Vol 7. Issue 2: September 2026

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.

Inside This Issue

MHRA Safety Roundup

Latest national medicines safety updates

- August 2026

- July 2026
- June 2026

Alerts, Notices & Shared Learning

Shared Learning: Key findings from HIS Inspections in Other Health Boards

Recent HIS reports from Inspections carried out in other Health Boards have included a number of medicines related requirements or recommendations which generally fall into the following categories:

- **Safe and secure storage of medicines**
- **Fridge temperature monitoring**
- **Safe administration of medicines**

The key messages are:

- Medicines must be stored in a locked cupboard or trolley at all times when not in use
    - NHSG Storage of Medicines Within Clinical Areas Policy
    - Policy And Procedure For The Safe Management Of Controlled Drugs In Hospitals And Clinics By Clinical Staff Working Within NHS Grampian
- Medicines Fridge temperatures must be recorded daily (on days that the department is open) and a temperature excursion must be escalated immediately on discovering it
    - Policy For Handling Refrigerated Pharmaceutical Products By All Staff Working Within NHS Grampian
    - Management of medicines refrigerators | Turas | Learn
- Time critical medicines should not be omitted and given as close to the prescribed time as possible
    - Guideline For The Management of Omitted or Delayed Medicines By Staff Working Within NHS Grampian
    - Prevention of Omitted Doses Poster
    - Time Critical Medicines Toolbox Talk

New or updated Guidance/Procedures

The following documents have recently been updated and are available on the Medicines Management A-Z Policies Page

Procedure for the Administration of Medicines by Registered Healthcare Professionals Working Within NHS Grampian updates focussed on the role of Healthcare Professional Students in medicines administration.

Guideline for Prescribing Parkinson's Disease (PD) Medication in Hospital Calculator updated to PDMedCalc which is now the calculator which should be used when converting doses when patients are unable to take their usual PD medication orally.

SPSP Adults in Hospital: Medicines

SPSP are moving forward with the proposed aim to: ***reduce inpatient episodes of Diabetic Ketoacidosis (DKA), Hyperosmolar Hyperglycaemic State (HHS) and severe hypoglycaemia as a result of diabetes medicine management by March 2028.***

We have completed the initial test phase:

- Gain feedback from clinical teams on the SPSP Driver Diagram and change package; specifically relating to the Primary Driver of Leadership at all levels to support a culture of safety.

We have started a 12 week baseline data collection phase collecting data on:

- inpatient DKA
- inpatient HHS
- inpatient severe hypoglycaemia.

Baseline data will give the local team an understanding on how easy it is collect the required data and inform potential areas to focus change ideas for improvement.

HEPMA Updates

Preventing record loss incidents between RCH and other NHSG site**s**

Medication incidents are occurring when HEPMA records are lost after Royal Cornhill Hospital (RCH) patients are temporarily transferred to Aberdeen Royal Infirmary (ARI) and return to RCH.

HEPMA records follow patients in Trak and if the correct ADT/HEPMA process isn't completed the HEPMA record is deleted.

Since HEPMA implementation, repeated incidents have been reported where HEPMA records are deleted during transfer back to RCH. Consequences include:

- Missed medicines, including anticoagulants, for several days
- Incorrect doses prescribed, including transplant anti-rejection medication
- Incorrect prescribing frequency (e.g. venlafaxine twice daily instead of once daily)
- Medicines suspended without documented plans

These incidents also create significant re-prescribing workload in RCH.

A **process flow** (applicable for transfers between RCH and all other NHSG areas) has been developed setting out the steps required to be taken by staff in RCH and the receiving/discharging ward. Please share this with all ward staff involved in patient transfers within Trak and HEPMA, and highlight the associated patient safety risks.

Any issues should be reported to the Digital Team via the HEPMA Patient Error Form in ServiceNow or IT service desk (desktop icon).

Time Critical Medicines

Progress towards Parkinson's UK's 10 recommendations

In 2022, NHS Grampian committed to supporting Parkinson's UK "Get It On Time" campaign. There have been regular updates on activities in both MedWatch and the Daily Brief and we are pleased to say we have met all 10 recommendations. A summary of our progress can be found on the Medication Safety Pages.

A reminder that the Time Critical Medicines Toolbox Talk was developed in order to meet the 2nd recommendation. It is aimed at all health professionals and provides a brief awareness of the use of time critical medicines where any delay in their administration will have a significant impact on the patient's symptoms.

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