The Walton Centre NHS Foundation Trust
Safer Medication Group Minutes

Tuesday 27th September 2022, 14:00 -16:00, MS Teams

Present:

[redacted]	[redacted]	[redacted]

1.	**Welcome and Apologies for Absence:** Apologies were received from [redacted]	**Actions**
2.	**Minutes of Last Meeting:** The minutes of the last meeting were reviewed and agreed as accurate.	
3.	**Matters Arising:** **Review of Action Tracker took place as follows:** [redacted]: [redacted] confirmed that an initial meeting has taken place and [redacted] advised that a process is to be agreed within the neurology division, close. [redacted]: [redacted] confirmed that both the prescriber and the ward pharmacist have been made aware, therefore, appropriate actions taken, close. [redacted]: On going monitoring and feedback to be provided when the information is available. [redacted]: To report [redacted] discrepancies if more than 10ml of Oramorph and more than 5ml of other liquids. [redacted] to include on the next risk bulletin and [redacted] to mention in the huddle, close. [redacted]: [redacted] to take forward and attend the ward managers risk & governance meeting, close. [redacted]: [redacted] to confirm that this has been actioned, close.	
4.	**Incident Reports from Previous Months Involving Medication Issues:** **August:** [redacted]: No further actions required as no patient details included in the datix, therefore, unable to take forward, close. [redacted]: [redacted] to take forward, close. [redacted]: Appropriate actions taken on the ward, close. [redacted]: Appropriate actions taken on the ward, close. [redacted]: The group discussed the issue and noted that spare keys are needed, or staff need to make sure that the key is stored safely, close.	

[redacted]: Appropriate actions taken, close.

[redacted]: Appropriate actions taken on the ward, close.

[redacted]: Inappropriate use of epipen, staff added appropriately on ward and gave correct advice to patient following incident. No further actions identified. Close

[redacted]: [redacted] to add hydrocortisone to ward stock on CRU, close.

[redacted]: [redacted] to chase with [redacted] and update the group at the next meeting.

[redacted]: [redacted] confirmed that this has been discussed with the staff involved and [redacted] to highlight to the prescriber, close.

[redacted]: [redacted] queried if [redacted] was aware that the anaesthetic went against trust policy. [redacted] to feedback.

[redacted]: Further issues were raised during the meeting by the ward managers. [redacted] to look into stock levels and to provide an update at the next meeting.

[redacted]: JAC upgrade scheduled 2023/24. It was noted that the issue stems from the use of two different systems. To add to the recurring medication errors incident log, close.

[redacted]: Appropriate actions taken, close.

[redacted]: Rapid review [redacted] was discussed by the group, and it was determined that the appropriate actions have been taken, close.

[redacted]: It was determined that the harm level was not as significant as what was documented on datix. Datix to be updated, close.

[redacted]: No harm caused to patient and no further actions required, close.

[redacted]: Rapid review [redacted] was discussed by the group, and it was determined that no further actions are required, close.

[redacted]: [redacted] confirmed that this is down to issues with the Royal Mail, therefore, looking at alternatives methods of getting prescriptions to patients. Datix to be updated by the handler, ongoing monitoring, close.

[redacted]: It was confirmed that both members of staff need to redo [redacted] competencies, close.

[redacted]: No harm caused to patient and no further actions required, [redacted] to update datix, close.

[redacted]: Appropriate actions taken, close.

[redacted]: [redacted] to chase and feedback at the next meeting.

[redacted]: Appropriate actions taken on the ward, close.

[redacted]: Appropriate actions taken, close.

[redacted]: Appropriate actions taken, close.

[redacted]: Appropriate actions taken, close.

[redacted]: [redacted] confirmed that there is ongoing work surrounding discharge letters, close.

5.	**Review of recurring incident log** Prescribing errors when patients are transferred to and from ITU: 1 incident this month, ongoing monitoring. Diabetic incidents, including GKI and insulins: No incidents this month, however Incident with GKI stock, which is to be looked into further, ongoing monitoring. Discharge medication errors: 2 incidents this month, Ongoing monitoring. Headache: No incidents this month, ongoing monitoring. Lack of Hardware on the wards: No incidents this month, ongoing monitoring. VTE incidents: No incidents this month, ongoing monitoring.	
6.	**Feedback from EPMA Safety Board or Other EPMA Issues:** • No update provided this month.	
7.	**National Alerts/Safety Warnings:** **NPSA Emergency Steroid Card** • It was confirmed that [redacted] met with [redacted], and a new process is being formalised. However, no further update this month. **NPSA Inadvertent oral administration of potassium permanganate** • [redacted] confirmed that use is to be eliminated from the trust. [redacted] has created an action plan and the alert is set to be signed off by CESG. Therefore, WCFT is compliant with the alert.	
8.	**SBAR/RCA Medication Incident Review** **Rapid Review** [redacted] • The full details can be found in the document attached. • The group discussed in further detail. The importance of the two-nurse check was highlighted and concerns regarding how this can be changed and managed appropriately were discussed. Ultimately, it was decided that a review of the process is required. **Rapid review** [redacted] **TR noted the following:** • The full details can be found in the document attached. • Wrong route administration of medication, although, no harm was caused to the patient. This incident has been put down to human factors resulting in human error. • Root causes: ➢ The saline syringe and ketamine syringe are near identical and can be easily mistaken ➢ The use of trays to segregate drugs. The Anesthetist would usually use a cardboard Kidney dish for certain drugs, but they have been removed since the advent of ANTT	   

9.	**Discussion: Enzyme inducing AEDS recommendation/prescribing for patients on DOACs** • Issues with interactions between enzyme-inducing anti-epileptics and DOACs was raised. [redacted] noted that this interaction can vary from agent to agent, however, quite often the interaction reduces the effectiveness of the anticoagulant agent (DOAC). • [redacted] noted that there has been an incident whereby a Walton consultant has recommended primidone in their clinic letter for a patient already taking a DOAC (apixaban), and primidone was then prescribed by the GP. [redacted] Direct cause of the PEs cannot be solely attributed to the interaction but it is likely that the primidone contributed to the apixaban treatment failure. • [redacted] confirmed that the consultant has been made aware and informed the group that upon review there was no reference to the patient's medical history or medication included in the letter. Consequently, a level of responsibility is to be taken from both the consultant and the GP who should have checked the patient's medical history and medication. • To try and prevent this issue, going forward one suggestion was to include a disclaimer in clinical letters along with advice regarding this concern. [redacted] to take forward to the clinical director within the neurology division.	
10.	**Missed doses audit** • Due to varied figures, the group have decided to look back at old, missed dose audit reports and review the figures from the last year to see why the numbers changed so much. • [redacted] suggested working with informatics to prepare and provide a new and more efficient report that will enable us to see a true reflection of figures. [redacted] and [redacted] to take forward.	
11.	**Medication Related Audits** • Nil submitted.	
13.	**Medication/EPMA related risks for escalation / addition to risk register** • To escalate the Enzyme inducing AEDS recommendation/prescribing for patients on DOACs to the neurology division and provide update in later meetings.	
14.	**Any Other Business** • N/A	
15.	**Date and Time of Next Meeting** Tuesday 25/10/22 – Time 14.00-16.00, ITU seminar & via Microsoft teams.	