East London NHS
NHS Foundation Trust

Title	Safe & effective use of medicines
Authors	Rajesh Jethwa & Indreet Anand Trust Medicines Safety Officers (MSO's)
Presented to	Medicines Committee
Date	11Th September 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	☐	

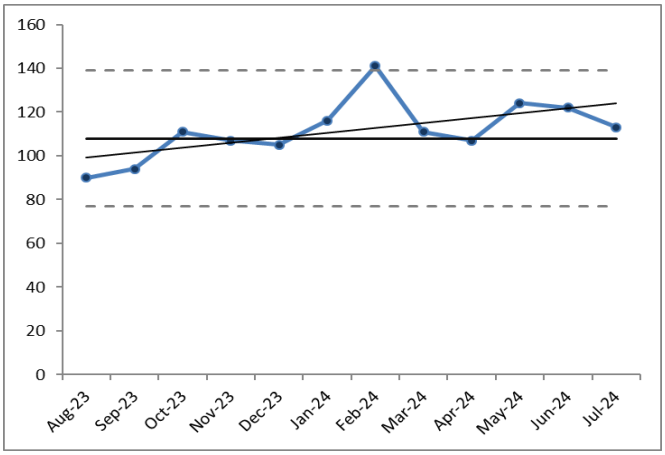
Committees/Meetings where this item has been considered:

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 Medication Incident Reporting over 12 and 24 months



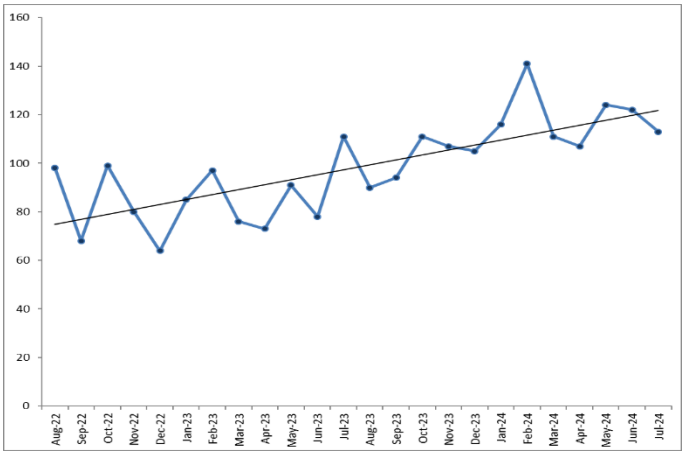


Figure 1 & 2 Total number of medication incidents reported per month

Medication incident reporting fluctuates within control limits. Inphase incident reporting system went live 1st November 23. Overall increase in reporting since launch of Inphase shown by upward trajectory. There is a high reporting culture within our Community Health Services in particular Bedfordshire Community Health services (BCHS) and Tower Hamlets Community Health Services (THCHS). A significant proportion of the incidents reported are as a result of service provided by external agencies and some of the key themes relate to the transfer of care, insulin/LMWH administration (task allocation) and MAR chart errors. This reporting has stimulated system wide workstreams to address gaps in service provision.

Actions

- BCHS are reviewing and updating MAR and insulin administration chart. Update will be presented at Medicines management committee.
- QI work on discharges pathway. Engagement with providers across BLMK.
- Competency framework for adminsitration of LMWH – Action following an After action review AAR.
- THCHS team attendance at Barts Medicines committee to discuss medication incidents at interface and solutions to reduce risk
    - ❖ May 2024 – Medicines bulletin that raised awareness of the importance of selecting insulin device on d/s
    - ❖ Insulin doses to not be included on dispensed label – ‘inject by subcutaneous injection as directed
    - ❖ All inpatient medication orders will have a not for discharge sticker added to reduce risk of items with no instructions being sent home with the patient
- CHS system wide Insulin Benchmarking group identifying number of insulin visits vs number of insulin incidents within community health services. Group generating system wide solutions to support challenges faced at system level.

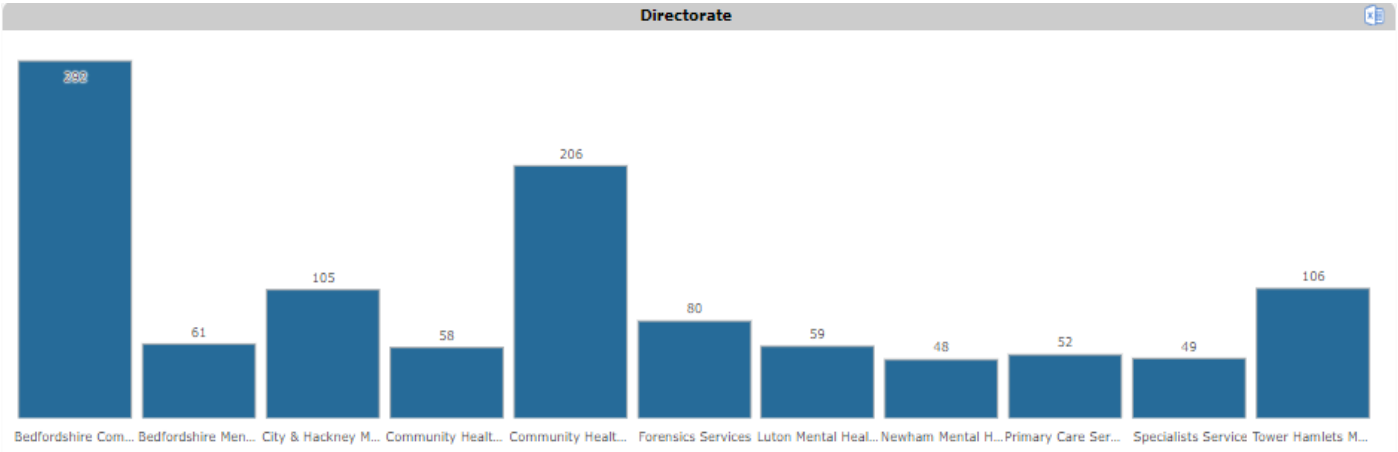


Figure 3- Total number of medication incidents reported directorate (Nov 23 – July 24)

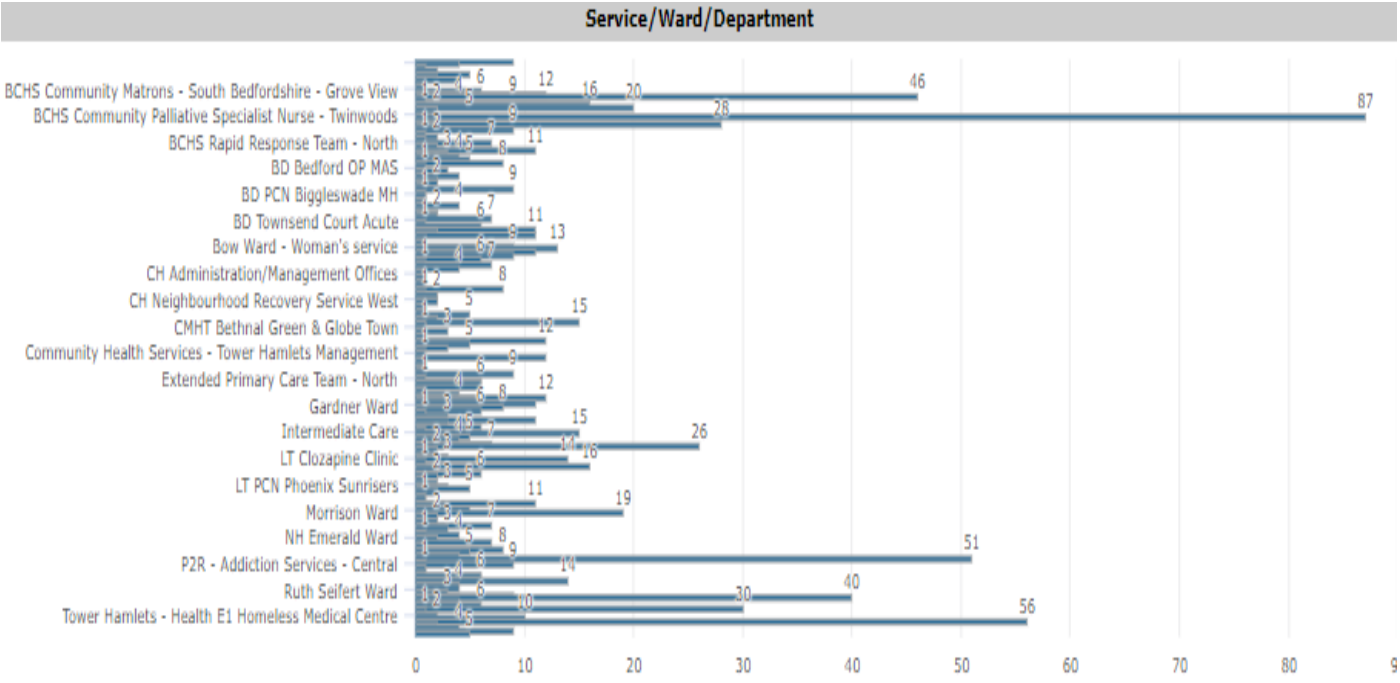
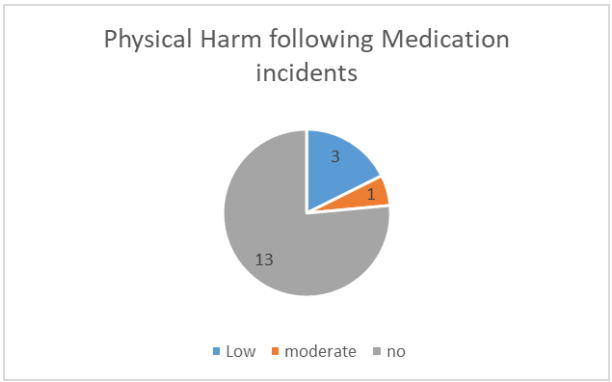


Figure 4 -Total number of medication incidents reported per service ward department (Nov 23 – July 24)



Physical Harm	% of total harm
No	68
Low	16
Moderate	5
No status	11

Figure 5 Medication incidents broken down by type of harm (Q2 July 24 – to date)

Key Medication Incidents (June - August 2024)

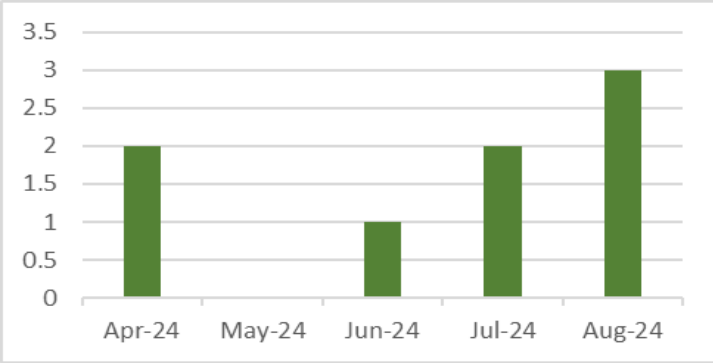
Incident ID	Directorate	Ward	Incident description	Harm (Physical/Psychological	Learning
16967	C&H	Bevan ward	Patient was administered a total of **200mg promethazine as PRN** on 04/08/24. Trust protocol max dose is 100mg/ 24hrs. Patient administered **50mg at 00:30**, **50mg at 00:44, 50mg at 10:45** and **50mg at 22:42**	No Physical or Psychological harm reported	DOC completed by Modern matron. EPMA team to look at an automated solution/reinforcing during training sessions for nursing staff to look at **administration history** before giving medicines. System does not allow for doses above maximum to be blocked out so solution dependent on user to look at administration history prior to giving the dose. To be followed up with some comms supported by the EPMA team
17902	CMHT Bedfordshire	BD PCN Biggleswade MH	Patient JL is an elderly man who was stable on lithium and monitored by GP. JL was referred to team earlier this year due to tremor in hand. When CMHT pharmacist reviewed his bloods, it was noticed that JL has had abnormal blood results (raised lithium levels and fluctuating renal function) however no referrals had been sent to team prior to this due to abnormal blood results. Please see below for abnormal blood results form July 2020: JL is currently CKD 3a (Jun 2021 - 61, Nov 2021 - 61, Jan 2022 - 53, Apr 2022 - 55, Aug 2022 - 56, Mar 2023 - 57, Sep 2023 - 51, Nov 2023 - 51, Nov 2023 - 54, Apr 2024 - 48).	Low Physical harm/no psychological harm	Responsibilities within shared care agreement. GP to notify specialist when monitoring is out of range and seek guidance from specialist on how best to manage situation. Inconsistency in lithium monitoring arrangements given patient had renal impairment. Expectation would be for lithium levels to be taken 3 monthly. Adjustment in dose not recognised in this case.

			History of Li+ levels from ICE: Jul 2020 - **1.13**, Sept 2020 - **1.38**, Feb 2021 - **1.13**, Nov 2021 **1.09**, Jan 2022 - 1.15, Apr 2022 1.22, Aug 2022 1.06, Dec 2022**, 1.05**, Mar 2023 **1.12.**		

72 hour Medication Incident reports Commissioned (July –August 24)

A 72-hour report is designed to support staff in providing critical and relevant information related to a patient safety incident to help executive team understand what happened. This is done to support incident-grading panel with deciding on most appropriate form of learning.

Incident descriptions and learnings taken directly from inphase.



Incident ID	Directorate	Ward	Incident description	Harm (Physical/Psychological)	Learning
14772 (15th July 2024)	CAMHS	Coburn	At around 21:30 MA was given QUETIAPINE XL 300 mg Modified-Release Tablets, 600 mg dose and QUETIAPINE XL 50 mg Modified-Release Tablets, 50 mg dose along with her night time medication as it was still due on the medication chart. Staff later noticed for other patients 18:00 medication was still due. Staff then decided to check with day staff whether or not 18:00 medication was given. Day staff confirmed it was given but not charted***. Double doses of Quetiapine were given to MA.***	Low Physical and psychological harm	Medicines administration training for member of staff involved. Staff to be under period of supervision for 4-6 weeks to support individual during medication rounds
15374 (12th July 2024)	Tower Hamlets MH	Lea ward	Staff M.S was walking down the corridor heard mumbling coming	Low Physical and psychological harm	72 Hour report Learning yet to be completed.

			from H.A room. checked through panel and observed him on the floor attempting to remove his trousers. H.A appeared sedated. M.S summoned for support. Staff member Y.S attended and supported H.A to the bed. H.A was supported into clean and dry clothing and staff cleaned his room as he had been incontinent of urine on the floor. H.A appeared very sedated, he was not alert but responding to voice. ***After investigation 5mg of lorazepam had been administered through the course of the day as well as 50mg promethazine.***		***MSO comments***: Another incident where member of staff has managed to administer above the recommended maximum dose of PRN medicine To ensure that before administering PRN medicine that the administration history is checked to ensure that medication is within timeframe and maximum dose for 24 hours.
17093 (8th August 2024)	BCHS	Twinwoods	Patients was seen on 8th August and insulin dose was missed on 7th August 2024. Patient BM was reading high on both blood glucose and libre sensor. Insulin given to patient and advised additional fluids. Observation completed NEWS 1 due to high HR. Patient was then seen an hour later BM was still high on both blood glucose meters. Escalated to GP, GP phoned back within 30 mins. Advise to return an hour later to recheck BM. Patient would also be followed up by GP this afternoon for a home visit. ***On returning to the patient 2 and half hours after insulin was given BM with still reading high.*** Ambulance called to be assessed. Phoned GP back to cancel visit.	Moderate Physical Harm and Low psychological harm • Required escalation to emergency services	Gaps in communication. Dose of insulin was missed as it was thought that patient was going away so care was suspended, however patient daughter was going away.

17115 (8th August 2024)	Tower Hamlets MH	Roman ward	Patient normally on clozapine at home - admitted to A&E and then transferred to MEH. ***Not prescribed clozapine for the day in A&E, then prescribed olanzapine on admission to MEH. Allergies stated to olanzapine and haloperidol noting NMS as reaction***. Patient received one dose of olanzapine on 28/07/24.	Moderate Physical Harm and Low psychological harm	**Immediate actions.** Olanzapine discontinued on Monday 29/07/24 and clozapine re-commenced as was up to the 48 hour mark of clozapine administration Awaiting 72 hour report completion ***MSO comments*** • Prescribing of mental health medicines outside of mental health setting. System wide work to address this gap • Recognition of allergy status and ensuring these are updated on each admission. 2nd incident in past 3 months where allergy status was not acted on.
17338 (12th August 2024)	Community Health Services Tower Hamlets	Rapid response	Patient discussed with RRT for next day Clexane injection, staff advised to forward details to RR inbound referral session on Emis record Duty staff reminded to ensure a referral is sent to RR inbound. No referral received at the time of closing of service on 09/07/2024. ***Patient missed 2 days (10th and 11th of August 2024) medications as a result of incorrect link episode created on EMIS records.***	Low physical and no psychological harm	Error occurred due to communication gap between transferring team (Duty staff T & A) and RRT as a result of Incorrect link episode created on EMIS for RRT inbound. This lead to omission of Enoxaparin Injection for 2 days over the weekend because the RRT did not receive the referral from T & A duty staff. In total patient missed 9 days of enoxaparin The Clinical lead for T & A was advised to liaise with RRT to check and resolve the EMIS system issue ***that possibly led***

					to the Incorrect linking of transfer of patient to RRT inbound process to avoid similar incident in future. To also contact EMIS team if required to resolve the technical issue.

Local Medicines Safety Updates

1. **Trustwide Medicines Safety Group (MSG)**
   - Good engagement across all disciplines
   - Workstreams underway to improve safety across the organisation. See action log.

Medicines Safety Action Log (June 202

Trustwide Medicines Safety Gr

2. **Valproate Policy Implementation Group**
   - Working with informatics to build valproate reporting into Pharmacy PowerBI dashboard.
   - Revised valproate form has been tested and approved. Awaiting go live date
   - MSO's presenting key points from trust valproate policy at academic learning sessions

3. **System Wide Working**
   - NEL MSQG: North East London Medicines Safety Quality Group. Workplan agreed for 24/25.
     - High-risk medicines – focus on teratogenic medicines. Safe use of valproate and Topirimate
     - Safe transition of care – anticoagulation safety, insulin safety, allergies de labelling and reduction in delayed and omitted doses
     - Incident management – Learning from medicine related patient safety incidents across the interface. Supporting implementation of LFPSE and PSIRF within NEL.
     - Safe use of dependent forming medicines across the system
   - BLMK Medicines Safety Group

BLMK Medication Safety Group Action

4. **Digital/Informatics update**
   - Phase one completed with live dashboard on PowerBI. https://app.powerbi.com/groups/me/apps/1d64c7fa-1146-46e2-b054-ca6c969e8f92/reports/b30a2cec-6c61-4e0f-9fa6-7ebc48c3a0dc/58e88676e04d0c3a3808?ctid=b7a2ec96-1f25-4ba8-b4e2-019abc93697f&experience=power-bi

Benefits Realisation of Medicines Dashb

5. **Q2 24-25 Trust wide Medicines Safety Bulletin**

Meds Safety Bulletin Aug 2024.pp

6. **Rapid Tranqulisation Quality Improvement work**
   - Working with Evah on identifying challenges with post RT monitoring.
   - Focus on areas that have poor compliance as identified in medicines audit programme.
   - Revision of audit questions to improve clarity for auditors

MHRA DRUG SAFETY UPDATES

July 2024

1. **Epimax Ointment and Epimax Paraffin free ointment: reports of ocular surface toxicity and ocular chemical injury**

ADVICE FOR HEALTHCARE PROFESSIONALS/PATIENTS.

- Do not prescribe for use on the face
- If comes into contact with face , this may present with pain, swelling, redness, watering of eyes, sensitivity to light, blurred vision, burning or grittiness.
- If product goes into eyes, rinse well with water and seek medical advice.
- Wash your hands thoroughly applying epimax ointment/epimax paraffin free ointment and avoid touching eyes after using these products

August 2024

1. **Yellow Card Biobank: call to contribute to study of genetic links to side effects –** The biobank is a collaboration between the MHRA and Genomics England. Goal is to improve how a patient's genetic makeup may increase their risk of experiencing harmful side effects to medicines and eventually develop pharmacogenetic testing strategies.
   - Side effects covered in pilot
     i. Severe bleeding events with DOAC
     ii. Rare severe skin reactions with allopurinol (Steven Johnson syndrome, toxic epidermal necrolysis, drug reaction with eosinophilia and systemic symptoms syndrome)
   - Report on yellow card. MHRA may contact you to discuss case further and ask you to contact patient to ask for participation in study. Patient will then be asked to provide a blood sample for genetic analysis.
   - See video link https://yellowcard.mhra.gov.uk/biobank

MEDICINES SHORTAGES AND LOCAL MEMO'S

1. Olanzapine (Zypadhera ®) 210mg,300mg and 405mg injection – circulated trustwide

ACTION FOR INPATIENTS & MENTAL HEALTH COMMUNITY TEAMS

➢ **NEW INITIATIONS**

- To **Not** initiate any new patients on Olanzapine depot during this time
- Prescribe an alternative long-acting preparation that meets individual patient requirements. Refer to prescribing policy for long-acting depots and summary of products characteristics (SPC) for information on doses used.

➢ **CONTINUING TREATMENT**

- **Option 1:** Switch to target oral olanzapine dose as per following table.
- **Option 2:** Switch to an alternative long-acting depot that meets individual patient requirements.
  Ensure any changes are communicated with the service user's community team as well as GP/Primary care provider for accuracy of treatment records.
- **Option 3:** Have a discussion with your ward pharmacist if patient unable to be switched to alternative formulation.

2. Hydroxcobalamin storage – safety risk identified by inappropriate storage. circulated trustwide.

BACKGROUND:

It has been highlighted that in some clinical areas, hydroxocobalamin injections are being incorrectly stored in refrigerators.

It is unclear where information came from to support this practice and it may have been associated with an old formulation that historically required refrigeration, leading to continuation of this practice.

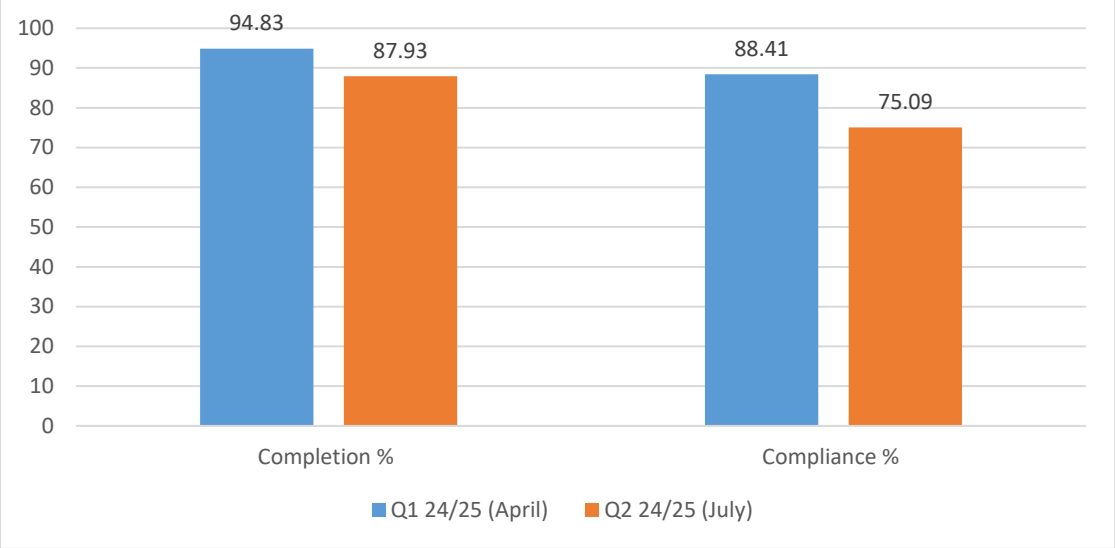
The manufacturer(s) of hydroxocobalamin (various brands checked) state that the injections should be stored below 25°C and to ensure the medicinal product is protected from light.

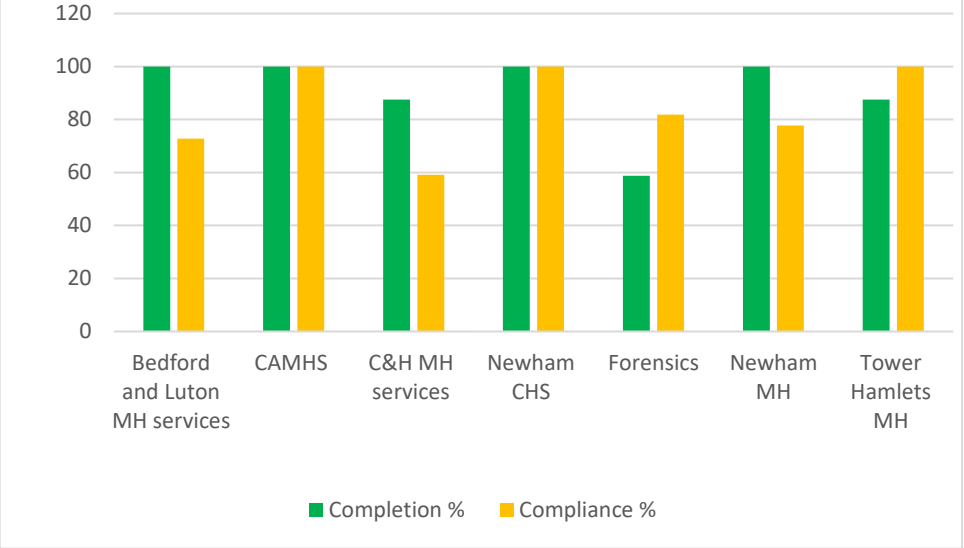
ACTIONS

- Please store hydroxocobalamin 1mg/1ml injections at room temperature (below 25°C) provided that there are no temperature excursions. See below for information regarding
- Follow the Trust document (ELFT intranet: Trust Policies ► Medicines subsection). "Standard Operating Procedure for Fridge and Clinical Room Temperature Monitoring for Safe Storage of Medicine"
  https://www.elft.nhs.uk/intranet/teams-support-me/governance-and-risk-management/policy-management/trust-policies
- When medication is delivered to your clinical area and also patients own medicines, always check the product packing/leaflet for instructions on storage requirements and store accordingly.
- Please actively check your refrigerators for hydroxocobalamin injections and also check the other medicinal products in the refrigerator are correctly being stored in there in accordance with the manufacturer's instructions. If there are any discrepancies, please contact your local pharmacy team for further advice.
- Note: For clinical areas which receive delivery of medicines from the ELFT pharmacy, any medicines that require refrigeration will be delivered in a cool bag/box or the bag will be flagged with a label/sticker to indicate it contains medicines that need to be refrigerated.
- If you require further information or advice, please contact your local pharmacy team.

Trust Wide Medicines Audit Programme – CONTROLLED DRUGS Q2 2024/25

Audit are now hosted on INPASE. Directorates leads are expected to directly access results from INPHASE and to prompt teams to view their results; dicussion expected at DMTs and associated actions should be forwarded to the directorate QA manager.





KEY FINDINGS

- The % of completed CD audits has dropped from Q1 24/24 (94.83% to 87.93%) – Leads to explore this further with their teams and feedback challenges to MSO's
- The % compliance against CD audit standards has dropped from Q1 24/25 (88.41% to 75.09%) – Leads to explore areas from the CD audit questionaire using 'Question compliance heatmap' on inphase module. This will identify wards that have performed poorly on specific areas within the audit. Leads to coordinate and identify effective actions as part of the DMT to improve compliance against these standards. https://elft.inphase.com/book/View?BookId=48&PageId=469&M=5

Medicines Risk register on Inphase

	Description	Owner	Opened	Control(s)	Control Effectiveness Score	RM01 Risk Consequence Score	RM02 Risk Likelihood Score	RM03 Risk Rating Score
28	Using controlled drugs in clinical environments as per CD policy. Primary concerns are in reference to correct record keeping and stock discrepancies; can appear that there is 'missing' stock, but in reality, often the register entry record has been inadvertently omitted during nurse medication administration. Added 15.05.24 - Potential risk of diversion and or abuse.	Stuart Banham	22 Apr 2024	▪ ADIOS ▪ CD balance checks ▪ Safe custody of Schedule 2 CD's ▪ stricter controls on lower scheduled drugs. ▪ Trust Policies and Procedures ▪ Trustwide Audits		Minor 2	Possible 3	6
29	Patient's may be prescribed antipsychotic(s) at doses above 100% of the BNF maximum dose. It is imperative that high dose antipsychotic health monitoring is completed for patient's as per trust policy. Without monitoring, there is no assurance that these medicines are being safely used.	Philip Baker	22 Apr 2024	▪ Audit programme - Clinical use of medicines. ▪ Trust Policies		Minor 2	Possible 3	6
30	Post RT monitoring figures low across Trust.	Evah Marufu	22 Apr 2024	▪ E Learning ▪ Trust guidance		Major 4	Possible 3	12
31	Medicines must also be checked by the ward team prior to handing over to the patient using the trust medicines discharge checklist. Medication changes may have occurred since the original TTA was prepared. A proportion of incidents reported on a quarterly basis relate to medicine and discharge process.	Indreet Anand	29 Apr 2024	Discharge Checklist in medicines policy		Minor 2	Possible 3	6
32	Implementation of new MHRA regulatory measures for valproate for both males and female patients and embed this into the organisation.	Stuart Banham	01 Nov 2023	Valproate Gudiance		Major 4	Possible 3	12
33	It is recognised that those Incidents involving insulin make up a high proportion of the medication errors reported in ELFT Community Health Services. A large proportion of these errors fall under the category of administration of medicines. Insulin is a high risk medication and has the potential to cause serious patient harm.	Rajesh Jethwa	29 Apr 2024	▪ Insulin e learning ▪ Insulin Policy		Moderate 3	Possible 3	9
34	Adhoc visits from pharmacy to CMHT due to staffing issues. Risk: Clinical safety issues/errors may go undetected. Pharmacy related tasks are not undertaken consistently/daily e.g. clinical screen of depot charts, depot management (including homecare) , clinical room management (room and fridge temperature monitoring, expiry date checks) and double checks on HDAT monitoring.	Andrea Okoloekwe	29 Apr 2024	Guidance for CMHT Pharmacy service underpinned by multiple policies		Major 4	Likely 4	16
35	Number of items dispensed increasing month on month. There is no increase in staffing levels. Staff not able to follow personal development plans because they cannot be released which will impact retention. Medicines storage limited leading to medicines not always being stored on shelves. Challenges with controlling ambient temperature monitoring within dispensary. Affect medicines stability.	Stuart Banham	29 Apr 2024	Over recruitment		Major 4	Possible 3	12