Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Medicines Management Operational Group (MMOG)
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Dr Sub Ghosh, Associate Medical Director for Quality and Safety
Cyfnod Adrodd: Reporting Period:	April 2020 - November 2020
Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:	

Critical Medicines
During the previous six months the MMG, with the pharmacy leadership team, has overseen the establishment of robust processes to mitigate the risk of shortages in a number of identified critical care medicines, these include:

- Critical care medicines used in intensive care units to support patients that require ventilation.
- Access to end of life medicines in the Community.
- Renal fluids.

This has been reported separately to previous QSEAC meetings.

National Institute for Health and Care Excellence (NICE)/ All Wales Medicines Strategy Group (AWMSG) COVID-19 Oncology/Haematology Guidance
The MMOG endorsed the recommendations to implement COVID-19 rapid guideline: delivery of systemic anti-cancer treatments [NG161] and endorse the advice given in 'Interim treatment change options during the COVID-19 pandemic, endorsed by NHS England', noting that some of the recommended alternative regimens are for 'off-label' or unlicensed indications and that the financial consequences of these treatment changes may extend beyond the end of the COVID-19 pandemic and may also have a financial impact from the Service Level Agreement (SLA) contract agreements with Tertiary Care centres treating Hywel Dda patients.

Healthcare Inspectorate Wales (HIW) Reports
During the previous year, a number of HIW reports consistently raised concerns and issues relating to medicines management. Any high priority issues are dealt with through the appropriate process and actions are implemented to address these immediate concerns if and when raised. However there is an underlying level of issues, covering a range of activities that are consistently identified such as:

- Refrigeration temperature monitoring;
- Controlled drugs running totals and signature lists;
- Incomplete Medicines Administration Records;
- Medicines rooms left open.

All of the above issues are fully covered within the Health Board's Medicines Management Policy http://howis.wales.nhs.uk/sitesplus/documents/862/268-MedicinesPolicy-v12.pdf
This is a working document developed predominantly with nursing input in addition to input from medical and allied health professionals. However, compliance rates still remain inconsistent and therefore to address these issues, a work shop has been established to understand the reasons

behind this persistent behaviour. Representation at the work shop included nursing, pharmacy and medical colleagues as it is recognised that these behaviours are not specific to any one profession. The workshop identified a number of areas for further work that should address the wider issues, these included:

- Medicine Charts – Omission. Themes: e-prescribing, the number of places where drugs are stored, communication/hand overs, and multiple charts.
- Medicine Charts – Legibility. Themes: Oxygen prescribing, e-prescribing, multiple charts, incomplete charts, and signatures.
- Administration Themes: training, space at ward level, movement of staff/patients between wards, transfer between and across sites, and pharmacy technical administration.
- Safe Storage - Themes: Fridge alarms, separate medicine keys from other keys, storage space, and review top up stock levels.

Overlap was noted between the key themed areas and a number of actions currently being considered for progressing as potential quality improvement projects, including:.

- Oxygen prescribing;
- Omitted doses;
- Safe storage of medicine cupboard keys;
- Fridge monitoring.

As these areas are progressed, monitoring and reviews will be undertaken and where necessary adjustments to the Medicines Management Policy will be made.

HIW Review of Local Intelligence Networks (LIN) – Chair Medical Director and Deputy CEO

The members of the Local Intelligence Network (LIN) reviewed and noted the recommendations from the HIW Report: *Summary report of Local Intelligence Networks across Wales September 2019.* The report identified a number of recommendations that require a national approach. Two of the recommendations included resourcing both a National Lead and the implementation of a National Controlled Drug Tool that would enable Health Boards to access consistent reports. These have been supported and are currently being implemented.

Medicines Event Review Group (MERG) - Chair Urology Consultant

The Group has been actively working through the action plan and implementation plan to address any identified shortfalls that were identified in the following two patients safety reports:

a) **Gosport Report (2018) -** this identified systematic misuse of controlled drugs to assist early death in a number of patients that the overseeing clinician deemed appropriate. The approach was not questioned by a range of clinical team members as it became the 'norm' in approach. Over 100 deaths were associated with the GP providing cover to the community hospital.

Gosport action plan: currently awaiting finalisation of palliative care guidelines to complete the action plan. MERG now review opiate use in community sites twice a year. All sites except Tenby commissioned beds now receive opiates from central stock, with assurance received that local processes are in place to oversee use.

b) Sodium Valproate in Child Bearing Age Women

An action plan has been developed to address the ongoing concerns with the prescribing of sodium valproate for women of child bearing age without appropriate contraception as identified in the Cumberlege Review: First Do No Harm
. https://www.immdsreview.org.uk/downloads/IMMDSReview_Web.pdf

The Primary Care Medicines Optimisation team has acted quickly with GP practices to:

- Identify patients in primary care on valproate.
- Establish which patients are of child bearing age.
- Offer specialist follow ups to consider whether they would benefit from a change of medication.
- Ensure that annual reviews are undertaken, linking with secondary care services.

Risgiau:
Risks (include Reference to Risk Register reference):

- Limited resource to address the level of monitoring and follow up required to support the local intelligence network effectively, leading to inconsistent approach across the networks. This is from both the Health Board and Police forces with specialist CD liaison Officers.

Gwella Ansawdd:
Quality Improvement:

Local Intelligence Network (LIN)

- The network has overseen the development of a controlled drug monitoring tool that is shared monthly across all clinical areas, providing usage and trends of controlled drugs that are liable to misuse. This allows for early detection of changes in usage in order that a review can take place to understand whether this is clinical need, change of practice or other causes. This has been well received by ward sisters and site managers across the Health Board.

MERG

- Following a void period, the Group is now receiving site improvement plans from across sites. This has led to focused training implemented by the Medicines Management Nurse Lead on controlled drugs on one site to address concerns identified following a number of Datix incidents that were scrutinised through MERG.

- Prescribing error training for medical colleagues: two core modules from the British Medical Journal (BMJ) learning are to be included in Health Board e-induction.

Thrombosis Group:

- MMOG approved the single venous thromboembolism (VTE) risk assessment for non COVID-19 patients which has been implemented across all sites (on World Thrombosis Day 13th October 2020). There is now only two colour coded VTE risk assessments (RA), one for COVID-19 and one for non-COVID-19 patients. This RA brings together 4-5 different RAs that have been in place across the organisation to provide a single consistent approach.
- This work has been promoted by the Hospital Acquired Thrombosis (HAT) Task and Finish Group with the support of hospital directors and the Quality Improvement site leads.

Argymhelliad: **Recommendation:**
QSEAC is asked to identify if further action is required to provide assurance on the issues raised relating to the Medicines Management Operational Group.
Dyddiad Cyfarfod Nesaf y Grŵp Gweithredol: **Date of Next Operational Group Meeting:**
January 2021