East London NHS
NHS Foundation Trust

Title	Safe & effective use of medicines
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Presented to	Medicines Committee
Date	08/11/2023

Purpose of the Report:

This report provides a summary of medicines safety data 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

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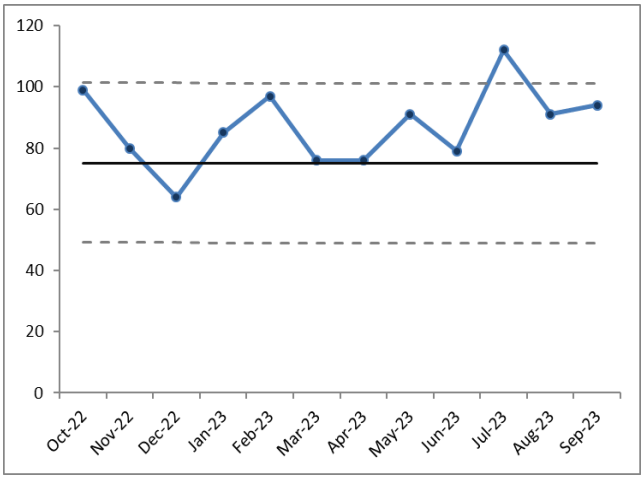
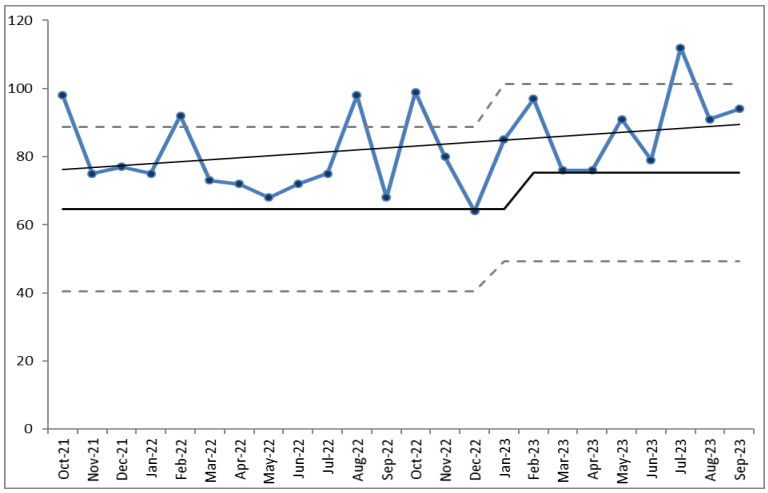
TRUSTWIDE INCIDENT REPORTING

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



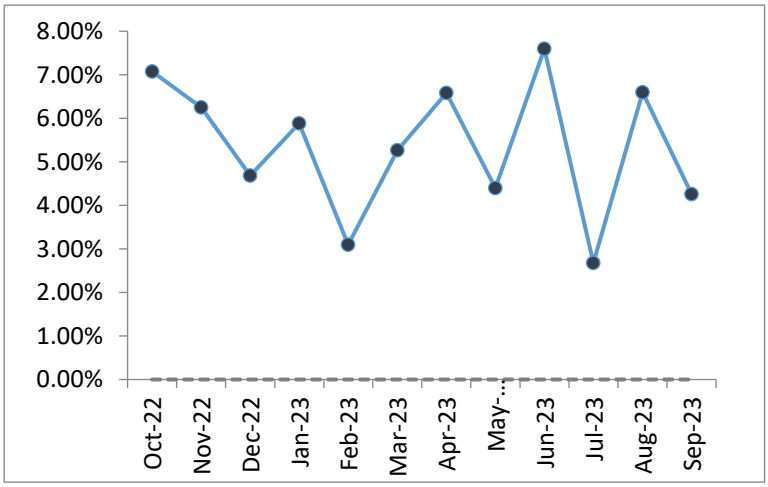
Medication incident reporting fluctuates within control limits. July 23 (112) – single point outside control limits set. Recognised increased reporting across all directorates and spike in reporting not related to one directorate. Aug – Sep 23 Increased reporting noted from Home treatment teams predominantly in Tower Hamlets. Key findings related to inaccuracies with supply of medicines from the dispensary and medicine supply directly to the patient. Improvement work is underway to address these issues.

Figure 2- Total number of medication incidents reported per month (Oct 21 – Sep 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.

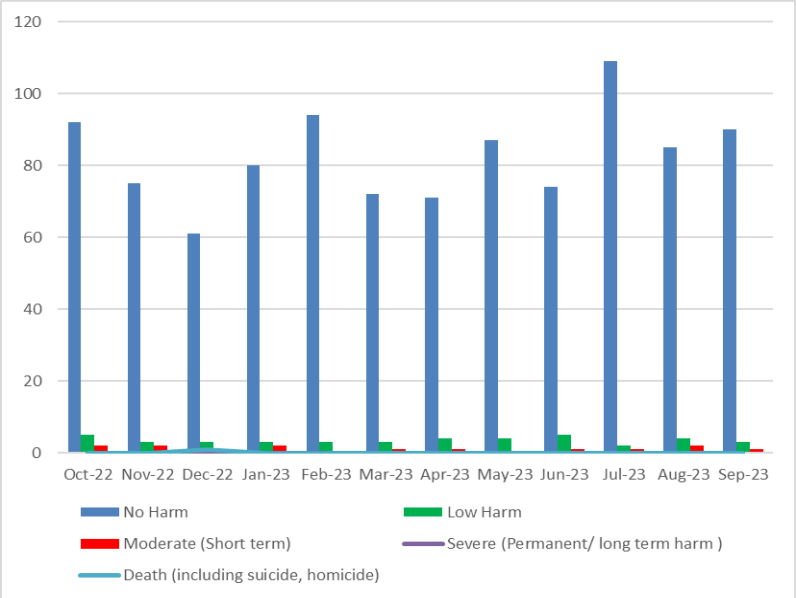
Figure 3 - % Medication incidents that resulted in patient harm (Oct 22 – Sep 23)



Medication Incidents resulting in patient harm over the last 12 months is sitting at an average of 5.36%. In terms of events this equates to between 3-7 medications incidents per month that result in low - moderate harm.

In the last 3 months, 4 incidents (1.40%) have been categorised as Moderate Harm from a total of 284 reported medication incident reports

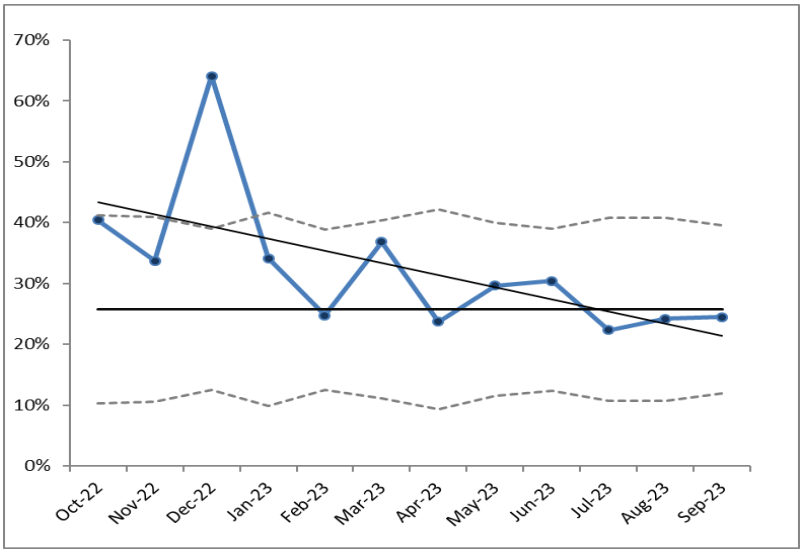
Figure 4 – Medication incidents broken down by type of harm (Oct 22- Sep 23)



Q2 23-24 (July 23- Sep 23) – 9 (3.16%) medication incidents categorised as LOW harm. 4 (1.40%) medication incidents categorised as MODERATE harm.

CHS services TH - External organisation error. Failed referral into CHS services for a pallative patient. Challenges noted (omitted doses) with administration of morphine sulphate for this SU. GP was eventually tasked with the referral which allowed patient to receive ongoing care,

Figure 6 - % of high risk medicines reported monthly (Oct 22 – Sep 23)



Decreasing trendline over the last year in terms of incidents related to high risk medicines. As we move to Inphase our new incident reporting system, the InPhase medication incident template will capture information on a larger list of locally identified high risk medicines. This way new emerging risks will be better picked up (See table below)

Our **PSIRF Medicines Priorities** will be focusing on practices relating to the use of Insulin and Clozapine across the organisation

Datix List	**Inphase List**	
Clozapine	Sodium valporate	Antipsychotic depots
Insulin	Clozapine	Lithium
Lithium	Insulin	Warfarin
Methadone		
	Controlled drugs	
	Methotrexate	
	Steroids	

LOCAL MEDICINES SAFETY UPDATES

- MSO representation at NEL Insulin safety and valporate group
- NEL Opioid Discharge workstream
- Continuous testing of Medicines Incident reporting form on INPHASE.
- Trust Medicines Safety Committee.
- Evaluation of near miss incident reporting in central dispensary site using Prescription Tracking System
- Interface Medication incidents being reported on at Barts Committee. Proposal for cross system working group to address challenges.
- Presentation of AAR at Luton and Beds Quality Meeting
- Review and revision of EPMA high risk drugs reports

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INSULIN PSIRF Learning

Insulin Administration – Learning from an Observation of Insulin Administration in Beds CHS (Leighton Buzzard Practice)

Person(s)	Tasks	Tools/Technology	Environment	Organisation at work	External
DSN review once a month – for challenging patients Transcribing training delivered by CHS team for external staff	Referral/updates on insulin type and dose (1 copy at home, 1 at base) Internet connection is variable on visits so information is transferred onto paper. Live updates could potentially be missed Old MAR charts with historic doses taken back to office to minimise risk 1 administration can take 45mins-1 hour (Allocated time is 20 mins) Pressure on the system	Whiteboard used for insulin allocations plus visiting list SystymONE is checked prior to visits. Use Pando/phone calls to communicate any changes to regimens as communicated by SPOA ELFT glucose machines only used as calibrated and would give accurate readings.	Team Office- Quiet environment with minimal distractions Good lighting in the office. Good work space for coordinator Care home visits – multiple distractions and difficulties noted with equipment to safely store and administer insulin	Morning Team huddles – allocation of workload. Triage role – communicate any changes from SPOA Handovers created by evening staff for morning staff SystymONE record updated at later points in the day. Not at time of administration.	Traffic/travel- impacts when patient receives their insulin. Challenging patients Low staffing levels at care home to support administration Codes for non administration not always being used correctly by care homes Disconnect between ELFT and care home staff. Inaccurate discharge summaries re: Insulin documentation/supply from secondary care

OBSERVATION

Insulin Errors in Community Health Services has been a longstanding issue so the focus of this work is to better understand why this is an ongoing issue. Observation of a normal day in Bedford Community Health Services identified some of the complexities re: insulin administration and how these may be contributing to insulin incident reporting. Our working group is focusing on identifying information relating to the below.

- The number of visits taking place in our CHS services for insulin
- The number of insulin administered
- Type of staff doing the visit.

Incident data from Datix has allowed me to extract out some common themes as below. The themes were also better understood on a recent observation as to how these errors could be made more easily given some of the challenges noted

- Omitted doses
- Wrong/unclear doses
- Double doses
- Wrong frequency

These have been contributed to by; inadequate communication at transfer of care between secondary and primary care services, inadequate communication between teams, MAR charts not always checked before administration, MAR charts not signed after administration, transcription errors and missed allocations on operational systems

Some of the improvement work that has started includes;

- Redesign of MAR charts
- To increase workforce to administer insulin (i.e pharmacy technicians)
- Empowering patients/families to administer insulin
- Transcribing training and audits

NATIONAL MEDICINES SAFETY UPDATES

MHRA Drug Safety Update August 23

Flouroquinolone antibiotics: reminder of the risk of disabling and potentially long lasting or irreversible side effects. A class of antibiotics that have been reported to cause serious side effects involving tendons, muscles joint, nerves and mental health (Suicidal thoughts and behaviour)

Methotrexate: Patients to take precautions when in the sun to avoid photosensitivity reactions. Sun exposure during treatment can result in severe skin reactions (Rashes, papules or blistering in some cases)

Valporate: Reanalysis of risk to men. Lack of confidence in the data that first thought that there is an increased risk of neurodevelopmental disorders to children born to fathers that were exposed to valporate in the 3 months before conception

MHRA Drug Safety Update Sep 23

Statins: reports of myasthenia gravis. Reports of new onset or aggravation of pre existing myasthenia gravis or ocular myasthenia associated with statin use. Symptoms include weakness in arms/legs that worsens after a period of activity, double vision, difficulty swallowing and shortness of breath

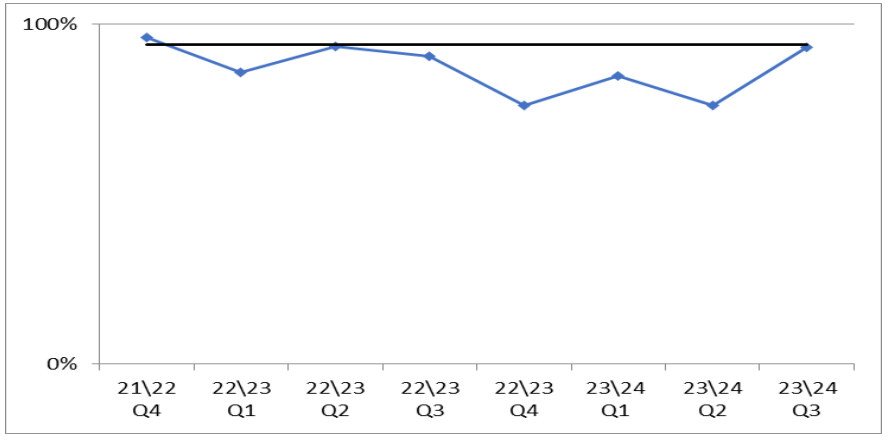
Full pack dispensing for valporate containing medicines. This new legislative amendment, requiring the supply of valproate-containing medicines in the manufacturer's original full packaging, is a further measure to ensure that patients taking valproate-containing medicines have access to information setting out the risks and need for patients of childbearing potential to fulfil the conditions of the Pregnancy Prevention Programme before taking valproate-containing medicines.

DIRECTORATE AND TRUST WIDE CONTROLLED DRUG (Q2 and Q3 23/24)

1. CD Counts and Calculations

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 Q4	76.00%
23\24 Q1	84.84%
23\24 Q2	76.19%
23\24 Q3	93.30%

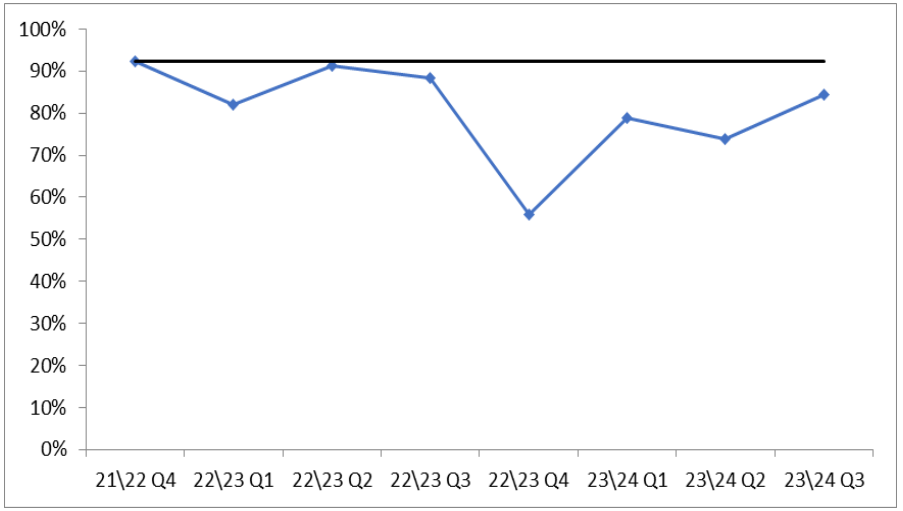


Areas of non-compliance

- Conolly ward (C&H)
- Gardner ward (C&H)
- Cazaubon (TH)
- Topaz (Newham)

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 Q4	56.00%
23\24 Q1	78.78%
23\24 Q2	73.80%
23\24 Q3	84.50%

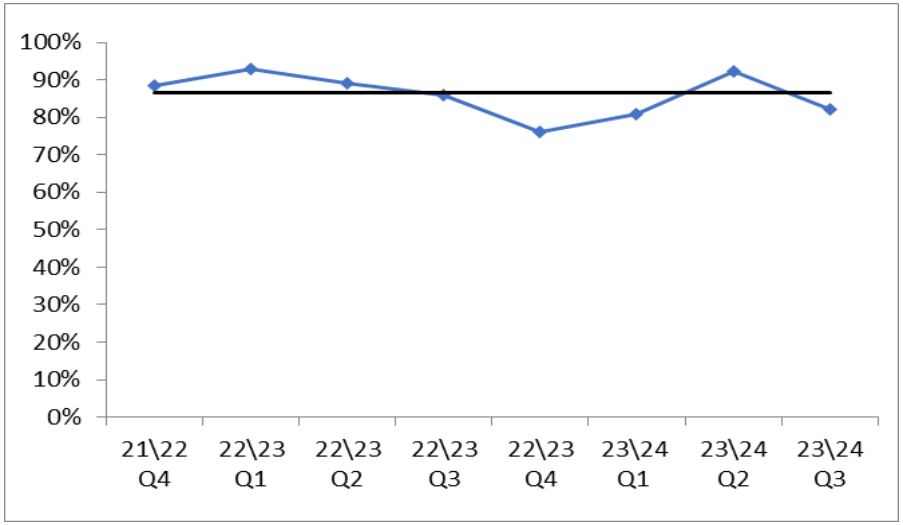


Areas of non-compliance

- Sally Sherman (Newham)
- Fothergill (Newham)
- Lea ward (TH)
- Joshua (C&H)
- Connolly (C&H)
- Gardner (C&H)

15) In the last 3 months, have the CD balances been checked at least **once every 24 Hours as per the controlled drug policy**? (*Amendment made in Q2 23-24 following discussion at Meds Committee).*

22\23 Q4	76%
23\24 Q1	81%
23\24 Q2	92%
23\24 Q3	82%

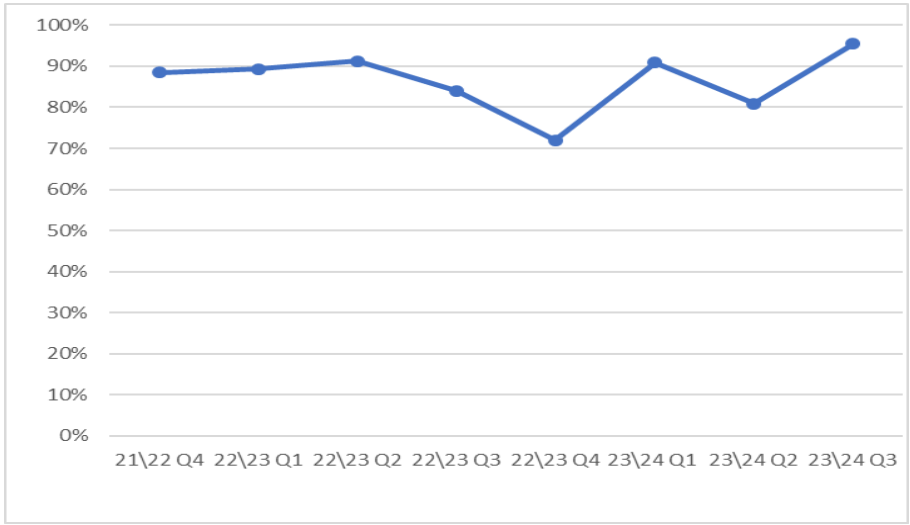


Areas of non-compliance

- Joshua (C&H)
- Connolly (C&H)
- Gardner (C&H)
- Brett (C&H)
- Jade (L+B)
- Coral (L+B)
- Poplars (L+B)
- Cazaubon (TH)

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 Q4	72%
23\24 Q1	90.90%
23\24 Q2	80.90%
23\24 Q3	95.50%



Areas of non-compliance

- Sally Sherman (Newham)

2. Receipt and Transfer of Controlled Drugs

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 Q4	60%
23\24 Q1	82%
23\24 Q2	74%
23\24 Q3	82%

Areas of non-compliance

- Coburn PICU (Newham)
- Aldgate (Forensics)
- Broadgate (Forensics)
- Cazaubon (TH)
- Connolly (C&H)
- Onyx (L+B)
- Crystal (L+B)
- Jade (L+B)

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. **Note (Sample size are different here. Information only applicable to situations where there has been a transfer)**

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

Areas of non-compliance

- Aldgate (Forensics)
- Sapphire (Newham)

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 Q4	43%
23\24 Q1	94%
23\24 Q2	69.20%
23\24 Q3	93.30%

Areas of non-compliance

- Aldgate (Forensics)

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 Q1	43%
23\24 Q1	67%
23\24 Q2	54%
23\24 Q3	100%

3. Controlled Drug Governance.

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

22\23 Q4	92%
23\24 Q1	88%
23\24 Q2	86%
23\24 Q3	93.30%

Areas of non-compliance

- Aldgate (Forensics)
- Poplars (L+B)
- Onyx (L+B)

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

22\23 Q4	96%
23\24 Q1	97%
23\24 Q2	100%
23\24 Q3	100%

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

22\23 Q4	100%
23/24 Q1	100%
23/24 Q2	100%
23/24 Q3	100%

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

22\23 Q4	73.90%
23\24 Q1	72.72%
23\24 Q2	91.00%
23\24 Q3	93.00%

Areas of non-compliance

- Poplars (L+B)

Findings

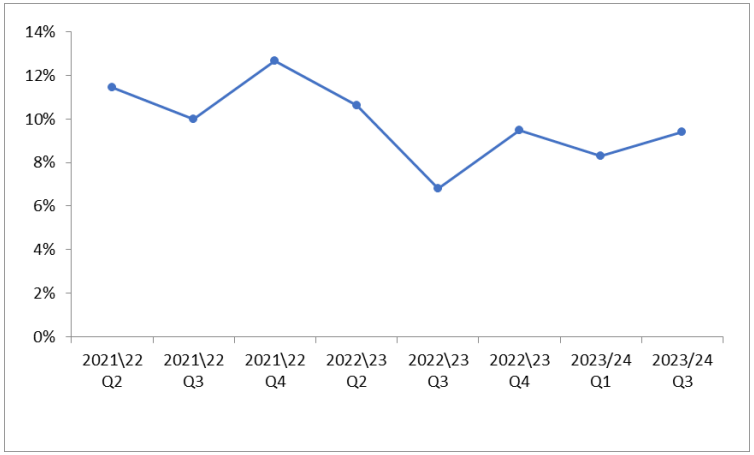
Focus for Q4 CD audits

- Ensuring Controlled Drug checks are being completed ONCE every 24 hours and there is evidence of this check in the CD register.
- When CD's are received from pharmacy, it is imperative that the CD(s) are signed into the register by 2 members of staff.

Areas of non compliance have been highlighted for each question. It is important that this information is discussed with you CG coordinator and amongst teams at ward/directorate meeting so that any actions can be tracked and there is strong assurance for the safe and secure storage of controlled drugs in all areas.

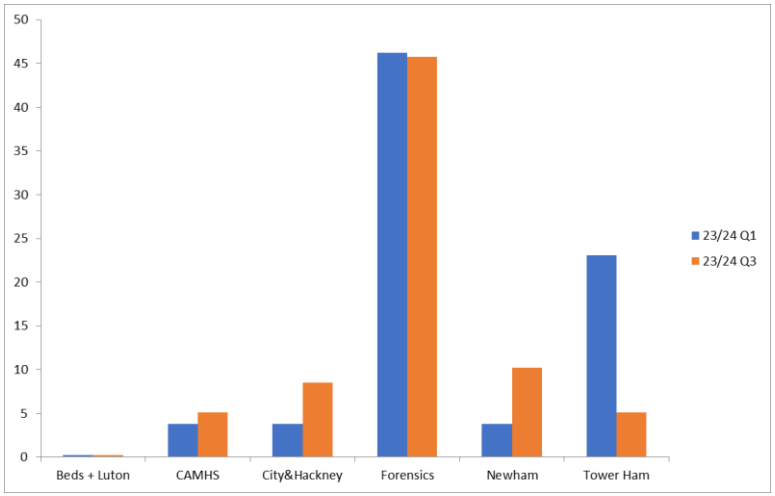
Reminder that any concerns re: safe and secure storage of controlled drugs must be escalated to the **Medicines Safety Officer** and the **Chief Pharmacist** who is the Trust Controlled Drug Accountable Officer (CDAO). This must be followed up with a incident report.

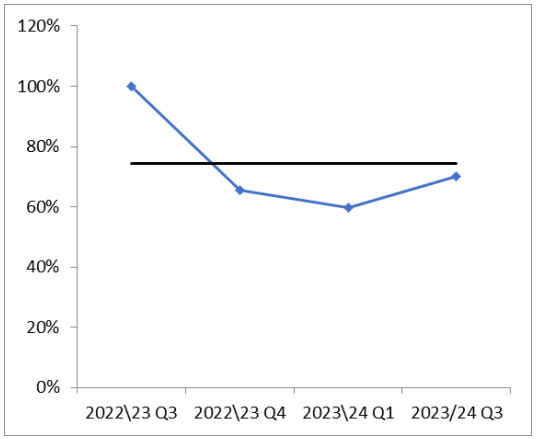
DIRECTORATE AND TRUST WIDE HIGH DOSE ANTIPSYCHOTIC PRESCRIBING (Q1 23/24 Cycle 1 and Q3 23/24 Cycle 2) from CUOM Audit. **Note: audit comepleted 3x year hence no data for Q2**



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. Slight increase noted in Q3 23-24

2. % of inpatients prescribed HDAT (reg + prn prescribing combined): Directorates
In Q3 and Q4 22/23 CAMHS had 0 episodes of high dose prescribing. This has creeped up ever so slightly since the beginning of this financial year.
Historically forensics has had a low -medium incidence of HDAT prescribing. Since the beginning of this fianancial year this has increased. Tower Hamlets has seen a reduction in HDAT episodes from Q1 23/24 to Q3 23/24



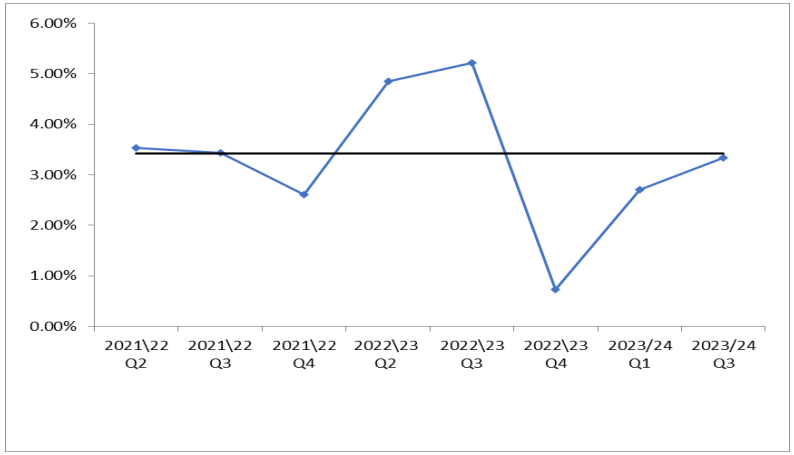


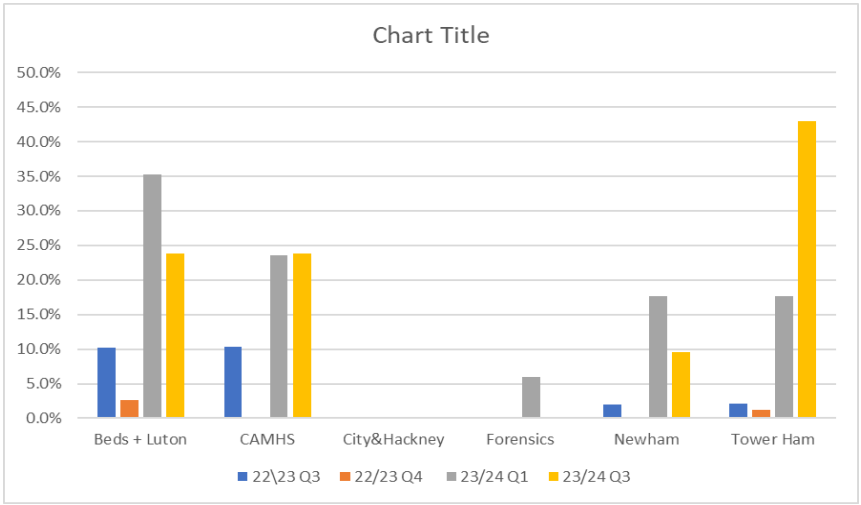
3. % of inpatients prescribed HDAT (both reg + prn prescribing considered) where HDAT monitoring form has completed.
Compliance with completion of HDAT monitoring forms have declined over the last few cycles.

DIRECTORATE AND TRUST WIDE RAPID TRANQUILISATION (RT) USE (Q1 23/24 cycle 1 and Q3 23/24 cycle 2) from CUOM Audit. **Note: audit comepleted 3x year hence no data for Q2**

1. **% of inpatients given intramuscular medication for RT in the preceding week**

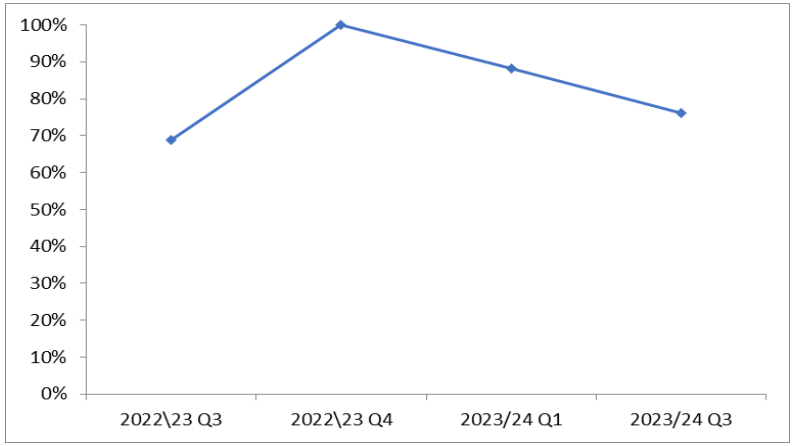
   Overall decline in the use of rapid tranqulisation across the trust over the last few audit cycles





2. **% of inpatients administered IM RT medication in the preceding week (DIRECTORATE) –** Tower Hamlets use has increased over the last 2 quarters. 9/21 (Q3 23/24) rapid tranquilisations observed in the week prior to audit. Noted increase in RT administrations within the Beds and Luton Directorate over last 2 quarters. Leads to identify if there has been a change in prescribing practice or if this was an anomaly

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 Q1 and Q3 (23/24). *After the administration of rapid tranquilisation (RT), a set of contact and non-contact physical observations must be taken and recorded every 15 minutes. These observations should be recorded on the NEWS2 chart (Appendix 3) on RIO.* See updated RT policy on the intranet



Actions

Focus for Q4 CD audits

- **Ensure completion of HDAT monitoring forms on RIO for appropriate patients.**
- **% Increase in HDAT prescribing noted within forensics directorate. Prescribing practice to be reviewed and picked up by lead Pharmacist**
- **Completion of RT monitoring decreased in Q1 and Q3. To ensure that any paper records are uploaded onto the NEWS2 monitoring form on RIO.**

DIRECTORATE AND TRUST WIDE SODIUM VALPORATE REPORTING (Q1 23/24 cycle 1 and Q3 23/24 cycle 2) from CUOM Audit

Valproate Audit	2022/23		2023/24	
Quarter 22/23 – 23/24	Q3	Q4	Q1	Q3
Is the patient a female and been prescribed Sodium Valproate, Valproic Acid or Semi-sodium Valproate?	2.9%	1.1	4.5	2.4
	9/307	6/548	28/629	15/627
ALL AGES – has RA form* been completed and uploaded on to onto RIO (dated within last 12 months)	89%	100%	61%	87%
	8/9	6/6	17/28	13/15
ALL AGES – where RA form* has been completed, it has also been sent to the GP	66%	100%	100%	54%
	6/9	6/6	17/17	7/15
< 55 YEARS – no. of patients under 55 years old	3	0		
Is the patient post menopausal, has had a hysterectomy or otherwise has no risk of pregnancy. NEW QUESTION Introduced in Q1 23/24			93%	53.3%
			26/28	8/15
< 55 YEARS – has RA form* been completed and uploaded on to onto RIO (dated within last 12 months)	100%	0	100%	100%
	3/3	0	2/2	7/7
< 55 YEARS – Is the patient also taking/using appropriate contraception as per ELFT policy?	66%	0	100%	29%
	2/3	0	2/2	2/7

Results

- **Numbers of valporate prescribing been low in 22/23. Increase noted in 23/24 where the number of inpatients seen and or prescribed valporate have increased.**
- **Q1 (2023-24) outlier where 17 out of a possible 28 RA forms were completed for patients prescribed valporate. This leaves 11 patients without a risk acknolwedgement form.**
- **Q3 (2023-24) outlier where 7 out of a possible 15 RA forms were onward forwarded to the GP.**
- **New Question introduced in Q1 23-24. Majority of patients seen in Q1 23-24 were post menopausal and therefore there is nil risk in this cohort. Q3 Identified 7 patients under the age of 55 who were of childbearing potential but in all of these cases a risk acknowledgement form was completed. However from this 7 patients, 2 were prescribed on on contraception as per guidelines.**

Actions/Next steps

- EPMA team/MSO have constructed a daily report for valporate which identifies female patient prescribed valporate and the clinical director responsible for this individuals care. This is sent to all ward pharmacy teams. Work underway to obtain a list of all clinical directors so that daily report can reach this staff group directly so that RA forms can be completed in a timely manner.

- 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. Further work to be undertaken, to discuss with the medical directors and define what the formal pathway should be and how that is communicated to primary care.
- NEL High risk subgroup formulated as a branch of the NEL MSQG where valporate and anysystem wide actions will be discussed further.

Directorate and Trust wide High Risk Medicines (Q1 23/24 cycle 1 and Q3 23/24 cycle 2) from CUOM

1. **DISCHARGE CHECKLIST -** A reduction noted in Q3 23-24 for completion of discharge checklist for appropriate patients. The importance of these to be discussed amongst ward teams. The discharge checklist can be found in annexe of the trust medicines policy. A tool used to support the safe discharge of patients from a ward setting.
2. **BENZOPDIAZEPINES** – In most case rationale for prescribing benzodiazepines was well documented over the last 2 quarters. Positive to also see that BZD are being reviewed regularly every 7 days for appropriateness. Pharmacy teams to support clinicians with plans for documenting BZD withdrawal on RIO and on discharge summaries so that medicines do not continue for long period of time in primary care without review/reduction
3. **LITHIUM –** Compliance for completion of lithium monitoring forms on RIO over the last 2 quarters has been low. Uptake of lithium purple books is also low. Lithium is a high risk medicine and close monitoring is required for its safe use Seek Lithium books from the ward pharmacy team as appropriate.

Q1 23/24	% of submitted sample
Is the patient prescribed lithium	7
has the monitoring form been completed on RIO.	55
Does the patient have a lithium treatment pack (purple booklet)	50
Q3 23/24	% of submitted sample
Is the patient prescribed lithium	7
has the monitoring form been completed on RIO.	44.7
Does the patient have a lithium treatment pack (purple booklet)	27.6

Discharge checklist Q1 23/24			
Has the patient been discharged?	Yes	Number in sample	%
	69	629	10.96
Has the discharge checklist been completed?			
	69	69	100.00%
Has the discharge checklist been uploaded onto RIO?			
	55	69	79.70%

Discharge checklist Q3 23/24			
Has the patient been discharged?	Yes	Number in sample	%
	187	627	30
Has the discharge checklist been completed?			
	84	187	44.90%
Has the discharge checklist been uploaded onto RIO?			
	64	84	76.00%

Q1 2023/24	%
Is the patient prescribed a benzodiazepine on the regular side of the chart for greater than 2 weeks.	7.63
Rationale for prescribing regular BZD	94
Has there been a clinical review of the prescription within the last 7 days	100
Has a plan for BZD withdrawal been documented	40%
Q3 2023/24	%
Is the patient prescribed a benzodiazepine on the regular side of the chart for greater than 2 weeks.	13.5
Rationale for prescribing regular BZD	84
Has there been a clinical review of the prescription within the last 7 days	100
Has a plan for BZD withdrawal been documented	27%