East London NHS
NHS Foundation Trust

Title	Safe & effective use of medicines
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Presented to	Medicines Committee
Date	13/09/2023

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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Note: Audit data will be presented at the next Medicines Committee in November 23

Trustwide Incident reporting

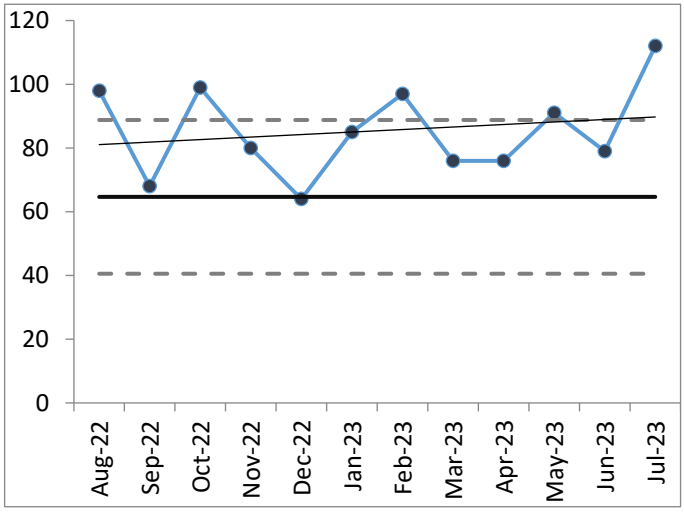


Figure 1 Total number of medication incidents reported per month (Aug 22- July 23)

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. Reporting in Community Health Services continues to be high with the greater proportion of errors being reported due to Administration of medicines (41), followed by Inaccuracies with notification/discharge letters (24)

Figure 2- Total number of medication incidents reported per month (Aug 21 – July 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.

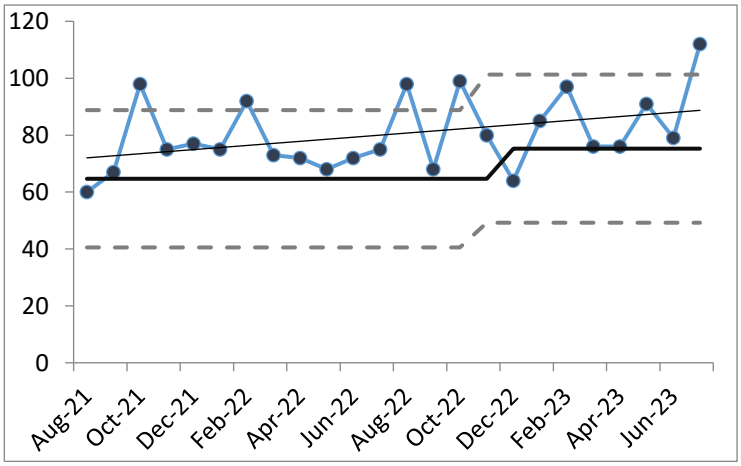
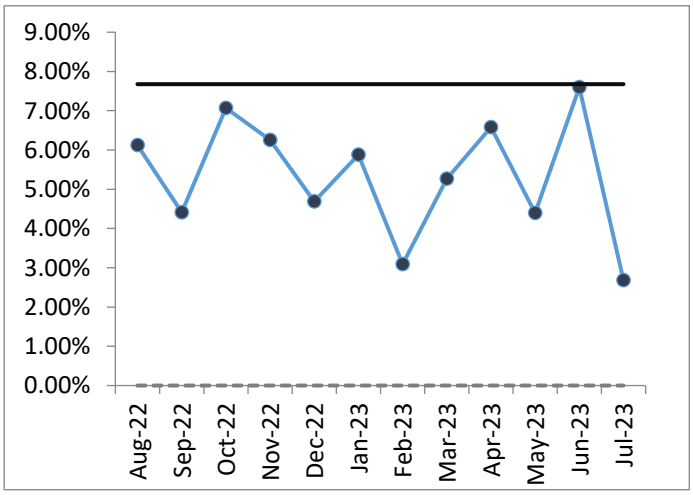
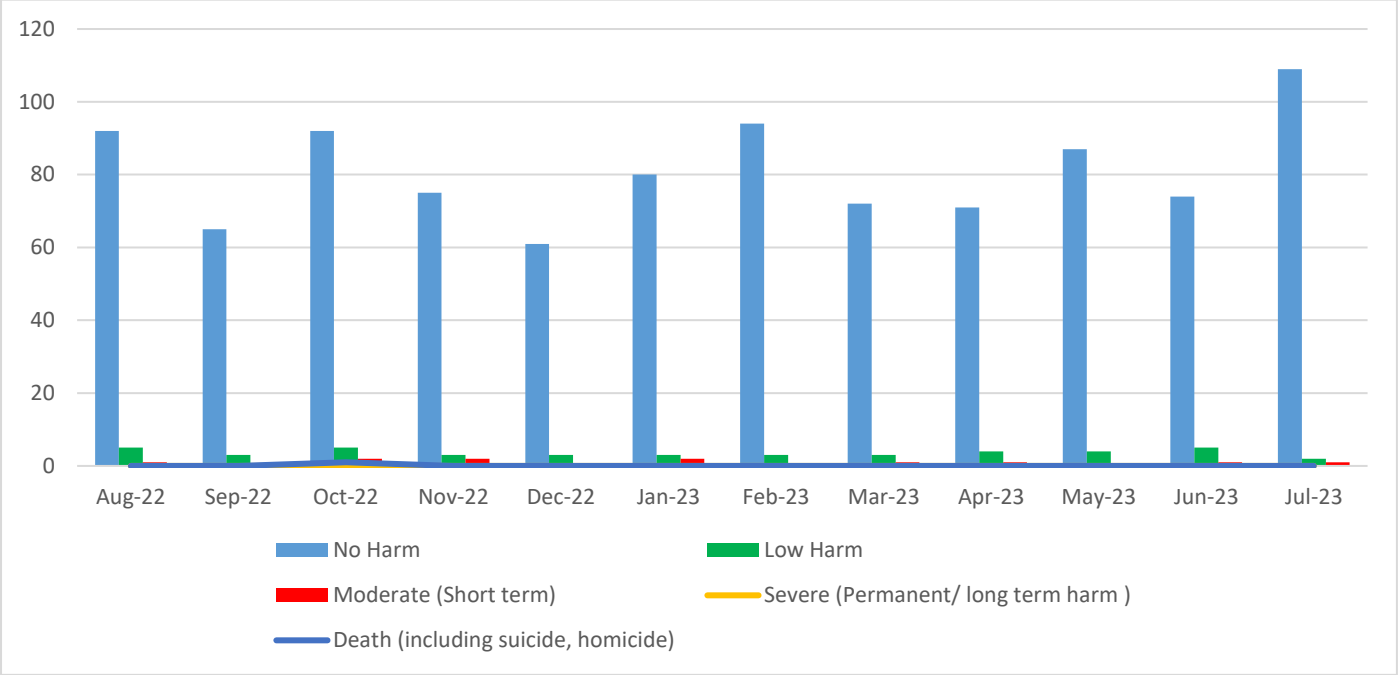


Figure 3 - % Medication incidents that resulted in patient harm (Aug 22 – July 23)



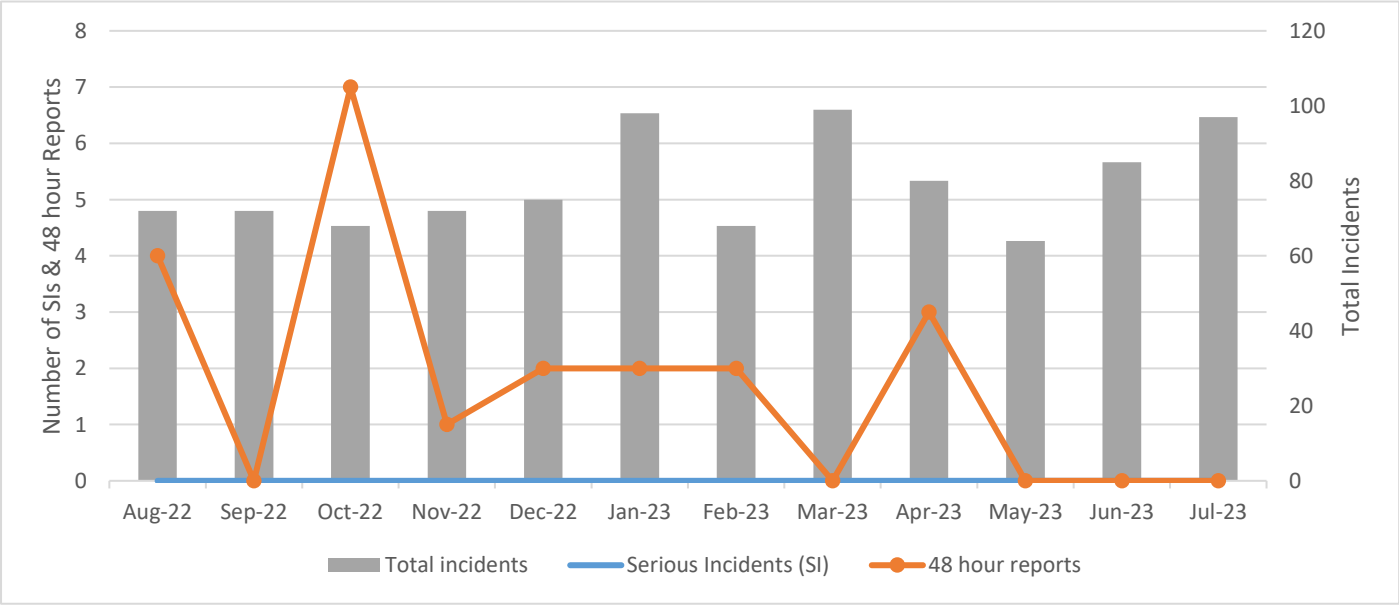
Medication Incidents resulting in patient harm over the last 3 months is sitting between (4-8%). In terms of events this equates to between 3-6 medications incidents per month that result in harm described as low-moderate. In the last 3 months, 2 incidents have been categorised as Moderate Harm from a total of 267 reported medication incident reports (0.74%)

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



Serious Incidents warranting 48 hour report (Aug 22 – July 23)

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

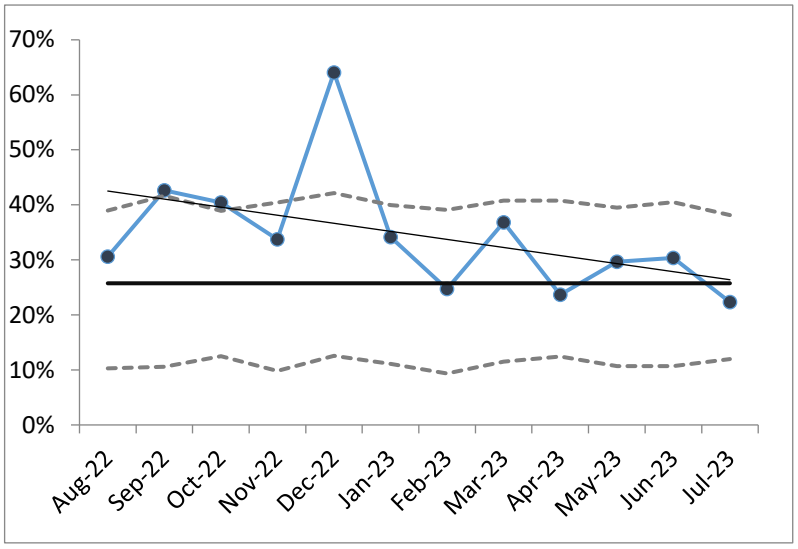


% decrease in the number of 48 hour reports since April 23. **Last SI: Sept 21**. As we move over to PSIRF, different responses to incident investigation and learning are being used.

Lead pharmacists/MSO to continue to flag/escalate appropriate incidents to the incident team for appropriate follow up and investigation. Panel will then decide on best way to learn from the Patient Safety Incident.

High risk medicine

Figure 6 - % of high risk medicines reported monthly (Mar 22 – Feb 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 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 incidents

Directorate: City & Hackney

Incident: SU being treated at General Hospital for sepsis,aki,pneumonia. ELFT staff nurse had dispensed night medication 200mg of clozapine and 2g sodium valporate and administered the medicine to the SU in the general hospital.Concerns; Clozapine was suspended when the SU was under ELFT services and double dose of sodium valporate was given.

Medication suspended on JAC as all medication to now be dispensed and administered by ACU as per usual protocol when a patient is transferred from MH ward to General ward. Duty of candour completed

Learning

- Ensure that nursing staff are all aware of processes of medication administration when a patient is transferred to acute hospital. Accountability for administration lies with nurse employed by organisation where patient has been admitted.

Directorate: Forensic Services

Incident: SU prescribed sodium valporate 2.4g Twice daily (Total daily dose 4.8g). This was not covered by his consent to treatment and without off label/unlicenced form. Identified by pharmacy but no action taken by clinical team. SU was admitted to the general hospital with unconsciousness, slurred speech, drowsiness, unsteady gait and lethargy. A+E reported sodium valporate toxicity secondary to worsening CKD. On return to the ward, valpraote dose was reduced to 1200mg BD

Learning

- Consult with pharmacy teams if unsure when prescribing medicines
- Use medication resources i.e maudsley,BNF, choice and medication platform to aid with prescribing decisions.
- Speak to the SU, identify how they are getting on with their medication. You may uncover some very useful information which may alter treatment strategy

Reducing Diversions of Lower scheduled Controlled Drugs.

- Review stock levels of these medicines. Do these stock levels tie in with usage on the wards?
- Reduce general clutter and keep medicine storage areas tidy
- Consider appropriate provision of staff lockers and designated areas for storage of coats
- Secure arrangements for return of medicines to your pharmacy team
- Ensure security and access to medicines is regularly reviewed.
- Ensure an open reporting culture is embedded

Medicines Safety Updates

- Review of Medicines Safety Priorities in line with PSIRF
- Testing of Medicines Incident reporting form on INPHASE.
- Review and revision of Safe and Secure Handling of Medicines audit
- Learning from incidents shared at BLMK and NEL ICB Medicines Safety subgroups
- Proposal to have a Trust Medicines Safety Committee.

PSIRF – Learning from the AAR approach

ELFT After Action Review Report Form	
Datix Reference:	217161
Date of incident:	20/07/2023
Date of AAR:	02/08/2023
Conductor/Facilitator:	Rajesh Jethwa
Directorate:	Luton CAMHS
Teams involved in incident (please detail all teams):	Evergreen Ward
Apologies	

Summary of the action or incident being reviewed

On 01/08/23 SU had complained of pains in her throat and coughing intermittently. SU had requested PRN paracetamol and was administered 750mg (15mls of 250mg/5ml preperation). On 02/08/23 at 14:30pm, Paracetamol 1g QDS was prescribed as regular on JAC. At 14:33 staff has administered 750mg PRN as it was available on the chart to give as PRN. At 18:54 staff had offered paracetamol (unrequested) and administered an uncharted and unknown dose of liquid paracetamol to SU. SU has also been prescribed regular paracetamol, So a further 1g was administered to SU at the 22:00 medicine round. Regular Paracetamol prescription stopped on 03/08/2023

Key Learning Points

- Prescriber to review the rest of the medication chart before prescribing additional medicines
- Awareness raised regarding functionality of JAC ePMA and how duplicate prescribing would have alerted the prescriber prior to prescribing episode.
- Clinician to document any prescribing actions on RIO.
- All doses must be charted on EPMA
- Incidents to be documented on RIO.
- If duplicate prescription is identified, then action should be taken to correct this consulting with Dr in hours and out of hours oncall doctor.
- Concerns around response from clinicians outside of hours when asked to review prescriptions and make amendments.
- Effective handover between nursing staff on the ward via progress notes.

Actions arising from learning, and names of person responsible:

- Work underway to fill Pharmacist post on the Evergreen ward
- To review JAC prescribing templates for Paracetamol in line with BNFC
- Staff to confidently raise any medicine concerns to clinicians both in and out of hours
- Progress notes to be consistently added to RIO to ensure there is a clear audit trail of actions taken
- All medicines must be charted for at the point of administration
- Clinicians to understand the importance of checking the rest of the medication chart before prescribing episode and have that awareness of JAC alerts to notify when medicines are prescribed as duplicates

Arrangements for sharing learning

- AAR to be shared with the Evergreen team
- AAR to be discussed at the next DMT meeting.

Actions to meet needs of those affected by the event

- SU vitals completed post incident and physical health monitoring was completed.
- Debrief with staff members involved.
- Incident to be discussed and reflected on at individual 1:1's

National Medicines Safety Updates

Drug Safety Update June 23

NSAID's: potential risks following prolonged use after 20 weeks of pregnancy. Prolonged use of systemic NSAID's from week 20 of pregnancy onwards may be associated with an increased risk of oligohydramnios and fetal renal dysfunction.

Adrenaline Auto Injectors: MHRA launched a Safety Campaign to raise awareness of anaphylaxis and provide advice on the use of adrenaline auto injectors. The resources are freely available to download from the MHRA guidance page on adrenaline auto injectors (AAI's)

- Infographic about the correct use of your AAI
- Video about the correct use of your AAI

Advice for healthcare professionals to provide to patients:

New information for patients about NSAIDs in pregnancy

- NSAID (non-steroidal anti-inflammatory) medicines such as ibuprofen, naproxen, and diclofenac are well established medicines for short-term pain relief, but all NSAIDs have recognised side effects and these are listed in the Patient Information Leaflet
- this advice is for oral NSAIDs (taken by mouth) and NSAIDs administered by injection
- if you are pregnant and are worried about taking a NSAID, please discuss this with a healthcare professional who will be able to advise further on your treatment plan
- NSAID should not be taken during the third (last) trimester of pregnancy (after 28 weeks of pregnancy) as they can in some cases cause labour to be delayed or last longer than expected. It can also have potential effects on the unborn baby's kidneys and heart
- while it is already well known that NSAIDs should not be taken during the third trimester of pregnancy, new information has identified that there may be potential risks to the baby following prolonged use of a NSAID after week 20 of pregnancy
- this new evidence has shown that prolonged use of NSAIDs after week 20 of pregnancy may increase the risk of problems with the unborn baby's kidneys and heart – however, these effects are usually reversible when the NSAID is stopped
- NSAIDs should be avoided from week 20 of pregnancy onwards unless absolutely necessary and advised by your healthcare professional
- if you and your doctor decide you should take a NSAID during pregnancy, then this should be at the lowest dose for the shortest period
- if you are treated with an NSAID during later pregnancy for more than a few days, your doctor may recommend additional monitoring such as ultrasound scans to check on your baby's health
- it is vitally important that you seek medical advice if pain persists for longer than 3 days or if you have repeated pain during pregnancy

Report and suspected defective AAI's to the MHRA yellow card scheme. Keep the defective AAI's for investigation purposes.

Drug Safety Update July 23

Hyoscine Hydrobromide patches: risk of anticholinergic side effects, including hyperthermia. Small number of reports related to serious and life threatening anticholinergic side effects with the patches. Healthcare professionals, patients, parents and carers should be aware of the signs and symptoms of serious side effects and the need to seek medical help.

Signs and symptoms of serious side effects

- High temperature
- Inability to urinate
- Confusion
- Disorientation
- Seeing or hearing things
- Fits/convulsions
- Reduced consciousness
- Breathing difficulties.