

Vol. 4 Issue 2 June 2023



MEDwatch is the e-bulletin for all NHS Grampian Staff who are involved with patients and medicine management.

Its aim is to improve the safety of medicines by sharing learning, and encouraging adverse event reporting from all staff groups.

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Healthcare Improvement Scotland (HIS) Safe Delivery of Care Inspections

This edition of MedWatch is focussed on the medicines aspect of Healthcare Improvement Scotland (HIS) Safe Delivery of Care Inspections, sharing good practice and highlighting areas that may need local (ward/clinical area) review.

Background to HIS Inspections

You will be well aware that as part of their scrutiny role HIS have undertaken [NHS hospital and services inspections](#) for a number of years. These inspections are unannounced and focus on:

- Infection prevention and control
- The care of patients
- Staffing within clinical areas
- The system and processes that NHS boards have in place to mitigate risks in relation to the delivery of safe care

Recent HIS Findings from Other Health Boards on Medicines Management

After undertaking seven Safe Delivery of Care inspections, HIS sent a letter to all Health Boards in November 2022 highlighting concerns of unsafe practice, including in relation to medicines, when patients are being cared for in non-standard patient areas. Non-standard patient areas is the umbrella term used to define corridor care, surge beds and non-standard bed spaces such as treatment rooms.

While the HIS letter identified issues in non-standard care areas they are relevant to all clinical areas and subsequent HIS inspections have continued to raise medicines management concerns in standard care areas as well as non-standard care areas. Full reports can be found on the [HIS website](#) but medicines related areas of concern have been summarised below. The relevant NHS Grampian Policy or national guideline is also highlighted:

Safe Administration of Medicines

- Inadequate checks of medication, dose or patient details; medicines appeared to be administered without staff checking if it was the correct medicine, the correct dose or the correct patient receiving the medicine
- Staff not witnessing patients taking their medicine during the administration process i.e. medication being left on patient bedside tables
- Intravenous medicines being prepared by staff in one unit then being given to staff in another unit to be administered
- Prepared intravenous medications left unattended in open ward areas
- Intravenous medicines being prepared then left unattended on another patient's bed table before being taken to the correct patient to be administered.

Relevant NHS Grampian Policies:

[Instructions for NHS Grampian Staff on the Prescribing and Administration of Medicines using the NHS Grampian Prescription and Administration Record](#)

[Policy and Procedures for the Prescribing, Preparation and Administration of Injectable Medicines and Infusions in Near Patient Areas \(nhsgrampian.org\)](#)

Delays to Medicine

- Patients experiencing delays in receiving their medication
- Delays to time critical medicines; anti-convulsants, anti-psychotics, Parkinson's medicine and insulin
- Pain relief not prescribed regularly or not administered timely when required for symptomatic pain relief.

Relevant NHS Grampian Policies:

[NHS Grampian Management of Omitted or Delayed Medicines Policy](#)

[NHS Grampian Prevention of Omitted Doses Poster.pdf](#)

[NHS Grampian Policy for Self-Administration of Medicines \(SAM\) in Hospital](#)

Medication Errors

- Patients receiving the wrong medication
- Not having regular medication prescribed

Relevant NHS Grampian Policies:

[Instructions for NHS Grampian Staff on the Prescribing and Administration of Medicines using the NHS Grampian Prescription and Administration Record](#)

[NHS Grampian Medicines Reconciliation Protocol](#)

Stock Issues

- The need for staff to leave departments to source medication.

Speak to pharmacy for a stock review if this is regularly happening in your area.

Safe and Secure Storage of Medicines

- Medicines cupboards left unlocked and unattended
- Patients own medicines left lying on open locker tops and under patient's beds.

Relevant NHS Grampian Policies:

[NHS Grampian Storage of Medicines within Clinical Areas Policy](#)

[Policy For Handling Vaccines And Refrigerated Pharmaceutical Products For All Staff Working In NHS Grampian](#)

Patients Not Well Informed About Their Medications

HIS did not give further detail on this however there is well established national guidance/good practice guides that advocate involving patients in decision making.

General Medical Council (GMC) Good Practice in prescribing and managing medicines and devices: “establishing dialogue and obtaining consent”.

NICE Guidance on prescribing: “It is important to discuss treatment options carefully with the patient to ensure that the patient is content to take the medicine as prescribed. In particular, the patient should be helped to distinguish the adverse effects of prescribed drugs from the effects of the medical disorder. When the beneficial effects of the medicine are likely to be delayed, the patient should be advised of this”.

Royal Pharmaceutical Society (RPS) A competency Framework for all Prescribers: during the consultation “present options and reach a shared decision”.

Realistic Medicine Shared Decision Making: “patients will better understand their healthcare and treatment, and feel more able to influence the decisions around this”.

In certain circumstances a patient in hospital may not have capacity to make decisions about their medicines in which case the NHS Grampian Covert Administration of Medicines Policy should be followed.

Local Assurance

Following the HIS letter the Medication Safety Advisor undertook local assurance visits to five areas using corridor care within Aberdeen Royal Infirmary (ARI) and assessments made using the following:

- Storage of Medicines within Clinical Area Checklist; appendix 1 Storage of Medicines within Clinical Area Policy
- Completion of Fridge temperature monitoring as per section 3.13 Policy For Handling Vaccines And Refrigerated Pharmaceutical Products For All Staff Working In NHS Grampian
- Observation of any medicines administration processes during the visit
- Discussions with staff to understand challenges to adhering to safe medicines processes particularly at times of corridor care.

These visits highlighted areas of good practice as well as areas for improvement. The learning from these visits is applicable across all areas and the points below should be considered by all clinical areas.

Areas of Good Practice:

- The doors to the clean utility room were locked in all wards
- The majority of wards had a system in place for POD drugs to be stored securely for patients in corridor care (either in the clean utility room or in the drug trolley)
- All cupboards used to store medication in non-standard care areas were locked.
- Most areas had regular fridge temperature monitoring completed
- Staff were open and honest during the discussions regarding the challenges of delivering care to patients in a non-standard bed area.

Areas for improvement:

- Patient's own drugs were found left on a bedside table in an empty room
- In every ward visited some or all of the drug cupboards within the clean utility room were unlocked. Keep all drug cupboards locked especially when in treatment/consulting rooms where patients are in corridor care
- Risk assessments should be in place when multiple sets of drug keys are in use
- If using drug trolleys ensure they are proper drug trolleys; do not use metal dressing trolleys etc.
- Ensure staff know how to read the drug fridge thermometers correctly and that there is a process in place for the monthly expiry date check and sign off to be completed.

Self Assessments

Ward/clinical areas can undertake self assessments to gain assurance of their own medicines processes. The following policies and tools can be used to give overall assurance within an area:

- Storage of Medicines Checklist (appendix 1 of [policy](#))
- [Policy for Handling Vaccines and Refrigerated Pharmaceutical Products For All Staff Working In NHS Grampian](#)
- Care Assurance Tool [Section 5 Medicines Management](#)

- Excellence in Care Omitted Doses Measure [Medication Safety Page: Data Collection Tools](#) (for use in non-HPEMA ward only)
- Datix review of medicines adverse events.

Where to Find Medicines Policies

NHS Grampian Medicines Policies can be found in the following places:

- [NHS Grampian Medicines Management Pages](#)
- [Grampian Guidance](#)
- [Medication Safety Intranet Pages](#)

Some policies are currently under review, the sites listed above are linked to the current version.

Contact

Lindsay Cameron

Medication Safety Advisor

lindsay.cameron2@nhs.scot