispensed item meets legal requirements.

Medicines administration and self-administration

The aim of crisis care is to avoid hospital admission and maintain an individual's independence as much as possible. An important component is the ability of patients to manage their medicines. The responsibility for the administration of medicines can be taken away from the individual due to intentional or unintentional non-concordance, or to remove access to means for individuals at risk of self-harm. Qualified nursing staff are legally allowed to administer medicines. Support staff can often find themselves in situations where they are asked to help with the administration of a medicine or oversee administration either by the patient or a carer. This can present the support worker with a dilemma; a patient is asking for help to complete a simple task (i.e. remove a dose of medicine from a container), yet to do this places them in a vulnerable position as this task is not within their job description and may not be covered by trust insurance.

Risks:

Administering medicines incorrectly might result in harm (e.g. administering sedating medicine in the morning) or lack of effect due to administering an incorrect amount or via an inappropriate route.



Secondary dispensing is not a formally agreed or defined process, and the legal basis for such practise is unclear, therefore undertaking such an activity potentially puts the individual practitioner at professional risk.

Incorrectly dispensing medicines might risk their stability, especially with medicines that are sensitive to moisture in the air (e.g. some orodispersible medicines).

Recommendations:

All dispensing should routinely be undertaken by a pharmacy service. On rare occasions where this is not possible in a timely manner, other local protocols should be formally developed and agreed. This may include the use of PGDs and pre-pack medicines, or nurse secondary dispensing.

All dispensed medicines should meet legal requirements, including secondary dispensing.

Administration of medicines should only be undertaken by qualified nursing staff (or doctors).

Basic training packages should be developed for CRHT team members to support their essential team processes such as managing medicine administration and the delivery of medicines.

Best practice example:

All dispensing is undertaken by a pharmacy department in a flexible and timely manner.

Best practice example for secondary dispensing:

A best practice example of secondary dispensing was a CRHT that held blank labels and boxes/tablet bottles. The instructions from the original label would be copied by a qualified nurse and this

would be double checked for accuracy by a second qualified nurse. The appropriate quantity of medicines would then be taken from the original bottle again being checked by a second qualified nurse. This process was approved by the local trust so that clinicians involved would not be held accountable in the event of a complaint.

Practice examples:

Other solutions to secondary dispensing adopted by CRHT teams include:

Asking the patient to take the appropriate amount of medicines and store it as he/she wishes.

Giving the patient a dispensing box and assisting him/her to re-dispense an appropriate amount of medicine.

Recording prescription information

Rationale:

The use of medicine charts to record information about the prescribing and administration of medicines is well established in residential settings. The basic requirements are that the chart should indicate the correct medicine, dose, frequency, prescriber and start/stop date. Information about administration of medicines is usually recorded alongside each individual medicine entry. The requirements of a crisis team recording system are different; administration or delivery may be complex and involve people outside of the crisis team.

Survey findings:

Several of the teams adapted in-patient charts to record basic prescribing information, whereas others relied on ad-hoc electronic or paper notes. When this issue was explored, very few of the teams had a system that



allowed a prescriber to see all currently prescribed medicines and allergy status in a single location. Furthermore because of a lack of complete records it would not be possible to audit the prescribing and administration of medicines in many teams.

Practice examples:

A bespoke medicine chart is used by one team that allows clinical staff to see all currently prescribed medicines and allergy status in one document (see chart below). Each individual medicine entry can be annotated with information relating to when the most recent prescription was written and when the medicines were delivered.

Risks:

A complete picture of current medicines is essential for safe prescribing. Not having this information readily available may result in inappropriate choices of medicines.

Recommendation:

Medicine charts (electronic or hard copies) should be used by all CRHTs to record all medicines that the patient currently takes, including those that the CRHT staff are administering or overseeing, as well as those that the patient is self-administering.

Crisis Resolution and Home Treatment team medicine chart

Medicine			Times	Date													
			Morning	Medicine delivery code*													
Dose and Frequency (also see times)				No. of doses left with patient													
Name of prescriber (print)			Lunch	Initials													
				Prescription written on:													
Signature of prescriber			Evening	No. of days prescribed													
Route	Start date	Stop date	Night	Written by													
Comments				Comments													

***Medicine delivery codes:**

- | | | |
|--|-------------------------------|-------------------------------------|
| 1) medicines given to patient/carer | 5) medicines not available | 9) observed taking medicine |
| 2) prescription given to patient/carer | 6) prescription not available | 10) delivered by community pharmacy |
| 3) medicines posted through door | 7) medicines refused | |
| 4) prescription posted through door | 8) unable to contact patient | |



De facto prescribing

Rationale:

A consistent strong theme emerged from the returned questionnaires, the semi-structured interviews and the focus group – that of de facto prescribing. Since the development of non medical prescribing in the UK, the issue of prescribing ‘by proxy’ has been well documented in the literature (Nolan et al 2006; Bridge & Hemingway, 2005). It has been reported that general practitioners, junior doctors and senior psychiatrists value a specialist opinion regarding medicines – including details of the choice of product and the dosage required.

Survey findings:

It was widespread custom and practice for non-medical staff to advise and instruct GPs on the choice and dose of psychotropic medicines to prescribe, this is known as “De Facto prescribing”. All of the nurses contacted were prepared to advise another prescriber about the appropriate choice and dose of a psychotropic medicine. Conversely, there was widespread reluctance to prescribe using the current legal options. Only one team had an active non-medical prescriber (NMP), whose role was mainly to prescribe repeat prescriptions. Several nurses had passed the NMP training course, but do not use the qualification. There was one pharmacist who worked as a supplementary NMP. Clinicians from various backgrounds were confident to advise prescribers what to prescribe, but were reluctant to take up the formal training required to register as a recognised prescriber.

Risks:

Safe prescribing in a psychiatric crisis requires the prescriber to assess the patient directly. The legal position of a nurse who incorrectly advises a GP or primary care worker about psychotropic medicines is unclear.

Recommendations:

Trusts should explore the potential use of PGDs in their CRHT to minimise the use of de facto prescribing, and offer staff training and support in their use.

Further exploration is required into the barriers to NMP within CRHTs and the impact on practice if the course is successfully completed.

Individual trusts need to consider the use of NMPs in their CRHTs, and invest accordingly in their training. Trusts with existing NMPs need to support the development of qualified NMPs in CRHTs to optimise their potential.

NMP courses should improve in the quality of mental health content, training at high education facilities and providing access wide to mental health practitioners across the UK. There are only two courses currently in existence which fulfil this educational need.

All prescribing instructions and advice given by telephone should be documented.



Managing concordance and suicide/self-harm risk

Rationale:

Poor adherence and risk of suicide/self-harm is often managed in the same way by CRHTs, by observing, withholding or removing medicine. Poor concordance is recognised as a major contributing factor for admission (and re-admission) (Tacchi and Scott 2005). Concordance is influenced by many factors; these can be cognitive (remembering to take the medicine), physical (opening tablet box), polypharmacy (too many medicines), the burden of side-effects, the individual's attitudes and beliefs relating to health, their views of the illness, and the behaviour of family and friends (Tacchi and Scott 2005). The risk of suicide/self-harm is constantly assessed during a mental health crisis, and a decision is made whether it is safe to leave medicine with the patient, and whether to restrict the amount supplied (e.g. to just a few days' supply).

Survey findings:

From the detailed exploration of this issue during the focus group and via semi-structured interviews, it became clear that the decision to observe medicines administration or remove medicines was complex and depended on several factors; clinician experience; patient safety and health needs; organisational capabilities (some teams could not remove patients' own medicines from their homes as they did not have suitable medicines storage facilities in their team bases).

There is an inconsistent approach to managing these issues due to the variety of team structures. Whilst there was widespread understanding of the benefits of removing

medicines, there was little regard to the risks and the processes involved in returning it. Removing medicines may reduce independence, and if prolonged may impair ability to manage medicines. Returning medicines without appropriate training may result in confusion and result in non-adherence. CRHTs need to develop a consistent approach to this, underpinned by shared decision making (including formal patient consent) and continuous risk assessment. Another recurring theme was the cost to patients of short prescriptions. Due to changing doses and/or the need to avoid large quantities of medicines some patients were faced with a significant prescription cost that would not be faced if they were admitted. There were anecdotal reports of non-adherence resulting from this, borne out of frustration with the financial cost of crisis team treatment.

As care given by a CRHT is an alternative to an inpatient admission, people under the care of CRHTs are not required to pay prescription charges for their medicines. When prescriptions are written on FP10 prescription sheets and taken to a community pharmacy for dispensing, potentially this can be problematic. In some circumstances local arrangements have been made with PCTs to facilitate this, and to avoid the issue of undue charges becoming an issue that impacts on the patients' concordance.

Risks:

Assessment of the patients' potential risks to themselves when left with quantities of medicines in their care needs to be routinely assessed. An inconsistent approach to assessing risk means that potentially risks may be missed, with untoward consequences.

Recommendations:

Adherence should be routinely assessed as part of home-based treatment, and training in health belief models and practical difficulties should be made available to all practitioners. Observing medicines administration improves adherence short-term, but underlying factors should be addressed for longer-term success.

Removing access to quantities of medicines is a recognised way of minimising patient suicide or self-harm with medicines. Where there is a risk of suicide/self-harm then medicines should be removed from a person's home, ideally following a team discussion. The situation should be reviewed regularly and medicines should be returned as soon as it is safe to do so. A staged process of returning medicines is recommended.

Best practice examples:

Removal and re-introduction of medicines

There were examples of staged re-introduction of medicines that were used for in-patients that had been adapted for CRHTs. There is no evidence that any are superior (or effective), but similarities include a gradual re-introduction of responsibility including in no particular order; knowledge of time of day for medicines; knowledge of name of medicines; knowledge of purpose of medicines; knowledge of how to order medicines.

Non-adherence due to prescription charges

An agreement with a local primary care trust (PCT) resulted in two CRHT teams being able to sign the back of prescriptions for all of their patients as medically exempt. The agreement with the PCT was that all patients with prescriptions identifiable as originating from the crisis team would not be pursued for prescription charges.

Carer involvement in medicines management

Rationale:

Successfully managing patients at home during a mental health crisis often involves a relative or carer. The DH suggest that 6,000 people each day take on a caring role in our communities and at any one time 1 in 10 people in Britain is a carer (DH 2008). However, carers frequently report that their involvement in care is not adequately recognised and their expert knowledge of the 'well person' is not taken into account (NMH DU 2010).

Evidence base:

Medicines management forms an essential criterion of the carer self-assessment tool (NMH DU 2010). Specifically, it recommends that treatments and strategies for medicines management be explained to the carer. Furthermore it has been recognised nationally that the needs of carers have not been met, and that they struggle to juggle several roles and responsibilities (NAO 2007).

Survey findings:

It was found that carers frequently are involved in administering medicines during episodes of crisis, and they feel responsible for several aspects of medicines management including the safe storage of medicines and monitoring for effectiveness/side effects. It is common for more than one family member to be involved in medicines management.

Involving service users and carers involves understanding their role in the management of medicines, and appreciating the difficulties associated with this. As part of our study we asked opinions from carers about their experiences of managing medicines. Currently there is no minimal standard to guide a basic carer training programmes.



Complex ethical and practical issues need to be addressed at a national level due to some carers being below 16 years. There is anecdotal evidence that some young carers are fearful of disclosing problems with medicines or concordance as this may mean their parents are admitted to hospital. Undoubtedly there are hidden pressures on carers to make home-based treatment a viable option.

Key findings from service users and carers

There are occasions when a simple task such as storage of medicines is difficult for carers:

"Just having to hide it at times is frightening."

"It's difficult just getting my husband to keep taking them."

There is often frustration at lack of improvement in the mental health of the person for whom they are caring with the use of medicines. There also seems to be a frustration over the lack of involvement in the decision making process:

"We seem to have tried several different types of medicine, and none have been successful"

"Yes but even when I have been unhappy with the effects of the medicine I have never questioned it as I never knew I could."

Educating carers about the therapeutic rationale for medicines, as well as their possible adverse effects is also important, as this information is available from many commercial sources on the internet:

"With medicines you hear inconsistent things off people, mixed messages about

side effects, but no one seems to do anything about it."

"I have worries, about if the medicine will work. And what will happen if it does not."

"I would like to be more aware, about how long the medicine will have to be taken for and the side effects, also what will happen when the medicine is stopped."

The input from several different teams has inherent frustrations:

"I worry that because there are so many doctors giving out medicines that they do not talk to each other and they make the situation worse."

Recommendations:

Support should be offered to carers to help them successfully manage medicines.

Carers should be helped to understand issues such as side effect profiles of particular medicines, and basic information on frequency, dosage and safe storage (especially if there are children in the home). The support should enhance their understanding of mental health conditions and treatment options.

Carers should have direct access to a clinical pharmacist for information and advice.

Best practice example:

One CRHT has weekly direct input from a mental health carer development worker. Each carer is offered support either by telephone or in person, and the opportunity to discuss any issues in confidence. Any issues raised with the development worker can be highlighted with the team if there is agreement from the carer.

A model framework for better medicines management in mental health

We propose that all CRHTs should adopt the following framework.



All CRHTs should have:

- 1) A designated clinician responsible for the leading on all aspects of management of medicines by the team.
- 2) A process for undertaking medicines reconciliation for every patient on admission to the CRHT. A designated team member should contact the patients GP and receive a copy of:
 - The list of the current medicines prescribed (all medicines including physical medicines)
 - A history of medicines prescribed for the service user (a 5 year record is useful but some GP practices can provide print outs of longer periods)
 - Recent laboratory test results.
- 3) If this is not possible the trained team member should receive an oral account of the current prescription. The information should be reviewed by an appropriate clinician and a pharmacist should be involved in order that:
 - The medicines taken by the patient can be confirmed
 - If access to the patient actual medicine containers is available whether they correlate with the prescription
 - Whether the patient has been taking the medicines
 - Whether the current prescription from the GP correlates with the prescription the mental health Trust are anticipating
 - A full account of the patient medicines can be transcribed onto a medicine chart.
- 4) Accurate records of all medicines that the patient is prescribed and taking.

- 5) Agreements about whether the patient will receive the medicines from staff members or self-administer will be clearly documented and reviewed on a regular basis. If the patient is to self-administer there needs to be agreement about the extent to which this is supervised and recorded.
- 6) On discharge a detailed account of the medicines prescribed by the patients CRHT is provided to the patients community mental health team and their GP.



- 7) Appropriate storage facilities for medicines that meet national standards for safe and secure handling of medicines.
- 8) 24-hour access to a psychiatrist for to prescribe as needed, and for clinical advice.
- 9) A pharmacy supply service (hospital and/or community) that meets the dispensing needs of service users, carers and staff in a timely and flexible manner.
- 10) Procedures are developed to enable rapid access to medicine supplies outside of regular working hours either via:
 - Stock medicines available from the team base
 - Out of hours pharmacy service
 - PGDs available for trained clinical staff.
- 11) All CRHTs should have regular and frequent input from a clinical pharmacy service.
- 12) Local policies and procedures that support all necessary nurse dispensing and administration procedures.
- 13) The CRHT staff have regular medicines training programmes, including in medicines concordance.
- 14) Medicines information and other supports for the administration of medicines are available to all staff and carers
- 15) The CRHT medicine management activities are audited on a regular basis and practice reviewed.

Concluding remarks

This project sought to evaluate the current medicines management schemes relevant to CRHTs in England, as well as suggest a model scheme for these teams.

Recent reports suggest that CRHTs vary considerably in their staffing, their funding and their impact on bed occupancy. With respect to medicines management in CRHTs evidence from this study demonstrates that CRHT teams have:

- 1) Varied input from pharmacy and medical colleagues
- 2) A lack of national guidance regarding medicines management.

There has been little formal evaluation conducted to assess the various medicines management systems adopted by CRHTs. Communication about successful, and less successful, medicines management schemes for CRHTs could be much improved to promote the sharing of best practice. There is a key role for further research and development to inform future developments in this area, and pharmacy teams would be well served to contact local research and development leads for support with this process.

Many of the proposed services, particularly medicines reconciliation and clarifying the prescription, lend themselves to the work of the CRHTs. Ideally medicines reconciliation would be completed as part of the crisis intervention prior to admission – a future role for the mental health pharmacy team.

The acute ward environment provides the opportunity for patients to learn about their medicines, and to establish the most

appropriate medicines regimen for their mental health condition. However, this work will only be beneficial in the long-term if service users are supported within the community to focus on medicines management. It would be of particular benefit to focus such work on specific teams working with service users who may be experiencing difficulty with medicines concordance, or those recently diagnosed with mental health difficulties. This needs to be an integral part of care co-ordination. To be successful in this work, it will be essential for pharmacists and nurses to develop closer working partnerships, sharing information and expertise, and developing systems of medicines management which will benefit service users under clear leadership.

This project has highlighted the importance of defined communication networks for effective co-working between pharmacy teams and the CRHTs. Further work needs to focus on improving communication across primary care and community services to fully meet the needs of service users and carers with respect to their medicines. Input from community staff and recently discharged service users has been suggested as one means of enhancing communication between inpatient and community services, but the format of this input requires further detail. The potential for peer support within the community could also be explored as a potentially valuable resource for former inpatients to increase their knowledge about their medicines as well as share their experiences.

CRHT medicine management services should be reviewed to assess whether they are tailored to meet the needs of the patients, not merely developed in response to the changing service.



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Appendix 1

The Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) 4th Edition

Accreditation for Inpatient Mental Health Services (AIMS) Standards for Inpatient Wards – Working-Age Adults

Standards have been classified as follows:

Type 1: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law

Type 2: standards that an accredited ward would be expected to meet

Type 3: standards that an excellent ward should meet or standards that are not the direct responsibility of the ward.

Standard Type	Standard
1	NMC standards for the administration of medicines are adhered to.
1	All qualified nurses have been assessed as competent in the administration of medications. This is repeated on a yearly basis using a competency-based tool.
2	During the administration or supply of medicines to patients, privacy, dignity and confidentiality are ensured.
2	The choice of medication is made jointly by the patient and the responsible clinician based on an informed discussion of: <ul style="list-style-type: none">■ the relative benefits of the medication;■ the side effects;■ alternatives;■ the patient's physical, emotional and social needs; involving the patient's advocate or carer where appropriate.
2	The patient's Allocated Nurse monitors the tolerability and side effects of medication on a daily basis.
2	The responsible clinician and the Primary Nurse monitor the therapeutic response to medication on a weekly basis.
2	Patients have access to a pharmacist and/or pharmacy technician to discuss medications.
3	Carers have access to a pharmacist and/or pharmacy technician to discuss medications.
2	In preparation for discharge, the ward helps all patients to understand the functions, limitations and side effects of their medications and to self-manage as far as possible.

www.rcpsych.ac.uk/pdf/Standards%20for%20Inpatient%20Wards%20-%20Working%20Age%20Adults%20-%20Fourth%20Edition.pdf

Appendix 2

Patient Group Directions (PGDs)

A full discussion of the scope and role of PGDs and their potential use and appropriateness in CRHTs is beyond the scope of this document.

Definition: PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

The majority of clinical care should be provided on an individual, patient-specific basis. The supply and administration of medicines under PGDs should be reserved for those limited situations where this offers an advantage for patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability. Wherever possible, medicines should be supplied in pre-packs made up by a pharmacist. There must be a secure system for recording and monitoring medicines use. A patient information leaflet should be made available to patients treated under a PGDs.

Further and specific guidance is available:

- 1) The National Electronic Library for Health has tools and resources to guide organisations and practitioners in England through the complex legal framework and associated processes of developing and approving PGDs.
www.nelm.nhs.uk/en/Communities/NeLM/PGDs/
- 2) The Medicines and Healthcare products Regulatory Agency (MHRA) has useful background information and a guide to the legalities.
www.mhra.gov.uk/Howweregulate/Medicines/Availabilityprescribingandsellingandsupplyingofmedicines/ExemptionsfromMedicinesActrestrictions/PatientGroupDirectionsintheNHS/index.htm



Glossary

CMHP	College of Mental Health Pharmacy
CRHT	Crisis Resolution and Home Treatment Team
DH	Department of Health
GP	General Practitioner
HC	Healthcare Commission, now called the Care Quality Commission (CQC)
HBT	Home-Based Treatment
IP	Independent Prescriber
MDT	Multi-Disciplinary Team
NHS	National Health Service
NICE	National Institute for Health and Clinical Effectiveness
NMHDU	National Mental Health Development Unit
NMP	Non-Medical Prescriber
NPSA	National Patient Safety Agency
PGD	Patient Group Direction
SP	Supplementary Prescriber
UK	United Kingdom



