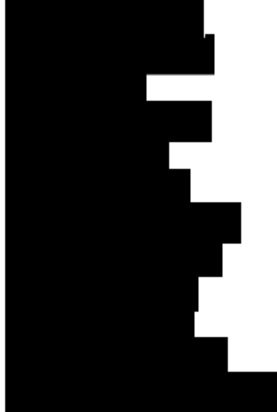
GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

MEDICATION SAFETY GROUP MINUTES
DATE: 23/05/2022 TIME: 10:00
Via: Microsoft Teams

PRESENT:

Martin Rolles (CHAIR) — Consultant Clinical Oncologist



Head of Pharmacy Acute Services
Medication Safety Officer
Head of Pharmacy, NPTH
Clinical Effectiveness & Formulary Pharmacist
Corporate Nursing
Pharmacist, Primary Care
E-Prescribing Pharmacist
Swansea Bay UHB – Cardiology
Head of Quality & Safety
GP, Mount Surgery
GP, Abertawe Medical Group & HMP Swansea

Open 10:00

No.	Agenda Item	Lead
1	**Welcome & Introductions** Attendees agreed the meeting could be recorded. Martin Rolles will Chair of the Medication Safety Group going forward.	-
2	**Apologies for absence:** .	-
3	**Dates of future meetings** Members of the group agreed that meeting on a Tuesday afternoon would be suitable going forward, to reschedule meetings.	
4A	**Minutes from previous meeting held 10/03/2022** Agreed minutes were an accurate reflection of the meeting.	-
4B	**Actions from previous meeting** • **DERS Project Update** – apologies noted. Agreed to schedule an update for the next MSG meeting. • **Vitamin D** – is meeting this week with a Pharmacist from T&O and to discuss. • **Second Checking Policy Review** – has completed work around the Second Checking Policy will arrange for to attend the next MSG to present. • **Medication Incident Review** – outstanding. Incident themes have been identified via the incident review groups. agreed to action and circulate via email. • **MSG Terms of Reference** – Endorsed and complete. • **Phenobarbital liquid** – Complete. • **MHRA Drug Safety Updates** – Complete, information passed onto SACT group by Pharmacy Aseptics in Singleton. • **BNF MSA** – Has been published and circulated.	**Complete (placed on agenda)** **Complete (Placed on agenda)** - - - -
5	**IV Iron Guidelines** • **Draft Version 7**	

	- [redacted], Pharmacist has done a significant amount of work on this item. [redacted] advised that there are 2 elements to the guideline; A) Clinical Choice & Formulary Review – [redacted] has liaised with all the specialities who routinely use Iron. B) Consent – The only aspect outstanding relates to the consent process. This is required in response to the Ombudsman case. - [redacted] is due to meet with the people involved in the Ombudsman case today and will gain advice from the Consent Committee thereafter. - We plan to follow a similar process as Gentamicin and we have updated the guidelines accordingly. Well-counselled, well-documented in the notes, as long as there is a record that the conversation taken place with patient as appropriate etc. is sufficient. - This is a case of practicality and proportionality. - [redacted] advised he primarily agrees this is a suitable process, noting the meeting with them today. Do we think we will have a complete policy by the end of today for MMOB to ratify this week? [redacted] advised it will probably need to be Draft at the moment. - MSG happy with the proposals made and need to go to the Ombudsman / Consent Committee. Will report back to next MSG.	[redacted] [redacted]
6	**Medication Incident Review** [redacted] will follow up via email.	[redacted]
7A)	**Patient Safety Alerts / Notices** PSA / PSN summary reviewed by the group. **PSN 055 Update:** • Ongoing discussions with Governance Leads around this, QSAG are currently reviewing their structure. • One sub group identified as the most appropriate for this to go to is the 'Patient Safety and Compliance Group'. • [redacted] agreed to feed this back to [redacted] felt it might be useful sharing the structure with MSG members to ensure everyone is content with the approach. We do not feel the ultimate governance should sit with this group; there is HB wide investment agreed to meet the standards within the document, many of which are Estates related. • MR requested [redacted] forwards a copy of the PSN 055 for his attention as well.	- [redacted] [redacted]
7B)	**PSN 057: Emergency Steroid Card** • [redacted] advised that we have declared compliance against this PSN. • There are just a few little actions outstanding; a) Publication of the Endocrine Emergency Guidelines, which the Endocrine Consultants have published without Pharmacy review. [redacted] is working through the guidelines with [redacted] at the moment to check drug doses and the practicalities of what they are suggesting. b) Hydrocortisone Kits and All Wales Educational Training Package awaited. • We have done all we can locally. • Once we get the Hydrocortisone kits and the All Wales E&T package, [redacted] **will bring back to MSG to update the group.**	[redacted]
7C)	**PSN 060 Wrong route administration of oral medication** • We haven't declared compliance as a Health Board to this PSN, [redacted] felt we are fairly close now. • An alert has been published around using Oral Syringes and this has been shared with everyone and is available on COIN.	

	• shared the results from the audit conducted across the Health Board with the group. noted the only response outstanding is from MHLD, they have conducted the audit slightly differently to other Service Groups, but confirmed they are following the guidance accordingly. • MSG agreed a decent audit had been conducted to establish compliance for the alert. • **MSG agreed they are content and this can be signed off.**	
8	**MHRA Drug Safety Updates** Updates reviewed for scrutiny and taken for exception; **March 2022** **Cladribine (Mavenclad): new advice to minimise risk of serious liver injury** - noted this has been sent to , as it is specifically for the MS indication. **Amiodarone (Cordarone X): reminder of risks of treatment and need for patient monitoring and supervision** - noted this isn't new information, it is a reminder of previous concerns around known risks. has updated Shared Care Protocols that outline pre-assessment and monitoring required for Amiodarone patients - this will go to next MMOB. **April 2022** **Pregabalin (Lyrica): findings of safety study on risks during pregnancy** - Needs to be signposted, goes hand in hand with another drug under AOB with additional warnings. There is a bit in the media around anticonvulsants in pregnancy at the moment, not around Pregabalin specifically. We need to be on our toes. - Agreed to liaise with , Lead Pharmacist for Women and Child Health, to link in with the Obstetrics Consultants to discuss how they manage it. noted he discussed the issue with & a few other members of the Epilepsy Team as there is new NICE National Guidance coming out which directs choice antiepileptic's in pregnancy which is updating previous information. That really centres on using Lamotrigine. - Used for neuropathic pain, therefore needs to circulate to the Pain Team also. **May 2022** **Denosumab 60mg (Prolia): should not be used in patients under 18 years due to the risk of serious hypercalcaemia** - We do not use it in under 18's for Osteoperosis, the Prolia brand, because it is off-licensed, so isn't really an issue.	-
9	**Welsh MSO and England MSO network feedback**	
10	**HSIB Unintentional Paracetamol Overdose Report** - summarized the context of the report for members. The report makes A number of recommendations around using HEPMA to prompt, therefore great that has addressed the recommendations already via HEPMA. - demonstrated the prompts that appear when dosing paracetamol. - ReW highlighted we now have a number of reports being produced from HEPMA data. Not all these reports are being used as intended. This includes a paracetamol dosing report. **MSG discussed that it would be useful to**	

	review the set of reports to try to establish a process to be used by doctors / nurses/ pharmacists etc. - The group considered how to stop the auto-pilot default 1g, 4 times per day dosing. The pre-set dose on HEPMA has been removed, prompts/ warnings have been created to alert the prescriber to consider dosing for a patients weight etc. to prescribe the appropriate dose. - **Medication Safety Alert to be drafted**. Alert focus around paracetamol dosing, raise awareness that this can cause harm, to be mindful of 1g dosing QDS. - Separate note re weighing issue – WNCR being rolled out across the Health Board therefore auditing much more closely and more focus on weighing as it gets rolled out across the Health Board. Anyone can record weight on the HEPMA system as long as they have access to HEPMA.	[redacted] [redacted]
11	**HEPMA System** [redacted] provided an update on the HEPMA System; - A couple of ongoing operational issues noted around prescribing and administering certain types of medication; Warfarin, Antibiotics and dose range Insulin. Risk Assessments and Medication Safety Alerts have been drafted, shared with the MSG for comments and guidance on taking this forward. **Medication Safety Dash Board:** - The dashboard is in progress. This is based on previous Medication Safety Thermometer. This gives a complete data set and automate some of the work previously completed manually by Pharmacy and Nursing staff. - VTE 99.99% however this should always be 100% therefore [redacted] would like to take this one step further and a report is currently under development to collate an operational report highlighting patients on wards where there are VTE Thrombotic / bleeding risks. This is under development to make the data more meaningful. [redacted] asked if there was a potential to prompt prescribing effective prophylaxis, [redacted] advised unfortunately this is not within the gift of the system. - [redacted] to continue to develop the dashboard - [redacted] highlighted that there is pressure within the organization to use the AMAT system to record this type of data. It also facilitates comparison to other Health Boards. [redacted] agreed to pick up reporting via AMAT outside of the meeting. - [redacted] replacement to look into re-establishing of the medication safety dashboard process. **Warfarin missed doses** - Theme of warfarin missed doses related to HEPMA use discussed. [redacted] **has developed an MSA, this will be circulated to the group for comments**. The HEPMA team have also developed a report for patients to aide healthcare professionals identify where warfarin doses are not prescribed with the aim of accessing it through Signal. **Dose banded insulin** - Prescribing of dose banded insulin discussed. Complexity noted and number incidents generated also noted. Concerns that prior to full role out in Morriston Hospital we need to ensure we have appropriate controls in place to address the issues identified. - [redacted] has drafted an FMEA and an MSA. [redacted] **agreed to circulate draft documents to the group for review, with 2 weeks to comment.**	[redacted] [redacted] [redacted] [redacted] [redacted]

	Group discussed how to make these alerts available at the point of prescribing ■ **will look into hyperlinking policies/ MSAs/ Guidelines etc. on HEPMA** **Self-Administration of Medicines on HEPMA (Critical meds, insulin, etc).** - For High Risk Meds such as Methotrexate, a drug file has been configured so this can only be prescribed once per week. - ■ advised that there is the ability to note that medication has been self-administered on HEPMA, we need to review the process. ■ noted there is work ongoing at the moment with ■ specifically focusing on Insulin, ■ **agreed to touch base with ■ regarding this. SAM policy needs to be updated to include recording on HEPMA**. - **In terms of education and training sessions, proposed implementing recorded video seminars so they can be made available for people to access. Interactive sessions for 'very key staff' who would be responsible for further dissemination of the training.** - Group agreed that the policy for SAM is difficult to find. Therefore, need to make it more accessible. Agreed to add key words to make it easier to find. ■ **agreed to get the key words updated as part of the policy group.**	■ ■ ■
12	**Any Other Business:** - **Yellow Card Champions: YCC Wales' Medicines Safety Training Day 9th June 2022** Looking for Yellow Card Champions to re-invigorate, one per site to link in and can be a Nurse, Pharmacist etc. **The group agreed this needed to be disseminated / coordinated via the Intranet in order to receive nominations via email from Nursing and Pharmacists.** - **New medicines chart for Buvidal®** For noting. ■ **agreed to proof read and feedback any comments to the group.** - **Chlordiazepoxide SmPC changes -** ■ noted this effects hospital only drug inpatients therefore controlled. ■ advised this will be discussed in MSO circles on Friday, for noting. ■ **agreed to a) discuss with ■, b) see what MSO's say on Friday and try to establish what we need to do with this and c) add as agenda item for next MSG.** - ■ **Nurse Staff Wales paper** – ■ reported there were no never events on any of our 25 B wards, for noting and completeness. - Thank you to ■ for their contribution to the group, on behalf of everyone on the committee and the Health Board.	■ ■ ■
	Dates of next meetings: • Electronic meeting requests to be sent to MSG Members noting the new date and time; **Tuesday 5th July 2022 from 1pm – 2:30** **Tuesday 6th September 2022 from 1pm – 2:30** **Tuesday 1st November 2022 from 1pm – 2:30** **Tuesday 1st January 2023 from 1pm – 2:30**	■