AUDITING METHADONE PRESCRIBING PRACTICES IN THE NATIONAL DRUG TREATMENT CENTRE

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Background

Opiate Substitution Treatment is the recommended treatment for opiate dependence. In the NDTC we need to provide an approach to care which guarantees that every patient receives a combination of diagnostic and therapeutic procedures that will ensure the best result in terms of health. This includes appropriate dosing of methadone.

Guidelines

For this audit I took guidelines from the following sources:

1. OST Clinical Guidelines, HSE. (2017)
2. Drug Misuse and Dependence: UK Guidelines on Clinical Management. (2017)
3. NHS National Treatment Agency for Substance Misuse, Auditing Dug Misuse Treatment (2008)
4. NICE Guidelines on methadone and buprenorphine for the management of opioid dependence. (2007)
5. BNF (2019)
6. British Association of Psychopharmacology

Guidelines suggest the following in terms of OST:

1. The nature and duty of prescribing is for clinicians to individually tailor dose for each patient, basing their decisions on research evidence or clinical evidence of effectiveness, and seeking the optimal balance between clinical improvement and minimising the dangers intrinsic in any medication.
2. It is inappropriate for such medications and their dose level to be used as a reward, or for them to be withheld or dose reduced solely as a punishment or sanction.
3. Clinicians should aim to optimise treatment interventions for patients who are not benefitting from them, by intensifying support rather than reducing it.

Reasons to Change Dose as per Guidelines:

- Altered metabolic handling.
- Re-emergence of drug misuse problem.
- Disengagement from a failing treatment.
- Adjusting a properly planned programme of detoxification.
- Interruption of medication.

Audit Questions

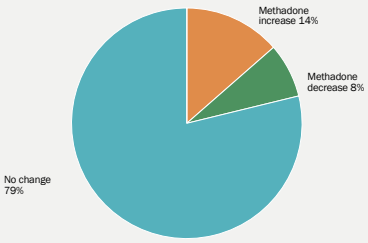
1. Are we documenting a reason for changes in methadone dosing?
2. Is that reason in keeping with current guidelines?

Methods

I audited all patients on our team who were prescribed methadone. I audited changes made to methadone prescribing between 28th July and 28th August 2019 inclusive. For each change I recorded if there was an increase or decrease in dose, if there was a reason documented, what that was, and if the patient was opiate positive at the time of the change. I did not look at changes made due to missed days as there is a clear protocol in place for this. Following this data collection, I presented the results to my team orally and circulated a document. The document included the results and a summary of guidelines. I re-audited between November 1st-December 1st 2019.

Results

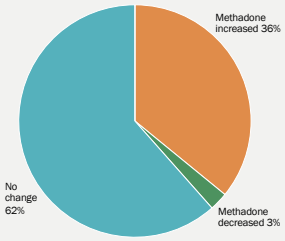
Out of 118 patients:



Out of 25 dose changes, 22 had a reason documented. (88%) Reasons given were:

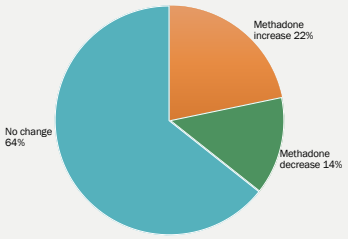
- Patient experiencing withdrawals- 5 (all increased)
- Methadone stolen- 1 (decreased)
- Dose changed in prison- 2 (all increased)
- Titration to a therapeutic dose- 7 (all increased)
- Blowing over on alcometer- 1 (decrease)
- Prolonged QTc- 2 (all decreased)
- Patient request- 2 (1 increase, 1 decrease)
- Methadone detox- 2 (all decreased)
- For weekly dispensing- 1 (decrease)

39 Opiate positive results:



Re-audit Results

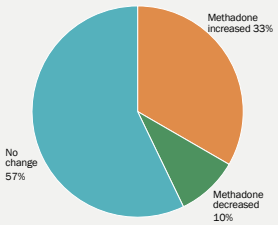
Out of 115 patients:



Out of 41 dose changes, 37 had a reason documented. (90.2%) Reasons given were:

- Patient experiencing withdrawals- 12 (all increased)
- Methadone stolen- 0
- Dose changed in prison- 0
- Titration to a therapeutic dose- 11 (all increased)
- Blowing over on alcometer- 0
- Prolonged QTc- 1 (all decreased)
- Patient request- 11 (3 increase, 8 decrease)
- Methadone detox- 8 (all decreased)
- For weekly dispensing- 0
- Reported heroin use- 7 (all increased)

63 Opiate positive results:



Discussion

- There was a small improvement in compliance rate for documentation of reasons for change in dose. (88-90.2%)
- In the re-audit, reasons documented were more in keeping with guidelines.
- Compliance is good (>90%).
- Of note, for the Opiate positive results:
  - In some cases decrease in methadone dose was requested by the patient despite on going positive UDS. This accounted for most of those with methadone decreased in the re-audit.
  - The majority of patients with UDS positive for Opiates had no change made to their methadone dose. This is most likely due to poor engagement with the service and subsequent difficulty titrating doses, however, this could be investigated further.

Conclusion

Compliance rate for documentation improved by 2% following intervention. There should be 100% compliance for documented reasons for change in dose of methadone. This will be a priority in the future and will be a subject of a re-audit. All prescribers must be fully aware of established clinical guidelines in prescribing OST.

Clinical Audit consent gained from Supervising Consultant and Clinical Director of the NDTC.