Medicines Safety Group Meeting
1.30pm-3.30pm pm Monday 5th September 2022 Via Microsoft Teams

AGENDA

Attendees
Jonathan Simms - Clinical Director of Pharmacy (Chair)
Jane Thomas- Senior Pharmacist
Stephen Edwards – Deputy Medical Director
Leeanne Lewis – Pharmacy Manager GUH
Sarah Beuschel – Lead nurse QPS Scheduled care
Caroline Rowlands – QPS Lead, Primary care
John Trezise – Concerns manager- Putting Things Right
Sarah Cadman -Mental Health QPS
Grace Hargreaves – Assistant Risk Manager

1	**Introductions/Apologies** Rhian Lloyd Evans, Carolyn Middleton, Gwyneth Radcliffe Jaideep Kitson, Penny Gordon, Maxine Hiscock, Chris Jones, Alex Scott, Richard Stubbs.
2	**Minutes and actions from May 2022** Actions 1- PSN055. RLE met with Alex Scott and Grace Hargreaves. 2- BESS. JS to discuss with James Calvert – actioned. SE reported Medics have a different approach reflecting on incidents. The BESS would need to be in a format easier to populate with their existing system. 3- Contributing factors on datix. More work needed. 4- Teams channel links circulated on sharepoint - actioned 5- DOACs AWMSG resources shared with Hazel – actioned 6- SPS document – on agenda 7- SB to link with Jane Hoiden re med records in theatre and updating of patient's med charts as patients transferred. **Action SB** 8- Patient safety thermometer/dashboard on agenda 9- Yellow card poster on agenda for info 10- JS to follow up progress of All Wales MAR chart workstream with Emyr Jones as no reply. **Action JS**

3	**Work programme (Action plan for discussion) Objectives:** • **ABUHB Med safety strategy /priorities update** RLE not present to give an update • **SPS Transcribing of Medicines update.** LL reported the SPS transcribing document was updated in March 2022. Pharmacists are able to transcribe as a stop gap until more IPs are in place. Governance issues and legal advice discussed at the All Wales group. What happens following transcribing and error occurred. More information is needed on the use by Physician Associates. Further discussion a have taken place at Chief Pharmacists meetings. ABUHB needs assurance that a governance framework and suitable training is in place. SE highlighted medical students (pre-reg) may be encouraged to transcribe as part of their learning but these would be countersigned. JS to pick up issue of transcribing with James Calvert **Action JS**
4	**Medicines Safety Incidents** JT discussed the summary report produced by RLE. IN April-June 2022 there were 189 incidents. The highest number in primary care due to use of datix by community pharmacy. 1 severe and 10 Moderate recorded. Incorrect dose and strength were the most common. It was noted delay of administration and omission of meds were in the top 10 but listed separately. If combined would be the highest type of incident. The report covered the top 7 concerning incidents. The most severe was a dose of Methotrexate being given on consecutive days in error. Moderate incidents included • Delay in prescribing of Clopidogrel • Delay in prescribing of Teicoplanin for MRSA • Delay of starting of Valganciclovir • Delay in administration of clozapine a time critical med due to supplies • Overdose of Vancomycin (incorrect frequency) • Overdose of paracetamol (patient given both paracetamol and co-codamol) Common themes included antimicrobials and delays and overdosing. **Divisional QPS Feedback** **Scheduled care:** SB discussed the 21 Medication incidents reported in August 2022. • 2 Moderate involved allergic reactions to antibiotics**.** • 3 low involved over dose of vancomycin, omission of analgesia and patient overdosing with own meds and prescribed meds • 16 no harm involved prescribing, administration, storage, patient and dispensing Some of which had potential for harm There were no themes or trends SB reported that all datixes are sent to the senior nurse and DPSQ. There was learning on safe storage and management of medicines. The division are contributing towards the medicines safety strategy through Recognition and escalation of deteriorating patients and Falls focused review on all SCD Falls.

5	**All Wales Med meeting update** LL reported that the group had discussed compliance with Patient Safety Notices and the up and coming World Patient Safety day.
6	**Medicines safety dashboard & thermometer** LL reported an SBAR to go to Chief Pharmacists discussing issues wit the data. Difficulties collecting and recording monthly data in a timely manner. LL suggested that collecting data was still useful.
	Patient Safety Notices • **PSN055**. GH asked for sign off of the Draft Housekeeping memo on storage of medicines. Purpose was to raise awareness in clinical areas. JS suggested memo go out in the Internal Alert format. SC asked about daily checking of area that aren't covered over weekends. GH to reword memo to cover shift patterns. GH and RLE to update Medicines Storage memo and format as an internal alert: **Action GH & RLE** The group discussed the difficulties of storing medicines in treatment rooms and other areas with no air conditioning during the excessive hot weather. This would result in non compliance of PSN055. • Potassium permanganate – Welsh alert awaited. • Oral paracetamol – PSN expected soon
8	**Internal Safety Alerts** • PSN055 housekeeping Memo to be internal alert.
9	**Drug safety updates -** https://www.gov.uk/government/publications/drug-safety-update-monthly-newsletter June -New monitoring advice for Metformin and reduced Vit B12 levels. July – Topiramate and increased risk of neurodevelopmental disabilities in children with prenatal exposure August – Rescue Therapy in children for home use: Specialist initiation only
10	**Yellow card scheme.** Lucy Higgins YC poster on the interactions of Primidone and apixaban. Was shared for information**.**

11	**Any other business** **Cymru Wales Audit report** The review of quality governance arrangements – ABUHB were shared for information **World Patient Safety Day 17th Sept 2022** LL reported that a small group had met on Sept 2nd to discuss ideas for the Sept World Patient Safety Day. Medication Without Harm was the focus of the day. **Objectives of World Patient Safety Day 2022** 1. RAISE global awareness of the high burden of medication-related harm due to medication errors and unsafe practices, and ADVOCATE urgent action to improve medication safety. 2. ENGAGE key stakeholders and partners in the efforts to prevent medication errors and reduce medication-related harm. 3. EMPOWER patients and families to be actively involved in the safe use of medication. 4. SCALE UP implementation of the WHO Global Patient Safety Challenge: *Medication Without Harm*. LL had contacted Alex Scott in Cardiff to see their plans for the day. RLE and CM were presenting on 6th September at a HEIW. LL suggested their presentation could be used as part of ABUHB messages on Twitter and the Pulse Intranet Carousel. LL to contact Amanda Powell re her CRT work on transitions of care. Pledges could be made and shared with patient safety messages.
12	**Date of Next Meeting: 21st November 2022**

Actions from September 2022 Med safety Meeting

	Action	Status	By whom
1	SB to link with Jane Hoiden re med records in theatre and updating of patients med charts as patients transferred. **Action SB**		**SB/Jane Hoiden**
2	JS to follow up progress of All Wales MAR chart workstream with Emyr Jones as no reply. **Action JS**		**JS**
3	JS to pick up issue of transcribing with James Calvert **Action JS**		**JS**
4	GH and RLE to update Medicines Storage memo and format as an internal alert: **Action GH & RLE**	On agenda	**GH/RLE**