East London NHS
NHS Foundation Trust

Title	Safe & effective use of medicines
Authors	Indreet Anand and Rajesh Jethwa, Medicines Safety Officer
Presented to	Medicines Committee
Date	May 2024

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

Contents

TRUST WIDE INCIDENT REPORTING

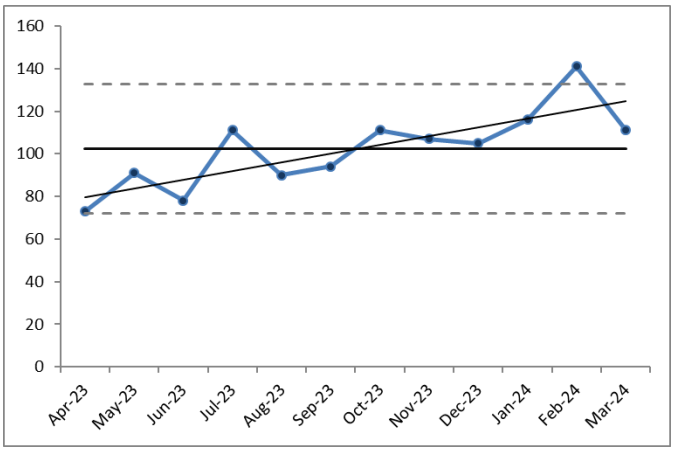
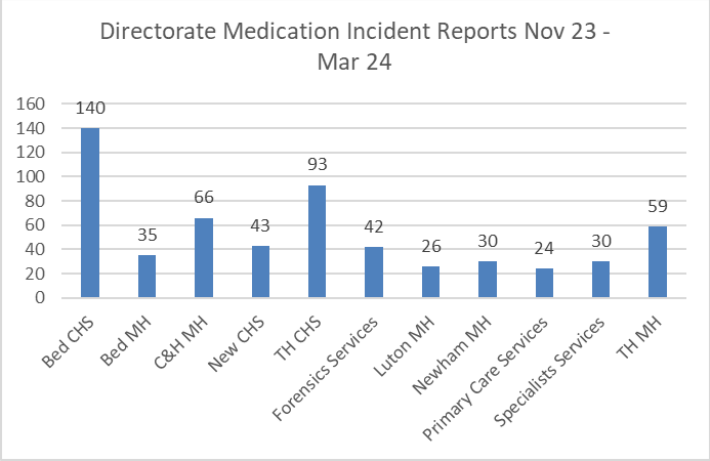


Figure 1 Total number of medication incidents reported per month (April 23 - Mar 24)

Medication incident reporting fluctuates within control limits. Inphase incident reporting system went live 1st November 23. Incident reporting has increased over the last 3 months. **March 24**: 111 Medication Incidents were reported on Inphase. Overall there is an increased trend in medication incident reporting, which isn't ncessarily negative but positive, as greater awareness amongst staff to report incidents.

Figure 2- Total number of medication incidents reported directorate (Nov 23 – March 24)

Inphase launched Nov 23. High reporting culture embeded within BCHS and THCHS. Recurring theme within CHS are around incident relating to insulin and transfer of care from hospital settings back to community. Good reporting within C&H and TH mental health directorates compared to the other mental health directorates. Important to continue to raise awareness to report incidents.



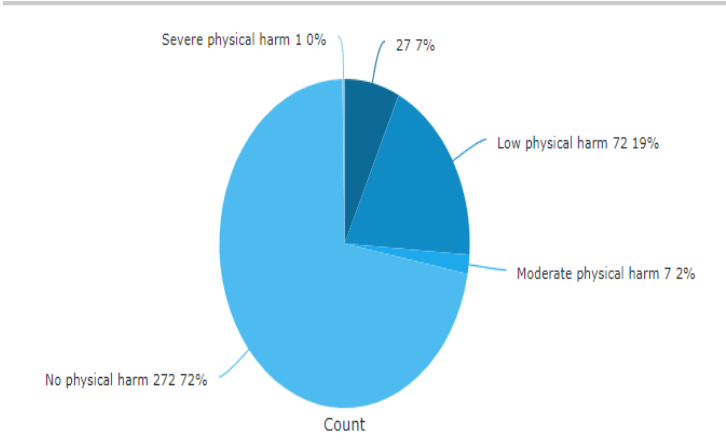


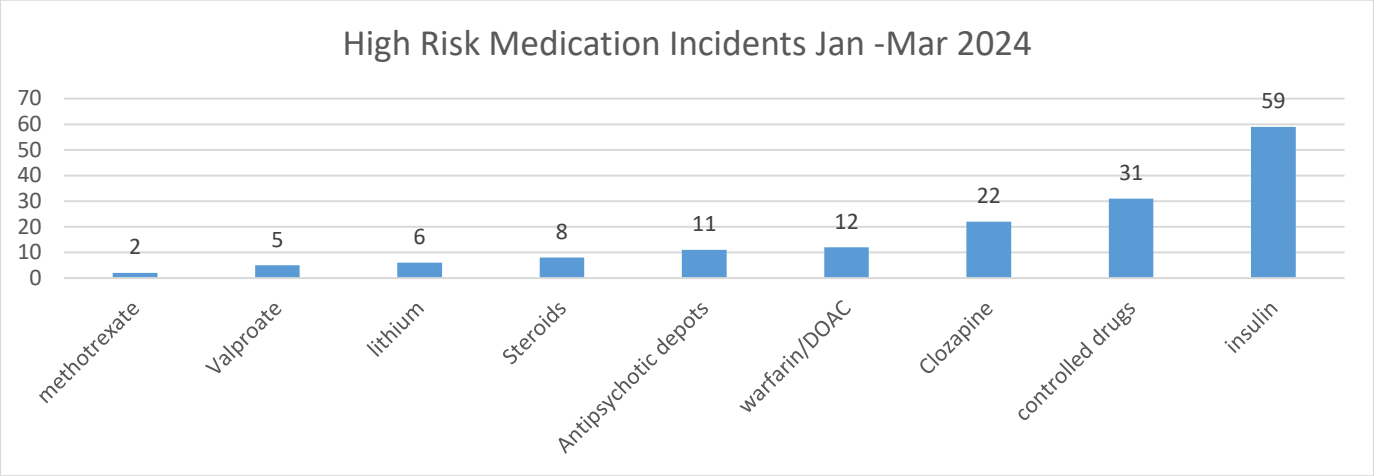
Figure 3 – Medication incidents broken down by type of harm (Q4 23-24; Jan 24 – March 24)

Assurance that incidents are being reviewed by the incident team and re-categorised to reflect true level of physical harm.

72%: no harm
19%: low harm
2%: moderate harm
0%: (1 incident severe harm Feb 24)
7%: blank – rectified on the form, blank option removed

Severe Incident: see Key Medication Incidents section

HIGH RISK MEDICINES (Q4 23-24 Jan – Mar 24)



Total medication incidents reported Jan to Mar 24: 370. Approximately 40% of total medication incident reported for Q4 23-23 were related a high risk medication.

Insulin: Highest reported of the high risk medicines. This is attributed to the high frequency of insulin administration within our community patients by community nursing teams and a good reporting culture. Having said this insulin is a known work stream for improvement nationally and this is a long standing priority.

Actions:

- 2x working groups looking at insulin errors within community health services. CHS Lead Pharmacists involved. Very early stages. Currently working to establish baseline data for ELFT.
- ICB work stream unfortunately on hold; engagement/capacity issues

Controlled Drugs: Second highest reported of high risk medicines. Just to provide some context, this also includes a large range of lower schedule controlled drugs e.g. zopiclone, codeine and could be related to incidents at any level of harm from storage to prescribing to administration.

CD incidents are directly picked up by CDAO, MSO's and Lead pharmacists.

Actions:

- See local Medicines Safety Updates

Clozapine: As a mental health trust we do have a high usage of clozapine, but also given the complexity of this medication; for example it's adverse effect profile, titration protocols, treatment break rules and monitoring, it is not unexpected that you would see more incidents being reported.

ACTIONS

- Clozapine – trust wide learning seminar presented at the end of March in collaboration with the trust learning team to raise awareness of incidents related to the use of clozapine. Key learnings were around physical health monitoring and transfer of care in this group of patients.

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KEY MEDICATION INCIDENTS (MARCH 2024)

Note: all incident descriptions have been directly extracted (copied and pasted) from INPHASE

MODERATE HARMS

Inphase ID	Directorate	Incident description	Action
7765	Newham	The patient was given a medication in a correct dosage but in a wrong route. Instead of oral route it was given intramuscular (IM) Olanzapine 5mg/1ml, IM. The medication supposed to be administered orally, but it was administered Intramuscular. Duty doctor was notified, as well as the matron of the ward because the manager is on leave. The patient's wife was contacted, and when she visited the ward she was told of the incident. The patient and the wife was apologized to. However, an interpreter was invited to speak with the patient so that he can understand the error and apologized to directly.	DOC has been requested Awaiting investigating manager to document investigation follow up, learning and actions.

8239	Bedford Mental Health Services CMHT	**Summarised**: Depot injection administered in clinic. Pre-vital signs in range and mental state stable. Had been on depot for quite some time. Patient refused to wait for post injection monitoring as per policy, became non responsive at home and paramedics called. Family and A&E doctor called to enquire what medication had been given; Olanzapine Zypadhera 300mg IM depot injection Inphase Incident Description: 14.03.2024, service user came for her depot injection as planned. Her mental state was stable and she stated that there have been no changes in her mood since her last depot injection. She agreed to have her vital signs checked as per trust policy and the following readings were recorded. Weight - 77.2kg; Height - 156cm; BP - 129/76; Pulse - 97; BMI - 31.7kg/m2 and Temp -36 degrees Celsius. As usual, XXXXX refused to wait for post medication monitoring as per medication guidelines and Trust Policy. On 14.03.24, around 1452hrs, I received a call via reception from her family, who wanted to know the name of the medication she had. The son reported that, the paramedics, wanted this information, after they contacted them when she became non-responsive at home. It's documented on Rio, that when paramedics arrived, the service user was found with a Glasgow Coma Scale (GCS) of 7, and when she arrived at A&E the GCS was 11, and she was minimally responding. On 14.03.24 at around 1609hrs, I received a phone call from a Dr from Bedford A&E department. She reported that she was attending to the service user and wanted to find out about the name medication of the medication which she had when she came to Florence Ball House. I was able to inform her that the service user was on Olanzapine Zypadhera 300mg IM depot injection which she has been having for sometime. I also informed her that, when service user came to the clinic, she was well, both mentally and physically, and her pre-injection vital signs were good. I however advised her that, we were not able to check the post vital signs after her depot injection as per policy and guidance, as she has continued to refuse.	Following day incident reported to ELFT pharmacist and her psychiatrist, and raising my concerns about this particular medication, which continues to be an ongoing problem, since service users have always refused to stay for post monitoring. DOC undertaken 72 Hour report undertaken Actions 1 Capacity to understand risks of not staying after receiving depot to be documented on RIO notes This to be clearly documented in the future.To be discussed with nurses in supervision 2. Consider if this particular depot be prescribed in the community? 3 hours of monitoring is difficult to facilitate in the community. To be raised at HCG meeting and discussed with team and medics To be discussed in next HCG 2/4/24

8482		Patient reports that she was given TTO by the ward when they sent her on home leave but K+ solution was not in her TTO pack. Patient has bulimia and has been purging at home. She required 3 visits to Bedford Hospital A&E to check her bloods and on 21/03/24 she was admitted to general medical ward with low K+, for medical monitoring and K+ infusion. When she visited A&E she was reviewed by PLS and necessary emergency treatment was provided. Note: 2 labelled bottles dispensed by pharmacy were on the ward .	Checking TTO medication with patient present before sending on leave. Patient went home with crisis team but they were no aware either that patient was not taking her K+ supplements. Lead Pharmacist also contacted to follow up from a pharmacy perspective DOC undertaken Ward manager has undertaken follow up, learning and actions. 'Nurse Discharge Medication Checklist' as per medicines policy. If used such errors can be prevented. Manger requested to re-enforce use of checklist

REPORTED AS A SEVERE PHYSICAL HARM

Inphase

5732		Patient was transferred back to Joshua ward from HUH on 31/1/24 without a discharge summary. It was discussed in morning huddle to chase up discharge summary. Patient had a hypo on 05/02/24 and was admitted to HUH again. Upon investigation, ward team found out that during patient's time at HUH, there were changes to anti-diabetic medication and so gliclazide was stopped. However, since there was no discharge summary when patient returned to Joshua ward, gliclazide was continued to be administered.	Ward team to ensure in future that patients should not return back from acute hospital without a discharge summary and a handover. Incident reported. DOC undertaken Escalated to request review for 72 hour report

			Potential Joint AAR. Escalated to the incident team grading panel. Escalated to MSO at Homerton to investigate the incident internally.

LOCAL MEDICINES SAFETY UPDATES

- **TRUSTWIDE VALPROATE GROUP**

- Formation of new policy in line with national requirements with valproate ongoing.
- Policy ratified by medicines committee March 2024 conditional on amendments. Final Policy launched trust-wide 10th April 2024 with trust-wide email communication.
- To link in with comms team to raise awareness via other platforms
- NEL ICB have sent over data on female patients prescribed valproate. Plan to analyse data yet to be established by the working group.
- Valproate Working Group to continue to identify gaps and ongoing requirements e.g. auditing.

- **SYSTEM WIDE WORKING**
  - **a.** NEL MSQG: North East London Medicines Safety Quality Group
  - **b.** NEL High Risk Medicines Network
    - **i.** Valproate and Insulin subgroups
  - **c.** NEL Opioid Discharge Workstream
  - **d.** BLMK Medicines Safety Group

- **DIGITAL**
  - **a.** Internal Review and revision of EPMA reports and work being undertaken to transition some of these onto PowerBI. Pharmacy Dashboard has been agreed and is being constructed by performance team

- **TRUST MEDICINES SAFETY GROUP –** First meeting held 10th April via Teams.
  a. Good engagement from multiple disciplines from nursing, digital, workforce development, education and training, primary care, pharmacy, NMP lead
  b. Very good engagement from nursing but limited engagement from medical clinician. To request engagement/volunteers at this platform or can clinical directors support with further engagement?

- **Controlled Drugs – Meeting with Lead Nurses chaired by Sasha Singh (SS) 03.04.24**

  a. Triggered by reported incidents of unaccounted for controlled drugs in recent months
  b. CDAO aware and ongoing work to address concerns
  c. A number of concerns discussed and potential solutions (more detailed plan separately documented sent to CDAO and SS):
     i. Approved a new CD flow chart for nurses for missing CDs; follow up steps listed to investigate unaccounted for CDs and escalation route.
     ii. Abuse/Diversion of lower schedule CDs not kept in a CD cupboard
     iii. Borrowing between wards out of hours; process should be formalise
     iv. Ordering of CDs by ward staff – more robust audit trail needed
     v. 72 hour automatic report to be triggered for missing CDs (criteria to be defined).
     vi. CD nurse training in development by Paul McLaughlin

Note: Some directorates are currently required to record the receipt and administration of lower schedule CDs as an added security measure in response to incidents of unaccounted CD quantities. This will be reviewed by CDAO in collaboration with relevant leads on an ongoing basis.

MHRA DRUG SAFETY UPDATES

March 2024 – None to report

NPSA alerts

March 2024 – None to report

DIRECTORATE AND TRUST WIDE CONTROLLED DRUG QUARTER 4 2023/24

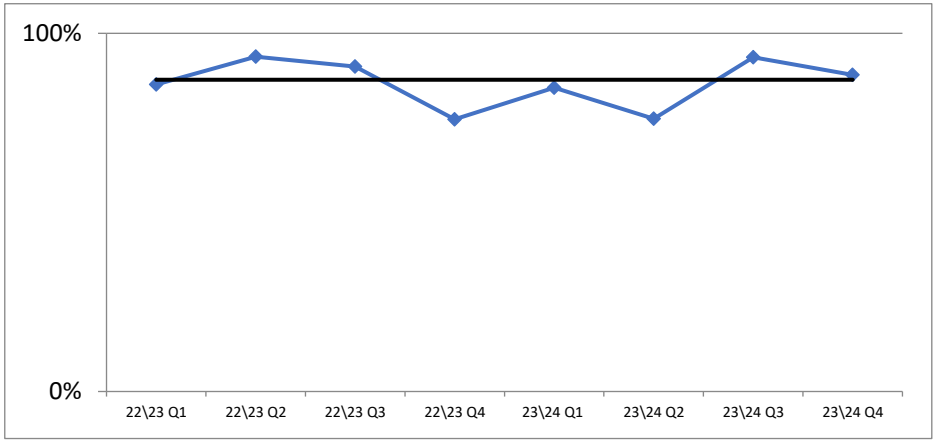
1. CD Counts and Calculations

14) 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.

23\24 Q1	84.85%
23\24 Q2	76.19%
23\24 Q3	93.33%
23\24 Q4	88.37%

Areas of non-compliance

Townsend Court [Townsend Court]	Bedfordshire & Luton [Bedfordshire & Luton]
Fountains Court [Fountains Court]	Bedfordshire & Luton [Bedfordshire & Luton]
Lea Ward [Lea Ward]	Tower Hamlets [Tower Hamlets]
Galaxy Ward [Galaxy Ward]	CAMHS [CAMHS]
Opal Ward [Opal Ward]	Newham [Newham]

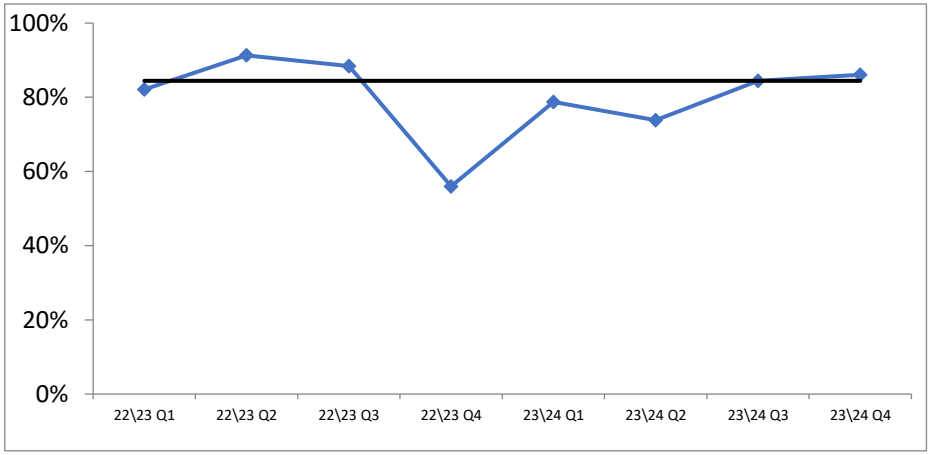


15) In the last 3 months have all pages had correct calculation of balances and all pages where CDs have been finished the balance is ZERO? If no, please inform the nure in charge and pharmacist for further investigation and complete a DATIX.

23\24 Q1	78.79%
23\24 Q2	73.81%
23\24 Q3	84.44%
23\24 Q4	86.05%

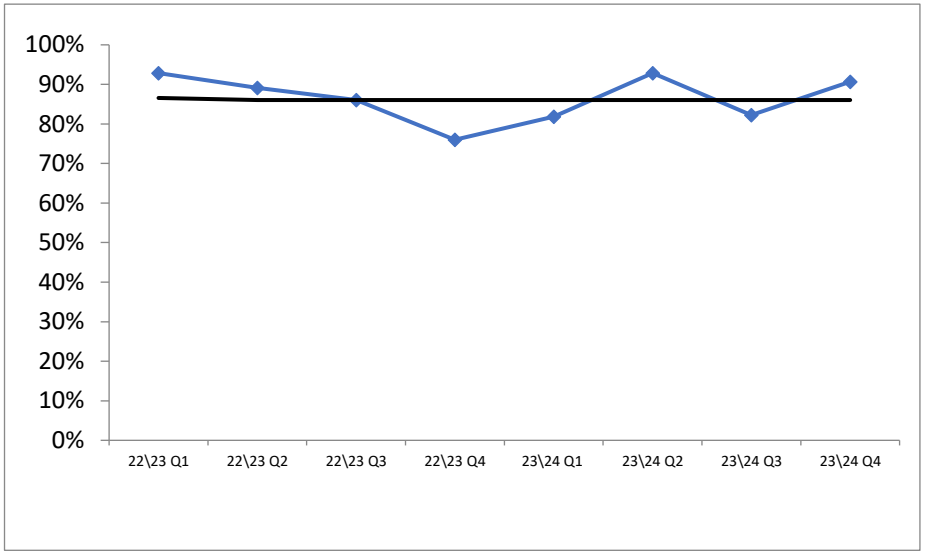
Areas of non-compliance

Townsend Court [Townsend Court]	Bedfordshire & Luton [Bedfordshire & Luton]
Coborn PICU [Coborn PICU]	CAMHS [CAMHS]
Joshua Ward [Joshua Ward]	City & Hackney [City & Hackney]
Galaxy Ward [Galaxy Ward]	CAMHS [CAMHS]
Opal Ward [Opal Ward]	Newham [Newham]
Topaz Ward [Topaz Ward]	Newham [Newham]



16) 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).*

23\24 Q1	82%
23\24 Q2	93%
23\24 Q3	82%
23\24 Q4	91%

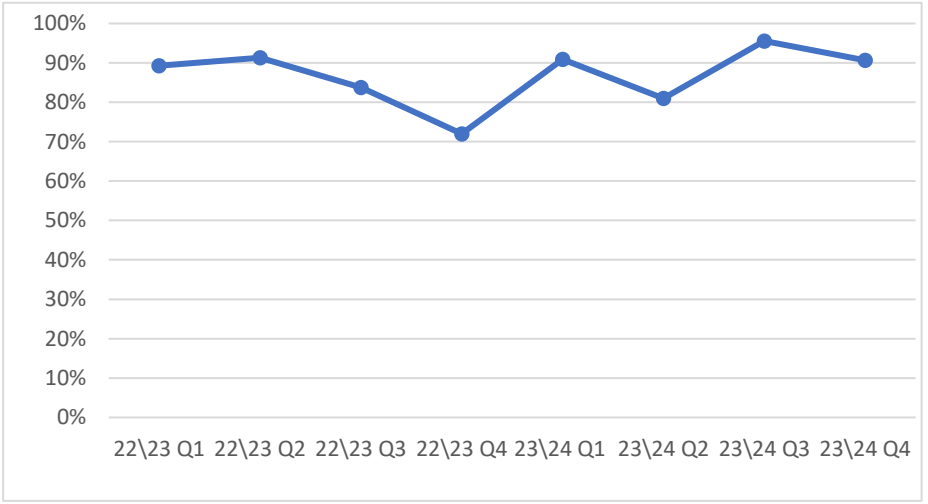


Areas of non-compliance

Crystal Ward [Crystal Ward]	Bedfordshire & Luton [Bedfordshire & Luton]
Joshua Ward [Joshua Ward]	City & Hackney [City & Hackney]
Galaxy Ward [Galaxy Ward]	CAMHS [CAMHS]
Opal Ward [Opal Ward]	Newham [Newham]

17) 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

23\24 Q1	91%
23\24 Q2	81%
23\24 Q3	96%
23\24 Q4	91%



Areas of non-compliance

Gardner Ward [Gardner Ward]	City & Hackney [City & Hackney]
Aldgate Ward [Aldgate Ward]	Forensics [Forensics]
Galaxy Ward [Galaxy Ward]	CAMHS [CAMHS]
Opal Ward [Opal Ward]	Newham [Newham]

2. Receipt and Transfer of Controlled Drugs

18) 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.

23\24 Q1	82%
23\24 Q2	74%
23\24 Q3	82%
23\24 Q4	91%

Areas of non-compliance)

Onyx Ward [Onyx Ward]	Bedfordshire & Luton [Bedfordshire & Luton]
Joshua Ward [Joshua Ward]	City & Hackney [City & Hackney]
Lea Ward [Lea Ward]	Tower Hamlets [Tower Hamlets]
Galaxy Ward [Galaxy Ward]	CAMHS [CAMHS]

20) 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)**

23\24 Q1	94%
23\24 Q2	100%
23\24 Q3	87%
23\24 Q4	81%

Areas of non-compliance

Conolly Ward [Conolly Ward]	City & Hackney [City & Hackney]
Onyx Ward [Onyx Ward]	Bedfordshire & Luton [Bedfordshire & Luton]
Joshua Ward [Joshua Ward]	City & Hackney [City & Hackney]
Fothergill Rehab and Continuing Care Ward [Fothergill Rehab and Continuing Care Ward]	CHN Adult Services [CHN Adult Services]

21) 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.

23\24 Q1	94%
23\24 Q2	69%
23\24 Q3	93%
23\24 Q4	95%

Areas of non-compliance

Crystal Ward [Crystal Ward]	Bedfordshire & Luton [Bedfordshire & Luton]

22) 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

23\24 Q1	67%
23\24 Q2	54%
23\24 Q3	100%
23\24 Q4	86%

Areas of non-compliance

Gardner Ward [Gardner Ward]	City & Hackney [City & Hackney]
Onyx Ward [Onyx Ward]	Bedfordshire & Luton [Bedfordshire & Luton]
Crystal Ward [Crystal Ward]	Bedfordshire & Luton [Bedfordshire & Luton]

3. Controlled Drug Governance.

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

23\24 Q1	88%
23\24 Q2	86%
23\24 Q3	93%
23\24 Q4	91%

Areas of non-compliance

Fountains Court [Fountains Court]	Bedfordshire & Luton [Bedfordshire & Luton]
Coral Ward [Coral Ward]	Bedfordshire & Luton [Bedfordshire & Luton]
Ash Ward [Ash Ward]	Bedfordshire & Luton [Bedfordshire & Luton]
Crystal Ward [Crystal Ward]	Bedfordshire & Luton [Bedfordshire & Luton]

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

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

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

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

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

23\24 Q1	73%
23\24 Q2	88%
23\24 Q3	93%
23\24 Q4	86%

Areas of non-compliance

City & Hackney [City & Hackney]	Gardner Ward [Gardner Ward]
Bedfordshire & Luton [Bedfordshire & Luton]	Coral Ward [Coral Ward]
CAMHS [CAMHS]	Galaxy Ward [Galaxy Ward]
Newham [Newham]	Ruby Triage Ward [Ruby Triage Ward]
Newham [Newham]	Opal Ward [Opal Ward]
Bedfordshire & Luton [Bedfordshire & Luton]	Poplars Ward [Poplars Ward]

Findings 12 parameters; 2 scored 100%, 5 scored 90 -99%, 4 scored >85 – 89% and 1 scored 81-85%. No scores below 80%

Our aim with all CD parameter monitoring should be 100%

The report highlights that partiuclar wards appearing multiple times as non-compliant across multiple parameters, highlighting a need for focussed education and training with some wards. Lead Directorate Pharmacists advised contact to make contact with these wards and co-ordinate support. CD training is being developed by Paul McLaughlin.

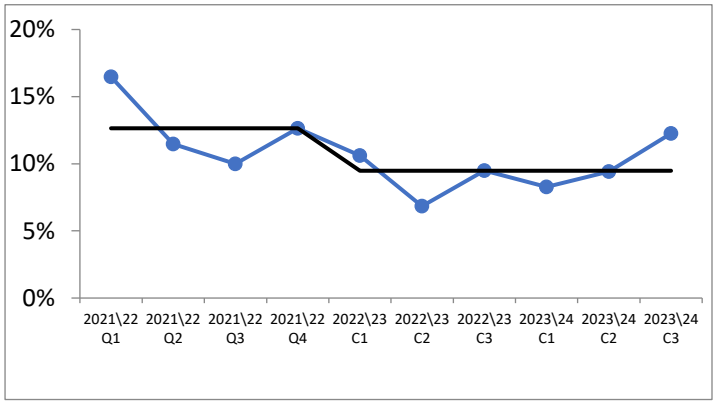
The QA team email a tailored audit report to each of the directorates. It is important that the information is discussed with the CG coordinator and amongst teams at ward/directorate meetings, so that any actions can be tracked and there is strong assurance for the safe and secure storage of controlled 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 FROM CUOM AUDIT.

Note: X axis denoted with 'Q' to represent Quarter and 'C'to represent cycle. Audits are now 3 times a year: Cycle1 to Cycle 3

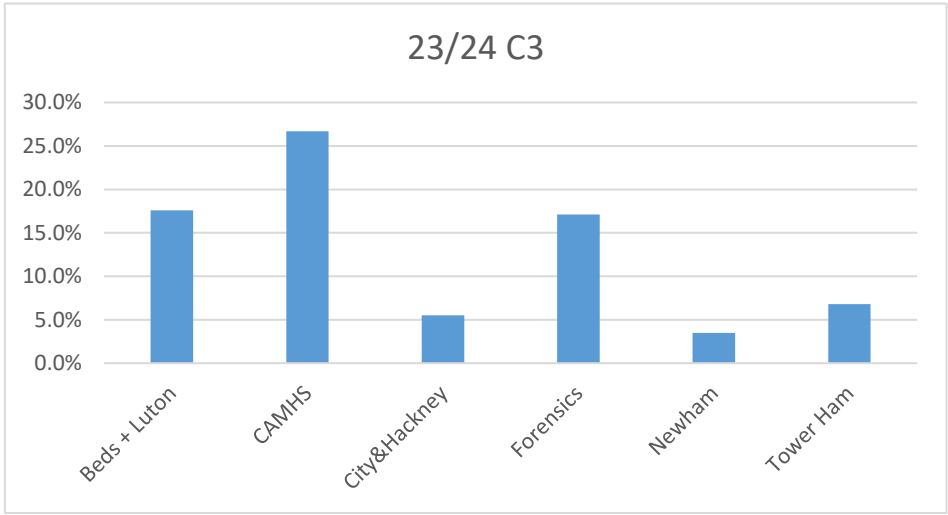
1. % of inpatients prescribed HDAT (both reg + prn prescribing considered)

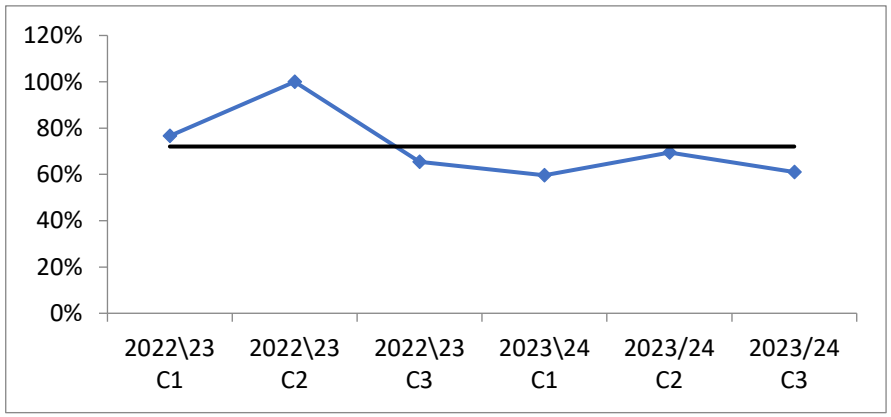


Overall, there is reduction in the percentage of patients prescribed HDAT across the trust over the last 3 years. Average for the last 2 years has been 9.5% of inpatients on HDAT. Slight, increase this cycle; will continue to monitor.

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

Although CAMHS appears to have a high usage of HDAT; 26.7% (trust average 9.5%), there isn't any cause for concern, as this can be explained by CAMHS's small sample size (usually 15-20 patients vs 160 -190 patients sampled in Forensics). Therefore, any small increase/decrease in absolute numbers of patients prescribed HDAT within CAMHS will result in a large percentage change. This cycle 4 out of 15 were prescribed HDAT. Bedford, Luton and Forensics have higher HDAT prescribing than other directorates.





3. % of inpatients prescribed HDAT (both reg + prn prescribing considered) where HDAT monitoring form has completed.

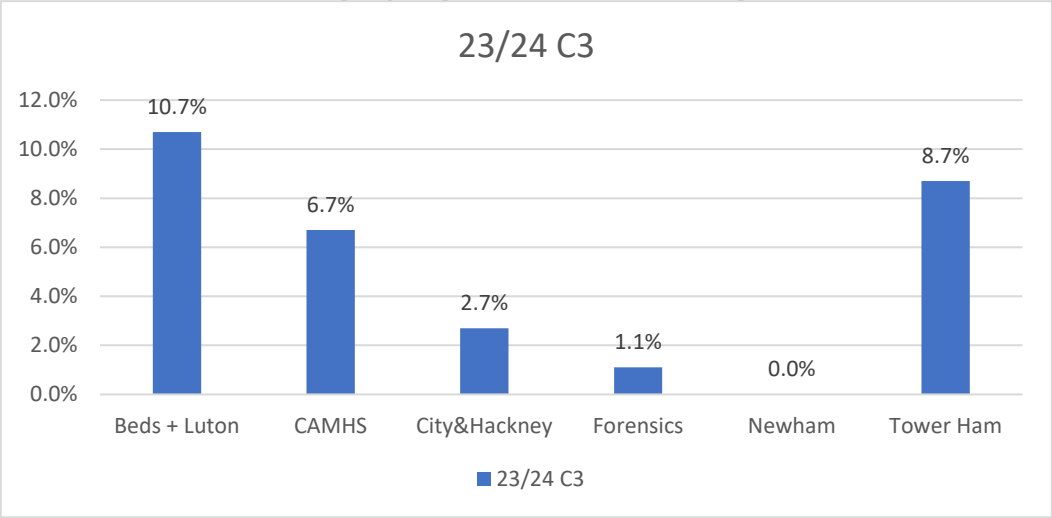
Compliance with completion of HDAT monitoring forms is below expectation. Medicines Committee to discuss actions to address.

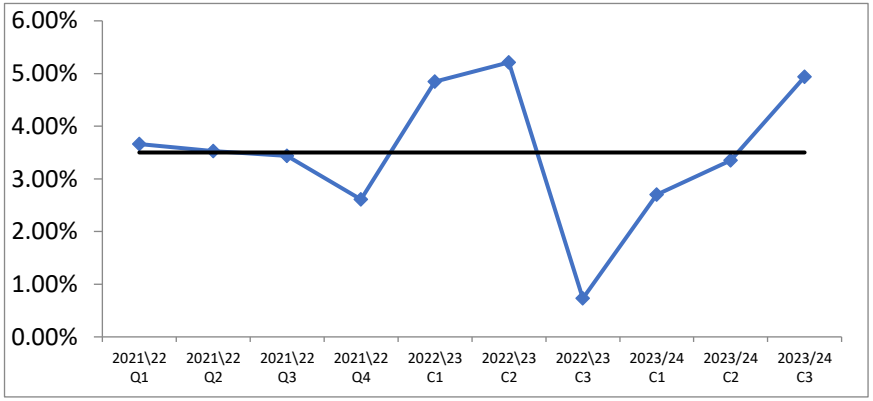
DIRECTORATE AND TRUST WIDE RAPID TRANQUILISATION (RT) USE FROM CUOM AUDIT

Note: X axis denoted with 'Q' to represent Quarter and 'C'to represent cycle. Audits are now 3 times a year: Cycle1 to Cycle 3

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

The use of RT IM across the trust remains low: Trust's last 3 year average = 3.5%. No concerns regarding frequency of usage. Usage appears to be low. C3 audit result was 5%; slightly higher than trust average.

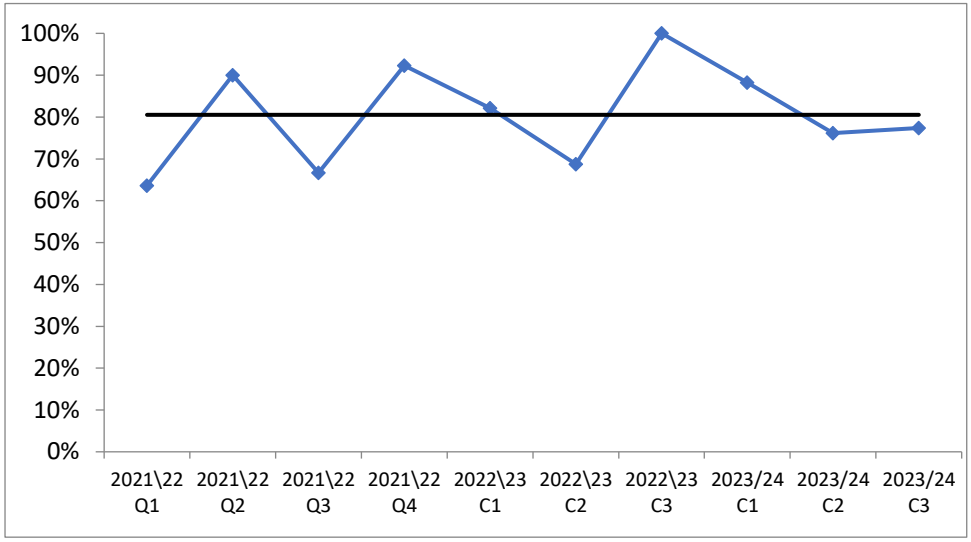




2. **% of inpatients administered IM RT medication in the preceding week (DIRECTORATE) –** B&L and TH usage exceeds trust average usage. This has been reported back to the lead pharmacists to investigate prescribing practices within their own directorates and determine suitability of this. No concerns with other directorates.

3. **% of inpatients given IM RT medication who had post IM RT monitoring completed as per policy –** Post RT monitoring isn't consistently being undertaken consistently across the Trust; a longstanding issue, results fluctuate every cycle. In the past (2021) a letter was sent out to staff by the Chief Nurse and Directors of Nursing re mandatory requirement to monitor, but there hasn't been a consistent improvement. Medicines Committee to discuss actions to address.

   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 on RIO.



DIRECTORATE AND TRUST WIDE SODIUM VALPORATE REPORTING (2023/2024) FROM CUOM AUDIT

Valproate Audit	2023/24		
Quarter 22/23 – 23/24	C1	C2	C3
Is the patient a female and been prescribed Sodium Valproate, Valproic Acid or Semi-sodium Valproate?	4.5%	2.4%	2.7%
	28/629	15/627	17/628
ALL AGES – has RA form* been completed and uploaded on to onto RIO (dated within last 12 months)	61%	87%	94.1%
	17/28	13/15	16/17
ALL AGES – where RA form* has been completed, it has also been sent to the GP	100%	54%	68.8.%
	17/17	7/15	11/16
< 55 YEARS – no. of patients under 55 years old			
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%	52.9%
	26/28	8/15	9/17
< 55 YEARS – has RA form* been completed and uploaded on to onto RIO (dated within last 12 months)	100%	100%	Error: question pertaining to age wasn't asked on this audit cycle so above result are all females
	2/2	7/7	
< 55 YEARS – Is the patient also taking/using appropriate contraception as per ELFT policy?	100%	29%	
	2/2	2/7	

Results

- **Numbers of valporate prescribing in the Trust is low in 22/23.**
- **Positively, Cycle 3 shows a high completion of rate of Risk Acknowldgment Forms as per policy, but only 68.8% of these forms were forwarded on to the GP, who also require this record.**

LIMITATION: Appears to be an error in the questioning of this audit cycle (Feb 24, C3); the question to establish age (<55 or >55) was not asked, therefore there are limitations in analysing the results with regards to follow on questions around contraception and yearly completion of the form.

Actions/Next steps

- There have been manjor overhaul of the the Vaproate Policy due to national regualtory changes introduced as a result of the National Patient Safety Alert (NatPSA/2023/013/MHRA) issued in November 2023.
- The Trust Valproate Policy has been updated and communication sent out trustwide
  As new valproate Risk Acknowledgment (RA) Forms have been published by the MHRA for males and females, our current elctronic RIO RA form has become redundant and we will now being using the paper forms, which will require manual coding and upload to RIO.
  AUDITING REVIEW

- Given the new regulatory changes, which apply to both males and females, we will need to review how we audit implementation of these new changes.
- The cyclical trustwide Valproate audit questions pertain to females and do not cover the new regulatory changes; notably the second specialist signatory requirement is not covered by the audit questions.
- Amendments have been made to the audit cycle question. However, this still pertains to females patients only. We still need to consider review of question pertaining to male patients and capturing data accurately.

WEEKLY REPORT REVIEW

- The current weekly power BI report, reports all inpatients prescribed valproate on EPMA who do not have a valid electronic Risk Acknowledgment form dated within the last year or a paper form coded correctly with 'VALP'
- This current report will be less useful going forward, as the electronic forms have been inactivated and we are paper based currently. Accuracy of the report is dependent on staff correctly coding the paper RA form when they uplaod it on RIO and the report only pertains to female patients and not male patients.
- Toby Baldwin (Interm Chief Clinical Digital Officer) will be working on implementaion of an electronic form, which would eliminate the above limitations, but this is a longer term workstream.
- 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 a CMHT. Further work to be undertaken, to discuss with the medical directors and define what the formal pathway should be and how this is communicated to primary care. There is some assurance; GPs prescribing Valproate in community should be referring back into the specialist services if there is not an up to date risk acknowledgment form.
- NEL High risk subgroup formulated as a branch of the NEL MSQG where valporate and any system wide actions will be discussed further.

DIRECTORATE AND TRUS WIDE HIGH RISK MEDICINES (2023/24) FROM CUOM AUDIT

1. **DISCHARGE CHECKLIST -**. The Nurse Discharge Medication Checklist can be found in annexe of the trust's Medicines Policy. A tool used to support the safe discharge of patients from a ward setting and mandated by the Medicines Policy. The checklist was introduced in Nov 2021, however uptake of use is around 45-53%.
   Discussion point: How can we increase uptake of the checklist to reduce errors at discharge? Also discussed at the medicines safety group; there should be a single trust-wide discharge checklist covering not only medicines but other discharge checks required to reduce the number of 'checklists'. This will be followed up the Trustwide Medicines Safety Group

	C2 23/24			C3 23/24		
Discharge checklist	**Yes**	**Sample no.**	**%**	**Yes**	**Sample no.**	**%**
Has the patient been discharged?	187	627	30%	181	628	29%
Has the discharge checklist been completed?	84	187	45%	96	181	53%
Has the discharge checklist been uploaded onto RIO?	64	84	76%	72	96	75%

	C1 23/24	C2 23/24	C3 23/24
Is the patient prescribed a benzodiazepine on the regular side of the chart for >2 weeks	7.6%	13.5%	21.6%
Rationale for prescribing regular BZD	94.0%	84.0%	95.6%
Has there been a clinical review of the prescription within the last 7 days	100.0%	100.0%	80.1%
Has a plan for BZD withdrawal been documented	40.0%	27.0%	44.9%

2. **BENZOPDIAZEPINES** – In most cases, rationale for prescribing benzodiazepines was well documented over the last 3 audit cycles. Positive to also see that BZD are being reviewed regularly every 7 days for appropriateness. Pharmacy teams should continue 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 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. Wards can request Lithium books from the ward pharmacy team as appropriate. Medicines Committee to discuss actions to address.

	C1 23/24	C2 23/24	C3 23/24
Is the patient prescribed lithium	7%	7%	12.10%
Has the monitoring form been completed on RIO.	55%	44.70%	52.60%
Does the patient have a lithium treatment pack (purple booklet)	50%	27.60%	69.70%