BOARD OF DIRECTORS MEETING (Open)

Date: 09 October 2019 **Item Ref:** 9

TITLE OF PAPER	**Medicines Safety Officer (MSO) Quarterly Report**
TO BE PRESENTED BY	**Dr Mike Hunter, Executive Medical Director**
ACTION REQUIRED	1) To review and support the report 2) Raise questions and challenge if necessary

OUTCOME	BoD is assured that the MSO in conjunction with the Chief Pharmacist, pharmacy team and Clinical Operations are working collaboratively by raising the profile for reporting incidents, ensuring there are robust governance arrangements for reporting incidents and reviewing them in place, promoting learning from incidents and addressing identified gaps in medicines safety.
TIMETABLE FOR DECISION	October 2019 Board of Directors
LINKS TO OTHER KEY REPORTS / DECISIONS	Patient safety Medicines optimisation Medicines Safety Learning from incidents
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	**A1 01**: Effective quality assurance and improvement will underpin all we do **A1 02:** Deliver safe care at all times
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	The Human Medicines Regulations 2012 http://www.legislation.gov.uk/uksi/2012/1916/pdfs/uksi_20121916_en.pdf NHS England – Patient Safety Alert https://www.england.nhs.uk/wp-content/uploads/2014/03/psa-med-error.pdf
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Delivered within allocated resources
CONSIDERATION OF LEGAL ISSUES	N/A

Author of Report and Designation	Emma Butcher (Medicines Safety Officer)/ Abiola A-M Allinson (Chief Pharmacist)
Date of Report	02/10/2019

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS**

Subject: **Medicines Safety Officer Quarterly Report**

Author: **Emma Butcher (Medicines Safety Officer)/ Abiola A-M Allinson (Chief Pharmacist)**

Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
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2 Summary

The role of medication safety officer (MSO) was created in 2014 in response to a Patient Safety Alert from NHS England, which called for large healthcare organisations to have a named person responsible for medicines and medical device safety. The role being central to working towards safer use of medicines in a range of different organisations, including mental health trusts.
Key responsibilities for MSOs include ownership of reporting medicines incidents, including raising reporting rates and promoting learning. MSOs work as a member of the medication safety group and are active in a National Medication Safety Network.

In June 2019, The Care Quality Commission (CQC) published the document *Medicines in health and adult social care - Learning from risks and sharing good practice for better outcomes.* Part of the recommendation within the documents *was that "*The role of medication safety officer is crucial to the oversight and responsibility for safety in mental health settings. This role should have higher recognition at board level. By providing updates on areas of concern from a medicines safety officer, a trust's board can be aware of issues and track progress on medicines safety". This is the first report highlighting issues/concerns and actions taken to mitigate.

3 Next Steps

Report to be presented to the Trust Board of Directors to provide some insight into some of the challenges regarding medicines management and safety within the Trust and to support the continued learning from incidents to improve the safety and effectiveness profile.

4 Required Actions

For the Board to note the Medicines Safety Officer quarterly report.

5 Contacts

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Sheffield Health and Social Care Quarterly Medicines Safety Report: Q1 (April to June 2019)

Summary

In quarter 1 there were a total number of 234 medication incidents reported Trust wide with the most frequently reported category being Medication Management (Table 1).

In April and May the number of incidents reported was above the mean number of incidents but below the upper confidence limit (Graph 1). The majority of incidents reported in Q1 were classed as negligible by the risk department. There were 2 incidents in May and June that were reported as moderate and no incidents reported as major or severe during the quarter.

The Crisis and Emergency Care network reported the highest number of incidents over all three months, reporting a mean of 7 incidents per month more than the Scheduled and Planned Care network (Graph 2).

Month	Administration	Management (Medication)	Pharmacy Dispensing	Prescribing	Side Effect/ Allergy (Medication)	Grand Total
Apr	20	49	9	6		84
May	12	41	9	2		64
Jun	23	51	7	4	1	86
Grand Total	**55**	**141**	**25**	**12**	**1**	**234**

Table 1: Breakdown of incidents by cause group over Q1

Burbage ward reported the highest number of incidents across the quarter. They also reported a high number of clinic room temperature incidents during this quarter.

Overall inpatient wards reported a greater number of incidents than community teams with a few exceptions. The majority of incidents reported by the North and South recovery teams were reported by pharmacy technicians undertaking audit work within these teams and were generally not reported by the teams themselves. This has highlighted a gap from a medicines management perspective.
This highlights the benefit of the input by the pharmacy technicians to ensure there are more robust medicines management processes. The collaboration between the pharmacy and recovery teams, however, has highlighted that teams are not consistently self-reporting medication management incidents and that there may be a lack of specific guidance around medication management for these teams and would benefit from further review. This will form part of the work undertaken by the medicines “Task and Finish” group.

Supply of medications in community teams comes from a greater number of sources as medications may be supplied via
1) GPs
2) Community pharmacies
3) Trust services

Errors made in the community may be reported directly to these sources (significant errors reported to the Trust that relate to primary care are passed to the CCG for further investigation).

Areas of concern highlighted by incidents reported in Q1 and mitigating action:

1) Controlled drug stock discrepancies

The Trust has had a long term issue with small scale benzodiazepine stock discrepancies. There were 40 incidents reported in Q1.

Action: A "Task and Finish" group was set up with one of the actions of this group being the review of the trust's CD SOPs. These SOPs with be actioned in Q2 and a reduction in the number of incidents reported is anticipated. The updated SOPs are due to be audited at the beginning of Q3.

2) Community drug stock discrepancies

Pharmacy technicians working within the Recovery Teams carried out audits regarding the handling of medications in clinic rooms. They regularly identified discrepancies in the paperwork used to sign medications in and out of the team bases. Alterations were made to the paperwork to try to streamline the process however this appears to have had little impact thus far on the number of discrepancies found.

Action: Following the appointment of a new fixed term contract technician into this role, the pharmacy team will continue to work with the teams to improve medication management issues and the
"Task and Finish" group will be reviewing the medication management processes in the community setting.

3) Clinic Room temperatures

Clinic room temperature incidents regularly see an increase in frequency during the summer months. During this quarter Burbage ward, ECT suite and Forest Close Wards 1 and 1a have regularly reported clinic room temperatures exceeding 25°C.

Action: The ECT suite has moved to a new location with better temperature control. Burbage ward, Forest Close ward 1 and 1a are still experiencing temperature excursions particularly in the summer months. Medication expiry dates are revised as required to ensure continued safety.
A review of the last two years' clinic room and fridge temperature data is currently on going to support a business case for air-conditioning in these areas.

4) Lost FP10 prescriptions

There were three reports of FP10 prescriptions being lost in the post. The current SHSC FP10 policy states that if it is necessary to post a prescription to a service user's home then this must go via recorded post. This is not currently the case when posting to a community pharmacy.

Action: Continue to monitor reported lost prescription incidents. If a trend emerges, the SHSC FP10 policy will be revised

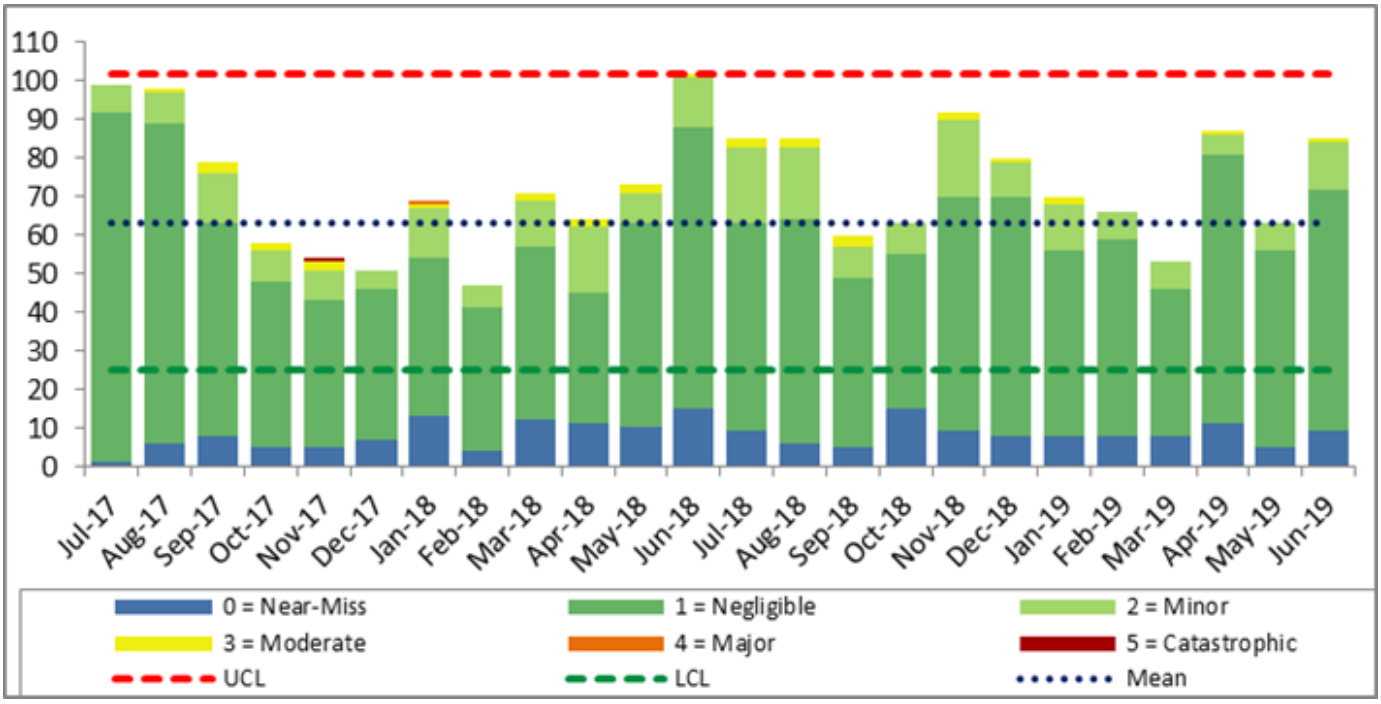
5) Service Users with complex physical health needs

During this quarter there were a number of incidents relating to a specific service user with a complex medication regimen due to a number of physical health conditions.

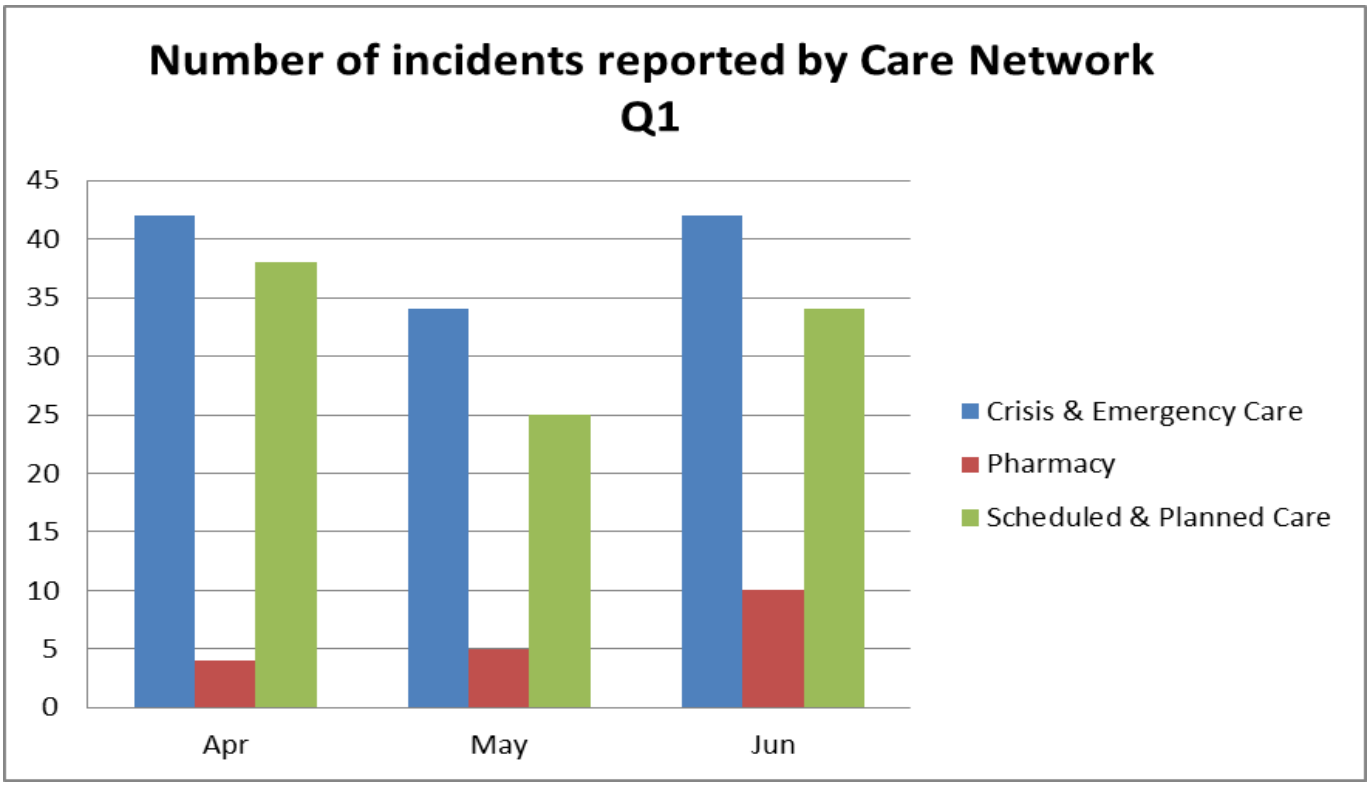
Action: Following reflection on this service user's experience as an inpatient it has been put on the medicines safety group agenda to discuss if specific guidance should be drafted around the MDT approach to ensuring service users' with complex physical health conditions are having their needs met.

October 2019
E. Butcher
Medicines Safety Officer
Sheffield Health and Social Care NHS Foundation Trust

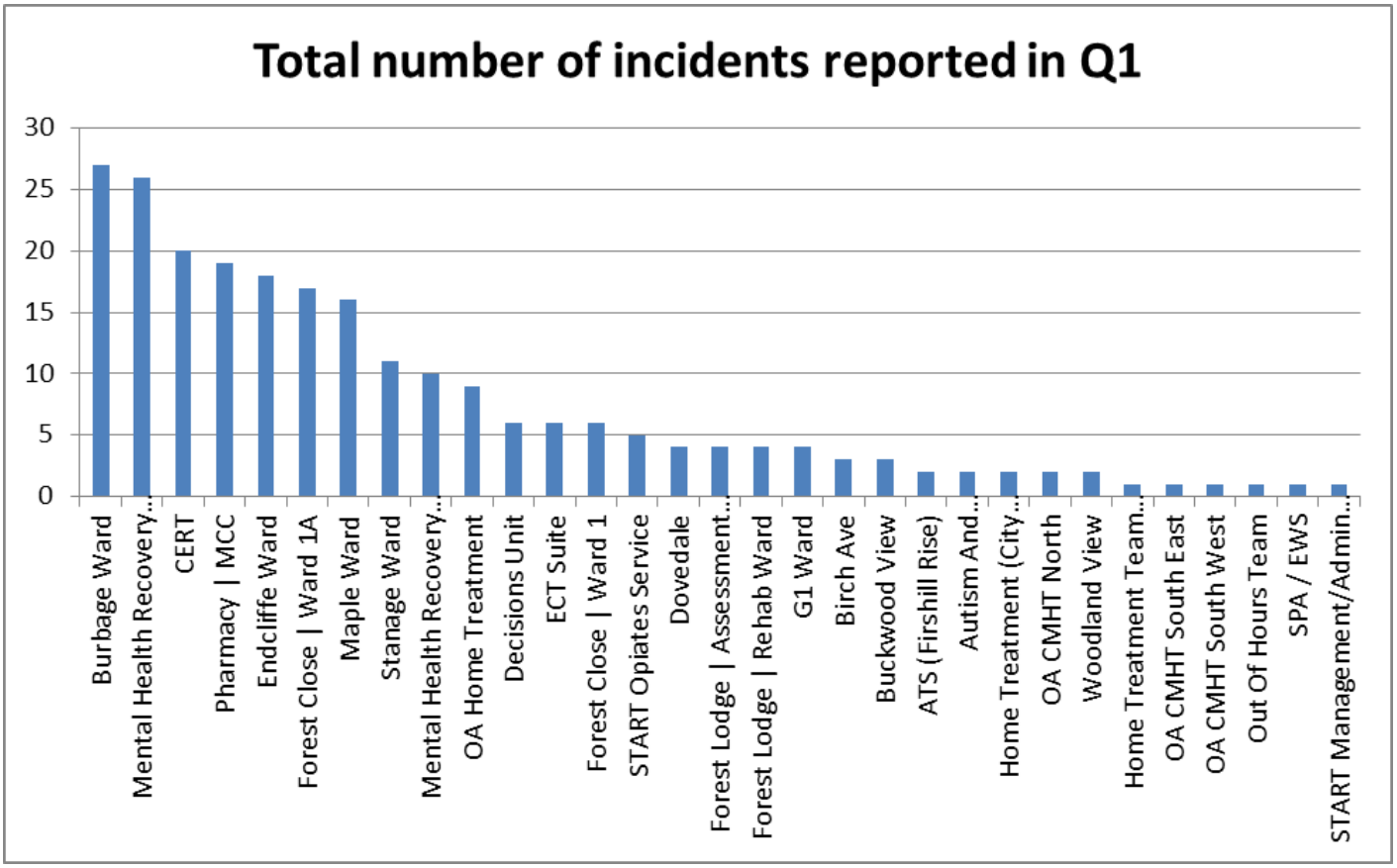
Appendix 1



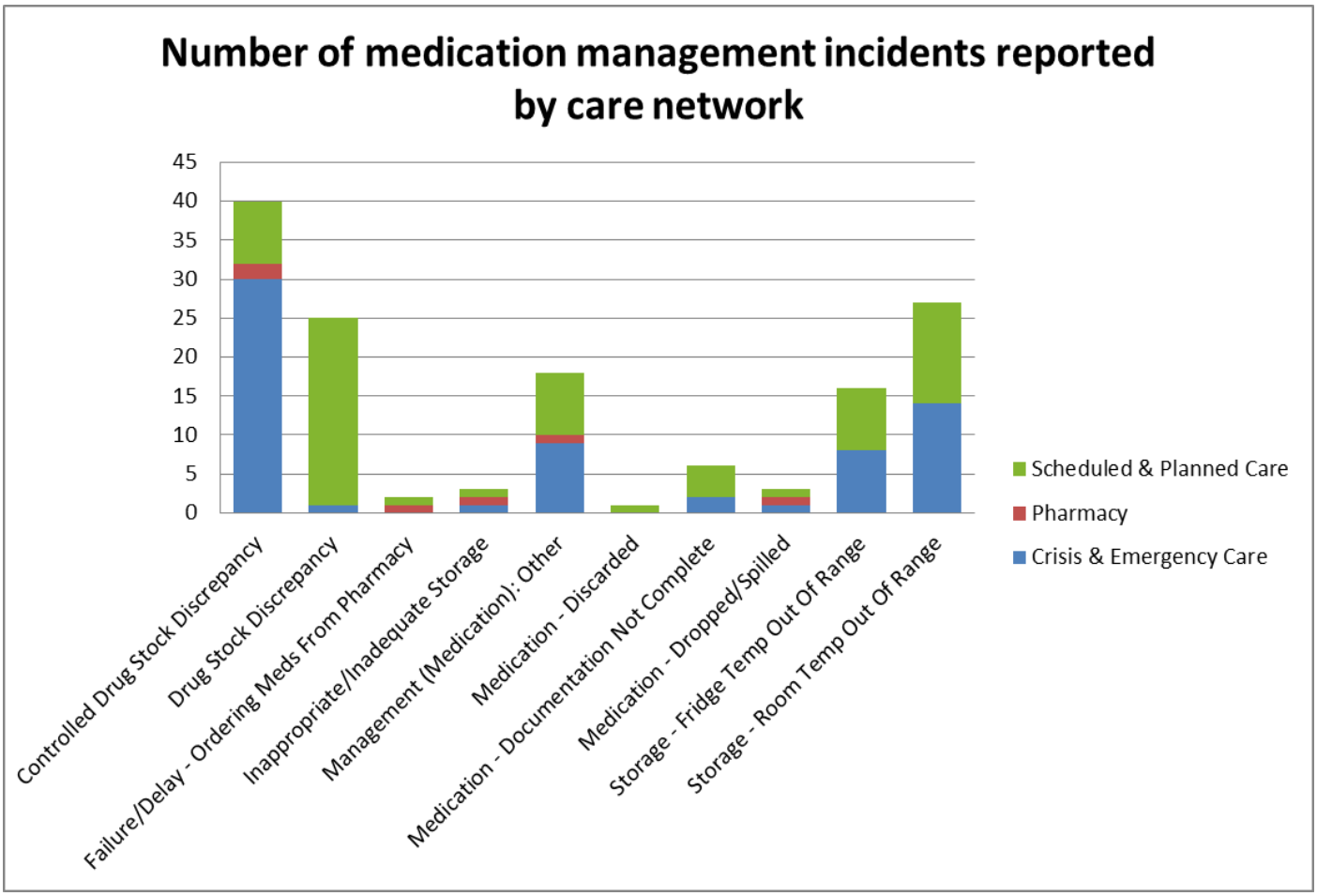
Graph 1: Total medication incidents by Risk category taken from July's Board report



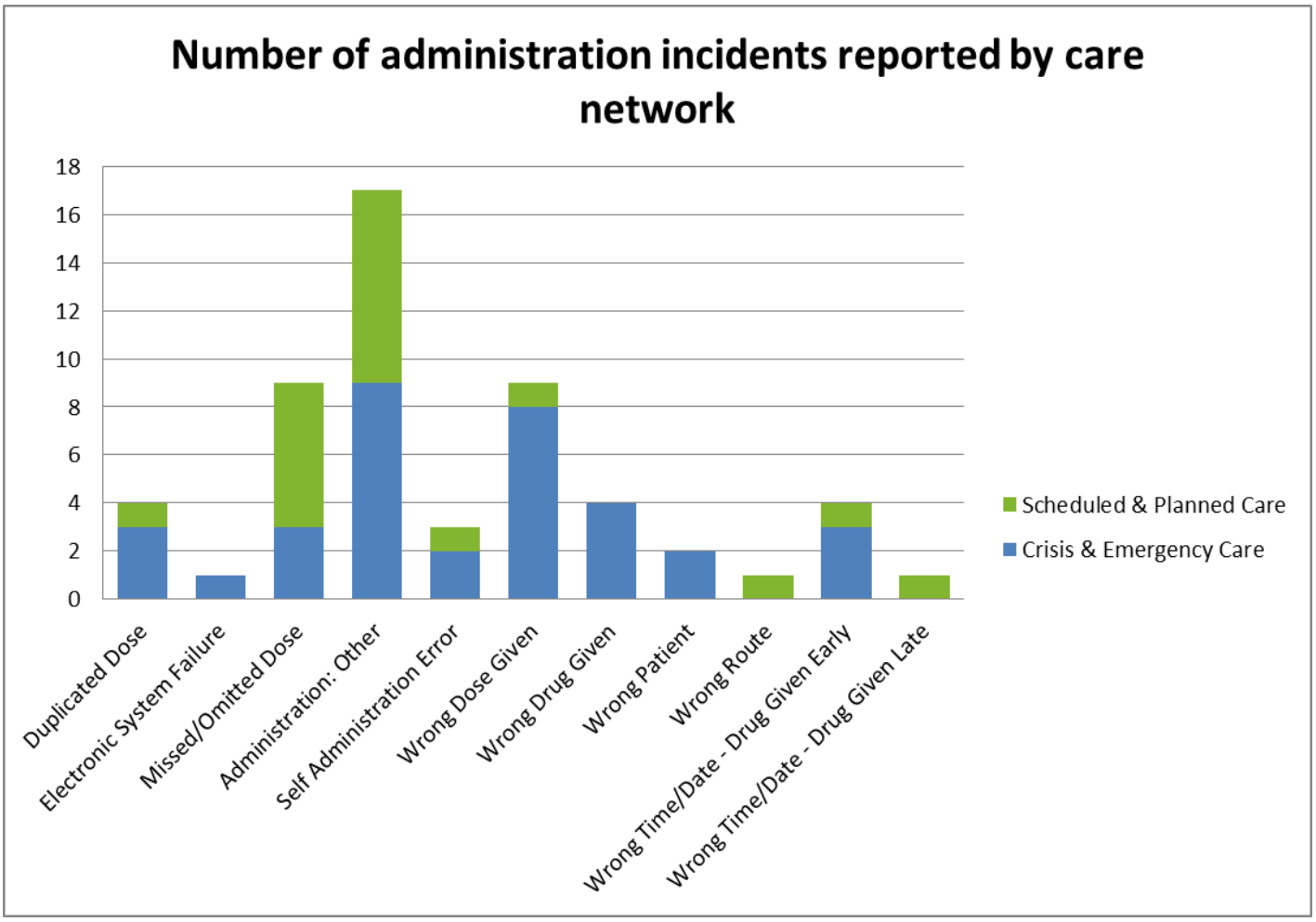
Graph 2: Breakdown of medication incidents by Care Network



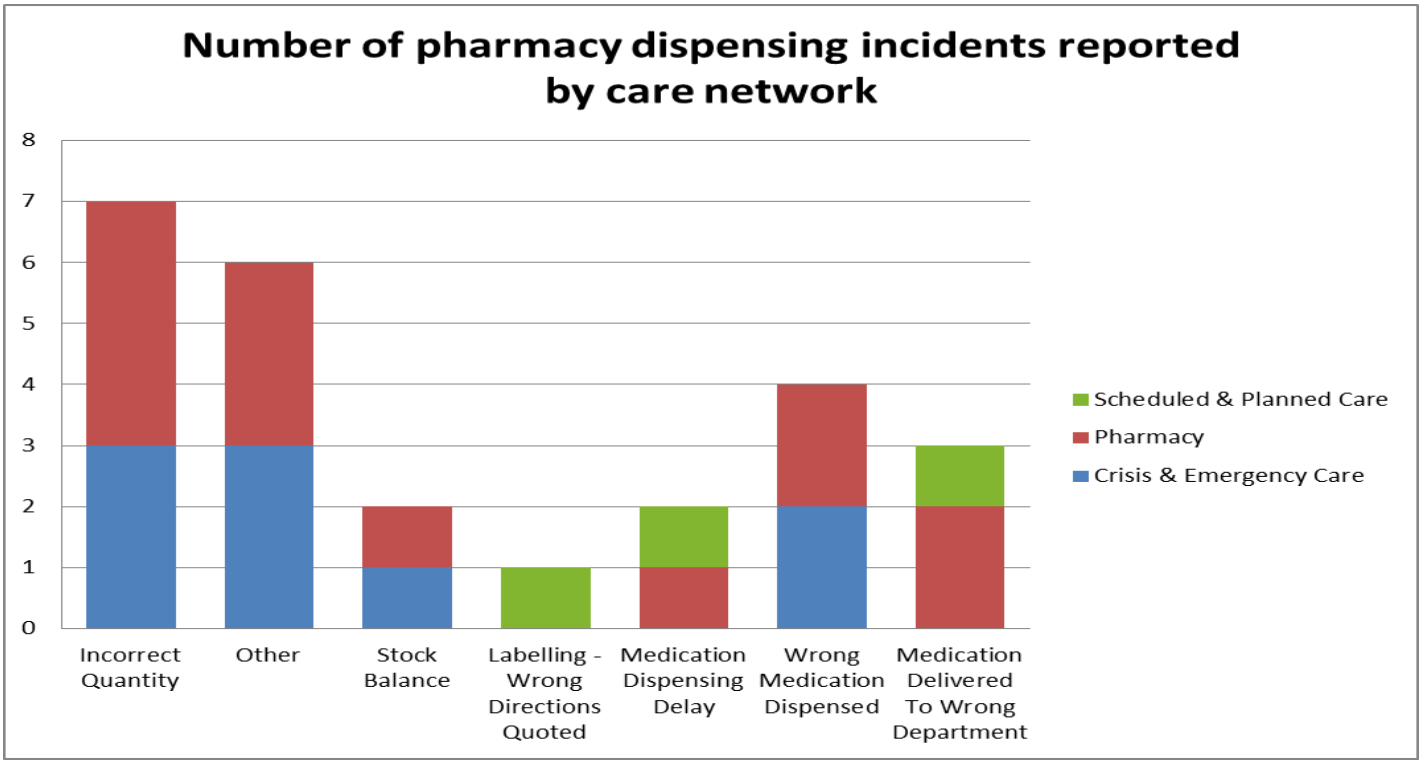
Graph 3: Number of medication incidents reported in Q1 by specific team



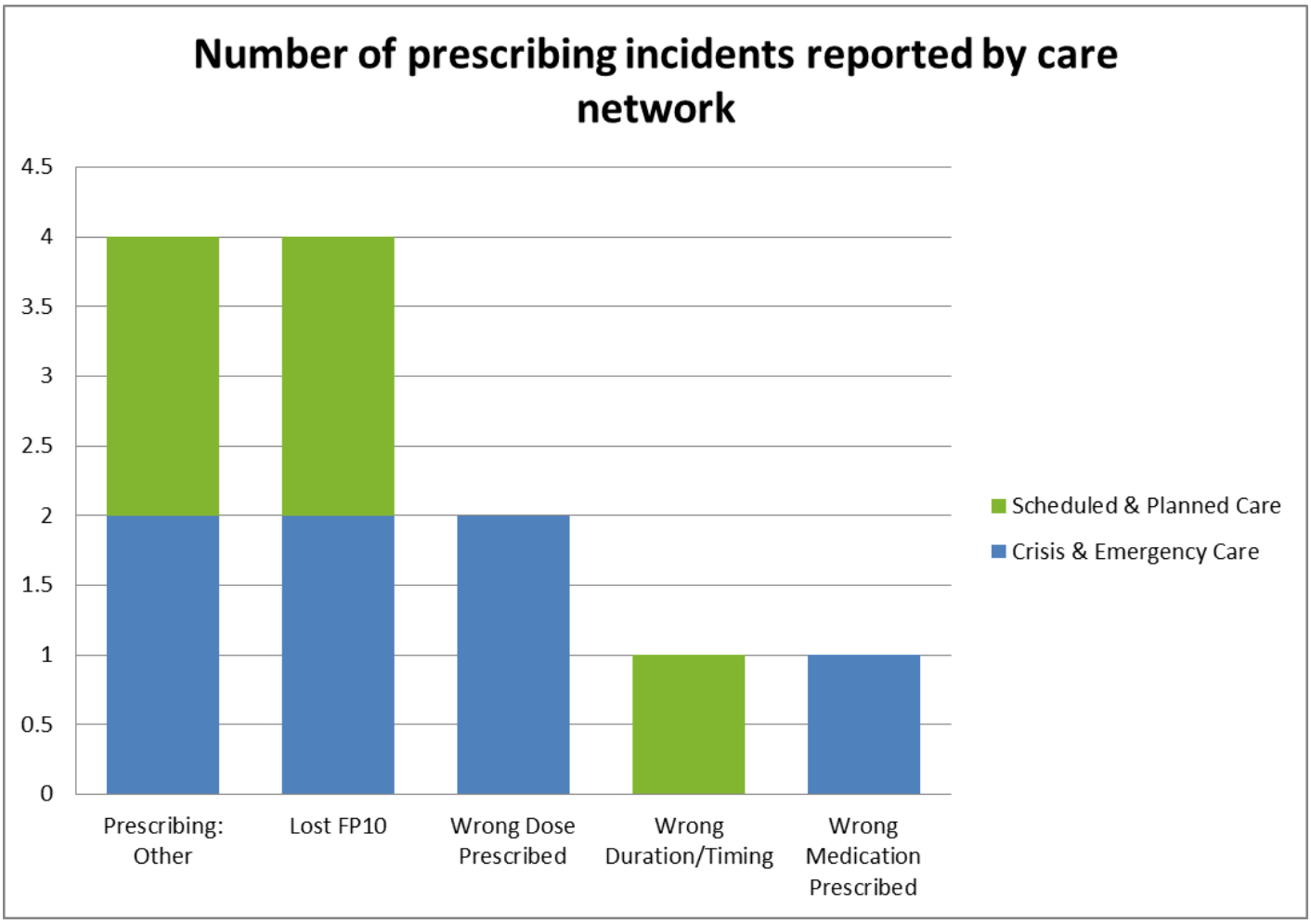
Graph 4: Breakdown of medication management incidents into subcategories.



Graph 5: Breakdown of administration incidents into subcategories.



Graph 6: Breakdown of pharmacy dispensing incidents into subcategories.



Graph 7: Breakdown of prescribing incidents into subcategories.