East London NHS
NHS Foundation Trust

Title	Safe & effective use of medicines
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Presented to	Medicines Committee
Date	12/07/2023

Purpose of the Report:

This report provides a summary of medicines safety and trust medicine audit data and in that is collected in the Trust and is presented to the Medicines Committee for information. The committee is asked to consider the level of assurance provided by the report and decide whether further action is needed.

Strategic priorities this paper supports (Please check box including brief statement)

Improving service user satisfaction	☒	Improve service user-related outcomes by ensuring that they receive safe pharmaceutical care.
Improving staff satisfaction	☒	
Maintaining financial viability	☐	

Committees/Meetings where this item has been considered:

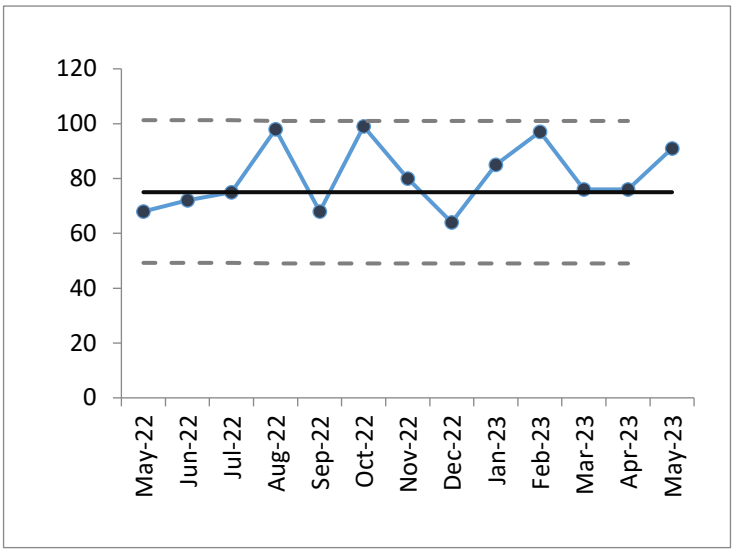
Date	Committee/Meeting
N/A	This report has not been considered in any other committees or meetings

Equality Analysis	This report has no direct impact on equalities

Contents

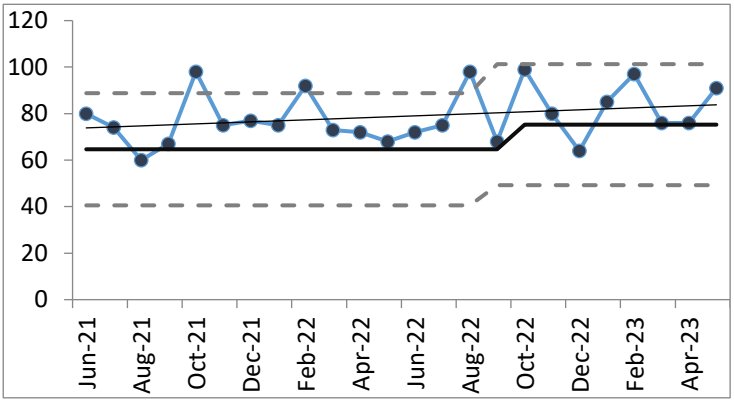
Trustwide Incident reporting

Figure 1 Total number of medication incidents reported per month (May 22- May 23)



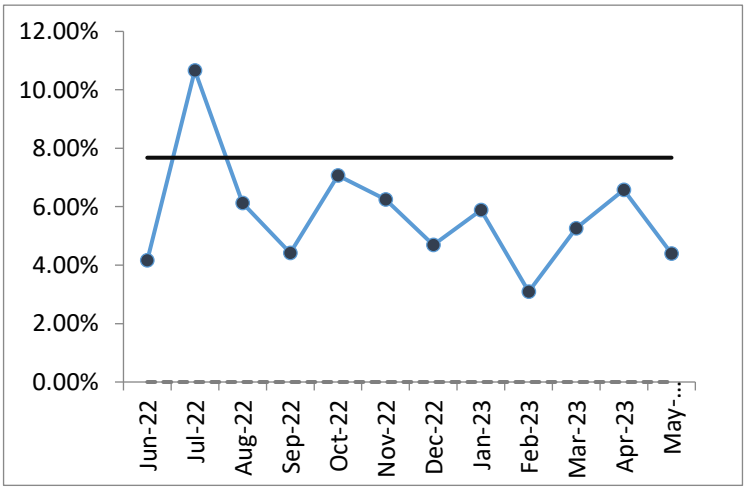
Medication incident reporting fluctuates within control limits. Reporting in December 22 was less then the centre of dataset. Incident reporting decreased between Mar - April 23 and has picked up again in May 23 . A Large chunk of the incident reporting (Mar – May 23) originated from Community Health Services (Over Half of them reported from bedfordshire), Tower Hamlets and Forensic Services. Incidents related to administration (100) and prescribing (36) of medicines, medicines not being available (43), dispensing errors (37) and inaccuracies within notification letters (24)

Figure 2- Total number of medication incidents reported per month (June 21 - May 23)



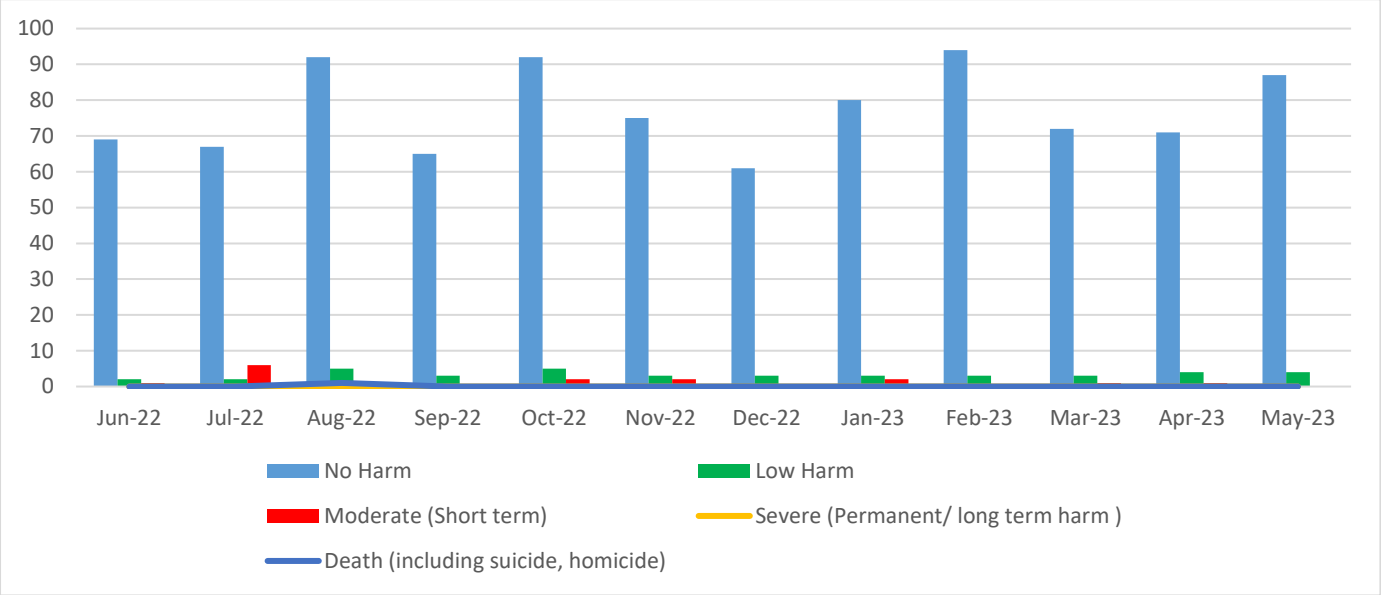
Over the last 2 years there has been a gradual increase in medication incident reporting trustwide (shown by data trendline); reflective of the increased awareness amongst staff to report and learn from incidents but also increase in trust services/expansion/geographical footprint.

Figure 3 - % Medication incidents that resulted in patient harm (June 22 – May 23)



Medication Incidents resulting in patient harm over the last 3 months is sitting between (4-7%). In terms of events this equates to between 4-6 medications incidents per month. Most of these being classified as Low harm.

Figure 4 – Medication incidents broken down by type of harm (June 22- May 23)

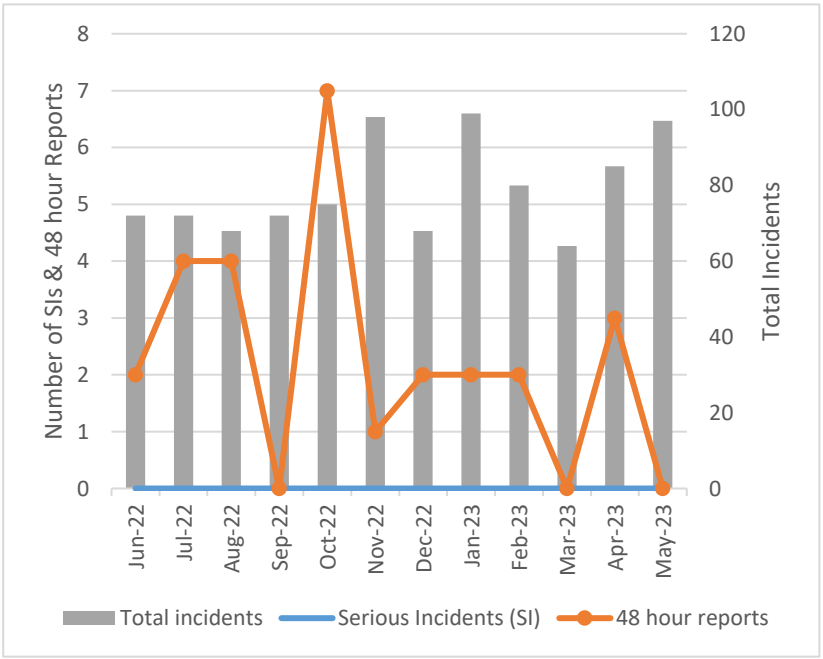


What is happening locally?

Medication Incidents warranting 48 hour report (June 22 – May 23)

Figure 5 - % of SI and 48 hour Medication Incident reports in last 12 months relative to the total number of incidents reported

% decrease in the number of 48 hour reports since October 2022. **Last SI: Sept 21**. When the incident is potentially a serious incident the medical director/patient safety team will request 48 hour report which is used to aid grading of incidents for further investigation. In April 23, we had three 48 hour reports requested. As we move to PSIRF, 48 hour reports may not be the best method to learn from incidents.

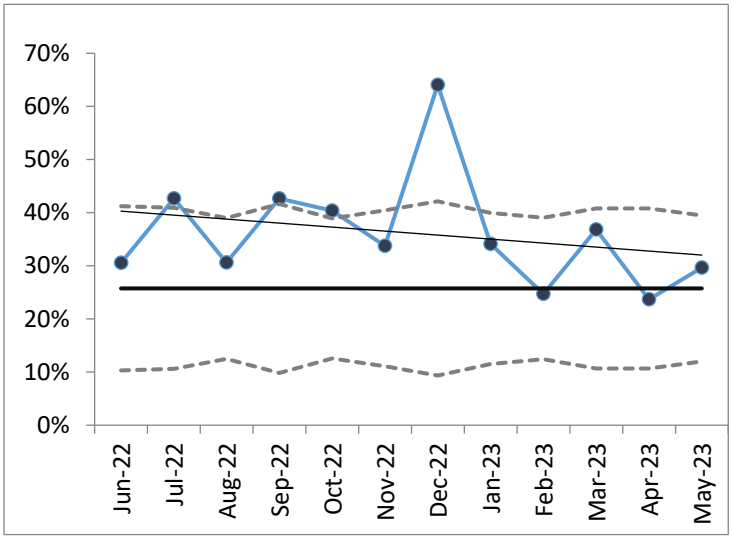


- Forensic services **(Ludgate ward)** Lorazepam 1mg tablets unaccounted for in EDR cupbaord. Staff not signing on sheet when medicines are taken. Weekly audit to be shared with DSN's
- City & Hackney **(Joshua ward)** Incorrect medicines prescribed during a night admission (Enoxaparin and Quetipaine) – historic medicines list sent by external hospital which was incorrectly transcribed by admititng doctor.

Lead pharmacists/MSO to continue to flag/escalate appropriate incidents to the incident team for appropriate follow up and investigation so that learning can be extracted from the incident in a timely manner

High risk medicine

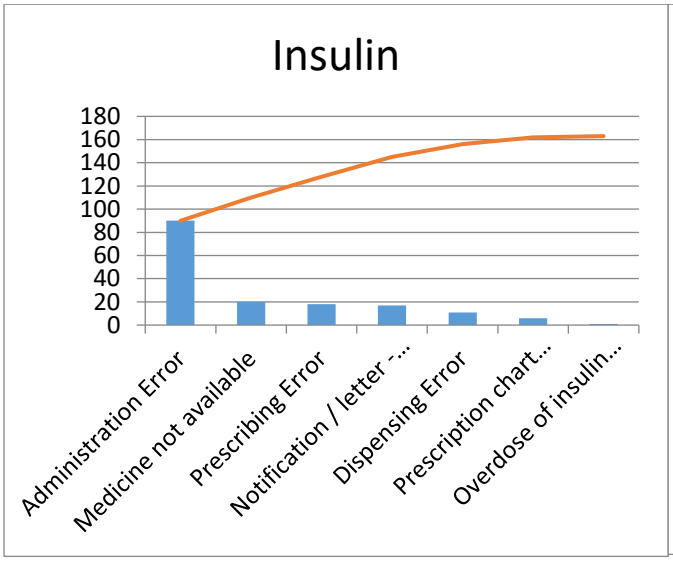
Figure 6 - % of high risk medicines reported monthly (June 22 – May 23)

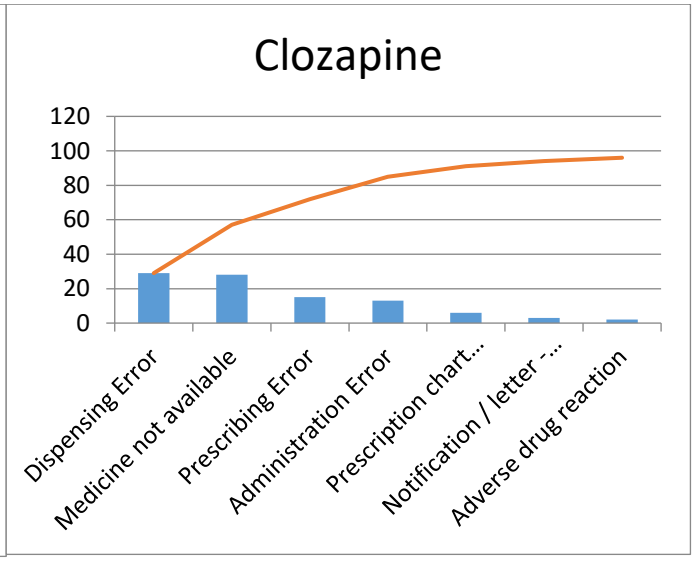


Decreasing trendline over the last year in terms of incidents related to high risk medicines. Incident on Insulin and Clozapine occupies most of the data. As we move to Inphase our new incident reporting system, the medication incident template will capture information on a bigger list of locally identified high risk medicines. This way new emerging risks will be better picked up.

Key Medicine Priorities Insulin and Clozapine

Figure 7/8 – Pareto graph showing areas of focus for Insulin and Clozapine (April – March 23)





Action taken towards priorities

1. System Wide (NEL/BLMK) Community Health Service Insulin working group
   - Large proportion of admin insulin errors occur in CHS.
   - Understanding Incident data across the system and extracting themes
   - Working with performance teams to extract information from clinical systems to better understand number of district nurse visits, number of insulins administered and type of staff completing the visit.
   - QI work including; increasing workforce to administer insulin, transcribing training and audits, redesign of MAR charts and empowering patient and families to administer insulin.

2. Shared learning Seminar in August on learning from Clozapine SI's

3. Prescribing errors – Issues identified with suspension protocol and work being undertaken to reduce the risk.
4. Electronic Clozapine prescriptions – Tower Hamlets leading on a project to digitalise clozapine prescriptions with electronic signatures. Patient demographics are automatically pulled from the clinical system which reduces risk of error from transcribing.

Key incidents

ID209034 LT Poplars ward (Luton MH services) – Medicines Reconciliation missed patient being on a medicine called Hydroxycarbamide for thrombocytopenia. SU went without this medication for 2 weeks

SEIPS approach to learning

- What sources were used to carry out this DHX and Medicines reconciliation?
- How familiar are team members with pathways/processes?
- What training and support is given to staff members?

ID208824 Fothergill ward (CHS Newham) – SU transferred from Newham General to fothergill ward. Discharge summary from acute hospital was misformatted. Dose and frequency of apixaban was confused with prednisolone. No gridlines on the discharge summary to separate medications and doses. Apixaban dose was transcribed as 4mg once a day

SEIPS approach to learning

- How does information flow
- How is the information presented on IT systems

ID 208987 Bow ward (Forensic services) – Procyclidine formulation amended on EPMA by pharmacist. This was not checked by another pharmacist for accuracy. Despite the correct formulation being chosen, the wrong dose had been prescribed as 1mg BD. This should have been 5mg BD. Not clear from conversation/ePMA system as to what dose was being given.

SEIPS approach to learning

- How is the information presented on EPMA
- Any distractions during this prescribing episode
- How familiar are team members with this medication and standard dosing.
- Are their any time pressure that led to this prescribing error.

Sharing the learning

- Ward safety huddles
- Trust ‘Medicines Matters’ bulletin. Latest bulletin available on the ELFT Medicines Safety page.
- Staff away days
- Staff 1:1
- NEL and BLMK ICS Medicines Safety meetings.

Local Medicines Safety Updates/Achievements

- Inphase Medication incident reporting form has been created and sent to the project team to implement.
- Trained AAR conductor for the trust
- NEL - Reducing harm associated with clozapine, lithium and depots at the interface.
- Review and revision of CUOM audit questions.

National Medicines Safety Updates

MHRA Drug Safety Update May 23

1. Direct Acting Oral Anticoagulants: paediatric formulations; reminder of dose adjustments in patients with renal impairments.
    - In paediatric use, counsel parents and caregivers about the reconstitution and dosing of dabigatran and rivaroxaban granules to reduce risk of medication errors.
2. Febuxostat (Gout): updated advice for the treatment of patients with a history of major cardiovascular disease based on the CARES study which showed a higher risk of cardiovascular related death.
    - NICE clinical guideline 219 recommends that allopurinol should be offered as first line treatment for people with gout who have major cardiovascular disease.

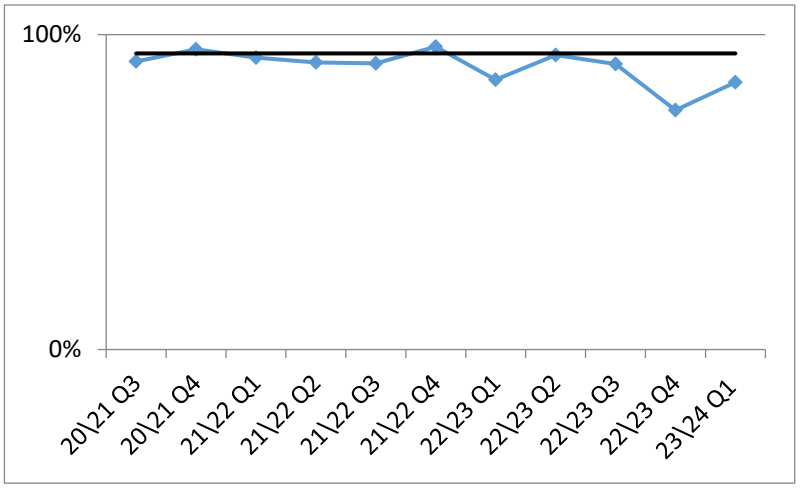
Directorate and Trust wide Controlled Drug Audits (Q1 23/24)

13) In the last 3 months have all CD levels in the CD cupboard correspond to those recorded in the CD register? If no, please inform the nurse in charge and pharmacist for further investigation and complete a Datix.

22\23 Q2	93.48%
22\23 Q3	90.70%
22\23 Q4	76.00%
23\24 Q1	84.84%

Areas of non-compliance

- Fountains Court – Beds and Luton
- Ruby Triage – Newham
- Leadenhall – Tower Hamlets
- Ivory – Newham
- Butterfield – Forensics

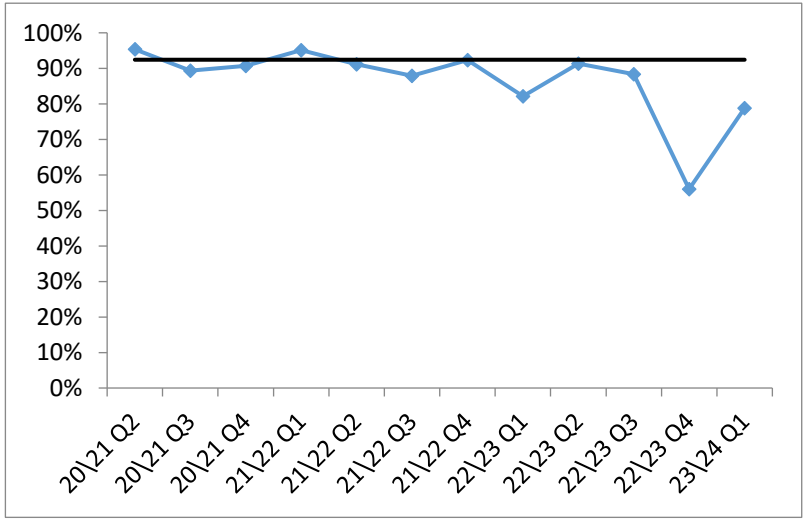


14) In the last 3 months have all pages had correct calculation of balances and all pages where CDs have been finished the balance is ZERO? If no, please inform the nurse in charge and pharmacist for further investigation and complete a DATIX.

22\23 Q2	91.30%
22\23 Q3	88.37%
22\23 Q4	56.00%
23\24 Q1	78.78%

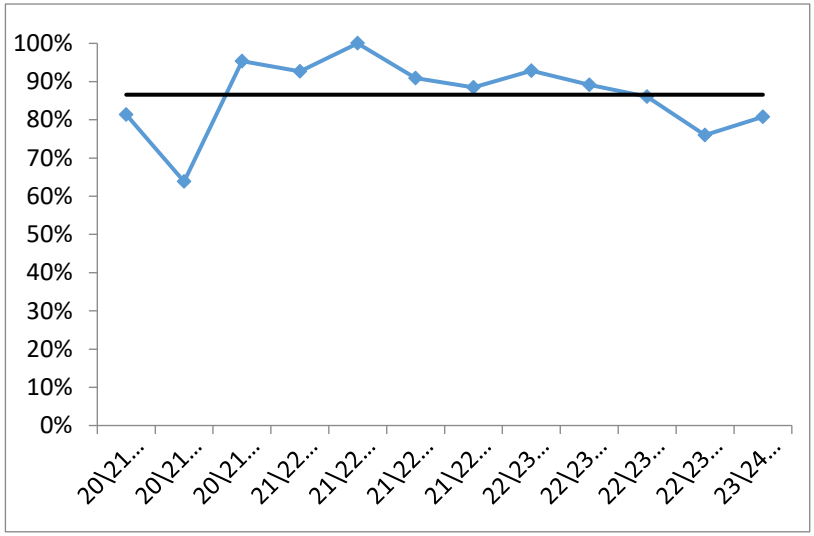
Areas of non-compliance

- Butterfield – Forensics
- Ruby triage – Newham
- Fothergill – Newham
- Leadenhall – Tower Hamlets
- Brick Lane – Tower Hamlets
- Fountains Court – Beds and Luton
- Poplars ward – Beds and Luton



15) In the last 3 months, have the CD balances been checked at least once every seven days? NOTE: In practice, wards MUST ensure that a CD stock balance of the register is checked against the physical contents of the CD cupboard daily (at least once every 24)

22\23 Q2	89%
22\23 Q3	86%
22\23 Q4	76%
23\24 Q1	81%

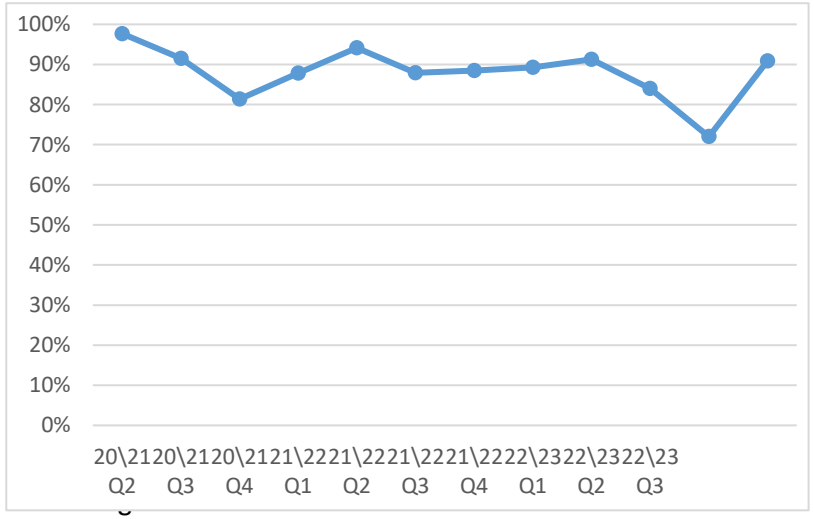


Areas of non-compliance

- Emerald – Newham
- Ruby triage – Newham
- Leadenhall – Tower Hamlets
- Gardner – C&H
- Onyx ward – Beds and Luton
- Jade ward – Beds and Luton

16) In the last 3 months, have two signatures been entered into the register for each administration of a CD? All details of administration must be completed accurately

22\23 Q2	91%
22\23 Q3	84%
22\23 Q4	72%
23\24 Q1	90.90%



Areas of non-compliance

- MBU - C&H
- Onyx ward – Beds and Luton
- Jade ward - Beds and Luton

17) In the last 3 months, when CDs have been received into the register have they been signed for by two members of staff one of which must be a registered nurse? Ensuring balance received is entered into register

22\23 Q2	83%
22\23 Q3	79%
22\23 Q4	60%
23\24 Q1	82%

Areas of non-compliance

- Roman ward – Tower Hamlets
- Westferry ward – Forensics
- Butterfield ward – Forensics
- Fothergill – Newham
- Ruby Triage – Newham
- Joshua ward – C&H

18) When a CD has been transferred from another ward/team, or to another page in the same CD register, the Details of wards/teams involved and page numbers must be entered in the register

22\23 Q2	100%
22\23 Q3	87%
22\23 Q4	57%
23\24 Q1	94%

Areas of non-compliance

- Jade ward – Beds and Luton

19) When a CD has been transferred from another ward/team, or to another page in the same CD register, the number of the new page that the CD has been transferred to, should be written on the container.

22\23 Q2	88%
22\23 Q3	87%
22\23 Q4	43%
23\24 Q1	94%

Areas of non-compliance

- Jade ward – Beds and Luton

20) When a CD has been transferred from another ward/team, or to another page in the same CD register, the order slip of the new page is crossed through and marked void and left attached in the register for checking as part of the three monthly pharmacy check

22\23 Q2	88%
22\23 Q3	80%
22\23 Q1	43%
23\24 Q1	67%

Areas of non-compliance

- Coral – Luton and Beds
- Townsend – Luton and Beds
- Onyx– Luton and Beds
- Townsend – Luton and Beds
- Ruby Triage – newham

21) Are all pages and order request slips in the CD register accounted for (e.g. no pages have been ripped out)? – 100% compliance

22) Is all CD stationary including CD register and CD returns books (if applicable) kept inside a locked cupboard? – 100% compliance

23) Are the keys that allow access to the controlled drugs cupboard only accessible by authorised persons, e.g. registered nurse or pharmacist? - 100% compliance

24) Are the CD keys kept separate to general medication keys

22\23 Q2	87%
22\23 Q3	100
22\23 Q4	73.90%
23\24 Q1	72.72%

Areas of non-compliance.

- Coral ward – Beds and Luton
- Joshua ward – C&H
- MBU – C&H
- Ivory – Newham
- Ruby triage- Newham
- Crystal – Newham
- Emerald- Newham

Key Findings

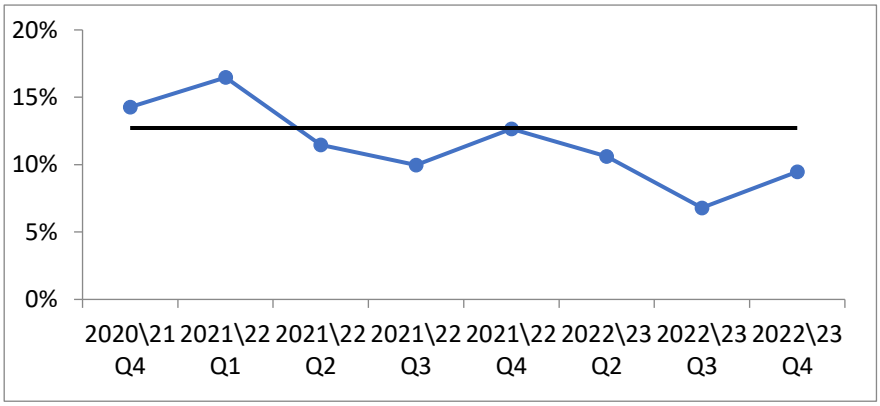
The data extracted from Section 13 – 20 of Q1 23-24 CD audit shows we have increased in compliance for 12 of the 12 standards assessed. Q3 scores were low which is the reason by this increase in Q4 compliance scores.

9 out of the 12 standards are sitting at a compliance score of between 80-100%. The remaining 3 standards are between 60-79%

Areas of non compliance have been highlighted for each question. It is important that this information is discussed amongst teams at ward/directorate meeting so that compliance to the safe and secure storage of controlled drugs is maintained.

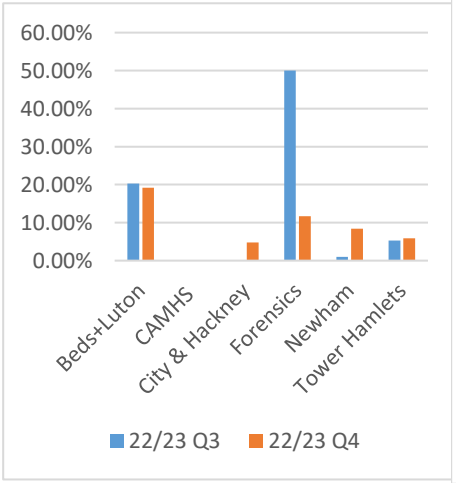
Directorate and Trust wide High Dose Antipscyhotic Prescibing (Feb Q4 22/23) from CUOM Audit.

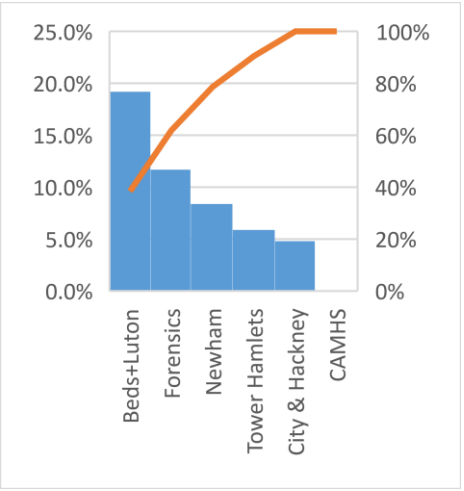
1. **% of inpatients prescribed HDAT (both reg + prn prescribing considered)**
   Overall reduction in the percentage of patients prescribed HDAT across the trust over the last 2 years**. A slight increase noted in Q4 from 6.8% to 9.5%**



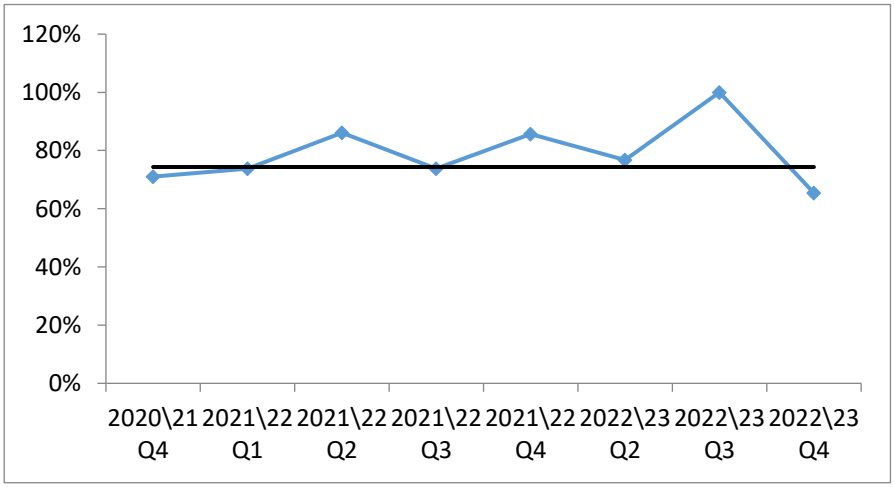
2. **% of inpatients prescribed HDAT (reg + prn prescribing combined): Directorates**

Only 2 samples were submitted in Q3 for forensics of which one patient was prescribed HDAT. In Q4 forensics (19/163) of the patients were prescribed HDAT. Despite reduction not actually a reduction due to low sample numbers in the previous quarter. CAMHS continues to have no HDAT prescribing which over the last 2 quarters. **L&B, Forensics and Newham are the top three areas where HDAT prescribing has been identified as higher**.



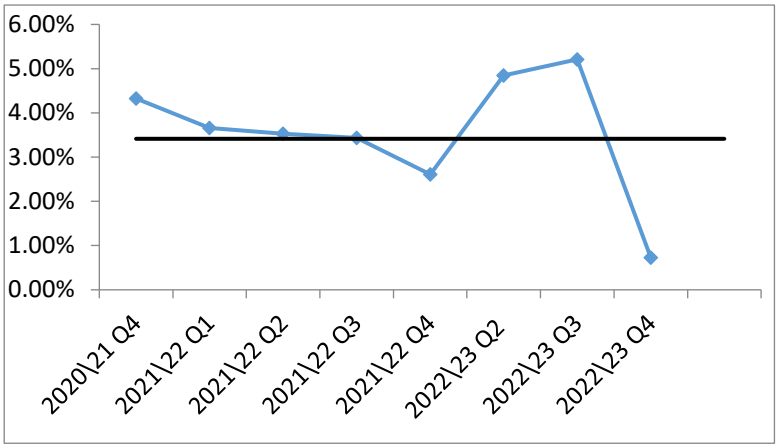


3. **% of inpatients prescribed HDAT (both reg + prn prescribing considered) where HDAT monitoring form has completed.**
   Compliance decreased from 100% in Q3 to 65.4% (34/52) in Q4. Electronic HDAT monitoring form is accessible under physical health forms in RIO. This must be completed when patient is prescribed above 100% of BNF maximum.

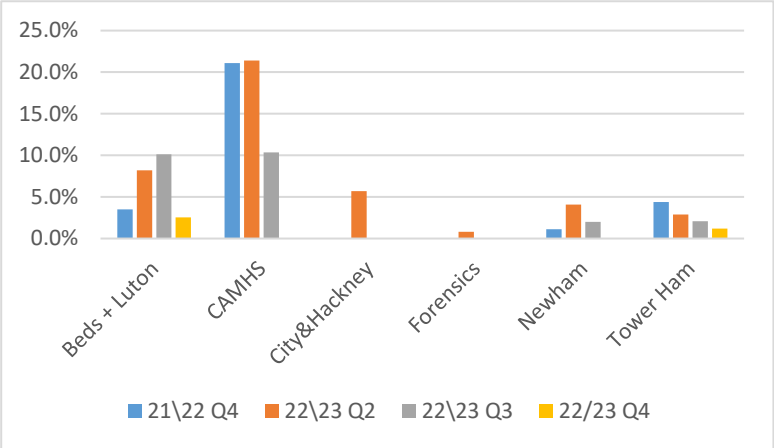


Directorate and Trust wide Rapid Tranquilisation (RT) use (Feb Q4 22/23) from CUOM Audit

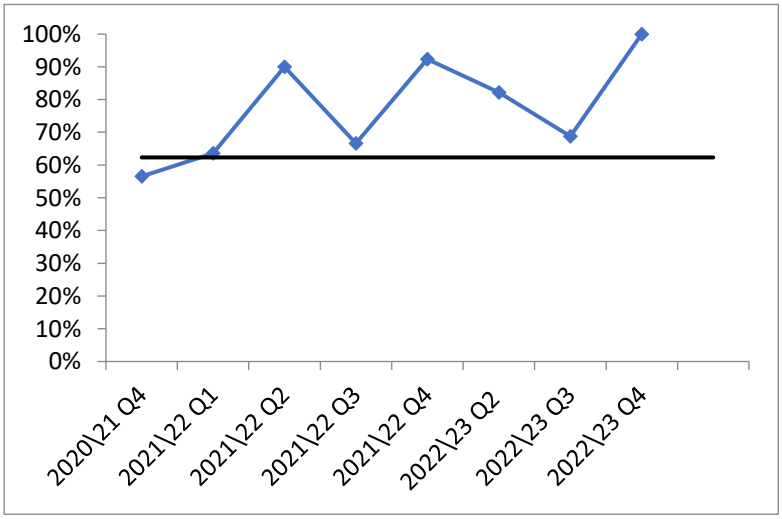
1. **% of inpatients given intramuscular medication for RT in the preceding week –** Decline in the % of patients receiving rapid tranquilisation from Q3 (5.21%) to (0.73%) in Q4



2. **% of inpatients administered IM RT medication in the preceding week –** RT prescribing in CAMHS services historically high. Q4 data shows reduction from 10.3% in previous quarter to nil. Also reduction noted in Beds and Luton MH services from 10.1% to 2.6% in Q4



3. **% of inpatients given IM RT medication who had post IM RT monitoring completed as per policy –** A reduction in post RT monitoring noted during Q2 and Q3. Recommendations made in the safe and secure report in January to improve compliance with these standards. See below. Despite low number of patients administered RT during Q4, monitoring was completed for all of the patients.

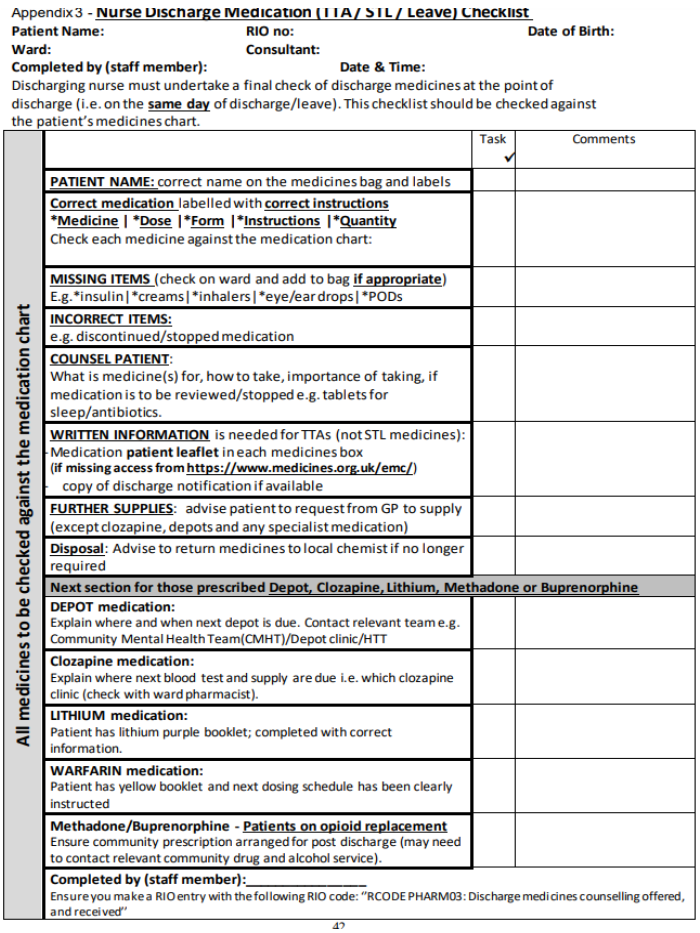


After the administration of rapid tranquilisation (RT), a set of contact and non-contact physical observations must be taken and recorded every 15 minutes. Monitoring must be recorded on the NEWS2 chart (or the MEOWS chart in pregnancy). This can be done by accessing the NEWS2 chart directly on RiO (and selecting 'post-RT monitoring' in the drop-down list) or printing off and using a hard copy of the form. The MEOWS chart is not directly available on RiO. When a hard copy is used, the completed chart should be scanned and uploaded onto the service user's electronic record on RiO and the physical copy should be filed in the service user's notes

Discharge Checklist use (Feb Q4 22/23) from CUOM Audit.

Discharging nurse must undertake a final check of discharge medicines at the point of discharge. All medicines must be checked against the drug chart to ensure a safe discharge. 7 out of 30 discharges were completed with the support of a discharge checklist. The checklist has been formualted to support staff when discharging patients from the ward, ensuring that all the neccesary information has been relayed and the correct medication has been supplied.

Q4 22/23 Discharge checklist			
Has the patient been discharged?	Yes	Number in sample	%
	30	548	5.47
Has the discharge checklist been completed?			
	7	30	23.30%
Has the discharge checklist been uploaded onto RIO?			
	2	7	28.57%



Appendix 3 - **Nurse Discharge Medication (TTA / STL / Leave) Checklist**

Patient Name: **RIO no:** **Date of Birth:**
Ward: **Consultant:**
Completed by (staff member): **Date & Time:**

Discharging nurse must undertake a final check of discharge medicines at the point of discharge (i.e. on the **same day** of discharge/leave). This checklist should be checked against the patient's medicines chart.

All medicines to be checked against the medication chart

	Task ✓	Comments
PATIENT NAME: correct name on the medicines bag and labels		
Correct medication labelled with **correct instructions** ***Medicine | *Dose |*Form |*Instructions |*Quantity** Check each medicine against the medication chart:		
MISSING ITEMS (check on ward and add to bag **if appropriate**) E.g.*insulin|*creams|*inhalers|*eye/ear drops|*PODs		
INCORRECT ITEMS: e.g. discontinued/stopped medication		
COUNSEL PATIENT: What is medicine(s) for, how to take, importance of taking, if medication is to be reviewed/stopped e.g. tablets for sleep/antibiotics.		
WRITTEN INFORMATION is needed for TTAs (not STL medicines): Medication **patient leaflet** in each medicines box **(if missing access from https://www.medicines.org.uk/emc/)** copy of discharge notification if available		
FURTHER SUPPLIES: advise patient to request from GP to supply (except clozapine, depots and any specialist medication)		
Disposal: Advise to return medicines to local chemist if no longer required		
Next section for those prescribed Depot, Clozapine, Lithium, Methadone or Buprenorphine		
DEPOT medication: Explain where and when next depot is due. Contact relevant team e.g. Community Mental Health Team(CMHT)/Depot clinic/HTT		
Clozapine medication: Explain where next blood test and supply are due i.e. which clozapine clinic (check with ward pharmacist).		
LITHIUM medication: Patient has lithium purple booklet; completed with correct information.		
WARFARIN medication: Patient has yellow booklet and next dosing schedule has been clearly instructed		
Methadone/Buprenorphine - Patients on opioid replacement Ensure community prescription arranged for post discharge (may need to contact relevant community drug and alcohol service).		
Completed by (staff member):_____ Ensure you make a RIO entry with the following RIO code: "RCODE PHARM03: Discharge medicines counselling offered, and received"		

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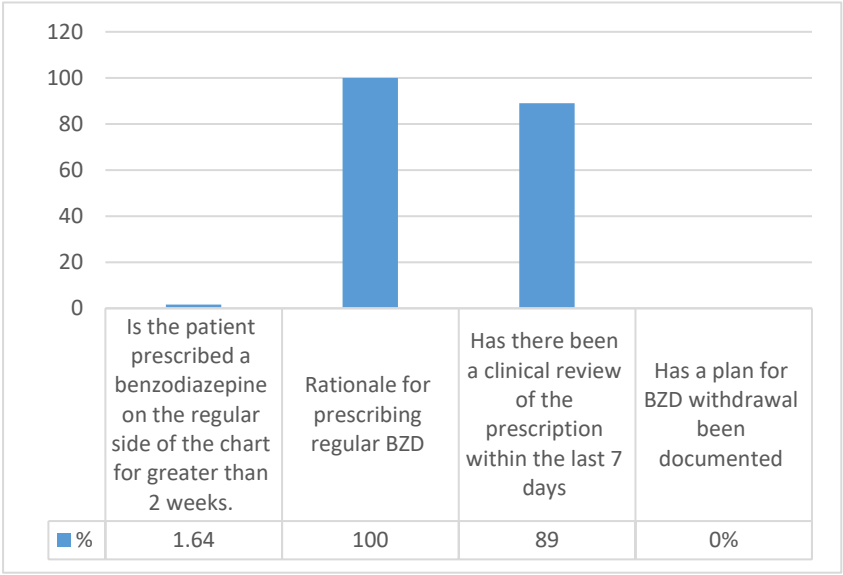
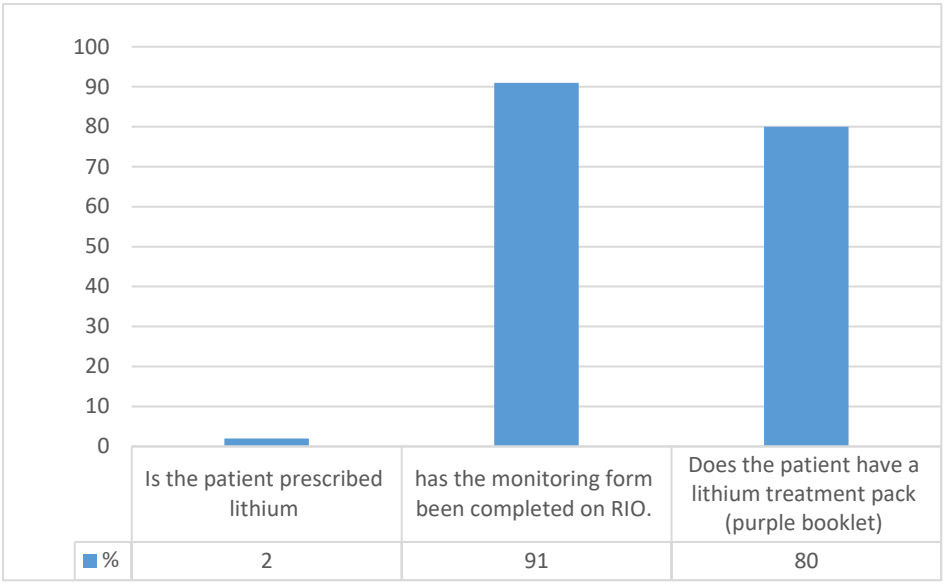
Safe use of Benzodiazepines (Feb Q4 22/23) from CUOM Audit

Questions regarding the safe use of benzodiazepines were added to the CUOM audit during this quarter. The audit results identify 9/548 sample size were prescribed regular BZD for greater than 2 weeks. The rationale for prescribing was clearly defined in all prescribing episodes. In all cases; management of acute agitation and agrresion was noted. 8 of the 9 episodes, auditors were assured that the prescription has been clinically reviewed by a clinician for appropriateness. None of the prescriptions had a plan for BZD withdrawal where potentially appropriate.



Safe use of Lithium (Feb Q4 22/23) from CUOM Audit

Questions regarding the safe use of lithium were added to the CUOM audit during this Quarter. 11 patients were prescribed lithium during Q4 22/23. In 10 out of the 11 prescribing episodes a monitoring form had been completed on RIO which gives assurance that all the neccesary monitoring requirements were completed whilst medicine was being used. 80% of the patients had a lithium treatment book/pack. This is an important resource to ensure that patients continue to receive safe treatment once discharged in the community.



Directorate and Trust wide Sodium Valporate use (Q4 22/23) from CUOM Audit

Valproate Audit	2022/23			
Q1 22/23 – Q4 22/23	**Q1**	**Q2**	**Q3**	**Q4**
Is the patient a female and been prescribed Sodium Valproate, Valproic Acid or Semi-sodium Valproate?	**2.1%** **13 out of 611**	**3.77%** **21 out of 556**	**2.9%** **9 out of 307**	**1.1%** **6 out of 548**
ALL AGES – has RA form* been completed and uploaded on to onto RIO (dated within last 12 months)	**46.2%** **6 out of 13**	**38%** **8 out of 21**	**89%** **8 out of 9**	**100%** **6 out of 6**
ALL AGES – where RA form* has been completed, it has also been sent to the GP	**100%** **6/6**	**75%** **6/8**	**66%** **6 out of 9**	**100%** **6 out of 6**
< 55 YEARS – no. of patients under 55 years old	**7**	**13**	**3**	**0**
< 55 YEARS – has RA form* been completed and uploaded on to onto RIO (dated within last 12 months)	**29%** **2 out of 7**	**23%** **3 out of 13**	**100%** **3 out of 3**	All SU's were either post menopausal, has had a hysterectomy or otherwise has no risk of pregnancy
< 55 YEARS – Is the patient also taking/using appropriate contraception as per ELFT policy?	**14%** **1 out of 7**	**40%** **2 out of 13**	**66%** **2 out of 3**	
< 55 YEARS - If the patient is not taking/using contraception, has a valid reason been documented to exclude the risk of pregnancy e.g. menopause , hysterectomy, pre-menarche	**17%** **1 out of 6**	**54%** **7 out of 13**	**100%** **1 out of 1**	

Results

- Overall, low number of valproate prescribing from inpatient quarterly audits. To be clear these are not new initiations.
- An increase in compliance with completion of risk acknowledgement (RA) and also assurance that form is sent to the GP using RIO function.

Actions

- EPMA team/MSO have constructed a daily report for valporate which idnetifies female patient prescribed valporate and the clinical director responsible for this individuals care. This is sent to all ward pharmacy teams. The daily report is also sent to the responsible clinician so that review and completion of RAF forms are completed in a timely manner

Next steps

- Valporate is on the corporate RISK register and there is a ongoing action regarding the issue in relation to the responsibility for completing annual risk assessment form for patients in community not assigned to CMHT. MHRA in december 22 has advised that no one under the age of 55 should be initiated on valportate unless 2 specialists independently consider and document there is no other effective treatment. Trust valporate group formed to discuss recommendations and what actions need to be taken at a system level once the change has been imposed