East London NHS
NHS Foundation Trust

Title	MSO report January 2025
Authors	Indreet Anand Trust & Rajesh Jethwa - Medicines Safety Officers (MSO's)
Presented to	Medicines Committee
Date	8th January 2025

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	☐	

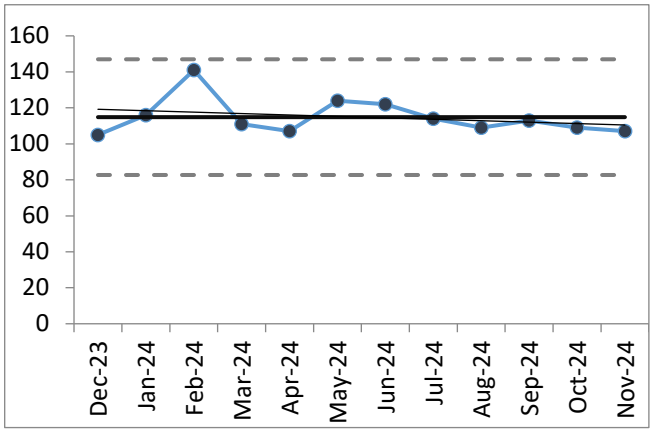
Committees/Meetings where this item has been considered:

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



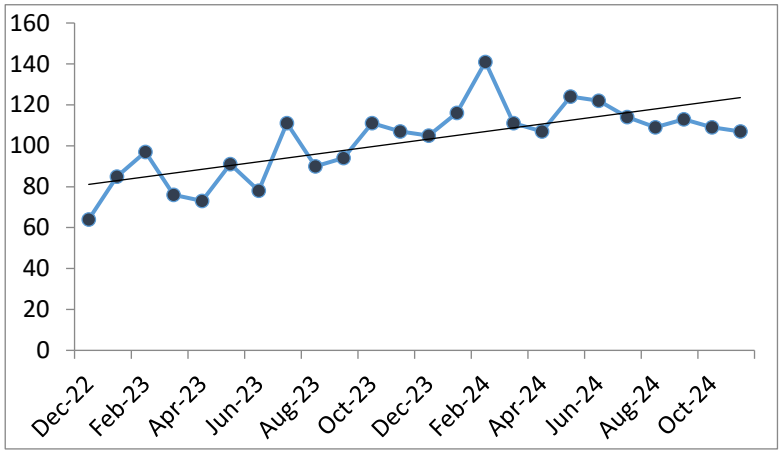


Figure 1 & 2 Total number of medication incidents reported per month (12 and 24 months)

Medication incident reporting fluctuates within control limits. Inphase incident reporting system went live 1st November 23. 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 services 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.The impact of this work should slowly start to reflect on the type and frequency of incidents being reported within these services.

Financial YTD (April to November 2024)

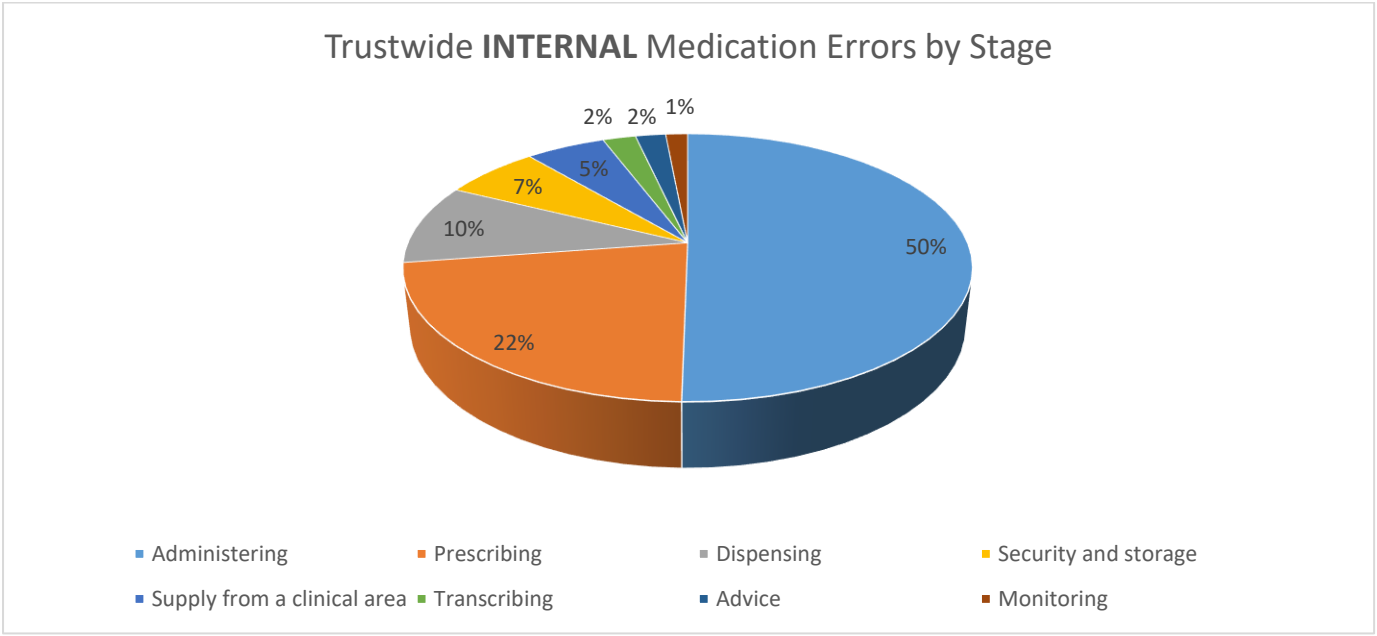


Figure 3 Percentage of internal medication incidents reported according to stage April to Nov 24 YTD.)

The above graph represents all internally attributed ELFT errors i.e. external errors reported by ELFT staff have been excluded. The largest proportion of incidents can be attributed to adminstration errors; this generally is the highest frequency task that occurs in a medicines cycle and therefore explains the higher

proportion of errors at this stage. Prescribing errors are the second highest, followed by dispensing errors. Reassuringly, Trust data is in line with national data; administration (54.4%), prescribing (21.3%), dispensing (15.9%). *[Reference: Elliott et al 2019, economic analysis of the prevalence and clinical and economic burden of medication errors in England].*

Ongoing work to focus on the top 3 stages

Administration:

- Training delivered to ELFT nursing preceptorship cohort of nurses.
- Webinar is in devlopment for piloting with the Forensics nursing cohort (increased reporting). Plan to adapt this next year for delivery trust wide on a individual directorate basis.

Prescribing

- ELFT Mandatory Precribing training module launched recently.
- Doctors (Induction) training delivered; covering prescribing aspects related to high risk drugs.
- Action: To focus/deep dive on type of prescribing errors being reported.
  A) To amend the training presentation to include any key problem areas.
- Valproate Learning Seminar delivered to doctors during academic learning sessions.
  - Aim to deliver further session next year after updated policy launch.

Dispensing

- Recent appointment of a new dispensary manager. Plans to focus on:
  A) Near miss dispensing recording and review.
  B) Incident management and formalised reflection/learning process within the dispensary.

Physical Harm – Internal errors (external organisation errors excluded)

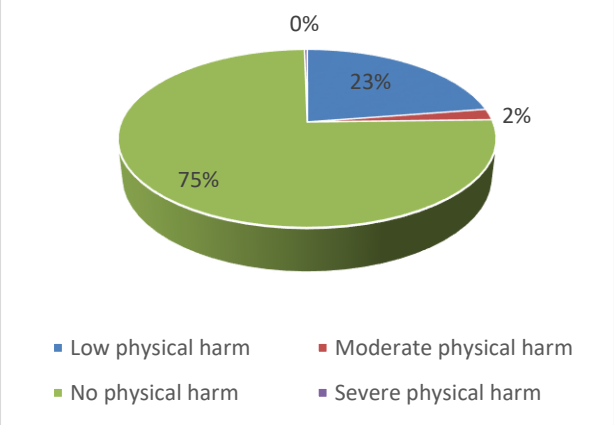


Figure 4 Internal medication incidents broken down by type of physical harm (April – Nov 24 YTD)

Physical Harm	Count	% of total harm
Blank	7	n/a
No Harm	263	75
Low Harm	79	23
Moderate Harm	7	2
Severe Harm	1	<1%

Key Medication Incidents (October to November 2024 – SEIPS model wrt learning

LFPSE Incident ID	Date	Directorate	Ward	Incident description	Immediate actions	Harm	Learning using SEIPS
20958	14/10/24	City and Hackney	Joshua Ward	Patient has missed 4 doses of Epclusa (Hep C treatment) over the weekend. Patient was transferred from Ruth Seifert ward to Joshua ward before the weekend and Epclusa was left on Ruth Seifert ward	Epclusa identified by Pharmacy ATO on Ruth Seifert and followed up to ensure a supply to the patient	Low physical harm	**Person** Staff training/Knowledge lacking around the importance of 'critical medicines' as defined within the Medicines Policy. Pharmacy team have relayed back to the ward as part of the follow up. **Organisation** Internal processes with respect to transfer of care between wards. To review medicines policy to ensure this is clearly defined.
19644	20/09/24	Forensics	Bow Ward	Patient was prescribed insulin 34 units twice daily, morning and evening. Decision made to increase evening dose to 36 units. Patient was prescribed 34 units in the morning and 36 units in the evening. The original prescription modified incorrectly, which meant the patient was due to have 34 units and 36 units in the evening on 20/09/24, i.e. 80 units in the evening instead of 36 units	Pharmacist alerted clinical team and duplicated prescription was discontinued	No harm (near miss)	**Person** Staff training/Knowledge regarding EPMA. Medication was modified, but should have been discontinued and re-prescribed as highlighted within EPMA doctors training session. **Tools & Technology** EPMA (digital drug chart) poses a 'duplicate prescribing' risk if the medication is modified instead of being discontinued; known risk on the EPMA risk register and EPMA team plan to review their doctors training to address this.

72 hour Medication Incident reports Commissioned (October – November 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 taken directly from inphase

Incident ID	Directorate	Ward	Incident description	Harm	Learning using SEIPS
Some of October's 72 hour reports were covered in the previous report.					
21767 14/10/24	Forensics	Loxford Ward	Reporter Description: ''Whilst checking the patient record, I notice that a dose of zopiclone 3.75mg PRN was administered five times in the space of 2 hours on 20/20/24. 3.75mg was administered at 21:30, 21:30, 22:00, 23:00, and 23:30. The prescription is for 3.75mg mg at night as required I brought this up to the attention of the ward manager who discussed it with the nurse who administered the medication. According to the nurse, the intention was to administer nicotine lozenges, but instead she chose zopiclone by accident. This means that the nicotine lozenges administration was not recorded, also nicotine lozenges are prescribed to be given every 2 hrs and looking at the frequency the zopiclone tablets were given on EPMA, the nurse administered a nicotine lozenge every 30min to 1 hr, which is against what the patient is prescribed''	No physical harm	**Person** Human error – misselection of the incorrect drug electronically. Also, lack of knowledge around the medication being administered (this was not in compliance with the 10Rs of administration); not I accordance with the Rx (minimum dose interval was exceeded). **Tools & Technology** Wider system risk within the EPMA; system does not block administration of PRN doses to ensure minimum dosing interval and maximum daily dose are not exceeded. System risk acknowledged by the EPMA team (on risk register). Requirement for nurses to manually check last PRN dose administered prior to administering a prospective PRN dose to ensure compliance with the Rx. **Areas of good practice** • Thorough follow up by Forensic lead pharmacist and nursing lead. • Staff member involved realised the significance of their error; undertook a positive reflective account, identifying shortfalls and areas of improvement /training to ensure competence.

22751 13/11/24	N/A	Patient's home	Reporter Description: ''S.M was assessed by CRHTT doctor on 7.11.24 and agreed informal admission to psychiatric hospital, supported on twice a day contact awaiting a bed. A neighbour called ambulance at around 4 am of 09.11.24 when SM contacted her to inform her that she is drowsy. SM on was conveyed her to the a&e dept. at it transpired that SM took unknown amounts of zopiclone, promethazine , melatonin, nytol, night nurse, at unknown time and GCS 14/15 on her arrival at a&e dept.''	Low physical harm	Further narrative: Medical review at patient's home; inpatient admission was agreed. As per protocol, service users await admission whilst at home. Reasonable clinical decision; risk assessment was completed and imminent plans to harm herself were denied therefore staff were supporting her in the community. The service has mechanism to prioritise bed allocation and involves the relevant clinicians in the community, inpatient representatives and the patient flow team. Service users are prioritised based on risk and clinical need. **Organisation:** Staff shortages contributing to earlier omissions; missed face to face review during CC's (care co-coordinator) sickness and no follow up after a missed appointment. **Person:** Opportunity to have considered removing medication on 7/11/24 at face to face review, however risk of suicide/overdose hadn't been identified here. **Areas of good practice** - The incident was reported for by the service, demonstrating a culture of openness and learning - Care coordinated promptly escalated the case to PLS to ensure mental health review/support was provided at the general hospital after admission. - Joint working visit between CMHT CC and CRHT. - Good liaison with NOK identified. - Welfare visit conducted by duty CMHT staff prior to CRHT referral
23591 25/11/24	City and Hackney	Joshua	Reporter Description: ''Patient missed approx. 73 hours of clozapine, and was then administered full usual dose''	Low physical harm	**72 hour report pending** **Person** Staff training/Knowledge lacking around the importance of 'critical medicines' as defined within the medicines policy. **Tool and Technology** Clozapine is a deemed a high risk medication and a critical medicine. Given the high usage of this medication as mental health trust, we need to explore how we could utilise you EPMA system to alert relevant HCP when doses of this medication are missed e.g. Live EPMA report alert (currently being explored by MSOs and EPMA team). **Areas of good practice**

					Detected by ward pharmacist following on from the weekend and reported. Pharmacist will work with the ward team to raise awareness so the learning can be shared.
23639 26/11/24	CAMHS	Coburn	Reporter Description: ‘’During medication round this morning, it was discovered that medication CLOZAPINE (ZAPONEX) dose (300mg) Tablet for night (25/11/24) was not charted. Staff rang the nurse (BJ) who was on duty last night and she confirmed that medication was missed as none was available. Patient missed approx. 73 hours of clozapine, and was then administered full usual dose	Moderate physical harm	**72 hour report pending** **Person** Staff training/Knowledge lacking around the importance of ‘critical medicines’ as defined within the medicines policy. Also Duty Senior Nurse was not informed in order to contact pharmacy on-call service for a supply. **Areas of good practice** - The incident identified promptly by other nursing staff on shift, which demonstrates nursing and knowledge competence around the significance of clozapine dose omission and the risk of treatment break leading to re-titration.

LOCAL MEDICINES SAFETY UPDATES

1. **Trust wide Medicines Safety Group (MSG)**
   - Good engagement across all disciplines
   - Work streams underway to improve safety across the organisation.
   - Feedback MS forms survey sent to group – analysis of responses and implement findings

2. **Valproate Policy Implementation Group -**
   - **Group has been disbanded.**
   - Trust-wide policy circulated to medicines committee members for feedback
     - 'Go Live' plan is scheduled for January 2025 with Trust-wide communication on updated policy launch.

3. **Preceptorship Training (Webinar)**
   - Medicines Safety and Safe Administration of Medicines session delivered (Nov 24)
     - Well received with documented positive feedback form completed.
     - Agreement for MSO to deliver prospective sessions live, but recorded as a contingency for future delivery.

4. **Forensic Nurse Training (Webinar Planning)**
   - Medicines Safety and Safe Administration of Medicines
   - Meetings with Forensic Senior Nursing leads to discuss ↑ in administration incidents reported.
   - Webinar session to be tailored to Forensic directorate requirements
   - Potential plans to adapt this for Trust wide delivery on a per directorate basis.

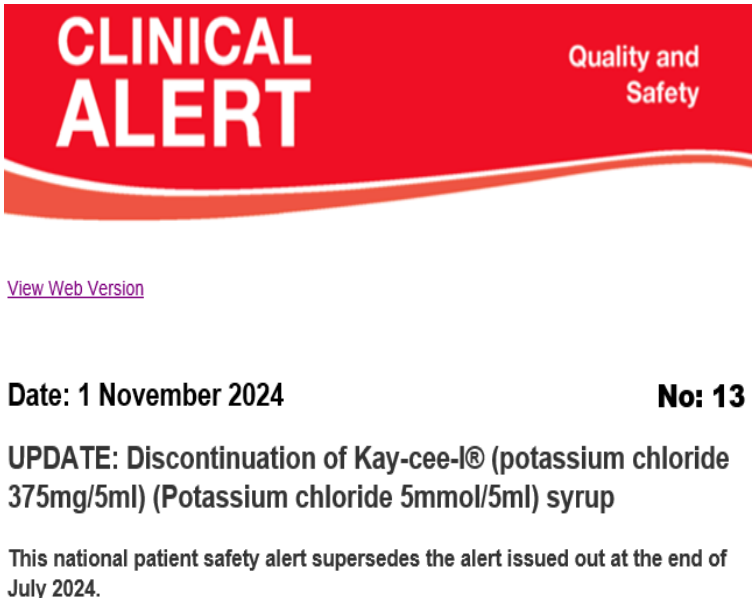
5. **Doctors Induction/Training**
   - Session delivered at learning academic sessions
   - Mandatory prescribing training module has been launched and communication circulated.

6. **Insulin Mandatory Training**
   - Mapped on as mandatory training for nurses, HCWs, HCAs
   - (Community Insulin incidents is an ongoing safety work stream)

7. **Medication incidents relating to Palliative care and Syringe Drivers**
   - Meeting with Deputy Chief Pharmacist (A.Okoloekwe), Tower Hamlet CHS Deputy Lead Pharmacist (C.Okoli) Lead for EOL (E.Robinson) and Lead for Advance Care Planning (C.Rego) to discuss the recent incidents relating to syringe drivers and palliative care. Discussed themes and actions agreed; local/mandatory training, Policy review (local and NEL wide), focussed teaching session.

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

9. **Clinical Alerts (x2)**


CLINICAL ALERT

Quality and Safety

View Web Version

Date: 1 November 2024 **No: 13**

UPDATE: Discontinuation of Kay-cee-l® (potassium chloride 375mg/5ml) (Potassium chloride 5mmol/5ml) syrup

This national patient safety alert supersedes the alert issued out at the end of July 2024.

Discontinuation of Kay-cee-l® (potassium chloride 375mg/5ml) (5mmol/5ml) syrup

Discontinuation of the product. Not to initiate any new patients, review those currently prescribed the medication and other relevant actions.

Access the full clinical alert: click here or link below:

Full alert can be accessed here:
(https://technology-trust-news.org/cr/AQjOmwUQibCDBxj6urLkBuUw4Vfap0CoSyuSrJYDpV403iRiS1bNtZYUdT1G6Q3Y)


CLINICAL ALERT

Quality and Safety

View Web Version

Date: 2 December 2024 **No: 14**

Neuroleptic Malignant Syndrome (NMS)
MEDICAL EMERGENCY

Neuroleptic Malignant Syndrome

MEDICAL EMERGENCY

Increased risk of NMS when:

- Antipsychotic medication recently started or dosage rapidly increased (but can also occur during long-term treatment on a stable dose).
- Restarting antipsychotic medication in patients with a history of NMS.

Symptoms to look for: | Action to Take:

Neuroleptic Malignant Syndrome - Medical Emergency

TWO incident this year, as a result of prescribing an antipsychotic documented in the patient's notes to have previously caused NMS. **NEW REQUIREMENT**: NMS is to be documented as an ALLERGY; 'NMS' drop down box to be selected, which would block prescribing of the associated drug if this is selected.
Access the full clinical alert: click here or link below:

Full alert can be accessed here:
(https://technology-trust-news.org/cr/AQjOmwUQjYuGBxj6urLkBjEln2ecr6g0N8osC_wRnvoITZh9a2PQwed0Ht_P1fpF)

MHRA DRUG SAFETY UPDATES

November 2024

1. No specific drug updates.
2. MedSafetyWeek November 2024: your Yellow Card report helps prevent future harm to others and improves patient safety
   4 – 10 November 2024 is MedSafetyWeek. The theme for this campaign is 'preventing side effects', focusing on the importance of using healthcare products in the right way to prevent harm and reporting suspected adverse drug reactions to medicines and suspected adverse incidents with medical devices. We ask healthcare professionals to support the campaign and talk to their patients and colleagues about side effects and how to report suspected safety concerns to the Yellow Card scheme.

3. Summary of recent letters and notifications sent to healthcare professionals in October 2024 about medicines and medical devices.
   Access via:
   https://assets.publishing.service.gov.uk/media/672b599940f7da695c921c04/Drug_Safety_Update_November_2024.pdf

December 2024

1. No specific drug updates
2. Summary of recent letters and notifications sent to healthcare professionals in October 2024 about medicines and medical devices.
   Access via:
   https://assets.publishing.service.gov.uk/media/675aabb7ad4694c785b0edf2/DSU_dec_24.pdf

Trust Wide Medicines Audit Programme 2024

Note: Directorate teams have access to inphase audit data results and are expected to; review data/trend analysis for their individual directorates, identify address areas of concern and action plan for improvement.

The last audit results for a) CDs(Q3) and b) Clinical Use of Medicines (Cycle 2 of 3) were presented in the last MSO report. However, since then the MSOs in conjunction with the QA team have developed tailored dashboards; enabling 'deep dives' and trend analysis down to directorate and ward level.

This report provides a deep dive into **HDAT and Rapid Tranquilisation,** as the monitoring aspect of both is currently on the risk register and a deep dive has been requested in previous medicine committee meetings to understand the scale of the problem; is it trustwide or specific directorates of concern?

1. HDAT – High Dose Antoipsychotic Treatment and Monitoring

Figure 5: Trust wide HDAT prescribing levels – Historic (pre inphase)

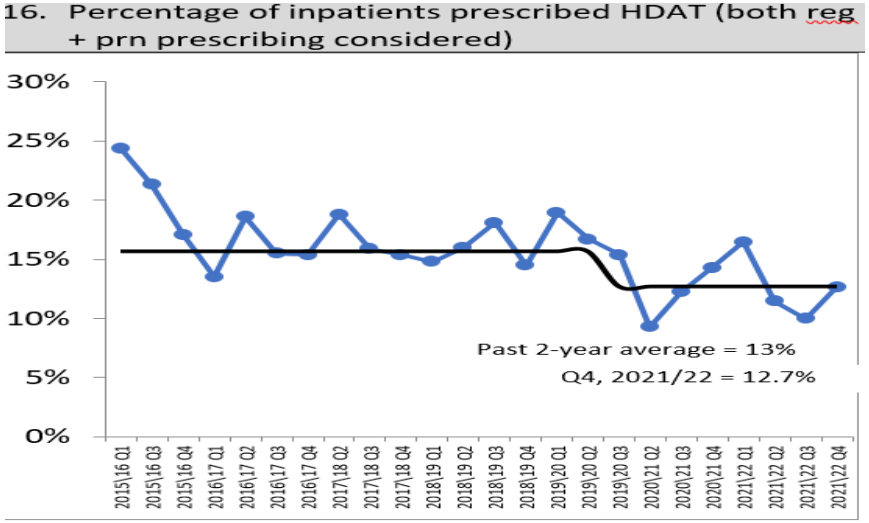
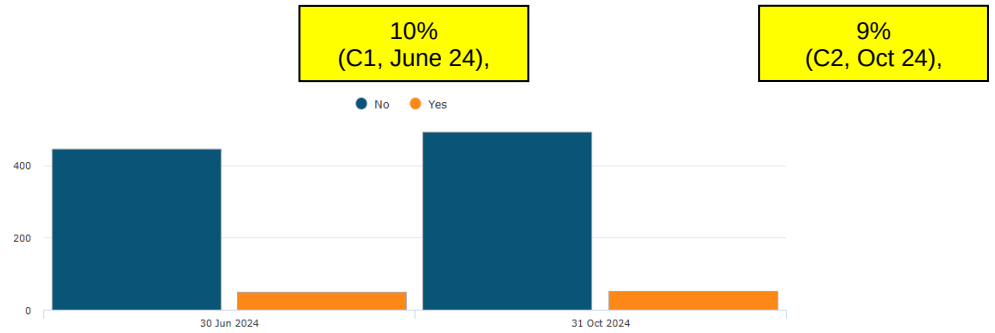


Figure 6: Current Trust wide HDAT prescribing levels 2024

Question	Answer	30 Jun 2024 Count	31 Oct 2024 Count
04. Is the patient prescribed high dose antipsychotic therapy (HDAT)	No	447	493
	Yes	49	51

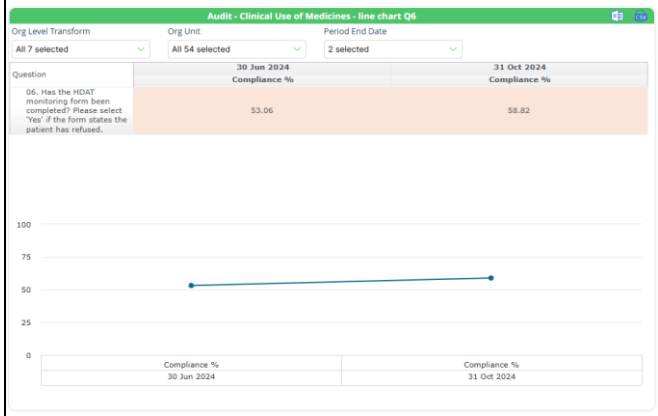


Historic data from 2015 displayed to highlight the overall reduction of HDAT prescribing within the Trust has been sustained and use of HDAT within the Trust remains at an all-time low. Currently, HDAT prescribing is at 9-10% (C1 and C2 2024/25).

A deep dive of the data shows that Forensics has the highest levels of HDAT prescribing; C2 27/157 (17%) and C2 32/157 (20%), which is significantly higher than the trust average (9.5%) and adversely skews the results. This higher usage has historically been the case for Forensics and was raised in the January 2022 Medicines committee; this higher use was acknowledged by the committee and agreed this was to be expected given the speciality in question. A deep dive/scoping was requested at the time by the directorate, but unclear of the outcome.

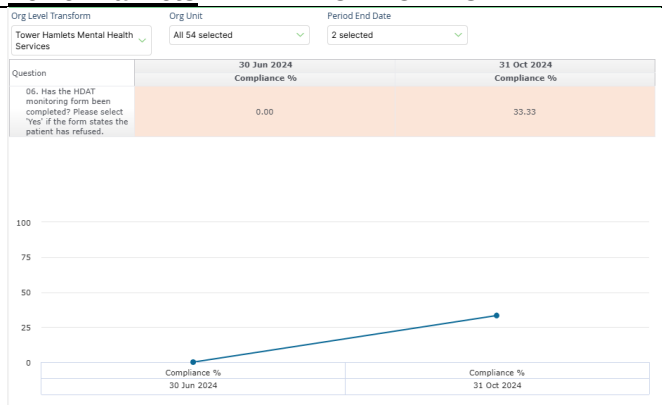
DISCUSSION POINT: Medicines Committee to discuss if happy to accept the higher usage within Forensics is justified or whether further work is needed by the directorate. No major concerns in relation to HDAT prescribing levels within the other directorates.

TRUSTWIDE – HDAT MONITORING



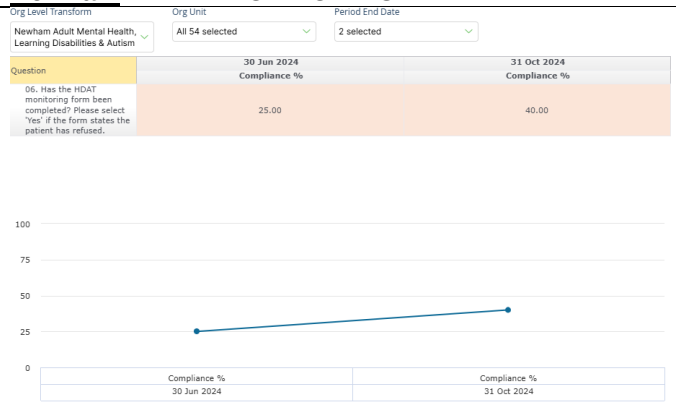
Cycle 1: 53% and Cycle 2 59%

Tower Hamlets - HDAT MONITORING



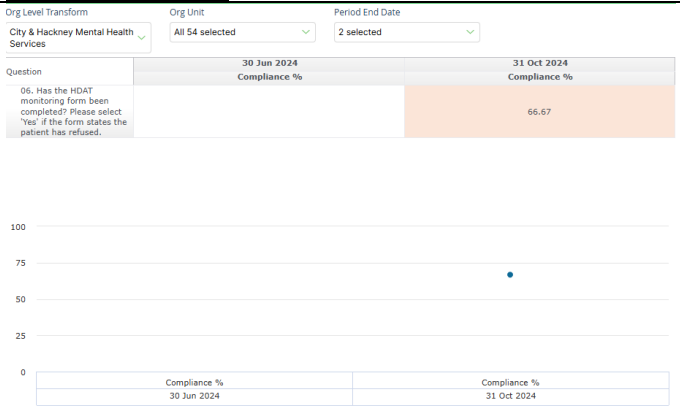
Cycle 2: 0%, 0 out of 1
Cycle 3: 33%, 1 out of 3
Average of 80 patients per cycle samples with only 1-3 patients on HDAT. Positive: Tower Hamlets has the lowest HDAT prescribing levels trust wide.

Newham - HDAT MONITORING



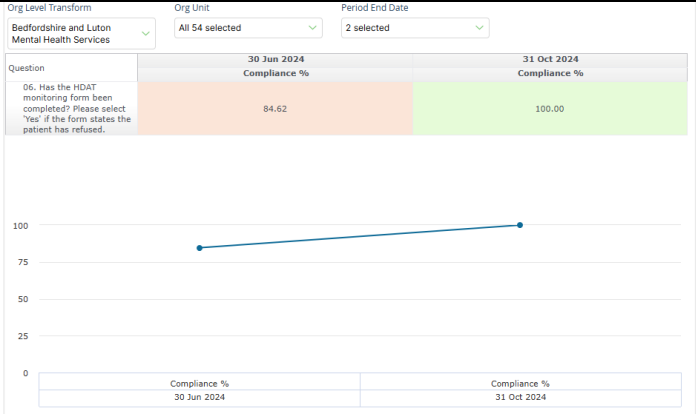
Cycle 2: 25%, 2 out of 8
Cycle 3: 40%, 2 out of 5
Average of 80 patients per cycle sample with 5-8 on HDAT.

City and Hackney - HDAT MONITORING



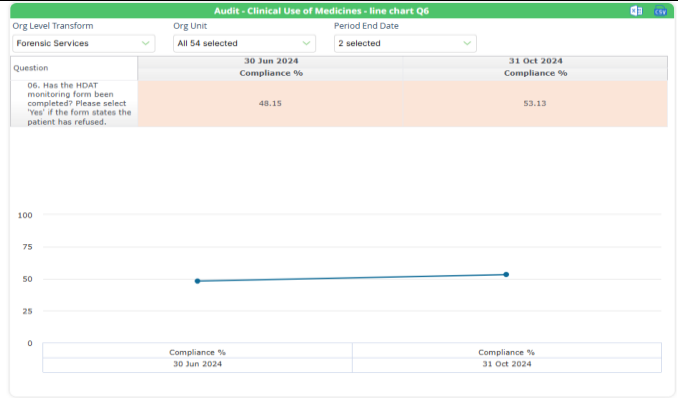
Cycle 2: N/A, no patients on HDAT
Cycle 3: 66% 2 out 3
Average sample size 70, 2 patients on HDAT.
HDAT.

Beds and Luton - HDAT MONITORING



Cycle 2: 85%, 11 out of 13
Cycle 3: 100%, 8 out of 8
Average sample size 101-103, with 9-11patients on HDAT. Positive: Good HDAT monitoring (>85%)

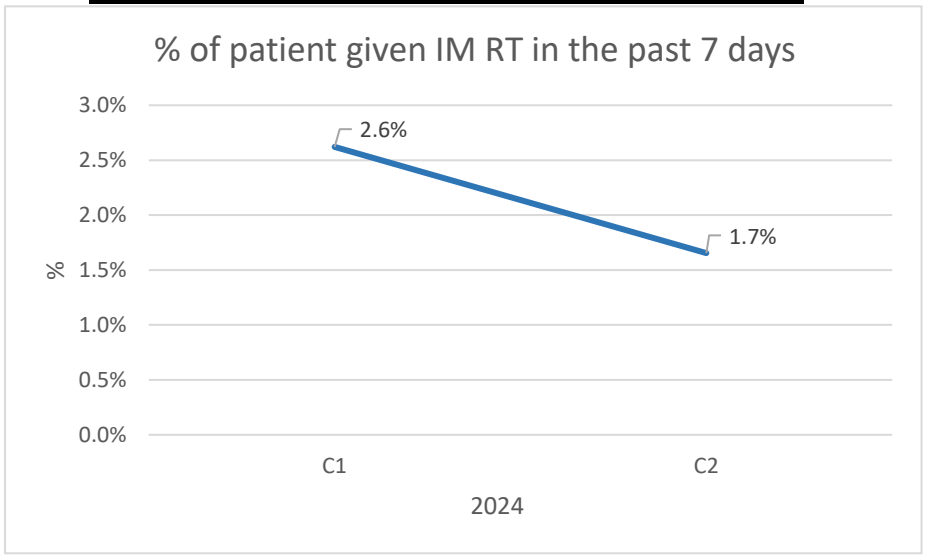
Forensics - HDAT MONITORING



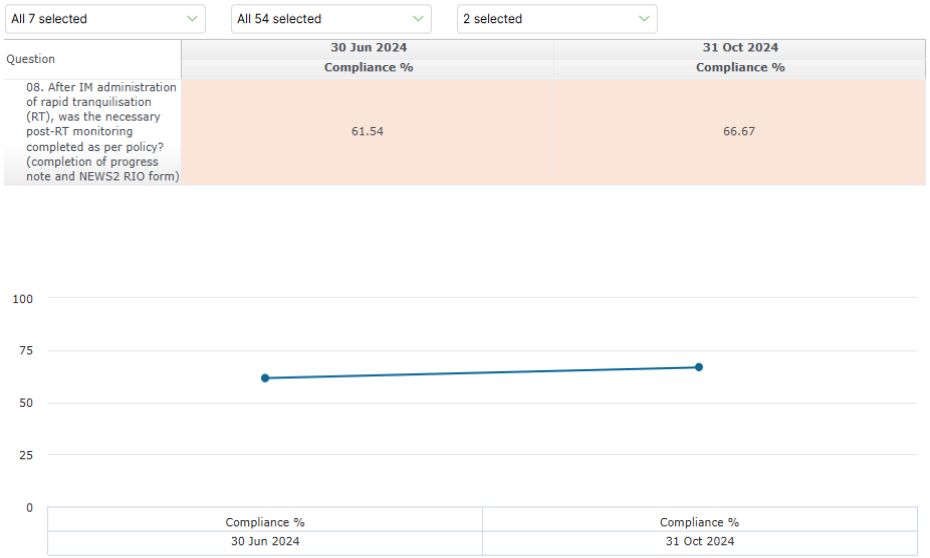
Cycle 2: 47%, 13 out of 27
Cycle 3: 53%, 17 out of 32
Average sample size 157, with 27-32 patients on HDAT.
Concerns: Highest usage of HDAT within the trust and poor compliance with monitoring approx 50%.)

ACTION: lead pharmacist to review ward breakdown and follow up with directorate
Area of concerns by priority; a) Forensics, as it has the highest levels of HDAT prescribing within the Trust (21-25% (27-32 patients) on HDAT) and HDAT monitoring sits about 50% b) Newham, no major concerns about usage but poor HDAT monitoring. Positive aspects to note; low prescribing within TH directorate and very good HDAT monitoring within B&L directorate.

2. Rapid Tranquilisation – Prescribing and Monitoring



RT given in the past 7 days	Cycle 1, June 24	Cycle 2, Oct 24
Yes	13	9
No	483	535
Total sample	496	544
Post RT monitoring	**Cycle 1, June 24**	**Cycle 2, Oct 24**
Yes	8	6
no	5	3
No	**Newham** Ivory (4) Ruby Triage (1)	**Forensic** Bow (1) Stratford (1) **Tower Hamlets** Roman (1)



Overall, the prescribing of RT within the Trust remains low (1.7-2.6%). However, a deep dive indicates Newham directorate as a potential area of focus; Cycle 1 shows 13 patients to have had RT in the last 7 days and more than half of these patients (8 out of 13) were within the Newham directorate with 5 out of the 8, not having had any post RT monitoring completed.

NOTE: this is a snap shot audit and conversely in Cycle 2, no patients within Newham were found to have had RT administered in the last 7 days.

Trustwide compliance with respect to post RT monitoring is currently 61-67% based on the last 2 cycles. However, concerns have previously been raised re poor compliance with post RT monitoring prior to Inphase audit implementation. Development of the audit dashboard, now enables better access for a data deep dive. Reassuringly, the absolute numbers of non-compliance wrt post RT monitoring are low (3-5) and therefore a more targeted approach can be taken for improvement.

ACTIONS:

1) Feedback deep dive results to nursing leads managing this risk; S.Singh and E.Mafaru.

2) Lead pharmacists will also be asked to relay these results to their respective directorates, so they can target wards highlighted.

3. Valproate Audit

The Valproate audit questions have been removed from the cyclical audits. As agreed by the Valproate Implementation Group, Instead a monthly snapshot report is sent to the MSOs for review re compliance with the national Risk Acknowledgement Form (RAF). Work is in progress to display compliance wrt completion of the RAF for applicable patients on the live power BI dashboard.

The national RAF form is to be completed by two specialists to independently document that there is no other effective or tolerated treatment for:

1. **ALL** patients (male and female) under 55 years of age **NEWLY** inititated Valproate.
2. For existing female patients of child bearing potential (the new RAF must be completed with a second specialist signature to authorise continuation of treatment, but subsequent annual reviews require only ONE SPECIALIST signature unless the patient's situation changes.

Inpatient Snapshot report generated 03rd Dec 2024. Criteria selected: a) under 55 b) last administered Valproate in the month of December 2024

Trust wide report generated 03.12.24		Valid RAF available
Males <55	62	Y=9, No = 53
Females <55	3	Y=2 NO=1 No - form expired 2 months ago

Females <55: 1 non-compliant female patient. Pharmacy team contacted to follow up with the clinical team.

Male <55: Unfortunately, it is not possible to audit male patients, as there isn't a mandatory or ELFT policy requirement for EXISTING male patients prescribed valproate to have a RAF completed. Unfortunately, the data extracted cannot differentiate between NEWLY initiated males and those males who have an existing Valproate prescription. Hence, unable to audit male patients. Positively 9 male patient were found to have a completed RAF, which provides some assurance forms are being completed for males in line with the new regulations. Further re-assurance in relation to males is that pharmacists are well aware of the new regulatory requirements and do gate keep medication, ensuring compliance with regulation as part of their clinical screening and supply function.

NOTE: New Policy launch is scheduled for January 2025 with implementation of the live electronic RIO Risk Acknowledgement Form.