Supervised methadone: an audit of multi-disciplinary communication

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Type of audit

Structure ✘
Process ✔
Outcome ✔

Who to involve?

Consider involving/informing the following individuals from the start:

- All community pharmacy staff – including locums and your pre-reg trainee.
- Other members of the multi-disciplinary team caring for patients receiving supervised methadone: Local GPs, Drug workers/counsellors attached to social services/local drugs initiatives, CPNs.
- Patients/clients receiving supervised methadone from your pharmacy.
- Local pharmacist group if established, or other pharmacists providing supervised administration of methadone schemes in your area.
- Local audit facilitator.
- Pharmacists with specialist knowledge in drug abuse – perhaps via your local Drug Problem Service or Pharmacy Misuse Advisory Group – PharMAG (the current Scottish contact for this group is Kay Roberts, Area Pharmacy Specialist – Drug Misuse, Greater Glasgow Health Board, tel: 0141-201-4891).

Background – Why is this audit worth doing?

- Drug misuse is an increasing problem in Scotland and is listed as a national priority area by the government [1]. National statistics indicate that NHS prescriptions for methadone almost doubled between 1992 and 1996 and 63% of Scottish community pharmacies reported involvement in methadone dispensing by October 1997 [2].
- Both the government [3] and the RPSGB [2] support a multi-disciplinary approach to patient care but identify patient confidentiality as a challenge to collaborative working. Any initiative involving transfer of patient-related information between healthcare workers **must** be debated and agreed at a local level and **must** be made with the patient's knowledge and agreement. This audit template aims only to serve as a starting point for local discussions involving patients.
- In this area, the literature proposes the following minimum standards of multi-disciplinary communication:
  - Prescribers should contact the appropriate pharmacist prior to issuing a prescription to a new patient [2,3].
  - Pharmacy contractors should record the no. of patients referred to other members of the multi-disciplinary team, including: local GPs; drugs initiatives run by social services; local drug problem services[4].

Benefits of doing this audit

- Benefits to patients ✔
- Benefits to pharmacists ✔
- Benefits to the health care team ✔

Aims and objectives of the audit

Aim

To ensure effective communication and team-working between pharmacists and other health care workers caring for patients receiving supervised methadone.

Objectives

- To agree 'locally appropriate' standards of multi-disciplinary communication, in consultation with patients receiving supervised methadone.
- To measure current practice against these standards.
- To identify areas where local communication could be improved.

The audit cycle

1 Defining criteria and setting standards

Criteria (i.e. the aspects of care which you are going to be measuring)
Suggested criteria which may be appropriate for this audit are:

Criterion	'Must do/could do'
New patients	
Prescribers should contact the pharmacist prior to issuing a prescription for a new patient.	Must do
Where the prescriber has not contacted the pharmacist in advance, the pharmacist should contact the prescriber to confirm arrangements.	Must do
New patients should have been informed by the prescriber that their methadone dose must be swallowed in the pharmacy.	Must do
All patients	
Pharmacists should directly contact the appropriate member of the drug problem team* for patients meeting locally agreed referral criteria.	Could do
Pharmacists should be informed of the outcome of their referrals.	Must do

** to be agreed locally for individual patients (could be GP/Drug worker/CPN).*

Standards (i.e. the proportion of times the criteria should be fulfilled)

It will be essential to agree these locally. An example of standards which may be appropriate are:

New patients

- Prescribers should contact the pharmacist on 50% of occasions, prior to issuing a prescription for a new patient [E 5,6].
- On 100% of occasions where the prescriber has not contacted the pharmacist in advance, the pharmacist should contact the prescriber to confirm arrangements [A].
- 95% of new patients should have been informed by the prescriber that their methadone dose must be swallowed in the pharmacy [E 6].

All patients

- Pharmacists should directly contact the appropriate member of the drug problem team on 70% of occasions where a patient meets locally agreed referral criteria [E 6].
- Pharmacists should be informed of the outcome of their referrals on 70% of occasions [A].

Footnote: The standards listed in this table are either 'anecdotal' (A) i.e. based the opinion of 2 or more Scottish Audit Facilitators, or 'evidence-based' (E) i.e. drawn from the literature or data from previously completed audits (see reference section at end of template).

2 Assess local practice

Getting things started

- Decide whether the audit will be run on an individual pharmacy or locality basis.
- Decide which criteria you wish to focus on (see 'defining criteria and setting standards' – some criteria are only 'could do').
- Decide whether to undertake one or both parts of the audit (new patients and/or all patients).
- Meet with local prescribers/other health care workers to agree locally appropriate standards of multi-disciplinary communication/patient referral (see attached 'sample local referral criteria', as a starting point for local debate).
- Ensure all patients receiving supervised methadone from your pharmacy are fully informed of the project's aims and objectives and the proposed local referral criteria (see attached 'sample patient information leaflet').
- Patient consent must be secured prior to the transfer of any confidential information between health care workers.

What data to collect?

- See relevant attached data-collection forms: form 1 (new patients); form 2 (all patients).
- It may be useful to keep a brief tally count of the total number of patients asked to participate in the audit and the proportion of those who agreed/refused to participate.

How much data to collect?

This should be agreed locally. The size of your audit will be defined either by the number of patients which are available for recruitment, or by the time period over which it is run.

Factors to consider include:

- Total no. of pharmacies participating in the audit.
- Total no. of prescribing sources participating in the audit.
- Total no. of patients per pharmacy included in the audit.
- Time available for data collection.

Further advice on selecting a suitable number of patients/time period over which to run the audit can be obtained from your local audit facilitator.

How to collect it?

- Collect continuously for a defined number of patients/time period, remembering to inform all staff, especially locums, if data is to be comprehensive.
- Only collecting data for a proportion of patients, or on certain days/during quiet periods, will bias your results.

3 Compare practice with standards

4 Change

Some suggestions:

- It would be valuable to hold a multi-disciplinary meeting to discuss your audit findings. Is there one aspect of patient behaviour which consistently leads to referral? If yes, can you do anything about this? Is there any one prescriber who may not be aware of the need to contact the pharmacist prior to writing a prescription for a new patient?

5 Re-audit

6-12 months after completion of the first audit.

Resources

- Sample referral criteria (attached).
- Sample patient information leaflet (attached) and photocopying costs.
- Data collection forms 1 and 2 (attached).
- Locum expenses to attend initial/follow-up discussions with local prescribers/ other health care workers.
- Estimated time to complete the first audit (during normal working hours): 2 months to set things up, X weeks to run the audit (dependent on your decisions reached under ‘how much data to collect’), project write-up within 1 month.
- Estimated time to complete the re-audit (during normal working hours): X weeks to run the audit (dependent on your decisions reached under ‘how much data to collect’), project write-up within 1 month.

References

1 The Scottish Office Department of Health. Towards a Healthier Scotland: A White Paper on Health. Edinburgh: Stationery Office, February 1999.

2 Royal Pharmaceutical Society of Great Britain. Report of the working party on pharmaceutical services for drug misusers. Pharmaceutical Journal 1998; 260: 418-423.

3 Department of Health. Drug misuse and dependence: guidelines on clinical management. London: Stationery Office, March 1999.

4 Methadone Dispensing – Good Practice Guidelines. Scottish Chief Administrative Pharmaceutical Officer's Group.

5 An Audit of Methadone Prescribing in Grampian. Grampian General Practice Audit Committee, Department of General Practice, Aberdeen, September 1998.

6 Supervised Methadone Self-Administration Programme. Greater Glasgow Health Board – Pharmacy Audit Programme. Report, September 1995.

Useful additional reading: Pharmaceutical aspects of methadone prescribing. Distance learning pack, Scottish Centre for Post Qualification Pharmaceutical Education, University of Strathclyde, Glasgow.

Pharmacists are also strongly recommended to refer to the sections in the current edition of Medicines, Ethics and Practice which relate to: patient confidentiality; instalment dispensing; needle and syringe exchange schemes; prescription requirement for controlled drugs.

Date of production April 2000

Suggested review date April 2001

For local debate and agreement between pharmacists/prescribers/other relevant members of the drug problem team/patients receiving supervised methadone.

Pharmacists should directly contact the **appropriate member of the drug problem team** for any patients meeting the following criteria:

- Patient refuses to consume the whole dose/part of the dose under supervision.
- Pharmacists feels the patients' general health has deteriorated significantly.
- Patient misses two or more doses – local agreement to set level and stipulate that missing doses should be forfeited.
- Patient behaviour is unacceptable e.g. shoplifting, intoxicated, verbal/physical abuse.
- Prescription details unclear/illegal (see Medicines, Ethics and Practice: prescription requirements for controlled drugs).
- Patient wishes to change pharmacy supplier.
- Others – for local debate.

N.B Patient consent must be secured prior to the transfer of any confidential information between health care workers.

According to local agreement, it may be more appropriate for the information contained within this letter to be adapted into a verbal counselling checklist.

N.B Patient consent must be secured prior to the transfer of any confidential information between health care workers.

Dear ____________________

We are involved in a project with local doctors and drug workers. The purpose of this project is to ensure good communication between all members of the team looking after patients receiving supervised methadone treatment in XXXX Area.

Following local discussion, pharmacists have been asked to contact other members of the team if:

- Any patient fails to collect more than X doses of their methadone
- Any patient is verbally abusive to pharmacy members of staff
- Any patient appears much more ill than normal
- Other – see locally agreed referral criteria

For our records, we need to ensure that you are happy for us to pass on this type of information to other health workers, and ask therefore that you sign and return the tear-off slip attached to this letter.

Please ask if you have any questions about this project.

Yours sincerely

Pharmacist

Methadone Project

I am/am not* happy for my pharmacist to pass on the above specified information about my methadone care to either my doctor or my key worker, if necessary (*delete as appropriate).

I understand that the purpose of this project is to improve communication between my pharmacy and the rest of the team looking after my methadone care.

Signed ____________________

Date ____________________

Data collection form 1 – new patients

This form should be completed for all **new** patients.

Date Rx received	Patient's name and address	Prescriber's name and address	Contacted by prescriber before receiving Rx? YES NO	If No, prescriber contacted to confirm arrangements? YES NO	Patient aware that dose must be swallowed on premises? YES NO
			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐
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			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐
			☐ ☐	☐ ☐	☐ ☐

Data collection form 2 – all patients meeting referral criteria

This form should be completed for **all patients** (new and regular patients) presenting at your pharmacy with a methadone prescription, **who meet locally agreed referral criteria**.

Date Rx received	Patient's name and address	Prescriber's name and address	What referral criteria does the patient meet?*	Was the designated member of the drug problem team contacted? YES	NO	DATE	If Yes, were you informed of the outcome of the referral? YES	NO	DATE
				☐	☐		☐	☐	
				☐	☐		☐	☐	
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				☐	☐		☐	☐	
				☐	☐		☐	☐	

* A Patient refuses to consume the whole dose/part of the dose under supervision
B Patient's general health has deteriorated significantly
C Patient misses two or more doses – local agreement to set level
D Patient's behaviour is unacceptable, e.g. shoplifting, intoxication, verbal/physical abuse
E Patient wishes to change pharmacy supplier
F Other (please specify)