Public Quality Safety & Experience Committee Meeting

Tue 26 September 2023, 14:00 - 15:40

MS Teams

Agenda

14:00 - 14:10
10 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 30.08.23

Ceri Phillips

1.4 Public QSE Minutes 30.08.2023.pdf (6 pages)

1.5. Action Log – Following the meeting held on 30.08.23

Ceri Phillips

1.5 Public QSE Action Log.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

14:10 - 15:25
75 min

2. Items for Review & Assurance

2.1. PCIC Assurance Report

25 minutes *Jason Roberts*

2.1 PCIC Quality Assurance Report - September 2023.pdf (9 pages)

2.2. Quality Indicators Report - Deep Dive:

10 minutes *Jason Roberts*

1. *Infection, Prevention & Control*

2.2 QI IPC Paper.pdf (7 pages)

2.3. Looked After Children – Assessment Backlogs

10 minutes *Jason Roberts*

2.3 QSE LAC Report Board Sept 2023.pdf (5 pages)

2.4. Covid Investigation Programme Update

5 minutes *Jason Roberts*

2.4 QSE Covid Investigations Sept 2023.pdf (4 pages)

2.5. Transition to NRFit for Neuraxial Procedures

5 minutes *Jason Roberts*

2.5 NRFit for neuraxial procedures.pdf (5 pages)

2.6. Paediatric PICU Pressure Damage

10 minutes *Jason Roberts*

2.6 PICU Pressure Damage - September 2023.pdf (19 pages)

15:25 - 15:30
5 min

3. Items for Approval / Ratification

3.1. Policies:

5 minutes

1. *UHB 389 Medicines Code 2023*
2. *UHB 494 Staff Winter Respiratory Vaccination Policy and Procedure*

3.1.1 The Medicines Code UHB389 Cover Report.pdf (2 pages)
3.1.1a UHB 389 Medicines Code 2023 for QSE.pdf (136 pages)
3.1.2 Staff Winter vaccines policy Report QSE.pdf (6 pages)
3.1.2a Staff Winter Respiratory Vaccination Policy.pdf (4 pages)
3.1.2b Staff Winter Respiratory Vaccination Procedure.pdf (7 pages)
3.1.3c 2023-24 WRVP EHIA 2023-24.pdf (22 pages)

15:30 - 15:30
0 min

4. Items for Noting & Information

4.1. Bi-Annual National Clinical Audit

Jason Roberts

4.1 Clinical effectiveness Bi annual report.pdf (10 pages)

4.2. NG Tube Patient Safety Notice

Jason Roberts

4.2 Compliance against PSA008 - Nasogastric tubes.pdf (4 pages)

4.3. Radiation Protection Group – Chairs Report

Fiona Jenkins

4.3 Radiation Protection Group Chairs Report 25.7.23.pdf (3 pages)

4.4. Minutes from Clinical Board QSE Sub Committees:

Jason Roberts / Meriel Jenney

4.4.1a MCB Minutes 18 May 23.pdf (6 pages)
4.4.1b MCB QSE Minutes 20 July 23.pdf (9 pages)
4.4.2 Specialist QSE Minutes 30.03.23.pdf (8 pages)

15:30 - 15:30
0 min

5. Items to bring to the attention of the Board / Committee

Ceri Phillips

15:30 - 15:30
0 min

6. Agenda for the Quality, Safety & Experience Private Meeting:

i. *Private Minutes*
ii. *Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*
iii. *Items to bring to the attention of the Board - Ongoing Developments (Letby) - (Confidential Discussion)*

15:30 - 15:30
0 min

7. Any Other Business

Ceri Phillips

15:30 - 15:30
0 min

8. Review of the Meeting

Ceri Phillips

15:30 - 15:30
0 min

9. Date & Time of Next Meeting:

Tuesday 10 October

Time – 2pm

Via MS Teams

15:30 - 15:30
0 min

10. Declaration

Ceri Phillips

"To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]"

Unconfirmed Minutes of the Quality, Safety & Experience Committee

Held on 30.08.2023

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Keith Harding	IM	Independent Member – University
Mike Jones	MJ	Independent Member – Third Sector
In Attendance		
Claire Beynon	CB	Deputy Director of Public Health
Mike Bond	MB	Director of Operations for Six Goals and Financial Improvement
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Dino Motti	DM	Consultant in Public Health Medicine
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Suzanne Wood	SW	Principal Public Health Practitioner
Observers		
Rebecca Aylward	RA	Deputy Director of Nursing
Richard Skone	RS	Deputy Medical Director
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Angela Hughes	AH	Assistant Director of Patient Experience
Rhian Thomas	RT	Independent Member – Capital & Estates

QSE 23/08/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh	**Action**
QSE 23/08/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/08/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/08/004	**Minutes of the Committee meeting held on 18.07.2023** The minutes of the Committee meeting held on 18.07.2023 were received. **The Committee resolved that:** a) The minutes of the meeting held on 9 May 2023 were approved as a true and accurate record of the meeting.	
QSE 23/08/005	**Action Log following the Meeting held on 18.07.2023** The Action Log following the Meeting held on 9 May 2023 was received. **The Committee resolved that:**	

	a) The Action Log from the meeting held on 9 May 2023 was noted.	
QSE 23/08/006	**Chair's Actions** No Chair's Actions were raised.	
QSE 23/08/007	**Quality Indicators Report:** The Quality Indicators Report was received. It was noted that the format of the reporting mechanism had changed and a slideshow was presented to the Committee. The Executive Medical Director (EMD) advised the Committee that reports had previously provided a large amount of narrative and not much data and so the change in format was to ensure better information was being received by the Committee. The Committee were provided with data and detailed information from a number of Quality Indicators which included: • National Reportable Incidents and Never Events • Infection Prevention and Control • Falls and Pressure Damage • Medication Incidents • Patient Safety Solutions • Mortality Data • Clinical Effectiveness • Covid Investigations • Patient Experience Data • Patient Experience - Ombudsman Referrals • Patient Experience - CIVICA • Safe Care Data • Proposed Timely Care Indicators • Proposed Equitable Care Indicators The CC advised the Assistant Director of Quality and Patient Safety (ADQPS) that benchmarking would be a useful visual tool to help provide further assurance to the Committee when receiving future Quality Indicator reports as well as providing an emphasis on the actions required for each area. The EMD thanked the ADPQS for pulling all of the work together and noted that it would be important to provide in future Quality Indicator Reports the: • Data for each quality indicator • The "Why" for each quality indicator • The actions coming out from each indicator • The target or trend that the Health Board would aim for to provide and drive improvement. **The QSE Committee resolved that:** a) The Quality Indicators Report and plans for further development were noted.	**AS**
QSE 23/08/008	**Stroke / Stroke Performance** The Stroke / Stroke Performance was received. The Committee was provided with information on the current operational performance of the stroke service as measured against the UK Stroke Sentinel Audit Programme (SSNAP) and were presented with areas where the service had improved as well as areas where there were still gaps in service provision. The Director of Operations for Six Goals and Financial Improvement (DOSGFI) who was providing cover for the Chief Operating Officer (COO) advised the Committee that the latest quarterly SSNAP performance data scored the overall Health Board stroke service as a C.	

The DOSGFI presented the Committee with a number of actions to improve the stroke service which included:

- 3 Internal Stroke summits had taken place which provided organisational support and focus on stroke patients' pathways and multidisciplinary meetings which brought together medical, nursing and therapy clinicians with operational and senior leaders.
- A Stroke Improvement Programme which was launched in January 2023 and overseen by a dedicated resource which consisted of a Stroke Service Manager and Clinical Director who would report to the Medicine Clinical Board and Executive Management Team.
- Collaborative, cross-clinical board workstreams which included a revision of the stroke imaging pathway and emergency stroke assessment pathway in the Emergency Department (ED).
- A workforce review through redesign of the optimal clinical model
- Implementation of digital solutions to support the emergency stroke assessment pathway and imaging interpretation.

The DOSGFI presented the Committee with the challenges faced by the stroke service which included:

- Delivery of thrombolysis treatment – treatment rates and timely administration
- The provision of senior specialist staff to ensure the optimal patient pathway could be delivered consistently
- Consistent scanning within 60 minutes
- Mortality was just within expected range.

He concluded by presenting the Committee with the next steps which included:

- Delivery of a SSNAP score of "A" which would be supported by the production of an investment business case for a 2024/25 consideration.
- A Clinical Model which had been agreed in principle that would enable 85% of suspected stroke patients to be seen by a consultant
- Consultant cover from 8am to 10pm, 7 days a week in the ED (stroke and neurology coalition).
- A middle grade doctor available 24 hours a day, 7 days a week in the ED
- A stroke Clinical Nurse Specialist (CNS) support 24 hours a day, 7 days a week in the ED, in a phased approach.
- Consultant led clinics for Transient Ischemic Attack (TIA) and established stroke symptoms in the Medical Same day emergency care (MSDEC)
- Junior Doctor and Stroke CNS support to the MSDEC.

The Executive Director of Therapies and Health Sciences (EDTHS) noted that pre-Covid, the stroke service had nearly received a SSNAP score of "A" and noted disappointment of the current "C" score.

She added that when observing national tables, England performed better in stroke than Wales and so regionalised care would be required.

The Independent Member – University (IMU) asked that patient involvement and outcomes be presented in any future data around stroke presented to the Committee.

	The DOSGFI concluded that in order for the Health Board to receive a rating of A, an investment in resource would be required. The CC noted that the data presented was for October until December 2022 and asked if up to date information was available. The DOSGFI responded that it was a monthly report and noted that the SSNAP report was audited and validated which took a while to compile. He added that there was an indication that the Health Board's SSNAP score for January – March 2023 was also a C and that the data for April and June 2023 was being reviewed. It was noted that an update would be received by the Committee more frequently and the CC advised the Committee that they would not rest until the Health Board had a score of A. **The QSE Committee resolved that:** a) The current stroke performance position, the improvements made and the next steps regarding the new clinical model were noted.	**PB**
QSE 23/08/009	**Policies** The following policies and procedures were received: 1. Laser Risk Management Policy and Procedure (UHB 324) 2. Consent to Examination or Treatment Policy (UHB 100) The Assistant Medical Director, Clinical Effectiveness & Safety (AMDCES) advised the Committee that there were some typing errors in the Consent to Examination or Treatment Policy which would require amendment. **The Committee resolved that:** a) The Laser Risk Management Policy and Procedure (UHB 324) was approved b) The Consent to Examination or Treatment Policy (UHB 100) was approved pending the typing error amendments.	**NS**
QSE 23/08/010	**Cardiff and Vale of Glamorgan Childhood Immunisation Action Plan** The Cardiff and Vale of Glamorgan Childhood Immunisation Action Plan was received. The Principal Public Health Practitioner (PPHP) advised the Committee that vaccination was a life-saving intervention, which prevented disease and outbreaks in communities. She added that uptake for vaccination was inequitable both locally and nationally and that the three 'C's' behind vaccine hesitancy needed to be addressed throughout the development of interventions designed to increase uptake which included: • Complacency – the low perception of risk • Convenience – the availability and accessibility of vaccines; health literacy; language barriers and cultural context • Confidence – trust in vaccine safety and effectiveness and in policy makers and programmes It was noted that The Cardiff and Vale of Glamorgan Immunisation Action Plan aimed to continue to work to improve uptake and reduce health inequities for vaccination in childhood, building upon previous improvement actions and insights work, which included 5 key themes: • A data-informed approach • A behavioural sciences approach • Stakeholder engagement • Communication • Evaluation and continuous improvement	

	The Independent Member – Community (IMC) noted their support for the Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan and asked if there was anything he could do to help support a reduction in inequities for vaccine uptake in the local communities. The Consultant in Public Health Medicine responded that he would arrange a meeting with the IMC outside of the meeting to discuss further. **The Committee resolved that:** a) The progress to date was noted. b) The Childhood Immunisation Plan was endorsed and supported.	
QSE 23/08/011	**Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan** The Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan was received. The PPHP advised the Committee that the Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan was an important agenda that the Health Board needed to be on board with. She added that the action plan outlined requirements to improve the uptake in vaccination and noted that in order to redress inequities, the Cardiff and Vale of Glamorgan Vaccine Equity Strategic Plan sets out five strategic themes which included: • A data informed approach • A behavioural insight approach • Stakeholder engagement • Communication • Evaluation and continuous improvement It was noted that those 5 themes framed a ten-point action plan for 2023/24 to deliver equity in the communities which would require a multi-agency response, and build on the successful programme delivered during the COVID-19 pandemic. **The Committee resolved that:** a) The content of the Vaccine Equity Strategic Plan was noted b) The Vaccine Equity Strategic Plan was approved and supported	
QSE 23/08/012	**Welsh Risk Pool Final Assessment Report** The Welsh Risk Pool Final Assessment Report was received. The Executive Nurse Director (END) advised the Committee that the report provided the findings for the health body following a review conducted by an independent assessment team from the Welsh Risk Pool. He added that the Health Board had received substantial assurance in 5 areas which included: • Management of Concerns (Complaints & Enquiries) • Redress Case Management • Claims Case Management • Learning from Events • WRP Reimbursement Process **The Committee resolved that:** a) The content of the report and the improvement plan was noted.	
QSE 23/08/013	**Introduction to the Public Health Wales Safeguarding Service, Self-Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts.** The Introduction to the Public Health Wales Safeguarding Service, Self-Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts was received. The END advised the Committee that it was received by the Committee annually and was for information to show that the Health Board were on target for the self-assessment.	

	The Committee resolved that: a) The Introduction to the Public Health Wales Safeguarding Service, Self-Assessment Safeguarding Maturity Matrix (SMM) for Health Boards and Trusts was noted.	
QSE 23/08/014	**Minutes from Clinical Board QSE Sub Committees:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/08/015	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/08/016	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
QSE 23/08/017	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 26 September 2023 via MS Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 26 September 2023
(Following the meeting held on 29 August 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 23/05/007	**Civica "Once for Wales" platform**	To undertake a deep dive into the Civica data via Quality Indicators Report.	**29.08.2023**	Jason Roberts	**COMPLETED in August 2023** *To note that a report was received by the Board on 27/07/23*
QSE 23/05/007	**Stroke Update**	Committee to receive a deep dive with regards to Stroke data	**29.08.2023**	Paul Bostock	**COMPLETED in August 2023**
Actions in Progress					
QSE 23/03/008	**Looked After Children – Assessment Backlogs**	An update report to be brought back to the Committee in 3-4 months.	**26.09.2023**	Jason Roberts/Catherine Wood	**Update in September 2023** *Agenda item 2.3*
QSE 23/03/007	**Specialist Clinical Board Assurance Report – re: South Wales Trauma Network**	To update the Committee with regards to the WHSSC funding for South Wales Trauma Network review and associated actions	**25.10.2023 (date tbc)**	Paul Bostock/Guy Blackshaw	**Update in October 2023**
QSE 23/04/007	**Children & Women's Clinical Board Assurance Report**	revisit the waiting list issue identified in 6 months' time to provide more assurance. Full Clinical Board assurance report not required	**25.10.2023 (date tbc)**	Jason Roberts	**Update in October 2023**
QSE 23/04/009	**Pressure Damage**	An update report to be brought back to the Committee in 6 months' time.	**25.10.2023 (date tbc)**	Jason Roberts	**Update in October 2023**

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 23/07/009	**MBRRACE Update**	A matrix report to be provided to the Committee to include the MBRRACE report.	**28.11.2023**	Meriel Jenney / Jason Roberts	**Update in November 2023**
QSE 23/07/014	**Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25**	An update to be provided in 12 months' time.	**July 2024**	Fiona Kinghorn	**Update in July 2024**
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					
AAC 4/7/23/013	**Regulatory Compliance Tracking Report**	Some of the Patient Safety Solutions had been on the tracker for some time and should be taken to a future Quality, Safety & Experience (QSE) Committee meeting to provide assurance.	**26.09.2023**	Aaron Fowler / Matt Phillips	**Update on 28 September 2023**
UHB 23/05/015	**Integrated Performance Report: QSE**	Mortality data assurance to be provided to November Board following a deep dive at a QSE Committee meeting in September	**26.09.2023**	Meriel Jenney	**Update on 28 September 2023**
UHB 23/03/013	**QSE Chair's Report**	A deep dive with regards to stillbirths to be considered at the QSE Committee.	**30.11.2023**	Jason Roberts/Angela Hughes	**Update to be given to Board on 30 November 2023.** *Deep dive provided to the QSE on 28 November 2023.*

Report Title:	Primary, Community & Intermediate Care (PCIC) Clinical Board Assurance Report			Agenda Item no.	2.1
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	26th September 2023
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Deputy Director of Nursing, PCIC				

Main Report
Background and current situation:

Current Assurances

Duty of Candour
The Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect from Spring 2023 and has imposed several new duties on all Clinical Boards, including PCIC, particularly around the Duty of Candour (DoC) aspects. The Act applies to both managed and commissioned services which adds greater complexity to effective implementation within PCIC. The Quality and Safety team has worked with the Patient Safety Team to implement an appropriate process for managing DoC declarations. PCIC has not been required to proceed with any DoC declarations to date.

The Medical Examiner Service (MES)
MES was due to be fully implemented for all non-coronial deaths (in hospital and in the community) from April 2023. Legislative process delays have resulted in the implementation within the Primary Care setting being delayed until April 2024. Local implementation arrangements for the Mortality Review process are being developed in line with the Mortality Review Model Framework. Preparatory work is underway, including encouraging GMS to ratify data sharing agreements with the MES, holding regular quality assurance meetings between MES leads and the Quality and Safety team, and regular case conference meetings with the UHB Lead for Mortality Reviews.

The introduction of the DoC and MES requirements have generated significant additional pressures for the Quality and Safety team and additional administrative support has been agreed.

<u>Safe Care</u>

Incidents
There are no nationally reportable incidents currently open; there were 3 closed through May and June 2023.

PCIC has reported 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incident to HIW. The incident has been investigated which has identified no harm. A full report will be submitted in October 2023 to meet the regulatory requirements.

There are currently **448** open Datix incidents within the Clinical Board (similar to last month with **431** for July 2023). There is an increase in reporting since last year and there is a decrease in timely closures due to the ongoing operational pressures. Lead and Senior Nurses continue to support teams in ensuring Datix incidents are reviewed within 7 days to reduce the risk of harm events not being actioned. The PCIC QSE team undertakes periodic scrutiny of all open Datix incidents to support the timely management and appropriate allocation of incidents to the correct clinical board.

Superusers have been identified and undertake a specific role in the management of Datix incidents within their business unit.

Primary Care Interface and Patient Safety Incident Reporting
There are currently **54** open Datix interface incidents within the Clinical Board. The majority of open incidents relate to laboratory samples and there is an ongoing focus from the Q&S to ensure timely management. All incidents are reviewed regularly and forwarded to the relevant clinical board for onward management. The overarching theme identified relates to insufficient information provided within discharge communications from secondary care services. This has been raised in meetings with other Clinical Board Directors.

Following the introduction of the DatixCymru system in March 2022, a pilot project was established with GPs to develop a process for practices to directly raise incidents using the Datix system, and there is a currently a dedicated member of staff in the Vale Locality who co-ordinates GP incidents specifically for that Locality. A one-year pilot of Optometry reporting to a central national coordinating point has been completed. These evaluation reports have all been received in PCIC.

DatixCymru has been offered to all General Medical Services (GMS). However, there is no legislative requirement for practices to do so and uptake remains low. In the absence of GMS practices adopting DatixCymru, GMS teams are asked to submit Datix incidents to the Health Board via the DatixCymru *off line* reporting process. This will eventually supersede the current interface incident process once robustly embedded in practice. The Deputy Clinical Board Director has also been chairing an All Wales Task and Finish Group regarding GP mitigations for ambulance delays in the community (ADC). This has led to advice and guidance for Primary Care colleagues being published by the GMPI team.

Pressure Ulcers
Weekly pressure ulcer scrutiny panels are fully embedded in practice within PCIC. The aim of the panels is to focus on grade 3, 4 and unstageable pressure damage prevention and management, ensuring patient safety through scrutiny, clinical supervision, education and integrity throughout and supports the All Wales Pressure Ulcer Reporting and Investigation process. The panels provide a focused approach and early management of incidents and create a forum for peer support and wider learning. This is a multidisciplinary approach. From 1st January to 20th July 2023, 70 pressure damage incidents have been discussed with 6 being deemed as avoidable. The themes identified for avoidable pressure damage include identification, timely assessment and documentation.

As part of development Care Home matrons in the Vale have been included within the weekly scrutiny meetings with positive feedback received from those who have attended with respect to increased confidence in using the All Wales RCA tool and process in those settings. It is intended to roll this out across the other Localities

Infection prevention and control (IP&C)
There is now a dedicated part time IP&C nurse supporting PCIC and part of their role includes supporting the Root Cause Analyses (RCA) investigation process for Clostridium difficile. The investigative requirements are shared with the relevant GP practices for action; there has been a robust engagement since the re-introduction of the requirement in February 2022. The IP&C nurse also investigates the PCIC attributed Staphylococcus aureus bacteraemia source to identify if there is any health care contact attributed to these, thus identifying areas for targeted training and support. MSSA bacteraemia are a particular area of concerns as we have seen an increase in cases across all of Wales compared to pre-pandemic cases.

PCIC are not currently on trajectory to meet the Tier 1 reduction expectation for five of the six organisms (Clostridium difficile, MRSA bacteraemia, MSSA bacteraemia, E. coli bacteraemia or Klebsiella bacteraemia) but is on trajectory to meet the Pseudomonas bacteraemia reduction expectation. There is ongoing work in conjunction with the IP&C team and Public Health Wales to identify themes and trends and understand where focused education and support is required.

IP&C training sessions have commenced and to date 96 staff have attended these sessions.

Community Pharmacy
In relation to community pharmacy independent contractors, pharmaceutical service contracts are managed and regulated against the NHS Wales Act 2006, NHS pharmaceutical services regulations (Wales) 2020, Pharmacy Order 2010 and GPHC standards. The introduction of Once for Wales Datix reporting system and Duty of Candour Act in community pharmacy during 2022 and 2023 has placed an increased pressure on the PCIC community pharmacy team to support the process and follow up incident reports in accordance with regulation, although the responsibility to report and investigate lies with the individual pharmacy.

There is a current risk included in the PCIC risk register relating to changes to the medication policy which will impact on the ability to support people with medication in their own homes and could also potentially impact on discharges from hospital. There is also an impact on community pharmacies which will require funding for them to provide monitored dosage systems (MDS).

Community Pharmacy Services and Sustainability
The introduction and ongoing implementation of the Clinical Community Pharmacy Service (CCPS) and Pharmacist Independent Prescribing (PIP) service in Wales continues to see growth in provision across the Health Board. There is currently ongoing pressure on Community Pharmacy Services and we have seen four contract withdrawals since August 2022 as well as the exit from Wales of a large multiple, closing and or selling its entire Welsh estate. After consideration through Primary Care Panel, one closure has resulted in an alteration to the availability of pharmaceutical services and as such the Health Board has published a supplementary statement to our Pharmaceutical Needs Assessment.

Escalation levels have remained at a steady state with 6% reporting moderate to high pressure, for significant periods of time. There has been an ongoing number of temporary closures by pharmacies over the year due to workforce issues and sickness but this has been well managed by our contractual breach management process.

There has been significant support from the community pharmacy team alongside NHS Wales Shared Service Partnership (NWSSP) to manage the contract withdrawals and change of ownership applications to ensure patients are still able to access services from other pharmacies close to their home. There has been contractual funding to support pharmacies to upskill their workforce but no funding to recruit additional staff or to improve buildings for more clinical space to manage the increase in patients accessing community pharmacy services.

The ongoing business viability and sustainability concerns of the Community pharmacy network has been escalated at a national level with Welsh Government and other national bodies to find solutions.

General Medical Services (GMS)

GMS sustainability remains a risk.The main contributing factors that affect GMS sustainability are:

- Workforce – recruitment and retention of clinical and non-clinical staff
- Finance – the increase in value per patient against other rising costs and how this affects business viability
- Patient demand – patient behaviours driven by expectations, perceived workload shift from secondary to primary care, the remaining backlog as a result of Covid
- Population growth – lack of capacity to meeting growing population due to workforce and physical space. Increased average age, changing demographic factors and increased complexity also impact
- Estates – ownership and/or security of tenure of GMS premises

Steps taken by the Primary Care Team in response to growing concerns around sustainability have included;

- Reviewing and delivering a quality assurance framework and process that provides us with a clear perspective on how practices are delivering the GMS contract, how delivery may be impacted by the factors referred to above, and to support any improvement actions identified.
- Recruited a multi-professional team to support our quality assurance processes and drive service improvement
- Reviewed our approach to GMS escalation to ensure that we are aware of where short-term issues for practices are reflective of more deep-rooted problems so we can offer support at the earliest stage.
- Developed a proactive and reactive approach to supporting service sustainability as follows

Reactive Response

- Peer support and advice to practice teams provided by our multi-professional team
- Refreshed the model of support offered to practices to comprise a three Stage Intervention – diagnostic analysis, reporting points identified and making recommendations for improvement and supporting the implementation of improvement actions.

Pro-active measures

- Increased incentivisation of practice merger payment scheme
- GPN Nurse scheme – improving recruitment and retention of skilled GP Nurse workforce
- Primary Care Apprenticeship Scheme – linked to development of skilled management workforce in general practice.
- Funded training opportunities for new practice managers
- Programme of Service Improvement projects to help improve e.g. patient management, workforce and retention, workload management.

Dental Services
In terms of the dental nurse shortage, there has been some improvement as HEIW have provided a course for 30 training places across Wales for Dental Practices to fund and PCIC has taken up 5 of these places.

The 2 Mobile dental Units (MDU) have not been fit for purpose since they have been purchased; however, following recent discussions with the supplier the warranty has been extended the warranty and the one MDU is now functioning.

More robust arrangements have been established to review progress against dental contracts. There are regular review meetings with targeted reviews for those practices where performance is flagged as a concern.

<u>Effective Care</u>

Acute Response Team
Following a review of the governance underpinning the anticoagulation arm of the service, alternative arrangements were made for referring clinical boards to retain the dosing and prescribing responsibility until the patient is stabilised and can be safely transferred over to Primary Care. There have been recent discussions with other Clinical Boards to ensure there are appropriate arrangements in place.

Two Advanced Nurse Practitioners (ANP) have been appointed to the team and are undertaking transformation work in conjunction with the Welsh Government *Closer to Home* initiative with a focus on crisis response, hospital avoidance and sepsis management.

District Nursing (DN)
All DN teams have been reporting escalation 3 level and occasionally level 4 for a number of months. Staffing has been managed across the teams depending on the level of risk.

Recruitment remains challenging, however there are new student streamlining staff due to commence in September 2023. All streamliners undertake a focused orientation education programme supported by the Professional Practice Development Nurse (PPDN) team. This provides excellent support and supports staff retention.

The six, Band 4 Assistant Practitioners have worked hard to complete their competency frameworks. They have enjoyed the diversity of the role and are ready to take the next steps into undertaking more enhanced delegated roles, such as medicines administration. PCIC is one of the first Clinical Boards to introduce this role, which will be a real asset to our DN teams. This role will be evaluated over the next three years.

Dignified Care

Complaints/Concerns
PCIC is achieving excellent performance with the response to complaints, currently there are 5 active concerns managed through the PTR process. The key themes from concerns across PCIC relate to treatment times and quality of care provided to patients. This is a similar picture to 2022.

Complaints in relation to our independent contractor services that are submitted directly to the Health Board are forwarded to the relevant independent contractor for onward management. It is important to note that we do not have sight of the detail for concerns that are submitted directly to the independent contractor services (GP, Optometry, pharmacy and Dental) as these are managed directly by the contractor.

Individual Care

Safeguarding
There are currently 9 open health cases of which 6 are pressure damage. There are 7 professional concerns currently ongoing within PCIC. All senior nurses have attended health lead professional training so are able to support the lead nurses in management of safeguarding.

Compliments
We receive many compliments from across our business units which are shared with the individuals/teams. We ask business units to log all compliments on the Patient Experience Quadrant Spreadsheet which is saved centrally. Recently received compliments include our Dental services, District Nursing teams and Mass Vaccination service. They were all praised for an excellent service provision, professionalism and compassion. Of note, one of our Community Pharmacy colleagues received the CAV Health Hero award in September 2023, the first time this has been awarded to an Independent Contractor

Cardinal Risk / Risk Register Score 20 and above

Change to medication policy and impact on supporting patients

Risk:
Inability to support people with medication in their own homes (for those needing support from domiciliary care), this could result in delays in discharging patients from hospital.

Source of uncertainty/cause:
change in policy and no formal requirement for community pharmacies

Consequence:
Impact on supporting people with medication at home and possible delay in discharges. Considerable amount of staffing resource used to ring round community pharmacies to try and find one with the capacity and goodwill to supply an MDS. This may be out of the local area to the patient and cause more logistical issues regarding prescription transfer. It also shifts workload to community pharmacies who are willing to provide MDS and could impact on sustainability of their service provision.
To note - discussions are currently ongoing at a national level (29/06/2023) in relation to national specification.

Controls:

- Relying on good will of community pharmacies to provide medication in MDS
- Secondary care and primary care teams working together to negotiate provision of MDS for individual patients if discharge is looking to be delayed – extremely time intensive, requires input from multiple (often senior) staff members and not always successful
- Working with Local Authority to review Regional medication policy to allow administration of medicines by care workers out of original packs with a Medicines Administration Record (MAR) chart

Assurances
Paper was taken to May SLG to agree handling and funding but not supported. Paper being revised and discussions to be held with LA colleagues (Dir of Ops, PCIC to action).

HMP Nurse staffing

Risk:
The Healthcare Dept at HMP Cardiff is unable to meet the needs of patients due to a high number of vacancies in the nursing team. This particularly affects the administration of medication, the assessment of new arrivals and the ongoing triage and care of unwell patients.

Controls:

- Senior management colleagues are working clinically
- Clinicians are being drawn from the in-house mental health, substance misuse and pharmacy teams to support the administration of medication
- Efforts to recruit to vacant posts are ongoing
- A recruitment event was recently held.
- Agency nurses have been utilised.
- Pharmacy Technicians have been recruited to dispense medication.
- Overtime payments are offered to staff.
- Regular support is being provided by PPDNs to train and support new staff.
- Working with the Governor and prison service to manage prison daily regime to support reduced capacity within health care

Assurances:
Staffing and escalation levels are reported on a weekly basis to the Locality Management Team and Clinical Board

Developments

PCIC Academy

Across Wales Health Boards are required to establish a local Primary and Community Care Academy, who will work to achieve the following vision: “To facilitate the delivery of high-quality education and training for people working in primary and community care to support the delivery of excellent evidence-based person-centered care”. PCIC have successfully recruited a team of 3 Academy members to progress the work throughout the Clinical Board.

The expectation of the Academy will be to effectively consider and coordinate training and education for a broad range of professionals working within primary and community services as set out in the Primary Care Model for Wales to ensure the multi-professional workforce has access to the necessary training and education and associated support to deliver a wider range of services and interventions within these settings. The Academy will work across the breadth of Primary & Community Care services aligned to

CAV 24/7

A risk for OOH is the procurement of the new OOH IT system by the National Team – Salus has been delayed on numerous occasions and the Health Board has had to re-enter in to a new 3-year contract with Adastra (current OOH IT system), bringing with it a financial implication. Currently unknown is any financial implication around Salus that the Health Board may need to absorb. Training for this new system is currently on hold, but once initiated this will also have financial implications.

The CAV 24/7 service has seen positive developments including:

- 111 press 2 – Mental Health - This service went live via a ‘’soft launch’’ on 1st February 2023. A National launch took place on the 14th June 2023. Challenges include, public communication and recruitment.

- UPCC- CAV 24/7 currently provide urgent care provision to the South and East Locality, situated within CRI, open 9-6pm Monday to Friday. Challenges include under utilisation of appointments.

- Emergency Dental Service (EDS) - The new dental contract came into existence April 2023. Service provision required from the general dental practices was increased and this has allowed the service to increase the number of available urgent patient slots..

- EU Re-Direction of Patients - Work between PCIC and Medicine Clinical Board has been ongoing to increase the number of re-directions EU send to CAV 24/7 – where patients symptoms / conditions are more appropriate for urgent care services. Patients are now starting to be redirected to the CAV24/7 service via this process.

- Step Down 2 Recovery (SD2R) - CAV 24/7 GPs have supported the TCU and SD2R beds at St David’s since November 2021. This is due to end in October 2023. Loss of GP shifts within the service may have a negative impact on shift fill for the UPCC and CAV triage as the same GPs support all three services via a designated rota.

- HMP Cardiff - A Standard Operational Procedure (SOP) was agreed by both services in July 2023. A pilot is now ongoing where CAV24/7 clinical staff provide clinical advice to HMP health care staff supporting the medical care of prisoners. This initiative takes place during the OOH period – i.e. evenings, weekends and bank Holidays. To date there has been a positive response from both services.

- *Contact First* -Patients contacting 111 and require a non-urgent assessment at EU are transferred to CAV 24/7 where a clinical triage takes place – patients may receive self-care advice, referral to their own GP, referral to other community service, allocation of a time slot to attend the emergency department – either minor injuries or ambulatory care unit. Availability of booked appointment slots are also available at Barry Minors Injuries Unit Monday to Friday 9 – 4.30pm.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- The teams across PCIC continue to work exceptionally hard to ensure the delivery of safe, effective care. It has been particularly challenging for the community teams due to the significant pressures arising from increased demand and staffing shortages. The teams have worked flexibility and have been deployed to other areas to help mitigate risks.
- There has been continued pressure on the primary care teams due to the GMS sustainability, contract reform and closures of community pharmacies. Additional capacity has been invested in these teams to ensure they are able to provide appropriate support to independent contractors, as well as robust contract management.
- There are continued pressures in HMP Cardiff and there have been some deaths. All deaths within the prison have been investigated via NRI, HIW and the Prison and Probation Services Ombudsman with any lessons learned being subject to action plans monitored via QS&E.
- The Covid testing and immunisation teams continue to deliver against all national requirements and more than 1,300,000 vaccines have been delivered. The Autumn boosters commenced on 11 September 2023. There has been an internal audit of the immunisation delivery and reasonable assurance was received.

Recommendation:

The Board / Committee are requested to:

Note the current position and also the actions taken since the previous report to strengthen assurance and manage risks within PCIC Clinical Board.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term		Integration	X	Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Risks are highlighted in the main report.
Safety: Yes
Safety issues and action taken or planned is included in the main report.
Financial: No
This report does not have specific finance implications.
Workforce: Yes
Workforce issues and associated actions are included in the main report.
Legal: No
There are no legal implications.
Reputational: Yes
There could be reputational implications if risks are not appropriately managed but this report includes action taken or planned in order to mitigate this.
Socio Economic: Yes
The actions taken or planned referenced in this report relate to the provision of services and how they can be improved. There are a range of services provided by PCIC which aim to improve access or quality of services for more vulnerable groups e.g. prison services, community dental services.
Equality and Health: No
No requirement as a result of this report for an EHIA to be undertaken.
Decarbonisation: No
Not applicable in relation to the content of this report.

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	**Infection Prevention and Control update for QSE September 2023**			Agenda Item no.	2.2
Meeting:	QSE	Public	X	Meeting Date:	26.09.23
		Private			
Status *(please tick one only):*	Assurance		Approval		Information
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Head of Nursing IP&C, IP&C Dr				

Main Report
Background and current situation:

The corporate Infection Prevention & Control (IP&C) team continues to support the Health Board in all aspects of IP&C with attendance at both Corporate and Clinical Board meetings to provide specialist advice and support whilst also representing CAV UHB at key All Wales meetings.

The IP&C team has expanded in size which has allowed more proactive support and engagement with clinical teams. The team is currently appointing a Band 8a Senior Nurse in IP&C which will free up the Head of Nursing for IP&C to undertake a more strategic role both within the health board and on an all-Wales level.

The IP&C team continues to support Clinical Boards with incident and outbreak management. Most recently, the team has been supporting clinical areas with outbreaks/incidents of infection including:

- MRSA outbreak in Neonatal Intensive Care
- MDR *Klebsiella pneumoniae* in West 8 UHL,
- SSI (Surgical Site infection) in Trauma & Orthopaedics,
- MSSA in Renal
- COVID19/Influenza/norovirus outbreaks in multiple clinical areas.

A meeting was held in August to close the W8 MDR *Klebsiella* outbreak after nearly 4 years.

The Welsh Health Circular 2023/031: Antimicrobial Resistance & Healthcare Associated Infection Improvement Goals for 2023-24 was received by the Health Board in August 2023.
This paper will describe the current Cardiff & Vale UHB position with regards to the reportable bacteremia's, outline whether we are on track to delivering our individual reduction goals and any actions the organisation is taking to ensure improvements in this position

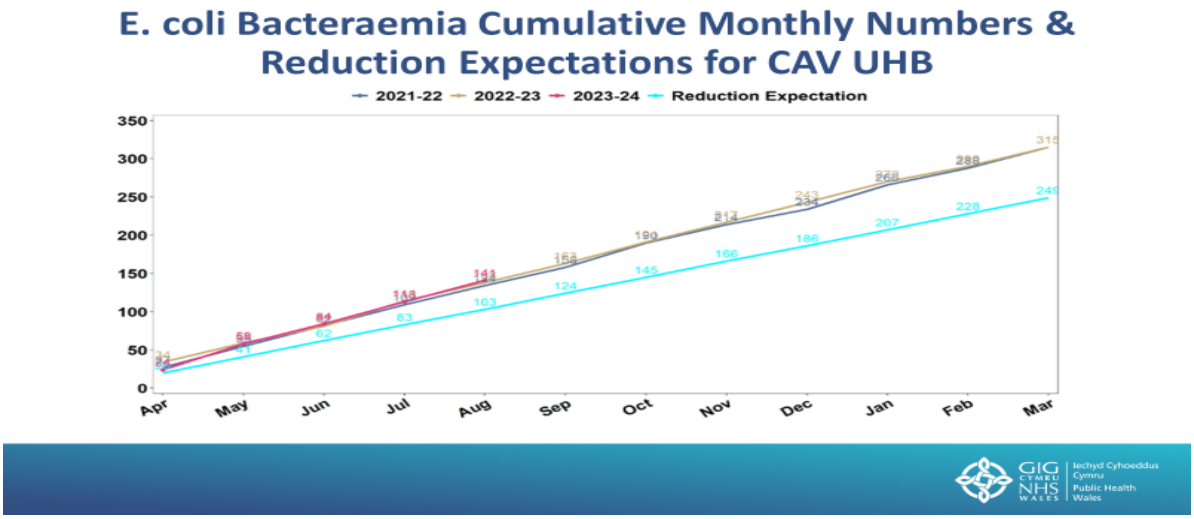
Current Financial Year Rate per 100,000 Population of Specimen by Health Board (April 23 – August 23)

Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Aug 23

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	30.79	0.8	14.8	57.98	19.99	4
Betsi Cadwaladr UHB	37.07	0.34	22.79	73.46	20.07	5.1
Cardiff and Vale UHB	23.23	2.37	31.77	65.91	23.71	4.27
Cwm Taf Morgannwg UHB	24.46	2.66	29.78	91.47	23.93	2.66
Hywel Dda UHB	41.13	2.46	24.55	114.17	26.39	8.59
Powys THB	8.99	0	0	3.6	0	0
Swansea Bay UHB	52.01	3.06	37.32	76.49	22.64	6.12
Velindre NHST						
Wales	33.13	1.74	24.75	74.57	21.81	4.75

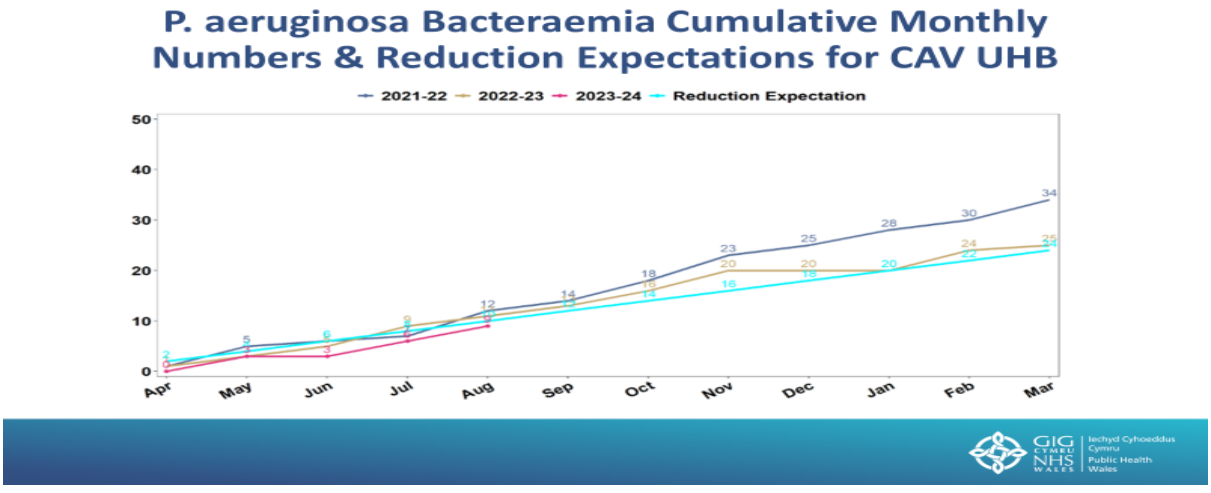
< than same period last FY
= same period last FY
> than same period last FY

Improvement Goal 6: Reduce the annual incidence of E. coli bacteraemia to below 67 cases per 100,000

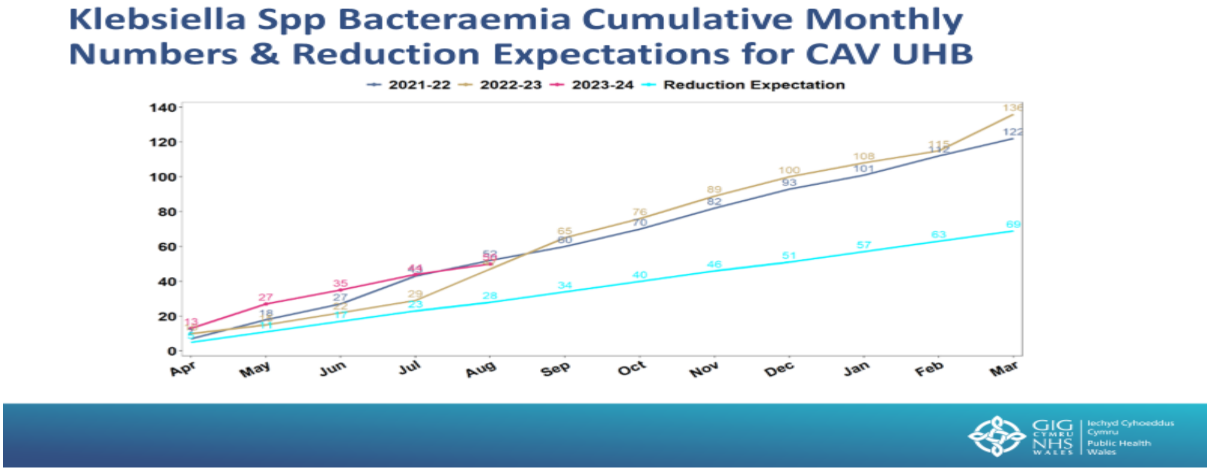


There have been 139 cases of *E.coli* bacteraemia to the end of August 2023, 1 more than the equivalent period in 2022. We are currently on trajectory to achieve and exceed the reduction goal with a current rate of 65.91 cases per 100,000 population and CAV has the second lowest rate in Wales. Work previously undertaken in Primary Care to support effective urine sampling and prescribing for urinary tract infections resulted in a significant reduction in *E.coli* bacteremias. The recent appointment of a Primary Community and Intermediate Care infection prevention and control nurse will further support this work.

Improvement Goal 7: Reduce the annual incidence of P. aeruginosa and Klebsiella spp. bacteraemia by 10% against 2017-18 figures.

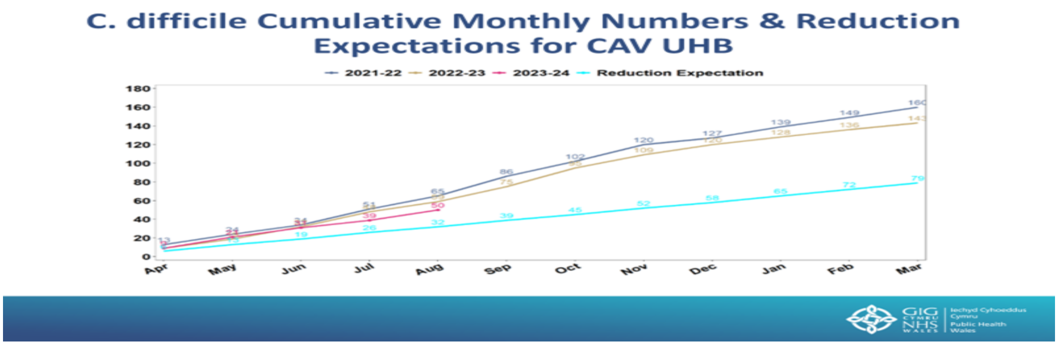


There have been 9 cases of Pseudomonas bacteraemia to the end of August 2023, a rate of 4.27 cases per 100,000. We are currently on trajectory to achieve the reduction expectation of 6.38 cases per 100,000 population and have the third lowest rate in Wales



There have been 50 cases of Klebsiella sp. bacteraemia between April and August 2023, a rate of 23.71 cases per 100,000 population. This is 4 cases more than the equivalent period in 2022. We are currently not on trajectory to achieve the reduction goal of 20.43 cases per 100,000 population and have the fourth lowest rate in Wales. An increase in Klebsiella cases was observed nationally over the pandemic, however, the underlying reasons for the causes of these infections and the increase is poorly understood.

Improvement Goal 8: Reduce the annual incidence of C. difficile disease to 25 cases per 100,000 or below

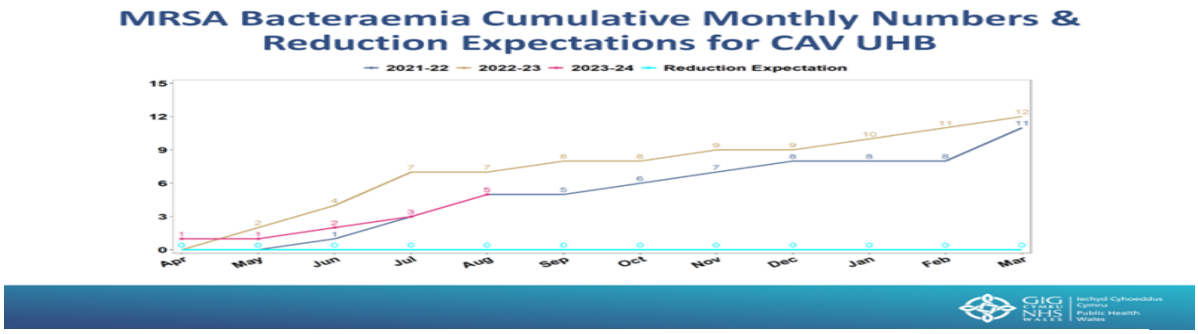


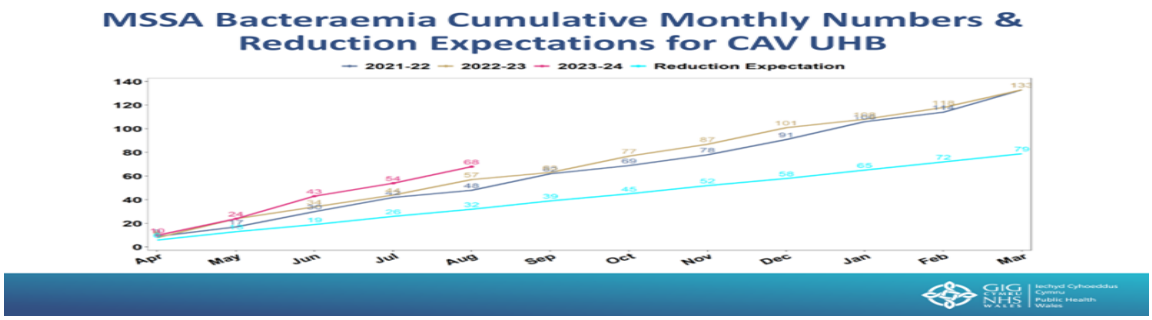
There have been 49 *C'difficile* toxin positive cases in CAVUHB from April 1st to the end of August 2023, 10 cases less than the equivalent period last year.

We are currently on trajectory to achieve the reduction expectation and have achieved the highest reduction in the number of cases compared to comparable Health Boards in Wales with the lowest rate of 23.23 cases per 100,000 population. Work continues to reduce the number of cases including:

- Review of each case by an MDT which includes an infection prevention & control nurse, Public Health Wales/Anaerobic Reference Unit specialist scientist, microbiology consultant/registrar, and pharmacist to identify any learning.
- Cases are discussed with the relevant clinicians and at the Clinical Board quality and safety meetings.
- Executive reviews with the clinical teams responsible for cases to identify good practice and areas for improvement.
- Funding for a dedicated Infection Prevention & Control Nurse was approved in 2020 to work with Primary, Community and Intermediate Care Clinical Board. The post was filled in October 2022, and now supports General Practices to review community related cases.
- Incident meetings with clinical areas where an increase in cases is identified including Renal and Medicine.
- Increased IP&C audits and education sessions delivered in clinical areas.

Improvement Goal 9: Reduce the annual incidence of Staphylococcus aureus bacteraemia to 20 cases per 100,000 or below. With zero tolerance of preventable MRSA blood stream infections and continued drive to reduce cases.





There have been 5 cases of MRSA in CAVUHB from April 1st to the end of August 2023. MRSA bacteraemia cases have reduced by 2 compared to the equivalent period in 2022/23, all 5 cases are community related and are not healthcare acquired. Improved screening on admission has resulted in improved identification of localised colonisation which in turn has supported effective decolonisation of patients with a subsequent reduction in MRSA bacteremia. CAV has the 3rd lowest rate per 100,000 population in Wales but will not achieve the reduction expectation which is zero cases.

Unfortunately, we have seen an increase in MSSA with 68 cases at the end of August compared to 57 cases for the equivalent period in 2022. Cardiff & Vale now has the 5th highest rate in Wales, contributed to in part by an increase in cases attributed to renal dialysis satellite units. 57 cases (85%) had a community onset and work is ongoing to identify how many of these have had healthcare interaction.

Ongoing work to reduce cases includes:

- Review of each case by an MDT which includes an IP&C nurse, Public Health Wales specialist scientist and Microbiology Consultant/registrar to identify any learning.
- Executive oversight and scrutiny of Clinical Board team from Executive Nurse and Medical Directors as part of the monthly Executive review.
- Cases discussion with the relevant clinicians and at the CB Q&S meetings.
- Review of all community attributed cases to identify if any are healthcare related -current information suggests only one third of community cases have had any healthcare interaction.
- Executive reviews with the clinical team responsible for patients with hospital acquired cases to identify good practice and areas for improvement.
- Increased auditing of compliance with PVC/CVC insertion/maintenance bundles using Tendable by the IPCNs. Tendable has been rolled out to areas outside of wards including radiology, outpatients, theatres, and the HSDU which has allowed standardisation of IP&C audits across all areas.
- Meetings have recommenced with Practice Development Nurses to increase compliance with Aseptic Non-Touch Technique amongst nursing teams. Discussions have started with

medical education leads to engage medical teams to increase Aseptic Non-Touch Technique training and compliance amongst medical staff

The IP&C team also works with non-clinical teams including Capital, Estates, and Facilities, and procurement.
Current work with procurement includes:

- reviewing the cleaning products used to clean clinical areas. This has the potential to make an annual saving for the Health Board of almost £29,000 while maintaining high standards of cleaning. Other products will also be reviewed once the All Wales Cleaning Standards guidance is published.

Other work streams the team is involved with include:

- Effective decontamination of Ultrasound probes
- Working with pharmacy to source appropriate pre-operative skin cleansing solutions due to a national shortage of what is currently in use
- Collaborative working between IP&C, Surgery Practice Educators and Procurement to promote the “RCN Gloves off Campaign”. Presentations have been completed, promotional material is in publications and a business case put forward to the UHB Sustainability Group to assist in promotion and UHB Spread

Tendable is an easy to use app for audit, quality improvement and assurance used by clinical staff including the IP&C team. Tendable data informs monthly Executive reviews as part of a quality pack. Increased IP&C auditing of admission screening compliance, equipment cleanliness, Peripheral Venous Catheter/Central Venous Catheter practice and the environment in clinical areas using Tendable will continue. The routine checking of decontamination of hospital beds declined in the pandemic but investment in the IP&C team and the roll out of Tendable, the volume and transparency of bed audits has increased supporting the development of local improvement plans and follow up audit.

Infection Prevention & Control Audit update for April 1st to 31st August 2023

UHW	**Environment**	**Equipment**	**Linen**	**Commode**	**Bed**	**Mattress**	**Hand Hygiene**	**Bare Below the Elbow**	**PVC (UHW)**
% score	84.4	87.3	90.5	59.8	57.1	76.3	85.8	96.6	84.8
No. of wards	39	35	35	19	31	30	51	47	17
UHL	**Environment**	**Equipment**	**Linen**	**Commode**	**Bed**	**Mattress**	**Hand Hygiene**	**Bare Below the Elbow**	**PVC**
% score	83.4	94.5	94.8	79.3	61.1	76.3	83.5	88.8	92
No. of wards	29	17	15	10	8	8	15	19	14
TOTAL	Environment	Equipment	Linen	Commode	Bed	Mattress	Hand Hygiene	Bare Below the Elbow	PVC (UHW)
% score	83.9	90.9	92.6	69.5	59.1	76.3	84.6	92.7	88.4
No. of wards	68	52	50	29	39	38	66	66	31

Monthly joint audits with housekeeping, estates, clinical teams and the Infection Prevention and Control team are underway with the aim of improving collaborative working and sharing of knowledge. This process will result in improvements to the clinical environment and to patient experience.

Since April 2023 there have been over 500 audits undertaken by the IP&C nurses which is the most ever undertaken by the infection prevention and control team.

We are developing a clinical quality dashboard to triangulate the staffing, capacity, acute / dependency and IPC data which gives greater intelligence and understanding of the impact of these variables in relation to healthcare associated infection

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Reduction Expectations are currently being achieved for this point in the year for E.coli and Pseudomonous.

Work to oversee and drive improvements in C.difficile cases has resulted in a significant reduction across the Health Board.

Executive oversight and scrutiny and IP&C focus on C.difficile cases is now being extended to Staphylococcus aureus cases.

Tendable is being used to improve oversight and local IP&C practices and to dive local improvements.

Recommendation:

The Committee is requested to: **NOTE** the assurance provided by the actions underway to support scrutiny and oversight of bacteremias and to embed improvements in practice.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: Yes/No
n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Children looked after– Assessment Backlogs			Agenda Item no.	2.3
Meeting:	Quality, Safety & Experience Committee	Public	X	Meeting Date:	26.09.23
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Executive Nurse Director				
Report Author (Title):	General Manager, Children, Young People and Family Health Services				

Main Report
Background and current situation:

The purpose of this report is to provide Committee Members will an updated position regarding assessments for Children looked after.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Children Looked After (CLA) team are an integral part of the Children, Young People and Family Health Directorate and deliver an area of work where there are statutory health requirements. It is well known that children in care have adverse health outcomes so the assessments are aimed at improving health outcomes and reducing health inequalities, as well as ensuring identified health needs are actioned and monitored. The service is provided by a small staffing team of 1.3 WTE Consultant sessions and 7.10 WTE Specialist Nurses. The nursing team was increased in March 2023 in response to the number of children waiting for a statutory health assessment.

Performance against Statutory Regulations

The regulations stipulate that within 28 days of a child being accommodated by the local authority they should have a holistic health assessment. For children under the age of 5 years a review health assessment should be undertaken every 6 months, for those aged 5+ years this should be completed annually. The statutory requirements to see children within 28-days of entering care for an initial health assessment, is often not achievable due to delays in notification from the local authority.

Growth

As previously report there has been a consistent increase in children in care in Cardiff and the Vale of Glamorgan.

There are currently 1,666 children on the CLA database in September 2023. Included within this are 399 children from Cardiff and Vale, who are looked after out of area. Therefore, there are 1,267 children living across Cardiff and Vale that the CLA team have statutory obligations around the new initial health assessment, and review health assessment. Health assessments for children placed out of area remain our responsibility, but are undertaken by the Health Board / Trust where the child is placed.

The increase in numbers of Looked after have a significant impact on the number of Initial & review Health Assessments required each year. However, capacity had remained the same until recently, resulting in a backlog of both new and review health assessments.

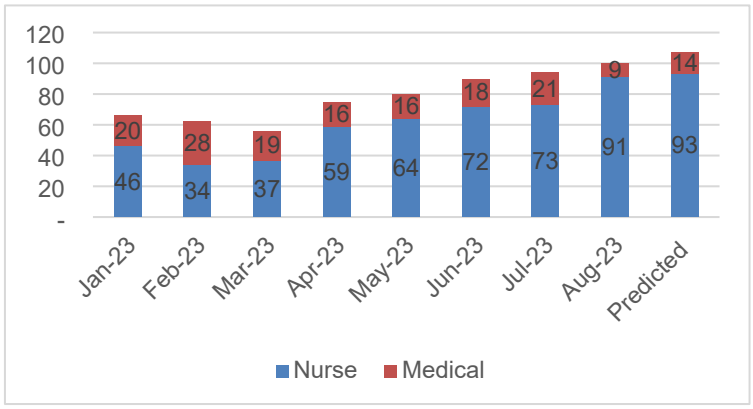
Actions taken

An additional 2.90 WTE nurses have been appointed to increase the nursing workforce to 7.10wte.

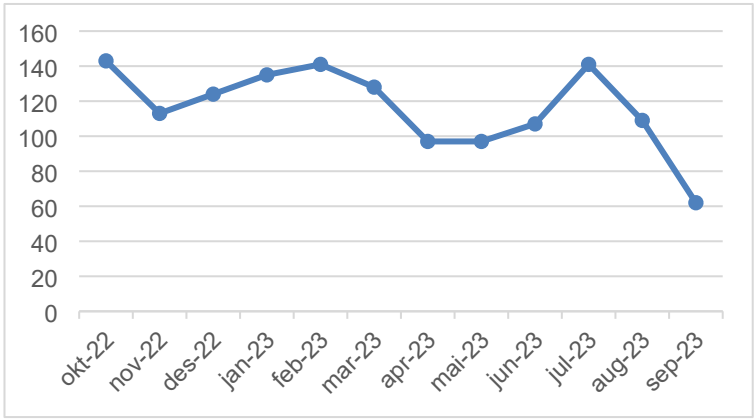
Nurse are now undertaking all initial and review health assessments for children over 5. Prior to March 2023 medical staff were undertaking all health assessments for children under 10.

The graphs below demonstrate the increase in Heath Assessments undertaken and the reduction in the backlog of Health Assessments.

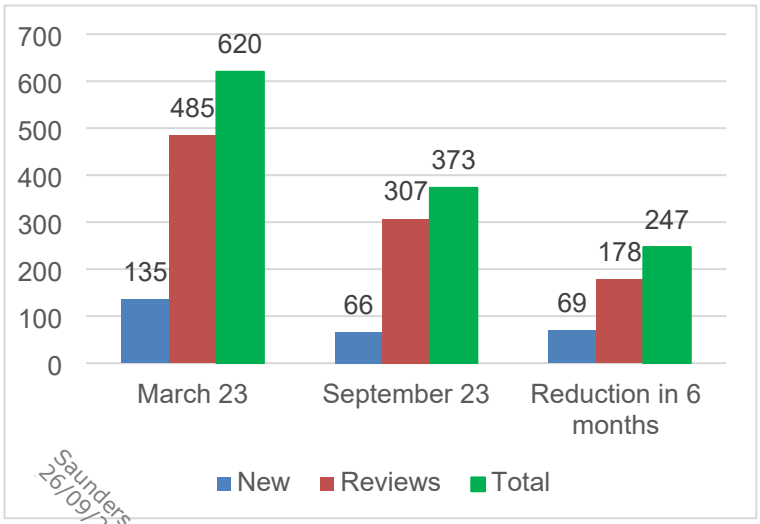
Graph 1 - Number of Health Assessments undertaken



Graph 2 - Number of Initial Health Assessments outstanding



Graph 3 – Backlog of Health Assessments – reduction March 2023 to September 2023



Whilst there has been a significant improvement in the numbers waiting, meeting these regulations continues to be a challenge.

Demand and capacity

Based on the current numbers looked after and predicted numbers entering care the estimated **demand** is summarised below.

Annual estimated demand	**How often**	**New IHA**	**Existing RHA**
Under 5s	Twice a year	312 *	644
Over 5s	Annual		945
Total		**312**	**1,589**

estimate based on 24 new referrals a month placed in C&V requiring IHA

As described assessments are delivered by both Medical and Nursing staff. Nurse led clinics are now undertaking assessments on over 5s. Medical staff are undertaking assessments for under 5s and children adopted.

The current workforce can deliver 1,307 assessments per annum, 1,116 nurse (over 5s) and 191 Medical (under 5s & pre adoption). Demand still continues to exceed capacity as summarised below, with a continued inequitable gap between under and over 5s.

	Under 5s (Medical)	**Over 5s (Nurse)**	**Total**
Estimated demand			
New	94	218	**312**
Review	644	945	**1,589**
Total Demand	**738**	**1,163**	**1,901**
Current capacity	191	1,116	**1,307**
Shortfall	**547**	**47**	**594**

In addition to the known shortfall in capacity, the capacity over the next 6 to 12 months (exact date of return not known) will be reduced due to maternity leave of one of the medical team. This will reduce capacity for under 5s by 8 a month.

In addition to the increasing backlog of assessments this increase in demand has resulted in nurses carrying significant numbers of children on their caseload, in excess of the recommended 100. Based on the current over 5 caseloads this would require 10.30 wte (inc 0.80 WTE manager case holding all children placed (OOA), an increase of 3.20 WTE.

Options to address gap

Alternative staffing models have been explored to consider options to address the backlog, meet current demand and also to manage caseload in line with recommendations.

- Immediate review of role of trainee doctors and their contribution to health assessments for under 5s.
- Review of completion of under 5s. These children require 2 health assessments per annum, currently undertaken by Medics. Consideration is being given to the nurse / health visiting completing one of the two annual assessments.

- Further nurse recruitment to consider Health Visiting roles, in addition to traditional Clinical Nurse Specialist roles.

- Review of outcomes from an Audit of quality of Health Assessments and information sharing. The audit will look at the quality and how differences information shared has an impact of the time the assessment takes, which will have a direct impact on the number of assessments that can be completed.

Recommendation:

The Board / Committee are requested to **note** the content of the paper and the actions taken to mitigate the risks associated child health assessments.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities	√	6. Have a planned care system where demand and capacity are in balance	√
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	√	Long term	√	Integration		Collaboration		Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes

This has been risk assessed and entered onto the Risk Register

Safety: Yes

In the main body of the report

Financial: Yes

Immediate financial risk has been mitigated by redirecting resource to CLA service due to risk being held.

Workforce: Yes

Detailed in body of the report

Legal: No

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation:No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
26/09/2023 09:52:26

Report Title:	Covid Investigations				Agenda Item no.	2.4	
Meeting:	Quality, Safety & Experience Committee		Public	X	Meeting Date:	September 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Head of Covid Investigations						

Main Report
Background and current situation:

The publication of the NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (the framework) supports the Communicable Disease Outbreak Plan for Wales (2020) by providing a consistent approach for NHS Wales organisations to identify, review and report patient safety incidents following nosocomial transmission of COVID-19 in compliance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR).

These reviews are under the umbrella of the final 'NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (2021) which supports the Communicable Disease Outbreak Plan for Wales (2020) by identifying, reviewing and reporting patient safety incidents, complaints or claims relating to nosocomial transmission of Covid-19 in line with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR).

On 26 January 2022, the Welsh Government announced £9 million investment over 2 years to support delivery of the framework.

The associated funding conditions were that all Health Boards:

- Put in place the necessary resource and infrastructure to deliver the programme of investigation work in relation to patient safety incidents of nosocomial COVID-19. Investigation work must be completed in line with the framework.

- Establish relevant internal assurance mechanisms such as scrutiny panels. Proactively engage with patients and families who have been affected by incidents of nosocomial Covid-19, including advocacy through the Llais Cymru.

- Put in place the necessary infrastructure to provide a dedicated point of contact for supporting families for five days a week.
    - Develop robust governance structures, including internal mechanisms to ensure the Board is fully appraised of progress with investigations; and
    - Reporting mechanism to update NHS Executive on progress. Monthly reporting against an agreed reporting framework will be required.

- Engage with colleagues in the NHS Executive who will have overall responsibility for national leadership and oversight in relation to implementation and application of the national framework.

- Work with the NHS Executive to develop the national learning plan which will incorporate the lessons learned throughout the pandemic.

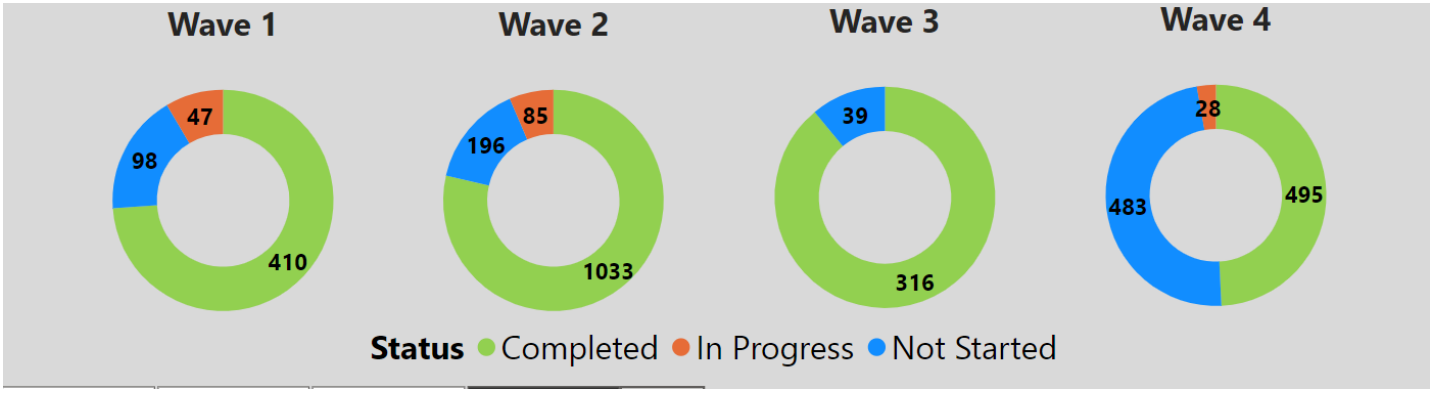
Cardiff and Vale UHB have a fully established Covid Investigation Team and are implementing all aspects of the National framework. The investigations into indeterminate, probable and definite Health Care Associated Covid -19 Infections (HCAI) as defined by the 4-Nations HCAI Surveillance group are in progress. The definitions are shown below.

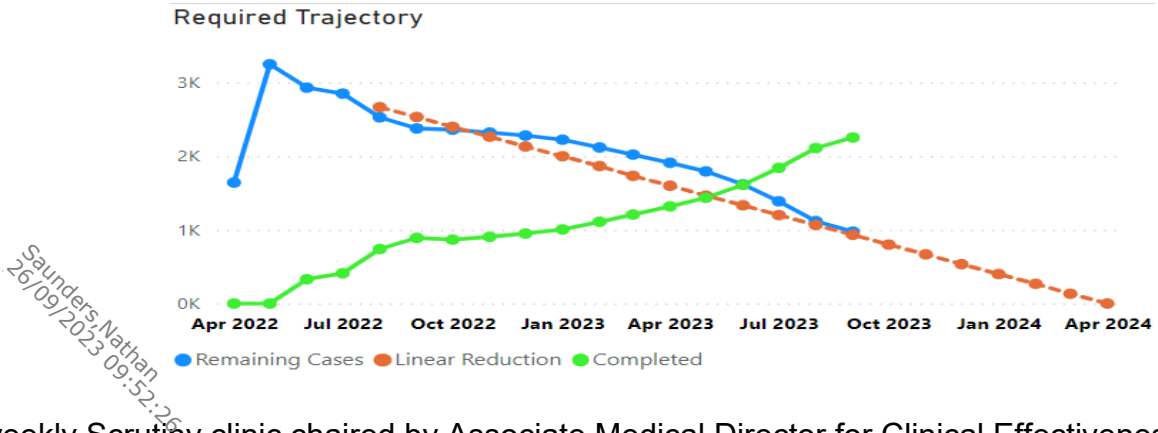
HCAI category	Criteria
Community onset	Positive specimen date ≤2 days after admission
Indeterminate healthcare-associated	Positive specimen date 3-7 days after admission
Probable healthcare-associated	Positive specimen date 8-14 days after admission
Definite healthcare-associated	Positive specimen date 15 or more days after admission

Criteria for determining if COVID-19 infection is healthcare associated following post discharge is shown below.

HCAI category	Criteria
Community onset **Possible** healthcare-associated*	Positive specimen date ≤14 days post-discharge, or within 2 days after hospital admission, with discharge from hospital in 14 days before specimen date.

There are 3230 patients who received care in the Health Board and who fit into the indeterminate, probable and definite categories of nosocomial Covid-19. As of the 04 September 2023 the Covid Investigation Team have undertaken 1786 proportionate investigations and reviews and are exceeding the required trajectory fort his point in the investigation programme.





A weekly Scrutiny clinic chaired by Associate Medical Director for Clinical Effectiveness & Safety and the Assistant Director of Quality and Patient Safety has been established to provide oversight of the outcomes of every review and to agree if further scrutiny is required. Scrutiny panels now convene

monthly to consider all elements of the Covid investigations, to establish if the care provided to each patient considered was in line with the evidence base at that point in the pandemic. To date 408 patients have been considered at scrutiny panel with a further 75 waiting to be reviewed.

The Health Board nosocomial review programme is governed by the UHB Nosocomial C&V UHB Programme Board which reports into the Quality Safety and Experience Committee. The Programme Board is chaired by the Executive Nurse Director who is the Programme Senior Responsible Officer and includes Health Board representatives, Welsh Health Specialised Services Committee and Llais Cymru.

Patient and family communications are undertaken in line with the Duty of Candour. All patients and families are made aware of a dedicated single point of contact phone number, a generic email address and a Web page which has further information on it, including details for Llais Cymru. Bereavement support is available for all families via a direct referral from the Covid Investigation Team and there is signposting on our Web page to bereavement support services.
A patient and family CIVICA survey was developed by the Patient Experience Team with implementation and piloted by the Health Board Covid Investigation Team before being implementation nationally.

Areas of good practice and learning continues to be collated. Learning fits under four broad overarching themes, Infection, Prevention and Control, Operational, Patient/Family Experience and Estates and Environment. Development of AMAT (Audit Management & Tracking) software is currently underway to strengthen the sharing of learning whilst ensuring the programme's legacy. This development has been shared with the NHS Executive who are looking to adopt nationally.

The programme is due to conclude at the end of March 2024, however it is anticipated that cases will remain within the Putting Things Right process beyond this time including the involvement of Legal and Risk, and the Ombudsman. The majority of the Covid investigation team have been employed on a fixed term basis as funding ends on 31st March 2023. They will, therefore, be commenced in a redeployment process at the beginning of December and if alternative employment can not be found, their employment will be terminated at the end of the financial year. As a result, many of the team are actively looking for alternative employment at present and therefore there is a risk that there will not be sufficient experienced staff to complete the programme.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

There are 3230 patients in waves one to four of the pandemic whose care requires investigation through the framework, 1786 investigations have been undertaken to date and the Health Board programme is currently exceeding the required trajectory.

There is a risk that staff will leave their current employment before the end of the financial year due to the risk of unemployment from April 2024.

Recommendation:

The Committee is requested to: **NOTE** the assurance provided by the progress against the framework

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care	

		sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration		Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
26/09/2023 09:52:26

Report Title:	Transition to NRFit for neuraxia procedures			Agenda Item no.	2.5
Meeting:	QSE Committee	Public	X	Meeting Date:	26th September 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Medical Director				
Report Author (Title):	Interim Head of Safety, Quality and Organisational Learning				

Main Report
Background and current situation:

Medications can be given by a number of routes, including oral, intravenous and neuraxial. Neuraxial includes spinal – into the cerebral spinal fluid, and epidural – into the extradural space.

There is a risk of serious harm or death when medications are given via the incorrect route. While the risk of these errors can be reduced through measures such as checklists, training and labelling of syringes, errors can still occur. It is part of human nature that we can make selection errors, despite these measures. Currently, both intravenous and neuraxial medication is given using syringes and other equipment which uses the Luer connector. Therefore, if a clinician selects the incorrect pre-filled medication syringe, there is no physical barrier preventing inadvertent wrong-route administration. In order to address this issue, healthcare and industry has developed a neuraxial-specific connector. The specifications for the connector are set out in ISO 80369-6, but is more commonly known as 'NRFit®'.

It is acknowledged that route-specific connectors will not completely eliminate the risk of wrong route medication errors as it remains possible for clinicians to draw a drug in the wrong type of syringe and inject in the wrong route. However, the introduction of NRFIT equipment adds another key safety mechanism by making cross-connection between neuraxial route and other routes impossible preventing a large proportion of these errors.

Making medicine administration an international standard improves safety, and use of NRFit is recommended by the Royal College of Anaesthetists for all neuraxial procedures including: spinals, epidurals, lumbar punctures, and regional blocks.

The Health Board is committed to implementation of NRFit to enhance the safety of neuraxial procedures and reduce the risk of errors and associated patient harm. The Health Board's transition to NRFit is required by Welsh Government, as set out in Patient Safety Notice 063. A further direction from Welsh Government to implement NRFit is expected to be issued imminently.

A Task and Finish group has been established to manage the transition to NRFit. The group includes representatives from a wide range of clinical areas, along with procurement, pharmacy and patient safety. The group developed a 12-week implementation plan, setting out the approach to ordering equipment, training staff and changing equipment in clinical areas and ensuring compatibility of equipment with certain drugs including chemotherapy.

Authorisation to start the deployment plan was given by the Clinical Effectiveness Committee in July 2023. This paper is being brought to the Quality, Safety and Experience Committee to agree the final decision to make the transition to NRFit in October 2023.

An overview of the work undertaken so far and the current position of the NRFit project is given below:

Changeover days
The main changeover from Luer to NRFit for neuraxial equipment is planned for 15th & 16th October. The timing of the changeover has been carefully planned in conjunction with clinical colleagues to avoid school holidays, winter pressures and rotation of junior medical staff.

Theatre areas will be transitioned to NRFit on Sunday 15th October to ensure that the changeover is completed ahead of elective surgery lists held on weekdays. Maternity will also transition on 16th October, along with Critical Care. Other areas will transition in the week commencing 16th October. Transition in Pharmacy is coordinated so that where pre-filled syringes are prepared by the department they are anticipating the changeover and these syringes will have the correct connector for the area to which they will be used.

It has been agreed by the local neuraxial task and finish group that the changeover should be implemented rapidly to minimise the period of time during which the Luer compatible neuraxial devices remain in circulation after the introduction of NRFit equivalents. This will reduce the risk of possible incompatible equipment and the associated risks/delays in completing procedures.

Stock
In order to ensure the safe transition to NRFit, an initial central order of NRFit equipment and consumables has been placed by procurement. The list of equipment has been developed with members of the Task and Finish Group to ensure that all of the required NRFit items have been included.

The central order will be isolated securely in Lakeside Stores so that it can be spilt into the required stock for each clinical area. During the week before changeover, this will be delivered to the clinical areas and clearly labelled to reduce the risk of it being used before the changeover. Stock for UHL areas will be transferred and delivered in the same way.

At changeover, the NRFit stock will be put into the clinical areas' stock rooms / procedure trolleys etc. Where the NRFit item is a direct swap, any remaining Luer versions will be removed (and redistributed where appropriate to prevent waste).

The initial central order has been designed to give approximately 6 weeks usage for theatre and maternity areas, and a minimum of 4 weeks usage for other areas. This allows time for clinical areas to take over ordering to ensure ongoing supply of NRFit equipment.

Education and training
A comprehensive SharePoint site has been developed with training material and resources, including educational videos for anaesthesia and all other specialities. Awareness of the change to NRFit is promoted through the use of screensaver messages, Health Board-wide emails issued by the Communications Team and targeted communication with Clinical Boards and individual staff groups.

Local NRFit Champions have been trained in key clinical areas and have access to NRFit equipment samples. These Champions have provided training to theatre staff as part of safety and quality sessions. Supplier representatives are supporting with product specific training in individual clinical areas.

A drop-in session has been held to give staff the opportunity to see and test the NRFit equipment and to ask any questions about the changeover plans.

Key risks and mitigation
Clinical areas missed from changeover

A considerable number of different neuraxial procedures are performed within the Health Board by a wide range of clinical teams across many locations. There is a risk that areas, particularly small areas with low volumes of neuraxial procedures, are not aware of the need to change to NRFit compliant equipment. This could lead to procedure or treatment issues due to the use of Luer neuraxial equipment which would not be compatible with the NRFit neuraxial equipment used in other areas.

This risk is managed by:

- Ensuring wide engagement with the Task & Finish Group from across clinical specialties.
- Using information from procurement systems to identify areas which currently use Luer neuraxial equipment.
- Engagement with Clinical Boards/Directorates and presenting at relevant meetings.
- Health Board wide communications

Procedure delays due to incompatible equipment

There is a risk that if an area is not fully transitioned to NRFit, this could cause delays in procedures. For example, if an NRFit spinal needle is inserted for medicines administration and the area does not have NRFit syringes. While the required equipment could be obtained from another area, this could create a delay.

This risk is managed by:

- Close working with clinical staff and those responsible for ordering stock in clinical areas to ensure that sufficient equipment is ordered and delivered ahead of changeover.
- Working with points of contact in each area to ensure that the NRFit equipment is exchanged/added to the relevant storage locations in the clinical areas.
- Providing ordering information for NRFit equipment so that clinical areas have continuity of stock following the initial central order.
- Education of staff to check that all the necessary equipment is available and NRFit compatible before starting a procedure.
- The manufacturers adoption of yellow as a signifier of NRFit to aid staff in identifying compatible equipment.
- A changeover plan that minimises the time that Luer and NRFit neuraxial equipment is in circulation concurrently.

Insufficient equipment received prior to changeover

In order to ensure a safe changeover to NRFit, it is vital that sufficient quantities of NRFit equipment are received into Health Board stores for delivery to clinical areas. Due to the range of suppliers involved and the potential fragilities in the supply chain, an assessment of the NRFit equipment received will be undertaken and a decision made by 26th September whether the changeover can go ahead as planned on 15th/16th October. Depending on any specific stock issues, a partial

changeover may be considered if necessary, but the risks of this would require careful assessment and mitigation.

The risk is managed by:

- Early provision of the initial central order (Mid-August) to procurement to allow time for orders to be placed with suppliers and received into stores.
- A planned second order prior to changeover to add additional required items that have been identified since the initial order was placed.
- Working with supplier representatives to receive early notification of any supply issues and resolving any issues.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Health Board will transition to neuraxial specific connectors by the end of the week commencing 16th October 2023 to minimise the risk of wrong route administration of medication.

A long-standing Health Board task and finish group has involved all relevant specialties in the planning for implementation including delivering training and testing compatibility of the equipment with certain drugs including chemotherapy.

Risks have been identified and mitigation put in place to minimise these risks

Recommendation:

The Committee is requested to:

APPROVE the changeover to NRFit for neuraxial procedures on 15th/16th October 2023, subject to sufficient NRFit equipment being received in Health Board stores by 26th September.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/~~No~~
Details of risk management is included within the main body of the report.
Safety: Yes/~~No~~
The changeover to NRFit equipment for neuraxial procedures will have a positive impact on patient safety through a reduced risk of wrong route medicines administration.
Financial: Yes/~~No~~
Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Workforce: ~~Yes~~/No
Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Paediatric Intensive Care Unit Pressure Damage				Agenda Item no.	2.6	
Meeting:	Quality, Safety & Experience Committee		Public	X	Meeting Date:	26/09/2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Director of Nursing – Children and Women Clinical Board						

Main Report

Background and current situation:

The purpose of this report is to provide assurance to the Committee of actions undertaken to minimise risks and incidence of pressure damage in the Paediatric Intensive Care Unit (PICU). Pressure damage results in mainly avoidable harm that is on occasion associated with healthcare.

A retrospective review of pressure damage within the Acute Child Health Directorate identified 44 patient safety incidents relating to pressure damage reported between 1st March 2022 and 15th March 2023, with 24 children affected.

- 11 of these cases related to incidents of moisture associated skin damage associated with incontinence or nappy rash.
- 15 incidents were relating to medical devices including ventilator masks.

Analysis of the incidents evidenced good risk assessment and Tissue Viability Service and Medical Photography involvement for the most complex cases. There were however, improvements required in the oversight and management of pressure damage related patient safety incidents. Immediate training was provided to senior and lead nurses to support appropriate management of incidents reporting and management. In response to the review, the Acute Child Health Directorate will implement a monthly Pressure Damage Scrutiny Panel to provide senior oversight of all incidents with involvement from the Tissue Viability Service, with the aim to identify areas of learning and improvement and to reduce pressure damage incidence.

Non-Invasive ventilation (NIV) masks were the most common medical device associated with device related pressure damage. A new skin integrity pathway *(appendix 1)* was developed to ensure appropriate action is taken to prevent device related tissue damage within this vulnerable patient cohort and complex service area. The pathway will commence within four hours of admission to PICU and will be reviewed daily. The pathway includes an NIV pressure ulcer care plan and monitoring tool to reduce incidence of device related pressure damage. The pathway also includes a moisture damage pathway to ensure a standardised and evidence-based approach to preventing and managing moisture lesions.

In June 2023 the Acute Child Health Directorate launched the use of the Paediatric Purpose-T pressure ulcer risk assessment tool *(appendix 2)* which is being rolled out across Wales and supports proactive identification of risks of developing pressure damage and mitigating actions.

The latest data review of pressure damage within the Acute Child Health Directorate has identified 11 Datix reported patient safety incidents relating to pressure damage reported between 16th March 2023 and 14th September 2023, with 10 children affected. This is an improved position with reduction in pressure damage incidents noted since implementation of the Purpose T pressure ulcer risk assessment and the new PICU skin integrity pathway.

- 7 of these cases related to incidents, relating to 6 patients, occurring within PICU. 1 of which was identified as present on admission.
- Of the 6 PICU incidents 4 were grade 1 and 2 with the other 2 relating to the same complex care patient who developed a grade 3 pressure lesion as a result of parental refusal of care.
- Of the 4 pressure damage incidents occurring outside of PICU 3 were grade 1 and 1 suspected deep tissue injury noted to be unavoidable neurosurgical wound related.

All pressure damage grade 3 and will be considered at the Acute Child Health Directorate monthly Pressure Damage Scrutiny Panel for scrutiny and learning and improvement.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

In response to a retrospective review of pressure ulcer reporting a number of initiatives have been implemented to ensure adequate assessment of risk and mitigation as well as scrutiny of all pressure damage cases to support learning.

Recommendation:

The Board / Committee are requested to:

- **NOTE** the progress made by the Clinical Board to date;
- **NOTE** the content of this report and the assurance given by the Children & Women Clinical Board.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
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4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term		Integration		Collaboration	X	Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No

Safety: No

Financial: No

Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

ADDRESSOGRAPH

GIG CYMRU NHS WALES
Bwrdd lech Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

PCCU

SKIN INTEGRITY

PATHWAY

Must be commenced for all PCCU patients within 4 hours of admission and reviewed on each shift

Responsibilities:

Bed-side nurse: should ensure that regular and thorough skin integrity checks are undertaken and risk assessment tools are completed, correct pressure redistribution equipment is utilized and documentation is clear and concise. Any concerns should be escalated appropriately and in a timely manner and care plans are followed.

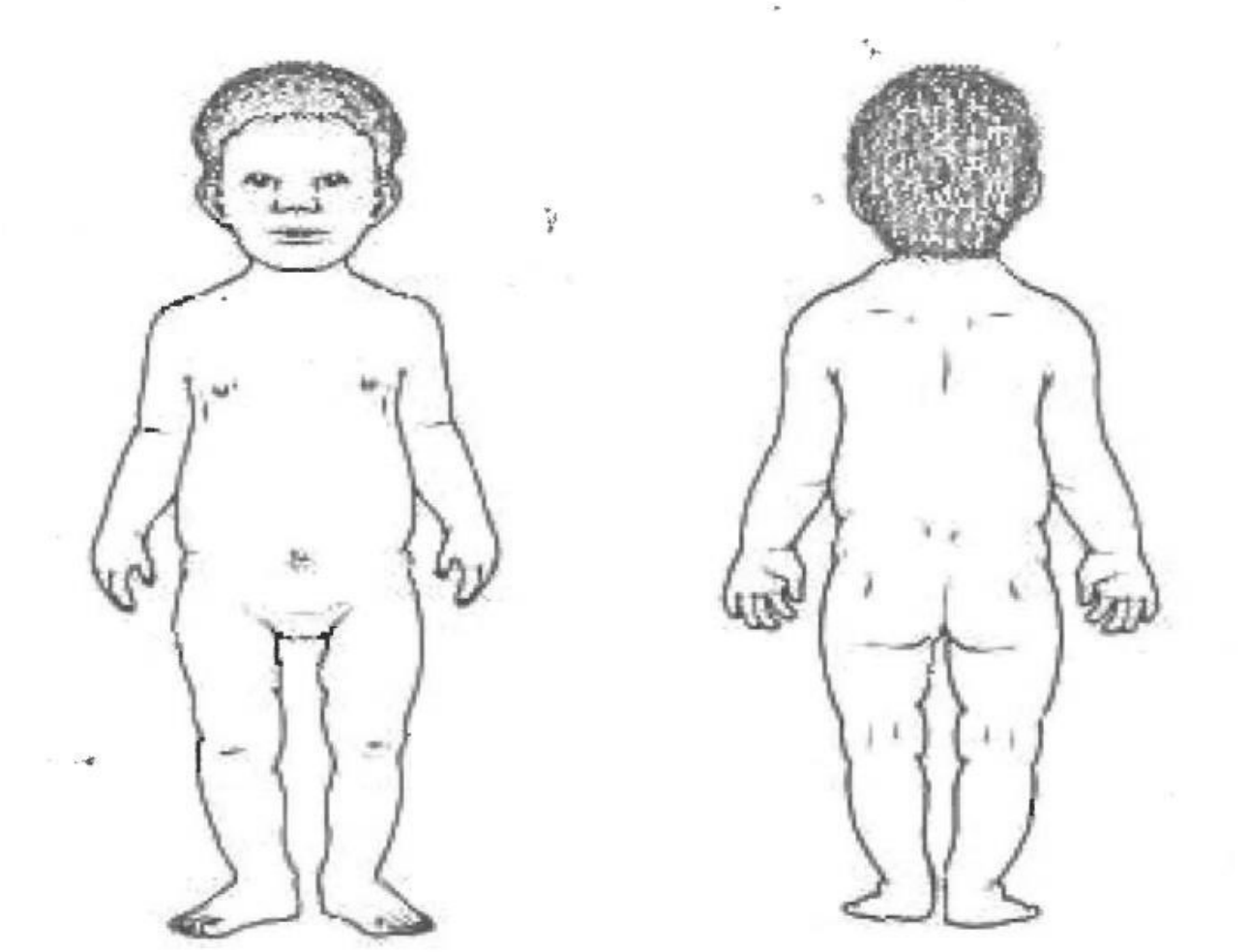
Nurse-in-charge: should ensure that skin assessments have been completed accurately, assist bed-side nurse in escalating concerns, follow-up on any referrals, or reviews by specialties and ensuring that care plans are being followed and evaluated if started.

Medics: should ensure they are trained and up to date with PCCU skin integrity pathway and escalation protocols, review skin integrity on ward rounds and support nursing team to follow care plans.

SKIN INTEGRITY ASSESSMENT ON ADMISSION

Please clearly document any wounds, pressure ulcers (PU), or Moisture Associated Skin Damage (MASD) present on admission to PCCU on body map below – then complete Purpose-T Risk Assessment

An E-Datix should be completed for any pressure ulcers present on admission; please clearly document on the incident form the location the pressure ulcer developed if known (other CAV wards, other health boards, WATCH/transport or home).



Assessment undertaken by: Name:	Date & Time:
E-Datix completed: Yes/ No/ N/A	ID:

NHS Number
Hospital No.
Forename(s)
Surname
Date of Birth DD / MM / YYYY
Address
Postcode:

PURPOSE T PRESSURE ULCER RISK ASSESSMENT

NHS Wales v2.1 (24/07/2020)

GIG CYMRU NHS WALES

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Walks independently with or without walking aids

If **ONLY** blue box is ticked

Skin status – *tick all applicable*

- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If **ONLY** blue box is ticked

Clinical Judgement – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
- No problem

If **ONLY** blue box is ticked

No pressure ulcer **not currently at risk**

Tick if applicable

Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional
- Frequent (2 – 4 times a day)
- Constant

Diabetes – *tick as applicable*

- Not diabetic
- Diabetic

Perfusion – *tick all applicable*

- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease

Nutrition – *tick all applicable*

- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Medical device – *tick as applicable*

- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2014)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Suspected Deep Tissue Injury (Depth Unknown)
Purple localized area of discoloured intact skin or blood-filled blister

Previous PU history – *tick as applicable*

- No known PU history
- PU history – *complete below*

Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*

For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐	☐	☐
L Buttock	☐	☐	☐	☐
R Buttock	☐	☐	☐	☐
L Ischial	☐	☐	☐	☐
R Ischial	☐	☐	☐	☐
L Hip	☐	☐	☐	☐
R Hip	☐	☐	☐	☐
L Heel	☐	☐	☐	☐
R Heel	☐	☐	☐	☐
L Ankle	☐	☐	☐	☐
R Ankle	☐	☐	☐	☐
L Elbow	☐	☐	☐	☐
R Elbow	☐	☐	☐	☐
Other as applicable *(may be medical device site)*	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

PU Category 1 or above or scarring from previous pressure ulcers

Tick if applicable ☐

PU Prevention/Management Care Plan

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

No pressure ulcer but **at risk**

Tick if applicable ☐

PU Prevention/Management Care Plan

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

No pressure ulcer **not currently** at risk

Tick if applicable ☐

Reassess risk as per Pressure Ulcer Policy

Nurse Printed Name	Nurse Signature	Date	Time
		DD / MM / YYYY	HH:MM

Pressure Ulcer Classification Guidance

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

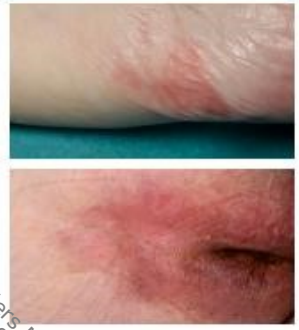
Is the clinical picture indicative of pressure damage or has the wound been caused by a medical device?

No → Please consider a differential diagnosis. Arrange clinical photography and discuss with the Tissue Viability Nurse team if you are concerned.

Yes

Is the skin intact, red/discoloured and does not blanch when pressure is applied?

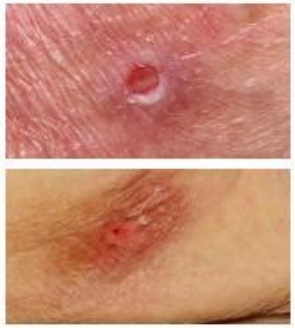
Yes → **Category I**



No

Is there a clear or fluid filled blister present or a superficial break in the skin with a red of pink wound bed?

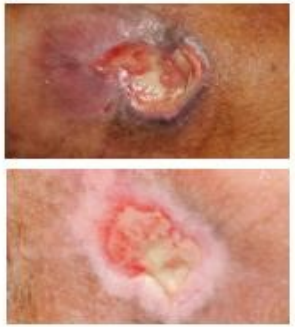
Yes → **Category II**



No

Does the wound bed contain slough (less than 80% of the wound bed) but with NO tendon, bone or muscle exposed?

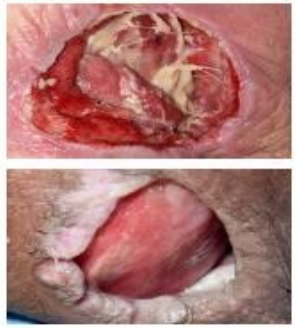
Yes → **Category III**



No

Can muscle, tendon or bone be seen or felt in the wound bed?

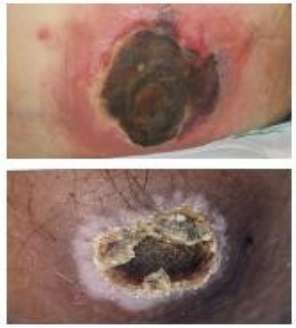
Yes → **Category IV**



No

Does the wound bed contain slough, necrosis or eschar covering approximately 80% or more of the wound bed so that depth cannot be determined?

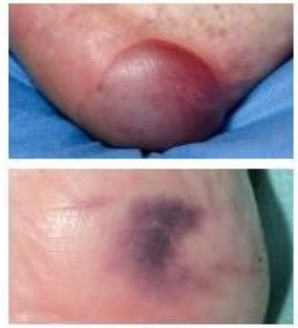
Yes → **Unstageable**



No

Is there a localised area of intact skin which is purple/ maroon in colour or is a blood-filled blister?

Yes → **Suspected Deep Tissue Injury**



Clinical photography is not required for Category I and II pressure ulcers unless you feel it is deteriorating to a category III or if and the category needs validation (as per policy).
Please ensure that a Datix entry is submitted for all pressure ulcers and a Focused Review is completed for Category III, IV and Unstageable pressure ulcers.

NO PRESSURE ULCER BUT AT RISK?

FOLLOW PRESSURE ULCER PREVENTION/ MANAGEMENT CARE PLAN BELOW:

Action	Rationale
Reposition patient every 4 hours including their head	To redistribute pressure and prevent skin damage
Inspect vulnerable skin areas 4 hourly and if pressure ulcer develops follow **red** care plan	To detect early signs of skin damage needed to be actioned
Re-position ALL **probes** 4 hourly (ensure patient not laying on lines/NGT)	To prevent device related skin damage from laying on equipment
Place thin hydrocolloid dressing underneath ALL medical equipment (e.g. NGT, nasal cannula, NIV masks)	To prevent device related skin damage
Nurse on **ARIA PRO** Mattress (unless patient has unstable c-spine)	To redistribute pressure and prevent skin damage
Use **glide sheets** for patient movement up/ down bed/off bed	To prevent any friction/shearing injuries to skin

PRONING CONSIDERATIONS

Action	Rationale
Place pillows under chest, knees & feet	To redistribute pressure
Ensure patient is not laying on lines	To prevent device related pressure ulcers
ECG probes placed on patients back	To prevent device related pressure ulcers
Use silicone gel pads for vulnerable areas (e.g. ears/ side of face)	To prevent skin damage
Change position of their head 4 hourly	To prevent any pressure ulcers on ears/face

PRESSURE ULCER CATEGORY 1 OR ABOVE OR PREVIOUS PU?

FOLLOW PRESSURE ULCER PREVENTION/ MANAGEMENT CARE PLAN BELOW:

Action	Rationale
Reposition patient 2 hourly including their head	To prevent further skin damage
Ensure **no pressure** is being applied to pressure ulcer: PU on **ear** = use gel doughnut PU on **heel / ankle** = use repose booties or silicone gel pad PU on **sacrum, buttock, hip, elbow** = nurse side-to-side and use foam adhesive dressing or silicone gel pad if unable to avoid pressure completely PU under **Non-invasive ventilation (NIV)** mask = follow blue NIV care plan on page 10	To prevent further skin damage
Inspect vulnerable skin at least 4 hourly and if PU worsens to become a grade 3 follow UHB Pressure Ulcer Management Plan, including referral to Tissue Viability and Medical Photography	To detect signs of skin changes and further damage and action appropriately
Re-position ALL **probes** 4 hourly (ensure patient not laying on line/NGT)	To prevent device related skin damage from laying on equipment
Place **thin hydrocolloid** dressing underneath ALL medical equipment (e.g NGT, nasal cannula, NIV masks)	To prevent device related skin damage
Nurse on **ARIA PRO** Mattress or **Dolphin** Mattress if PU grade 3 or above (unless cspine unstable)	To protect vulnerable areas from skin damage
Use **glide sheets** for patient movement up/ down bed/off bed	Prevent any friction/ shearing injuries to skin

See Tissue Viability Folder for Equipment Guidance

REPOSITIONING CHART

Complete Purpose-T First

Use this chart for subsequent turns. Document with each set of cares.

Date/ Time	Position (B)ack (L)eft (R)ight (P)rone	Lines/ Enteral tubes clear from patient	Comments ***Assess skin: including ears, shoulders, back, sacrum and heels*** *Early sign of pressure damage is changes in skin colour, it may appear red, or on darker complexions purple or darker hues	Initials

Date/ Time	Position (B)ack (L)eft (R)ight (P)rone	Lines/ Enteral tubes clear from patient	Comments ***Assess skin: including ears, shoulders, back, sacrum and heels*** *Early sign of pressure damage is changes in skin colour, it may appear red, or on darker complexions purple or darker hues	Initials

NON-INVASIVE MASK PRESSURE ULCER PREVENTION/ MANAGEMENT CARE PLAN:

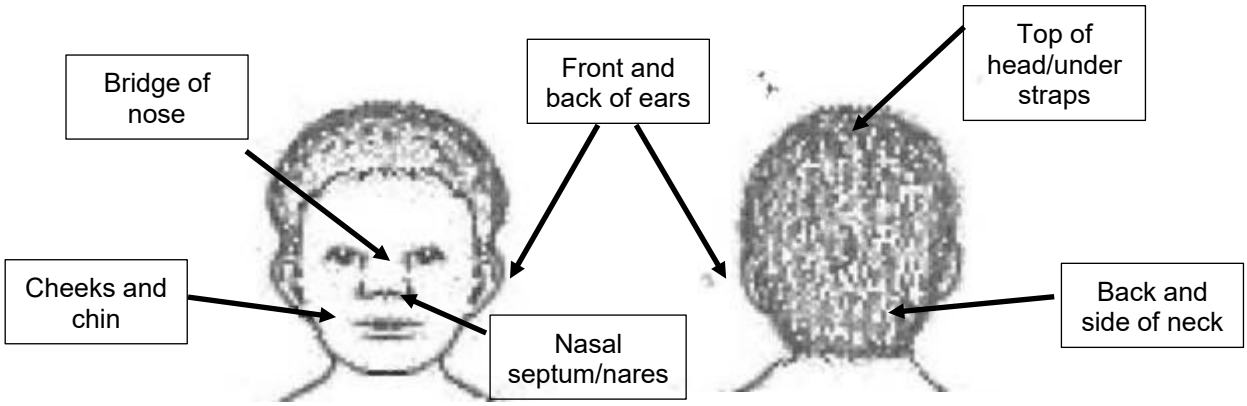
Action	Rationale
Ensure mask is **appropriately fitted** with silicone rim not compressed onto face. If headgear is tight change mask size/shape.	Correct size increases NIV therapy effectiveness and prevents device related skin damage.
Remove mask from patient 4-hourly if safe to do so	To relieve pressure and assess skin integrity
Perform **facial skin care** 4-hourly, ensuring skin is dry and intact	To prevent device related skin damage
Ensure **headgear** is changed if soiled (replacements available with mask stock)	To prevent skin damage to head/neck
Inspect vulnerable skin areas (as per guide above) 4-hourly and if PU develops follow **red** care plan	To detect early signs of skin changes and commence treatment if needed
Place thin hydrocolloid dressing underneath **ALL** masks or use cotton mask liners. Only change every 72hours or when soiled using adhesive removing wipes.	To prevent device related skin damage
Alternate interface prongs / mask 4 hourly. Consider alternating oro-nasal mask with full face mask for patients at high risk.	To redistribute pressure and prevent device related skin damage

NIV PRESSURE ULCER PREVENTION AND MANAGEMENT

ASSESSMENT

Complete Purpose-T First

Use this chart for subsequent assessments



TIME Max of 4hrs between checks	**COMMENTS** Skin intact, discoloration*, marking, pain when touched. *Maybe red, or on darker complexions purple or darker hues	**MASK/ PRONGS** Max of 4hrs between rotations	**DRESSING/ LINER IN-SITU AND INTACT**	**PU – YES/NO** If yes what category?	**INITIALS**

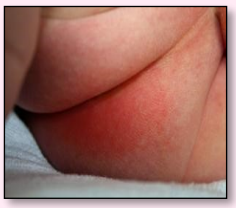
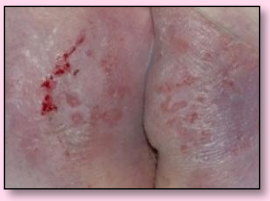
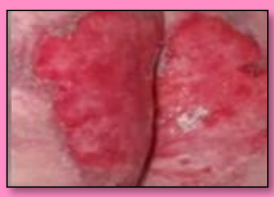
TIME Max of 4hrs between checks	**COMMENTS** Skin intact, discoloration*, marking, pain when touched. *Maybe red, or on darker complexions purple or darker hues	**MASK/ PRONGS** Max of 4hrs between rotations	**DRESSING/ LINER IN-SITU AND INTACT**	**PU – YES/NO** If yes what category?	**INITIALS**

Moisture Associated Skin Damage Pathway-

Medi Derma S Barrier Range

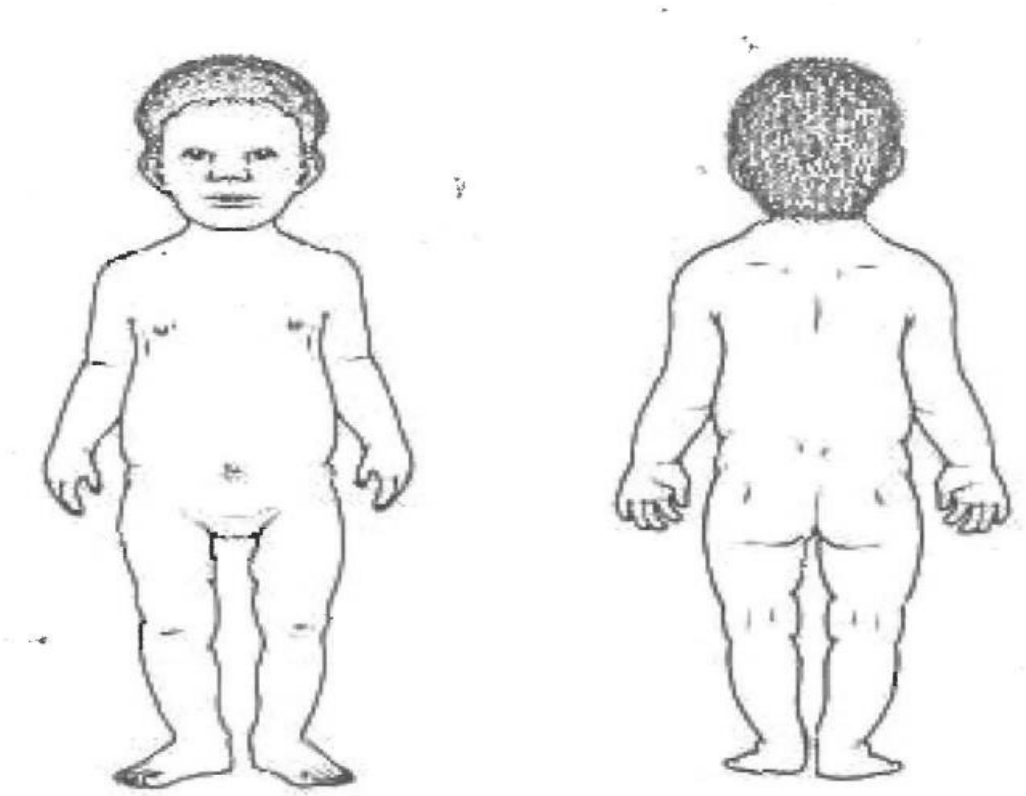
Not a pressure ulcer – E-Datix should only be completed after review by PCC Tissue Viability link nurses

Treatment for each stage of the pathway should be followed for 72hrs before moving across the protocol

	Mild Intact Damage skin intact but discoloured (red or on darker complexions purple/ darker hues)	**Moderate Damage** < 50% broken skin bleeding/ oozing maybe present	**Severe Damage** >50% broken skin with
Description			
Which product			
Directions	Apply a pea size amount to clean, dry skin	**Not to be used alongside barrier creams** Spray: hold 10-15cm away from skin and apply light layer Barrier sticks: apply directly to skin in sweeping motions	Spray foam: apply directly onto skin & gently wipe off Do NOT rinse off with water Ointment: apply thin layer
Frequency	With each set of cares	With each set of cares	With each set of cares

PRESSURE ULCER AND MASD CHART

Please document any PU or MASD that have developed during PCCU admission on body map below.



PU/ MASD number	Date First Observed	Description (including size (cm) and appearance (Skin colour? Skin intact or broken? Blister present? Device related?)	Treatment (Remember pain assessment)	Datix completed?

TISSUE VIABILITY REVIEW/ CARE PLAN

Saunders,Nathan
26/09/2023 09:52:26

Pressure Ulcer Risk Assessment – Paediatric assessment adapted from PURPOSE T (V2)

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Patient name	DOB	Hospital / NHS number	Ward

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Moves independently with or without aids

If ONLY blue box is ticked

Skin status – *tick all applicable*

- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If ONLY blue box is ticked

Clinical Judgment – *tick as applicable*

- Conditions / treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids, poor nutrition
- No problem

If ONLY blue box is ticked

- No pressure ulcer not currently at risk — *Tick if applicable*
- Not currently at risk pathway

If ANY yellow boxes are ticked, go to Step 2

If ANY yellow or pink boxes are ticked, go to Step 2

If ANY yellow boxes are ticked, go to Step 2

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)		Extent of all independent movement. Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Frequency of position changes	Doesn't move	☐	N/A	N/A
	Moves occasionally	N/A	☐	☐
	Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. paralysis, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional
- Frequent (2–4 times a day)
- Constant / nappies

Diabetes – *tick as applicable*

- Not diabetic
- Diabetic

Perfusion – *tick all applicable*

- No problem – Capillary refill <2 secs
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. meningitis, medication, inotropes

Nutrition – *tick all applicable*

- No problem
- Unplanned weight loss
- Poor nutritional intake
- <2 centiles below weight
- >2 centiles over weight

Medical device – *tick as applicable*

- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2014)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Suspected deep Tissue Injury (S) Purple discolouration on intact skin/blood filled blister

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*
For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Occipital	☐	☐		☐
L ear	☐	☐		☐
R ear	☐	☐		☐
	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Medical device skin site				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

- PU Category 1 or above or scarring from previous pressure ulcers — *Tick if applicable* ☐ — Secondary prevention and treatment pathway
- No pressure ulcer but at risk — *Tick if applicable* ☐ — Primary prevention pathway
- No pressure ulcer not currently at risk — *Tick if applicable* ☐ — Not currently at risk pathway

Nurse printed name	Nurse signature	Date	Time

Report Title:	The Medicines Code (UHB 389)			Agenda Item no.	3.1.1
Meeting:	Quality, Safety and Experience Committee	Public	X	Meeting Date:	26/09/2023
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	Information	✓
Lead Executive:	Executive Medical Director				
Report Author (Title):	Senior Nurse for Medicines Management				

Main Report
Background and current situation:

Background:

Cardiff and Vale University Health Board (C&V UHB) is committed to the safe and secure handling of medicines to protect its patients, staff and visitors, and its financial resources. This Medicines Code updates and replaces previous Medicines Policies and Procedures used in Cardiff and Vale Hospitals. Cardiff and Vale's Pharmacy Directorate prepared the Medicines Code which was supported by the C&V UHB Medicines Management Group and the Nursing and Midwifery Group, and approved by the C&V UHB Quality Safety and Experience Committee.

The Medicines Code incorporates the UHB Medicines Management Policy to uphold the Health Board's commitment to avoid waste, minimise harm and avoid unwanted variation. The Health Board's Medicines Code sets out the procedures to facilitate implementation of these policy principles.

The purpose of this Medicines Code is to set out a clinical and corporate governance framework to promote safe and secure systems for the controlling and handling of medicinal products in the hospitals and clinics operated by the C&V UHB as part of an overall medicines management process.

The Medicines Code (UHB 389) has been reviewed within the relevant professional meetings and have been agreed there. Once agreed there, the Medicines Code (UHB 389) was put out to consultation for 28 days as per policy process and no comments were received.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Recommendation:

The Quality, Safety and Experience Committee is requested to:

- NOTE the content of the Medicines Code (UHB 389)
- APPROVE the Medicines Code (UHB 389)

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	✓
3. All take responsibility for improving our health and wellbeing	✓	8. Work better together with partners to deliver care and support across care	✓

		sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	✓	Long term		Integration	✓	Collaboration	✓	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk:
n/a
Safety:
n/a
Financial:
n/a
Workforce:
n/a
Legal:
n/a
Reputational:
n/a
Socio Economic:
n/a
Equality and Health:
n/a
Decarbonisation:
n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Reference Number: UHB 389 **Version Number:** 4	**Date of Next Review:** July 2026 **Previous Trust/LHB Reference Number:** See Appendix 1 for all superseded documents

Medicines Management Policy

The Medicines Code

Introduction and Aim

The Medicines Code incorporates the UHB Medicines Management Policy to uphold the Health Board's commitment to avoid waste, minimise harm and avoid unwanted variation. The Health Board's Medicines Code sets out the procedures to facilitate implementation of these policy principles.

Objectives

- Ensure that people receive medication for the correct reason and receive the right medication, via the right route at the right dose and the right time.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts, involved in all or part of the medicines management process.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and found there to be a positive impact.
Documents to read alongside this Procedure	Infection Prevention and control All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal. Cardiff and Vale Good Prescribing Guide. Parenteral Cytotoxic Chemotherapy. Extravasation Policy Patient Property Policy
Approved by	Quality, Safety and Experience Committee and Executive Medicines Management Group

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Director

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1		Put on intranet only for launch in November 2017	New document that replaced 19 controlled documents (see Appendix 1)
2	Via QSE Chair's Action in March 2018	28/03/2018	EHIA produced & Cover for document
3	Via eMMG Dec 2018		Inclusion of TTH on Short Stay and Gynaecology Areas \Procedure – Signed off at MMG March 2017 Update of Medicines Reconciliation Procedure – Signed off at MMG August 2018 Update of Methotrexate Procedure – Signed off at September MMG Nurse Initiated Medicines Procedure – approved by MMG Dec 2018 Advice for provision of TTH out of hours. Improvement to index and page numbering Link to UHB Approved Covert Medicines Documentation. UHB Approved Medication Error Action Form. Appendix 2
4	Via NMB (May 2023) Via DoNs (June 2023) Via cMMG (July 2023) Via Corporate Governance (Sept 2023)		Chapter 8.5 & Appendix 2 refer to the All Wales Practice Learning Framework for student Nurses in reconstitution of IV medications. All Wales Delegation Guidelines for medication administration. Bennion Error Scoring System for management of staff involved in a medication error (Appendix 3) – approved by NMB, DoNs, CMMG

Medicines Code Version 4

Document Title Medicines Management Policy: The Medicines Code		Approval Date:
Reference Number: UHB 389		Next Review Date: JULY 2026
Version Number: 4	Update Dec 2018	Date of Publication:
Approved By:	NMB, DoNs, Patient Safety Team, cMMG	

Any questions or enquiries relating to the Medicines Code should be emailed to welshmedicines.information@wales.nhs.uk under the subject heading Medicines Code

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Chapter 7 – Administration of Medicines

Chapter 8 – Administration of Intravenous Medicines

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Chapter 10 – Return, Disposal and Destruction of Medicines

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Chapter 1 – Introduction to the Medicines Code

Cardiff and Vale University Health Board (C&V UHB) is committed to the safe and secure handling of medicines to protect its patients, staff and visitors, and its financial resources. This Medicines Code updates and replaces previous Medicines Policies and Procedures used in Cardiff and Vale Hospitals. Cardiff and Vale's Pharmacy Directorate prepared the Medicines Code which was supported by the C&V UHB Medicines Management Group and the Nursing and Midwifery Group, and approved by the C&V UHB Quality Safety and Experience Committee.

Purpose of the Medicines Code

The purpose of this Medicines Code is to set out a clinical and corporate governance framework to promote safe and secure systems for the controlling and handling of medicinal products in the hospitals and clinics operated by the C&V UHB as part of an overall medicines management process.

Guidance on safe and appropriate prescribing has been considered and disseminated through the Medicines Code by the C&V UHB Medicines Management Group. In general, medicines need to satisfy tests of clinical and cost effectiveness and use should be justifiable on grounds of safety, given the alternative therapies available and the circumstances of the patient.

In addition to this Medicines Code, healthcare professionals must abide with the current version of their relevant professional bodies' Policies, Standards and Codes of Practice. If extreme circumstances arise, such that this Code cannot be applied, then the prime consideration will be the safe and effective treatment of any patient concerned. However; if any deviation from the Code occurs, those staff involved must document all alternative measures taken in the appropriate records and inform senior professional staff.

Scope

This Medicines Code with the underpinning principles of legal, quality and safe practice, applies to all doctors, nurses, midwives, pharmacists and other health care professionals across C&V UHB involved in the ordering, supply, storage, prescribing, administration and disposal of medicines. The medicines include Prescription Only Medicines (POMs), Pharmacy Medicines (P), General Sales List Medicines (GSL) and Controlled Drugs (CDs). The Code also includes complementary medicines, pharmaceuticals (non-therapeutic items) which include certain medical devices traditionally supplied through hospital pharmacy departments.

Standard Operating Procedures (SOP)

Each Clinical Board may develop and implement SOPs describing safe working practice for aspects of work conducted within their Clinical Board. If a SOP involves medicines, or aspects of medicine usage, across a multi-professional area Doctors/Nurses/Pharmacists, the SOP must be approved first by the Clinical Board and then by the C&V UHB Medicines Management Group.

1.1 Classification of medicines

Medicines are considered as two main sub-groups, Controlled Drugs and Medicines.

a) Controlled Drugs

Controlled Drugs are those drugs classified under the 'Misuse of Drugs Act 1971', and its associated regulations.

b) Medicines

Medicines will be taken to be all substances defined under the 'Medicines Act 1968' as being medicinal products. These include those restricted to supply on prescription (POM), those that can only be sold from a Pharmacy (P), and those that can be sold at any establishment, General Sales List medicines (GSL). Unlicensed medicines do not have a United Kingdom Product License.

c) Complementary medicines

The principles adopted for the use of medicines will also be followed for complementary medicines.

d) Pharmaceuticals

The term "pharmaceuticals" will be used to describe those non-therapeutic items covered by the policy (e.g. disinfecting and sterilising agents). It will also include certain devices carrying a 'CE' mark traditionally supplied by pharmacy.

e) Black triangle medicines

These are newly introduced medicines, subject to intensive monitoring for potential side effects by the European Medicines Agency (BNF) and Medicines and Healthcare Products Regulatory Agency (MHRA) (identified by ▼ in the British National Formulary).

f) Medicines used outside product license

These are medicines used in a manner where indications are outside the 'as defined' in the Summary of Product Characteristics (SPC). E.g. different dose, indication, administration route.

g) Specials

These are unlicensed medicines that do not have a product license and are usually commissioned from a licensed manufacturing unit at the request of a prescriber, or by a pharmacist acting on behalf of that prescriber.

h) Unlicensed

Medicines which do not have a UK product license (unlicensed medicines). Usually obtained on a named patient basis.

1.2 Corporate Health Board responsibilities

a) Chief Executive

The Chief Executive has overall responsibility for medicines management in C&V UHB.

b) Medical Director

The above responsibility is delegated to the Health Board's Medical Director, supported by the C&V UHB Medicines Management Group.

c) Director of Pharmacy and Medicines Management

The Director of Pharmacy and Medicines Management is responsible for organising, monitoring and reporting on medicines management, it's systems and procedures.

Chapter 2 - Operational Responsibilities for All Professional Staff

2.1 Responsibility of the Director of Pharmacy and Medicines Management

The Director of Pharmacy and Medicines Management is responsible for ensuring that there are sufficient systems in place for the following:

- Providing a safe, effective, efficient and secure system for medicine stocks held within pharmacy. The Health Boards Pharmacies.
- Providing a safe, effective, efficient and secure system for medicine distribution.
- Providing a system for monitoring ward medicine usage and advising on appropriate stock range and stock holding levels.
- Providing advice on medicines and controlled drug security.
- Providing advice on appropriate environmental storage conditions.
- Providing advice on safe and proper means of disposal of unused/unwanted medicines.
- Providing advice on safe and effective systems and arrangements for medicine administration. This includes commenting and advising on medicine administration errors and near misses reported via the DATIX Incident Reporting system.
- Providing advice on transport of medicines and other pharmaceuticals.
- Providing a system, when the pharmacy is closed, of access to emergency medicine stocks and the availability of a pharmacist for emergency duties.
- Where a pharmacy led stock control service is provided there is a shared responsibility between the ward/unit ward manager/clinical lead and the clinical board pharmacist
- Providing advice on clinical pharmacy services and ensuring that there is consistency of approach such that prescriptions are monitored and appropriate action taken to ensure effective use of resources.
- Ensuring that there are adequate mechanisms in place to monitor and report on the usage of medicines throughout the Health Board and to devise strategies to promote cost effective prescribing.
- Ensuring that there are systems in place with the use of medicines throughout the Health Board.
- Ensuring medicines are held to meet the need of hospitalised patients and immediate response to civilian emergency.

Each Clinical Board will have an assigned Clinical Board Pharmacist who has a delegated responsibility for implementation of the above.

The Director of Pharmacy and Medicines Management Nurse Advisor are charged with the responsibility for medicines management throughout C&V UHB. This includes ensuring pharmacy representation on local medical devices committees to ensure safe usage of infusion systems and devices within C&V UHB

2.2 Responsibility of the Executive Nurse Director and Clinical Board Nurse Directors

The Executive Nurse Director and Clinical Board Nurse Directors are responsible for ensuring that systems are in place within wards and departmental clinics to facilitate the processes within the Medicines Code and that information guidance within this Code is available to staff and adhered to.

- The ordering of medicines and pharmaceuticals.
- The appropriate storage (physical and environmental conditions of medicines and pharmaceuticals).
- The administration of medicines including patients' own medicines other than those administered by a doctor
- The recording of administration of medicines.
- The security of medicines and prescription forms.
- The supply of medicines to patients in accordance with Patient Group Directions (PGDs) / Patient Specific Directions (PSDs).
- The reporting of medicines related incidents and errors via the DATIX Incident Reporting System.
- The safe and proper disposal of unused/unwanted medicines and pharmaceuticals.
- The retention of documents relating to the ordering, storage and administration and supply of medicines.
- The induction of new staff with respect to informing them of the Health Boards' Medicines Code
- The education and training required to enable nurses to comply with this Medicines Code and for ensuring that a copy is readily available to staff.

2.3 Responsibility of the ward manager /clinical lead

- The ward manager/clinical lead, will have joint responsibility with the pharmacy directorate for the ordering system where there is a pharmacy provided led stock control service.
- The ward sister/charge nurse/clinical lead is responsible for the secure storage of medicines in their area.

2.4 Responsibility of Individual health care professionals involved in the medicines management process

Each individual health care professional is responsible for:

- Reading and understanding this Medicines Code.
- Complying with this Medicines Code and their own regulatory bodies, guidance, standards policies etc.
- Ensuring they have the required qualifications, competence and/or authority to complete the tasks.
- Maintaining the security of medicines within their practice area.

2.5 Responsibility of prescribers

Medical and non-medical prescribers will practice in accordance with local procedures and guidance and will comply with their respective professional Code of Practice.

Chapter 3 Medicines Audit, Suspected Fraud and Suspected Theft

3.1 Monitoring and audit

As part of the responsibility for delivery of the medicines management process, the Director of Pharmacy and Medicines Management will ensure that the following explicit, written, quality standards are prepared and regularly audited as part of the C&V UHB audit cycle:

The process of prescribing of medicines in C&V UHB hospitals

The appropriateness of medicines prescribed for individual patients including license status and adherence to agreed therapeutic guidelines.

The preparation of parenteral medicines. This will include all C&V UHB hospital clinical areas as well as the main pharmacy department.

- The clinical pharmacy review of prescriptions and dispensing of medicines.
- The administration of medicines to patients.
- The supply of medicines to take home and the counselling of patients about those medicines.
- The reporting of medication errors.
- Medicines administered for clinical research and drug trials.

3.2 Risk management and patient safety initiatives

The Director of Pharmacy and Medicines Management and/or the Medicines Safety Officer will lead on safe medicines practice within the Health Board. This will be via The Medicines Safety Executive (MSE) a multi professional sub group of the UHB's Corporate Medicines Management Group (cMMG). The MSE will maintain clear and identified links with the UHB Patient Safety Team. The Director of Pharmacy and Medicines Management, MSE and Pharmacy Management Team will actively participate in patient safety initiatives e.g. 1,000 Lives Plus.

The Director of Pharmacy and Medicines Management or a senior member of the Pharmacy Management Team) will hold responsibility for communication and liaison with the Welsh Risk Pool and Patient Safety Wales on medicines safety and risk issues.

The risks inherent in medicines management and the effectiveness of risk control measures must be monitored and reviewed on a continual basis. Senior Management, both within Pharmacy and C&V UHB, must be informed of any significant risks and risk control measures. Medication incidents should be regularly monitored and issues of significance reported to the C&V UHB Safety and Standards Committee via the Medicines Safety Executive (MSE).

3.3 Anti-theft and fraud culture

C&V UHB has a zero tolerance anti-fraud and theft culture and is committed to the principle that the NHS resource of medicines is always put towards the patient in need of that prescribed medicine. C&V UHB will seek to reduce medicine losses from theft and fraud to an absolute minimum by sanctions against those determined to steal or defraud the NHS. Possible sanctions may include criminal, civil or disciplinary proceedings, and C&V UHB will seek to recover the cost of stolen or defrauded medicines. Incidents involving members of staff, patients or visitors that are suspected to have stolen C&V UHB medicines or prescription forms pads, must be reported through a clinical incident entry completed by the senior nurse or senior pharmacist on duty. The local security manager must be notified on how to access this person. The directorate lead nurse and/or directorate pharmacist may conduct initial enquiries and then, should matters proceed to an investigation, the local security manager will take responsibility for any subsequent investigation of alleged theft. The security manager will liaise with South Wales Police and the human resources manager as appropriate.

3.4 Suspected fraud in respect of medicines

Some examples of NHS medicine and prescription frauds are as follows:

- Falsified medicine stock records
- Falsified orders for medicines
- Prescription fraud e.g. forged signatures and/or false representation by the patient for medicine not prescribed by an authorised NHS prescriber
- Self-prescribing
- Prescribing for family members or friends
- Prescribing for those who are not entitled to be prescribed NHS medicines e.g. foreign nationals who are not entitled to NHS treatment

This list is not exhaustive and those determined to commit fraud may develop new and sophisticated methods to avoid detection.

If an alleged theft involves suspected fraud, the Medicines Safety Executive and/or the Security Manager will refer the incident to the Local Counter Fraud Specialist of C&V UHB.

Chapter 4 – Prescribing Medicines

4.1 Prescribing medicines

All prescribing must be on C&V UHB approved prescription stationery before supply or administration to patient may occur. In strictly defined situations e.g. via a Patient Group Direction, homely remedy guidance/discretionary medicine a verbal order, in role as a midwife, or the use of specified parenteral medicines for the purpose of saving life in an emergency a prescription it is not necessary to authorise administration (see chapter 16 for list of medicines).

Each prescriber has a duty of care when issuing prescriptions to patients, to ensure that they are issued appropriately to patients under their care. Prescription forms and pads are controlled stationery and therefore must be stored in accordance to the C&V UHB guidance.

Each prescriber is responsible for the safe storage of any blank prescription forms and pads issued to them. Should blank forms or pads be lost, they must inform their line manger must be immediately informed and an investigation be instigated

4.2 Persons authorised to prescribe medicines

Only those employed by C&V UHB or working under a service level agreement (or contractual arrangement) and legally authorised to prescribe e.g. doctor, dentist, registered non-medical prescribers (NMPs), may prescribe medicinal products. Non-medical prescribers must have gained sign off from their appropriate line manager and in the case of a nurse or midwife NMP sign off from the appropriate Clinical Board Nurse Director. NMP's must also be registered on the C&V UHB NMP database before prescribing within their area of competence. Provisionally registered doctors (FY1s) may only prescribe in connection with their employment with C&V UHB and cannot prescribe for out-patients. Medical students cannot prescribe, but may write prescriptions to acquire and demonstrate competency. This must be under direct supervision, with the prescription being countersigned immediately by an approved prescriber. Dentists are required by their registration to restrict their prescribing to their areas of competence.

4.2.1 Dietetic products

Whilst Dietetic products are not medicines, dietitians can initiate formulary dietetic products by writing them on the patient's in-patient medicines administration prescription chart or a C&V UHB approved nutrition chart. They should endorse any item not to be continued at discharge as 'For in-patient use only'. This avoids inadvertent long-term continuation.

4.3 Prescribing guidance

4.3.1 Formulary and non-formulary medicines

All newly initiated medicines for both in and out-patients should be prescribed from the approved formulary list. Patients admitted on most non-formulary medicines will be continued on these medicines, but in certain situations pharmacy will agree substitution with an alternative formulary item in accordance with a local procedure approved by the C&V UHB Medicines Management Group. If a non-formulary medicine is needed for treatment of an in-patient, the patient's own medicine supply

should be used as a first option. If/when a further supply is needed a medicines review should be undertaken and medicines swapped to formulary items where appropriate.

4.3.2 Unlicensed medicines

See Medicines Code: Chapter 12.

4.3.3 Off License / Off Label medicines

See Medicines Code: Chapter 12

4.3.4 Anti-cancer medicines

The prescribing of cancer medication is limited to authorised prescribers in C&V UHB. Full guidance can be found in the Management of Parental Cytotoxic Chemotherapy Policy.

4.3.5 Controlled Drugs

See Medicines Code Chapter 9

4.3.6 Intravenous (IV) and parenteral medication

See Medicines Code Chapter 8

4.4 Prescription writing

4.4.1 Handwritten prescriptions

Each prescription must be legal, legible, unambiguous and written or printed in indelible ink that can be photocopied. Upper or lower case may be consistently used. A simple test for legibility is for another person who is unfamiliar with the prescriber's handwriting to read it without difficulty.

4.4.2 Computer generated prescriptions

The planning, development and implementation of any electronic prescribing system must be approved by the C&V UHB Medicines Management Group. Different electronic prescribing systems may exist within C&V UHB. Electronic prescribing will be limited to prescribers trained in use of the particular system. Once a prescriber is enabled as a user, access will be via individual Nadex log on. Prescribers must adhere to the C&V UHB IT information technology policies.

4.5 Prescribing competence

All authorised prescribers must ensure they have appropriate knowledge and experience to prescribe competently in their area of practice. Knowledge of the "Guidance on Prescribing" sections in the current British National Formulary and the UHB Good Prescribing Guide is essential. Completion of the e-prescribing training package for the All Wales In-Patient Medication Administration Record is mandatory

4.6 Prescription documentation

Permanent changes to prescribed medicines must be noted within the patient record along with the indication for treatment or reason for stopping treatment (e.g. ineffective / side effects).

4.6.1 In-patient medication administration record (prescription chart)

The All Wales In-Patient Medication Administration Record is to be completed in accordance with the instructions for this task. (See prescribing e-learning package on Learning@nhswales). The following patient details must be entered:

- Name
- Address
- Unit number and NHS number when practicable
- Date of birth
- Name of consultant
- Weight (as soon as practical)
  Medicine sensitivity (allergies)

A pre-printed addressograph label should be used whenever possible and attached to the prescription chart or form before other details are added. If more than one chart is in use “1 of 2” etc. must be written. The clerking doctor must complete the drug/allergen section on admission, even if no allergies are known; this must be signed and dated. An allergy record in medical clerking notes is not sufficient. The medicine(s) in question must be specified and the type of allergy noted or the ‘none known’ box signed and dated. Medication must not be administered until this section is completed. A doctor, nurse, pharmacist or a pharmacy medicines management technician can complete the allergy section at a later stage if an allergy is subsequently discovered or the detail is initially incomplete.

The weight of the patient must be entered for all paediatric patients and for patients where medicine dose adjustments by weight will be made. If an additional specialist chart is in use e.g. warfarin, insulin or other options, as shown on the front of the All Wales In-Patient Medication Administration Record, it must be indicated on the main chart.

The following medication details must be entered:

- Route of administration
- The recommended International Non-Proprietary Name (rINN) (i.e. the approved/ generic name) of the medicine should be written legibly using either upper or lower case.
- Proprietary names (i.e. brand names) may only be used for multi-ingredient preparations with no approved name, for products whose proprietary name defines a specific formulation (e.g. slow release theophylline preparations, certain creams and ointments) or for safety reasons to avoid miss selection of product (e.g. OxyNorm(R) and OxyContin(R)) or bioavailability (e.g. Neoral(P) and Sandimmun(R)).

Medicine names must not be abbreviated e.g. [MTX, MMT, ISMN, GTN, FeSO4 are not acceptable]. The date on which the treatment is to commence must be entered on the prescription chart. If rewritten, the *original* start date, not the rewrite date is used.

4.6.2 Variable routes

Medicines for administration by variable routes in certain circumstance can be prescribed once on the prescription chart indicating the routes e.g. PO/IV but only where the doses by each route are the same e.g. metoclopramide. When the doses by each route are different e.g. prochlorperazine, each route required must be prescribed individually.

4.6.3 Approved abbreviations for routes of administration

IM – Intramuscular	PR - Rectal
INH – Inhaler	PV - Vaginal
IV – Intravenous	SC – Sub-cutaneous
NEB – Nebuliser	S/L – Sub-lingual
PO / O – Oral	Top - Topical

Other routes of administration should be written in full. Intrathecal must always be written in full ref to IT policy).

4.6.4 Further guidance

Further guidance on prescribing, how doses should be expressed, permitted terminology and the use of multiple charts, refer to the C&V UHB can be found within Good Prescribing Guide and the British National Formulary section on prescribing.

4.6.5 Dose Frequency

For regular medication the prescriber should preferentially use the pre-set medicine round times to indicate administration time, the 24-hour clock must be used when specific timings are needed e.g. for antibiotics to space doses evenly through 24 hours, or for frequent dosage regimen used in Parkinsonism.

4.6.6 When required medicines (pro re nata / PRN)

For “when/as required” medicines. Full details of the directions for administration in frequency of a for when 1 as required meds must be recorded. The time or frequency of administration and maximum dose in 24 hours must be stated e.g. cyclizine 50mg p.r.n. is not acceptable. This should be written “cyclizine 50mg every 6 – 8 hours p.r.n., MAX 150mg in 24hours. Temazepam 10mg p.r.n. is not acceptable. Likewise, “Temazepam 10mg p.r.n. at night for sleeping” is acceptable.

4.6.7 Discontinued Medicines

A diagonal line must be drawn through the prescription so that cancellation is obvious, but the prescription is not obliterated. This should be signed and dated. In some cases, a large 'Z' or a can be used as an alternative to a diagonal line and this should be signed and dated.

4.6.8 Care pathways and the use of pre-printed prescriptions and/or pre-printed labels

Certain patient pathways include pre-printed prescription details and/or pre-printed labels that are used where there is a need for clarity when prescribing complex regimens, or to provide a safe and complete package of care. Examples are insulin regimens where there is dosage titration dependent upon blood glucose results, and in post-operative pain relief for parenteral or epidural opioid analgesia. Before use in C&V UHB, all pre-printed prescriptions or labels must be approved by the C&V UHB Medicines Management Group.

The prescriber is responsible for placing the prescription label on the patient's chart and must sign and date the prescription in order to authorise its use. The signed chart becomes a Patient Specific Direction (PSD). Medication must not be administered until there is an authorised prescriber's signature present.

4.7 Medicines Reconciliation

Medicines Reconciliation (Collect information, check, communicate)

Medicines should be checked and reconciled whenever a patient is transferred between care settings.

To assist in the medicines reconciliation process it is requested that all patients are admitted from primary care with sufficient information about their medication and medical history. This information is referred to as the minimum data set.

It is understood that patients presenting directly to the Emergency Unit may not bring this information with them, but it should be obtained and verified using reliable source(s) at the earliest opportunity. The patient's Welsh GP Health Record (WGPR), an electronic summary, may be accessible via Welsh Clinical Portal (WCP) and should be considered a primary source of supporting information.

The doctor's/prescriber's responsibilities:

- Take a medication history from the patient, and/or carer to the best of their ability and using the information sources (including WGPR) available to them at that time, including the ambulance handover sheet. Document this and include with the admission documentation in the patient's medical record.
- It is recognised that the quality and accuracy of the initial medication history may be limited, particularly outside of normal working hours, owing to lack of access to key information sources e.g. Mental Health records. Every effort should be made to obtain this information at the earliest opportunity. Any inaccuracies and incomplete information must be rectified as soon as

possible. Outstanding issues must be documented clearly and handed over when the patient's care changes.

- Be aware the single sources of information may not be complete. In particular, CAVUHB patients under psychiatric care may have information recorded in PARIS, which may not be readily accessible at all times. Medicines prescribed in secondary care may also not be included in WGPR.
- Annotate the medication list indicating the sources used to find the medication history, the name, signature and bleep number of the admitting doctor.
- Document intentional changes to regular medication made on admission and during the patient's hospital stay i.e. stopped (with reason), held (with reason and intended review date) or amended (with reason).
- Write an inpatient medicines administration record ("drug chart") for the patient's hospital stay.
- Prescribe medication intentionally withheld on the 'drug chart' but insert a 'X' in each drug administration box for each dose to be intentionally withheld. Regularly review to determine when appropriate to restart.
- Respond promptly (and within 24 hours) to any amendments or discrepancies highlighted by the pharmacy team on the drug chart or in the patient's record; update the patient's prescription chart as necessary.
- Further changes to medication during a patient's hospital stay must be documented in the medical record with a clear explanation of the reasons for change.
- In preparation for discharge ensure that the electronic Discharge Advice Letter (DAL) accurately lists medicines for discharge, and includes details of changes made to medicines to inform the next stage of patient care.

The pharmacy team's responsibilities:

- Check the medication history documented by the admitting doctor using at least one reliable source (preferably more). This can include sources previously accessed by the doctor.
- Be aware the single sources of information may not be complete. In particular, CAVUHB patients under psychiatric care may have information recorded in PARIS, which may not be readily accessible at all times. Medicines prescribed in secondary care may also not be included in WGPR.
- Reconcile the patient's medications by comparing the medication prescribed on the drug chart to the medication history, ensuring that any omissions or changes are intentional by referring to the medical record or the consultant team.
- If changes and omissions have been made without documented reason then an explanation and rationale will be requested from the doctor in charge of the patient's care, to be documented appropriately for the record.
- Any pre-admission medicine found to be required (i.e. indicated according to the patient's current or previous clinical status) but not documented in the medication history obtained by

the doctor will be noted in the medical record. Please also refer to the All Wales Pharmacist Enabling and Therapeutic Switch Policy for further guidance. Discrepancies will be communicated to the doctors in an appropriate and timely manner for their attention and action.

- Document (on MTeD or in the medical record, which includes the drug chart) which doctor has been informed and their bleep number/method of contact.
- Pharmacists will sign and annotate entries made in the medical record and/or the inpatient drug chart with their name and contact/bleep number.
- When the medication history is accurate and complete, discrepancies and changes have been documented, and necessary urgent actions initiated then initial medicines reconciliation has been completed. **Medicines Reconciliation (MR) for the majority of patients should be carried out within 24 hours of admission.** This may be delayed e.g. at weekends but systems should be in place to facilitate identification of cases where MR has not been undertaken to enable timely follow up.
- On completion of the initial MR, the medicines reconciliation section on the front of the drug chart must be signed and dated by the pharmacist.
- Any further changes to medication during a patient's hospital stay must be documented in the medical record with a clear explanation of the reasons for change.
- If a pharmacy technician identifies discrepancies when completing a check of patients' own medicines or when importing medication history from the patient's individual healthcare record (WGPR) then these should be highlighted to the pharmacist for prompt action.
- Where appropriate, discrepancies and action to be taken should be communicated to the nurse looking after the patient.

The nurses' responsibilities:

- Ensure all medicines supplied for a patient are held securely, are accessible, and are transferred with the patient. This applies equally to medicines brought into hospital, which are the patient's personal property and should be dealt with accordingly.
- Medicines reconciliation issues may be identified in the course of routine nursing care e.g. administering medication. Any discrepancies should be documented appropriately and discussed with the doctor and/or pharmacist.
- Any medicines reconciliation issues or actions documented in the medical record but not addressed should be brought to the appropriate member of staff's attention for prompt review.
- At the time of patient's discharge home, following a Pharmacist's clinical check of medications, a Registered Nurse **MUST** go through the discharge medication with the patient and/ or carer to ensure that the patient can access all current medication as listed on the DAL, and to make sure they are aware of any changes made during admission.
- When a patient is ready for discharge with their TTH medications, the nurse is responsible for counselling the patient on any new medications they have commenced, any dose changes to their current medication list and confirm if any medications are being discontinued. The

nurse must ensure that the medications in the TTH bag match the medications listed on the DAL before they can be discharged safely.

- Any concerns or questions raised by the patient/carer must be responded to by reference to information documented in the medical record (including the DAL) or referred to the patient's doctor or pharmacist.

4.8 Prescribing for patients with swallowing difficulties or patients with naso-gastric or gastrostomy tubing

Some patients are unable to take medication in solid oral dosage forms. A stepwise approach is suggested to choose a suitable alternative:

- If possible, use a licensed medicine in a suitable formulation to meet the patient's needs(e.g. a dispersible tablet or licensed liquid medicine)
- If there is no suitable licensed formulation, consider using a licensed medicine in an unlicensed manner, for example by crushing tablets or opening capsules
- In order to use a licensed medicine consider switching to a different therapeutic agent in the same class, or to a different route of administration. In most cases a suitable licensed preparation will be available to meet the patient's needs.
- In the few situations where the patient's needs cannot be met by licensed medicines, the use of special-order "unlicensed" products ('specials') may be considered.

Prescribers should be aware that many medicines are not available in a form that can be administered via naso-gastric or gastrostomy tubing. The crushing of a tablet or opening of a capsule changes its licensed status. If a tablet requires crushing or a capsule requires opening to facilitate their administration, the pharmacist should indicate this on the patient's inpatient drug admin medicine chart. In the absence of such directions a pharmacist should be consulted for advice. Alterations that change the licensed status of a medicine must be brought to the prescriber's attention and recorded in writing.

4.9 Out-Patient Prescribing

Out-patient prescribing and supply should be minimal, limited to hospital only products or when an urgent clinical need exists. The internal hospital out-patient prescription form HMR 112 (W) can only be dispensed from the hospital pharmacy. Routine and non-urgent amendments to medication should be made by the use of a GP prescribing referral form. An 'Outpatient Department GP Medication review' form is available to facilitate this process. The WP10 (HP) (or non-medical prescriber {NMP} equivalent) prescription form may only be used in exceptional pre-agreed circumstances e.g. clinic held remotely to a hospital pharmacy. This form can be dispensed from community pharmacies. Prescribing quantities should be for short duration of therapy, and regular supply of medicines will be obtained from the patient's GP. The maximum quantity prescribed will usually be not more than one original pack. The WP 10 (HP) or NMP equivalent form must not be used to circumvent any hospital prescribing procedure e.g. non-formulary medicine and prescribers

need to be aware that data from WP 10 (HP) s or NMP equivalents is audited for compliance. The prescriber must clearly print their name and contact number when using a WP 10 (HP) or NMP equivalent, to enable contact should a query arise from the dispensing community pharmacy. When medicines are to be prescribed for administration in out-patients they should be written within the patient notes or written on a prescription chart to allow the details of administration to be recorded and signed, include detail of COPPS etc.

4.10 Prescription amendment in order to correct individual in-patient prescriptions

Under an agreed enabling protocol pharmacists may amend in-patient medication records and transcribe GP treatments onto prescription charts for elective and emergency admissions in order to correct and/or clarify prescriber's intentions. Any pharmacy alteration must be legible, dated, and identify the amending pharmacist by their initials and bleep number for contact. It will specify when appropriate which clinician agreed the amendment. Where amendments would decrease readability, the prescription will be rewritten and signed by the pharmacist. The nurse is permitted to administer the medicine without a medical countersignature. Where actual or potential clinical reasons exist for omitted items, the item will not be added to chart. If the reason for omission is not documented a note will be left on the in-patient medication record or contact made with the prescriber, depending on the urgency. The pharmacist will not amend anything beyond their experience or competence. Communication with the prescriber is essential to maintain safety and ensure correct treatment.

4.11 Validity of an in-patient prescription

The prescription is valid until stopped by prescriber, administration section is full or patient is discharged. A new medicines record must be written if patient is readmitted. The use of a continuation sheet is not allowed when the administration section is full. Only charts originating within the C&V UHB are valid.

4.12 Validity of out-patient prescriptions

The prescription is valid for 6 months. Schedule 2, 3 and 4 Controlled Drug scripts are valid for 28 days.

4.13 Prescribing for discharge (To Take Home)

TTH prescriptions or MTED Discharge advice letter should ideally be written 24 hours prior to discharge to avoid delays in dispensing. They may be written by an authorised prescriber from the responsible consultant team, by other medical prescribers covering shifts or by a non-medical independent prescriber.

4.14 MTeD

The Medicines Transcription and electronic Discharge (MTeD) system is a module of the Welsh Clinical Portal which has been implemented across all inpatient wards across Cardiff and Vale UHB.

MTeD allows for the electronic transcription of a list of patient's medications which contributes to a final discharge advice letter (DAL). The DAL is sent electronically to a patient's GP in any area of Wales automatically when a patient is discharged and is stored on Cardiff Clinical Portal and the Welsh Clinical Portal.

A patient's medication can be transcribed from the chart onto the MTED system by a pharmacy technician, pharmacist or prescriber at any stage during the inpatient stay, inpatient drug admin, depending on the agreed procedure for each ward. On many wards the transcribed medication list is kept up to date by pharmacy during the inpatient stay and must be reviewed by the doctor at discharge when the DAL is prepared. Here, MTeD provides a comprehensive list to the GP of all medication continued, started, stopped or withheld while in hospital. It is used during the inpatient stay for ordering of medication both on site and remotely, and any additional information regarding supply in the community can be recorded. On other wards all medication is transcribed at the time of discharge by the prescriber. The final DAL is printed and signed by the prescriber ready for assembly by pharmacy in during opening hours, or ward staff out of hours according to the protocol.

4.15 Leave medication

Leave medication should be ordered as set out above in 4.13 'Prescribing for Discharge'. Where a local procedure exists, and it has been approved by the Clinical Board and if appropriate the C&V UHB Medicines Management Group, medication dispensed and labelled by pharmacy for leave can be supplied to cover the period of time until the patient is readmitted to hospital in accordance with the procedure. Nurses must not dispense medication from ward stock to facilitate supply of leave medication as this is a contravention of Regulations under the Medicines Act.

4.16 Discharge of patients from community hospitals

Community Hospitals will arrange prescriptions for discharge medication as for acute hospitals in 4.13 above. This will ensure a safe process for prescription writing, dispensing and supply of discharge medicines for patients to take home. Supply of discharge medication may be obtained from the local hospital pharmacy or by use of the patients own drugs (PODs) or from a local community pharmacy if a C&V UHB approved procedure is in place.

4.17 Faxed prescriptions for discharge (TTHs)

Faxed discharge prescriptions are not permitted within acute hospitals. In community hospitals, where a POMs system of medicines management is not in operation, discharge prescription supply is usually obtained by sending the original discharge prescription to the local hospital pharmacy for dispensing. In certain circumstances, the use of faxed prescriptions to the local hospital pharmacy may be used to facilitate efficient discharge. Each faxed discharge prescription must be accompanied by a copy of the in-patient medication record. Controlled Drugs cannot be issued from faxed prescriptions, but may be dispensed and supplied only when the original prescription is received and checked against facsimile copy.

4.18 Prescribing for relatives and visitors of in-patients

Relatives and visitors of in-patients may occasionally stay overnight locally or within the hospital. They are responsible for supplying their own medication. When they have not brought their own medication to the hospital and their health may suffer as a consequence they should obtain an emergency supply from a community Pharmacy, or if not local to the area, a local GP practice may be willing to prescribe as a temporary resident. The GP Out of Hours Service can issue a prescription to a temporary resident, and in certain circumstances attendance for treatment at the Accident and Emergency Department is appropriate.

If relatives cannot leave the hospital, and the consultant team treating the patient agree to take prescribing responsibility, the hospital pharmacy may agree to dispense a prescription written by the hospital team treating the inpatient.

4.19 Verbal prescriptions to nursing staff – prescribing by telephone

Telephoned prescriptions are permitted only in exceptional circumstances when in the nurses' professional judgment, patient safety or care would otherwise be compromised. It is emphasised that verbal orders are only appropriate in exceptional circumstances and are expected to be minimal in number. Exceptional circumstances will mainly be for areas where there are no doctors on site, e.g. Community Hospitals, Minor Injuries Units, and when treatment is needed to urgently relieve symptoms.

Verbal prescriptions can amend, delete or add a prescription item. They cannot be used for controlled drugs. Any refusal by a nurse to accept a verbal prescription must be documented by the nurse.

The following principles for confirmation of prescription should apply:

The prescriber must be informed of other medicines currently prescribed for that patient

- A verbal order must be received by a nurse and confirmed ideally by a second nurse (except in circumstances detailed in paragraph below).

The prescriber must state:

- The prescriber's identity
- The name of the medicine to be administered (spelt to avoid confusion)
- The dose to be administered
- The route and time to be administered

This information must be given to the first nurse, entered on the in-patient medication record or casualty card and then repeated back to the prescriber by the second nurse. The nurse taking the verbal message should be familiar with the medicinal product. When it is not possible for two nurses to be present to receive the verbal order, a second member of staff who may be qualified or non-qualified should be present. Both members of staff involved must sign and date the entry.

In exceptional circumstances, when a community health professional is working alone and is unable to receive a fax or electronically transferred instruction, the health professional may accept a verbal order from a prescriber to administer an urgent single dose of a medicine until such time as a fax or electronically transferred instruction can be made. The prescriber must sign the form as soon as possible after giving the verbal order. Where doctors are on site, this must be signed as soon as possible and within the prescriber's shift. In areas where doctors are not on site, the order must be signed within 72 hours**.**

Where an Out of Hours service is in operation, the prescriber giving verbal instructions can arrange for a second prescriber to countersign the verbal order. In areas where doctors are not on-site doses may be administered for up to 72 hours without the doctor's signature until the verbal instructions are signed by a prescriber.

4.20 Verbal prescriptions to pharmacists – corrections by telephone

Verbal orders can be given by a prescriber to a pharmacist to amend delete or add a prescription item. This need often results from a pharmacist-initiated query.

Having confirmed the identity and name of the patient with the prescriber, the pharmacist must confirm the following details:

- The patient hospital number
- Date of birth
- Address
- The medicine name, form and dose
- The name of the prescriber.

The pharmacist must also have access to sufficient information to assure themselves of the appropriateness of the medicine and dose. The pharmacist must read the alteration or addition back to the prescriber who must then affirm the original instructions. The pharmacist will then amend the in-patient medication record or out-patient prescription recording the name of the prescriber, who has been contacted, then sign and date the amendment.

If the alteration is to formulation, frequency or timings of dose, then that part of the prescription may be crossed out and altered to ensure that the alteration is clear. If the alteration involves any other changes e.g. new medicine change in dose, then the whole prescription for that item must be written out as a new entry on the in-patient medication record or outpatient prescription form.

4.21 Controlled Drug prescribing

See Chapter 9

4.22 Prescribing for Controlled Drug Dependency

See Chapter 9

4.23 Prescribing medicines which carry a black triangle symbol in the BNF

The black triangle symbol ▼ identifies those preparations in the BNF that are monitored intensively by the Medicines and Healthcare Products Regulatory Agency (MHRA). Prescribers are urged caution when prescribing these preparations and should report adverse drug reactions to the MHRA

4.24 Prescribing medicines for which the Patient Safety Wales (and former NPSA) has issued safety concerns

Patient Safety Wales and formerly the National Patient Safety Agency (NPSA) may/have identified certain medicines as having particular risks associated when they are prescribed. This risk is highlighted by the production of a Patient Safety Notice/Alert (NPSA through the issue of a Rapid Response Report (RRR)). Prescribers are urged to familiarise themselves with these.

4.25 Prescribing for patients detained under 'The Mental Health Act'

Circumstances arise where a patient is detained under The Mental Health Act and will need medication prescribed either by consent or against the patient's wishes. The prescribing team must ensure that any prescribing will be in accordance with the current legislation set out under the Mental Health Act.

4.26 Patient Group Directions (PGDs)

Each Clinical Board is responsible for gaining approval of the C&V UHB Medicines Management for their Patient Group Directions. PGDs must be prepared in accordance with WHC CMO (2000) 1 using a C&V UHB template for PGDs. Advice in the preparation of PGDs can be obtained from Pharmacy. A record of approved PGDs is displayed on the C&V UHB intranet. When the review date arrives, the appropriate Clinical Board will be responsible for reviewing and updating the PGD.

4.27 Prescribing for staff who are unwell at work

In order to standardise practice for staff that are unwell at work and to ensure compliance with the Welsh counter fraud initiative and the principles of clinical governance, this protocol describes the circumstances in which it is acceptable for doctors to prescribe medicines for staff.

Self-prescribing is held to be generally undesirable to many authorities, including the General Medical Council, and will not be accepted. This avoids the dangers associated with the loss of objectivity, misdiagnosis and circumvention of the normal general practitioner-patient relationship. All routine medicines for doctors, their families and other hospital staff should be obtained through the General Practitioner Services. Prescriptions are subject to routine and random audit and exceptions to this protocol will be brought to the attention of the C&V UHB Audit department. There are, however, circumstances when it is reasonable for a doctor to prescribe limited quantities of medicines for a medical colleague:

- The prescriber must be a fully registered practitioner and hold the post of Consultant, Staff Grade Doctor, Trust Specialist or Specialist Registrar.
- The prescriber's decision to prescribe is taken to support the attendance of his/her colleague in the workplace.
- A maximum of one week's treatment (or one original pack where appropriate) will be supplied, prescribed.
- Prescribers should note that data from prescription forms WP 10(HP) dispensed by community pharmacies, are returned to C&V UHB for audit purpose and are subject to regular scrutiny.
- Prescriptions outside this guidance will be treated as a private transaction, and the full cost of the medication will be charged to the patient in accordance with the private prescription and signed order charge arrangements within the local hospital. Pharmacy will not dispense any prescription for any medicines that significantly affect performance, mood altering medicines or controlled drugs under this protocol.

Chapter 5 - Ordering of Medicines

5.1 Ordering ward stock of medicines

The process of ordering and receiving medication from pharmacy as stock medication for a ward or unit must ensure that certain controls are in place to cover the safety and security of the medicines (to include a clear documented audit trail), ensure that only controlled stationery is used, prevent overstocking of the area, ensure safety of the staff and patients, and clearly show who has the direct responsibility for each stage of the process.

5.1.1 Stock control

Each ward or unit must have an agreed stock list of medicines which are either used regularly on that ward or unit, or are required in case of an emergency. The stock level should be agreed between the pharmacy department and the clinical lead and this should be reviewed on a regular basis (usually at least twice a year). The sister/charge nurse/clinical lead has responsibility for all medicines on that ward or unit. This overall responsibility cannot be transferred to anyone else since it covers the strategic elements of medication handling on the ward or unit which ensures that day to day practice is in line with current legislation, local and national policies/guidance. The pharmacy will arrange which system of regular top-ups/stock control is be best suited for that ward or unit, and the frequency with which these will take place. Ad-hoc orders should be processed as described in the Medicines Code. Community Hospitals will order stock medicines as arranged with their local hospital pharmacy.

5.1.2 Ordering ward stock (WOREQ)

The ordering system in use on that ward or unit will determine who raises the order. Where wards or units have a pharmacy top-up/stock control, the pharmacy staff that carry out the top- up/stock control will initiate the order. Wards or units that do not have pharmacy top-up/stock control will order

using an agreed medicines requisition that will be completed by a member of the ward or unit staff who has been authorized to initiate orders. Authorization of staff will be the responsibility of the ward/clinical lead and all authorized staff will have their name and signature logged with Pharmacy, Ad-hoc orders maybe initiated by the ward or unit staff, but they can only be made in the manner agreed with pharmacy and by a member of staff who has been authorized to initiate orders.

5.1.3 Documentation

All documentation used in the ordering of medicines will be classed as “controlled stationery” and as such should be stored safely except when in use. Access to medicines requisitions should only be to authorised staff and any electronic medicines ordering documents or system is limited to staff with authorisation attached to their individual user name and log on. All order documentation records whether paper or electronic will need to be kept for 2 years as a record of the transaction for audit purposes

5.1.4 Order assembly and transfer of Medicines

Order assembly and the transfer back to the ward or unit will be the responsibility of the pharmacy department. The pharmacy will highlight medicines needing special storage or temperature conditions, to ensure the security and stability of the medicines until they are delivered to the ward or unit.

5.2 Receipt of medicines on the ward or clinical unit

When medicines have been delivered to the ward or clinical unit the delivery must be signed for. The ward/clinical lead in charge should delegate a member of the ward staff to check the medicines received against the delivery note issued with the medication. If all the items are correct then the nurse shall sign and date the delivery note and then put away the medicines in their designated locked cupboards on that ward or unit. Any discrepancy identified must be notified to pharmacy as soon as possible.

Chapter 6 – Control and Storage of Medicines

6.1 Storage of medicines

Medicines dispensed by pharmacy and will be labelled in a manner to indicate to patients and nurses, the correct manner of storage and use of medicines. Medicines needing storage in a controlled drug cupboard will be labelled ‘Store in a Controlled Drugs cupboard’ Medicines needing cold storage will be labelled ‘Store in a refrigerator’. Certain medicines can carry risk of harm to those who need to handle the medicines e.g. cytotoxic medication or hormonal medication and will carry warning labels indicating this risk.

6.1.1 Stock medicines in clinical areas

The stock held in a ward or department should be the minimum for safe and effective patient treatment and efficient service provision. The ward or clinical area will agree the items to be held as

ward stock with pharmacy whose staff are authorized to inspect all medicines on any C&V UHB premises at any time. Storage of medicines no longer in use can increase risk of error and they should be returned as set out in this Code.

If it is found that the storage conditions are inappropriate; the nurse with continuing responsibility must be informed. In a situation of a continuing problem the Nurse Advisor for Medicines Management will notify in writing the Senior Nurse responsible for the ward or clinical area.

6.1.2 Patient's own drugs (PODs)

When a patient is in hospital, the term 'Patient's Own Drugs' (PODs) refers to medicines that have been brought into hospital by the patient, having been dispensed for that patient outside of the hospital. It also includes over the counter (OTC) medication purchased by a patient and brought into the hospital. PODs medicines are not C&V UHB property but to ensure safe use and control for an individual patient their medicines must be stored and handled as set out in 6.1.3.1. **NB Patients own medicines are patient's property, if a patient refuses to surrender their medicines for safe keeping and or use whilst in hospital, this must be recorded in the patients notes. Patients must be asked to return the medicines to their home address. Patients must be reminded of their responsibilities for keeping these medicines safe. Refer to Patient Property procedure.**

6.1.3 Storage of PODs

Where appropriate PODs are stored in lockable bedside medicine cupboards used exclusively for that patient. Cupboards or lockers designated for PODs storage must only be used for storage of PODs, and must not be used for patient's own property, money, food or valuables. If a ward is not utilising PODs then the PODs must be stored in a cupboard or trolley until such time that they can be returned to the patient or relative. PODs should be assessed for suitability for use by a pharmacist or pharmacy technician or registered nurse/midwife in accordance to the local pharmacy procedure. An in-patient may be self- administering certain medication that is not practical nor is expedient to be kept in a locked cupboard. Examples of this are be patient controlled analgesia, inhaler therapy, glyceryl trinitrate spray or topical preparations e.g. creams. These need not be stored in a locked cupboard when prescribed and used by those patients capable of self-administration. PODs that need cold storage must be kept in a refrigerator, and the medication record should be noted with the place of storage.

6.1.4 Suspicious substances or suspected illicit materials

If a patient is found to be in possession of a suspicious substance or illicit material then the member of staff must follow the guidance for disposal in the Medicines Code Chapter 9 and Chapter 10. A Datix report should be completed.

6.1.5 Medicines cupboards and trolleys

A ward or clinical area must have sufficient and proper storage cupboards, medicines trolleys, racking and shelving to safely store medication in a dedicated room or area. Each area where medicines are stored must be kept clean, be well ordered and comply with current legislation for storage of medicines (PSN030 sets out the requirements). Internal and external medicines should be stored in separate cupboards or where this is not possible, on separate shelving within a cupboard.

Testing reagents shall be stored in a separate locked cupboard. Disinfectants shall be stored in a locked cupboard, separate to internal medicines. Where a traditional ward medicines trolley is used to facilitate medicines administration it is good practice to ensure that medicines held on the trolley are restricted to individually dispensed items and the minimum stock from ward stock required to meet the needs of the medicine round. When the trolley is in use it must not be left unattended unless locked. When the trolley is not in use it must be locked and secured to the wall or floor by a chain, padlock or security system. Medicines must not be left on top of the trolley or on any exposed shelf of the trolley.

CDs must not be stored in the medicines trolley. Where an automated ward or department medicine storage system is in use e.g. Omnicell, the system and its access controls must be approved by pharmacy. Infusion fluids, peritoneal solutions and large volume sterile irrigations are best stored in a locked cupboard, but where they are stored on shelving it must be in a secured area, providing clean conditions and where there is not public access.

6.1.6 Medicines refrigerators

Medicines labelled ‘Store in a refrigerator’ shall be stored between 2-8˚C in a dedicated locked medicines refrigerator. Guidance is set out in Patient Safety Notice PSN015. Medicines refrigerators should preferably be hard wired to the electrical supply to prevent accidental switching off. The use of refrigerators with temperature recording charts is preferred. Medicines refrigerators must have the temperature monitored and recorded daily, and this should be regularly audited by a named individual. Non-medicines e.g. milk or food must not be stored in a dedicated medicines refrigerator.

6.1.7 Storage of medicines in intensive care, high dependency and coronary care units and recovery rooms

In the above clinical areas where there is continuous high-level nursing/staffing, medicines may be stored in a secure or convenient location and not in a locked cupboard. However, the storage location must allow constant oversight by nursing staff. Each registered health care professional accountable for the individual patient is responsible for the safe custody of these medicines at all times. When these medicines are no longer required by the patient they must be returned to the pharmacy or the unit’s medicines cupboard.

6.1.8 Epidural levobupivacaine bags

Epidural levobupivacaine bags must be stored separately from intravenous infusion bags to minimise risk of erroneous selection of levobupivacaine and inadvertent administration by an incorrect route. Compound epidural bags containing levobupivacaine and fentanyl must be stored in a CD cupboard.

6.1.9 Emergency boxes, anaphylaxis kits and hypo (hypoglycaemia) boxes

These medicines are provided to wards to provide immediate lifesaving treatment therefore they should not be stored in locked cupboards, but be kept in a safe location in the clinical area so as to be readily available when needed. This must be balanced against the need for medicine security, therefore wherever possible they should be stored out of direct view of the public. Some areas will have alarmed trolleys for storage of emergency boxes. Each emergency box will have a tamper evident seal and expiry date, and once the seal is broken or the box expires it should be replaced via the pharmacy as soon as possible.

6.1.10 Medicines and Health and Safety

Flammable materials must be stored away from sources of ignition and preferably locked. Medical gases are generally piped but when medical gas cylinders are used they must be secured and stored in a dedicated cradle trolley and in accordance with the supplying company's safety instructions.

6.1.11 Storage of Controlled Drugs

See Chapter 9

6.1.12 Storage of medicines by community nurses

Where community staff need to carry medicines to a patient's home or elsewhere, they must ensure that the medicine is securely stored until use or return to the originating storage cupboard at base. If the medicine requires cold storage the medicine must be carried in appropriate packaging to maintain the 'cold chain'. Medicines should be carried concealed in the boot of a vehicle and should not be left unattended,

6.2 Security of medicines

6.2.1 Custody of keys controlling access to medicines

6.2.1.1 Pharmacy

The safe custody of medicines within the Pharmacy, pharmacy keys and pharmacy entry swipe cards are the responsibility of the Director of Pharmacy and Medicines Management.

6.2.1.2 Wards

In wards or clinical areas, the responsibility for safe custody is that of the nurse/midwife in charge/clinical lead of the ward or clinical area. The person with continuing responsibility can be delegated responsibility for possession of the custody of the keys to the medicine cupboards,

medicine refrigerator and medicines trolleys. All ward medicines keys must be passed to the next person in charge at handover. Unauthorised persons must not be permitted access to medicines within hospital premises. The ward/area should provide a copy set of medicines cupboard keys to pharmacy in order to maintain service in certain circumstances, such as the loss of keys.

It is deemed best practice to keep CD keys separately from non-controlled medicine keys as they must remain with the person in charge of the ward/area when not delegated or in use.

A master key for PODs cupboards is held by each ward team. Lost keys must be reported in accordance with the local security procedure. A patient may hold the key to their individual bedside PODs cupboard where they have been assessed to be able to self-administer their medication according to a C&V UHB approved local procedure.

6.2.2 Custody of Controlled Drugs

See Chapter 9

6.2.3 Discrepancy or misappropriation of medicines

Each member of staff will maintain their own record of any incident and their subsequent action. The WRN lead will make initial enquiries to establish if any suspected theft or suspected fraud may have occurred. See section 3.3 and 3.4

6.2.4 Apparent loss of medicines in clinical area

The person in charge of the clinical area should assess the significance of the loss of the medicine (whether it is a CD or not) and then determine if the procedure set out for missing CDs will be followed (see Section 9.10). If theft or fraud is suspected see sections 3.3 & 3.4. All losses involving CDs must be referred as soon as possible to the senior nurse who will contact the Duty Pharmacist as necessary and the procedure set out in the Controlled Drug section of the Medicines Code must be followed.

6.2.5 Apparent loss within the pharmacy

Any apparent loss of medicines within the pharmacy must be reported immediately to the Duty Pharmacist. The senior pharmacist and the person reporting the loss should examine the records against the physical stock to confirm the apparent loss. If no satisfactory explanation is forthcoming the senior pharmacist will inform the manager or their deputy who will again check the stock records against physical stock. Should the apparent loss remain unexplained, the Director of Pharmacy and Medicines Management or deputy will inform the Security Manager of the loss and in consultation with him/her may report the incident to the Police and ask for an independent investigation. The relevant disciplinary and finance procedures will be applied, if appropriate.

6.2.6 Dispensing errors discovered on a ward

When an apparent dispensing error is discovered on a ward or in a department the WRN lead in charge of the ward or department will contact the pharmacy as soon as it is practical, in order to

confirm the status of the medication and ensure that where necessary a new supply is made available to the patient. The ward staff should complete a Clinical Incident Report on Datix detailing the error or provide information to the local hospital pharmacy for completion. Dispensing errors are considered 'must report incidents' within the C&V UHB policy for clinical incident reporting.

The pharmacist receiving such a report will complete a pharmacy incident report to be submitted to the local pharmacy operations manager. The pharmacy will maintain a record of such incidents for audit and clinical governance purpose. If a patient has wrongly received any medicine the consultant in charge of that patient will be informed of the incident so that any clinical action needed can be taken, and that the patient and/or relatives can be informed.

6.2.7 Samples of medicines left by pharmaceutical representatives

It is imperative that C&V UHB must know what products are being used within its boundaries. Samples of medicines must not be left in clinical areas, or issued to individual healthcare staff by pharmaceutical representatives for use within C&V UHB. Representatives wishing to discuss supply of samples for use for evaluation of a medicinal product must be referred to the hospital pharmacy.

6.3 Transport of medicines

When medicines are being transported from the pharmacy to ward or unit it shall be in such a manner that ensures they reach their destination safely, undamaged and have been kept under the correct storage conditions. Each hospital pharmacy will put in place a system for recording dispatch and delivery of medicines from the originating pharmacy.

6.3.1 Storage conditions in transport

Whenever medication is to be transported from one area to another, then the recommended storage conditions e.g. Safe storage for Controlled Drugs, temperature or humidity must be considered and the method of transfer must take these storage conditions into account. When sending out items with highly sensitive temperature conditions e.g. vaccines, it is good practice to notify the receiving unit of the day/date of transportation to maintain the cold chain as described in the NPSA Rapid Response directive (RRR008 Cold Storage)

6.3.2 Packaging for transportation

When transporting any medicine due regard must be taken of the fragility of the item being dispatched. Those items known to be fragile e.g. items already packed in a glass container, or items which are known to have a COSHH hazard must be packed carefully (these may require extra padding around the container) in order to remain intact throughout the transport process. It is essential that when the item reaches its destination it is still intact and can be used for a patient. Pharmacy must be notified immediately of any damaged receipts.

6.3.3 Transport documentation

Medication should only be transferred from pharmacy to a ward or unit on the same site by hospital staff. In most cases this will be pharmacy/hospital porters. Other staff e.g. Pharmacy, nursing or health care workers can also transport medication, but only if they can be identified by their employer identification badge. For any transfer that is going off site to another health premises, then the person carrying out the delivery must sign a pharmacy transport note on pickup within pharmacy and also ensure that the receiving staff signs for receipt of the medication to ensure a complete audit trail. The carriers in this case will be signing for the outer transport bag or box and not for the individual contents. The record of receipt will be returned to the supplying pharmacy as soon as possible. If voluntary transport arrangements are in use then a badge or similar identification system must be in place.

Chapter 7 – Administration of Medicines

The purpose of this section is to establish the principles for safe practice in the management and administration of medicines by registered nurses, midwives and other healthcare professionals. It is aligned to the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS 2015). Definition of administration: Administer is 'to give a medicine either by introduction into the body, whether by direct contact with the body or not (e.g. orally or by injection) or by external application (e.g. application of an impregnated dressing).

Definition of second checker: A staff member usually authorised to administer medication or a person on a training placement from a university course that is undergoing training for registration as a nurse or health professional. In certain defined situations the second checker may be a health care support worker who has undergone training for this task.

Remember: In order to administer medicines safely the person administering must:

- Establish the identity of the patient in accordance with the UHB Patient Identification Policy.
- Check the prescription is clearly written, unambiguous and appropriate for the condition being treated
- Check that the patient is not allergic to the medicine to be administered.
- Check the medicine against the prescription to ensure correct dosage, route and timing of the administration.
- Check the expiry date of the medicine to be administered.
- Ensure that the patient takes the medication
- Make a clear and accurate recording of initials on medicines administration chart once you are sure all medicines administered have been taken/applied. Medicines intentionally withheld or refused by patient must be annotated with the appropriate code and where necessary an entry made in the patient's notes.

Note: Medicines must never be left unattended, and must be securely stored when not in use.

7.1 Persons who are authorised to administer medicines

All health professionals set out below and deemed competent to administer medicines can administer medicines on the authorisation of a medical practitioner, dental officer, and non-medical

prescriber. Patient group directions only authorise those named within the PGD to administer the particular medicine. For in-patients they must be prescribed on an approved computer prescribing system or the appropriate hand-written prescription chart or stationery approved under a model of service. It is recommended that medicines to be administered orally and by injection should be prepared and given at different times.

7.1.1 Nurses and Midwives authorised to administer medicines

All nurses and midwives with a current registration with the NMC and assessed as competent within Cardiff and Vale UHB including bank nurses. Agency nurses must have received appropriate training and assessment by the agency providing the nurse/midwife and the agency must be able to demonstrate this to the UHB.

7.1.2 Non-nursing staff authorised to administer medicines

- Registered Medical Practitioners and Dentists
- Registered Operating Department Practitioners with the appropriate training and assessment of competence
- A nurse in training or student under the supervision of a registered nurse (Level 1) or registered nurse (Level 2) or midwife who remains accountable for ensuring that the correct procedure takes place
- After appropriate training and competence assessment, specific medicines may be given by Pharmacy staff, Radiographers, Podiatrists, ECG Technicians, Physiotherapists and Clinical Support Workers.
- Under the All Wales guidelines for delegation (2020), a registrant can delegate specific medications to be administered by a trained and competent Assistant Practitioner.
- All unregistered nursing staff assisting with medicines administration must adhere to the relevant local medicines policies/procedures/frameworks within the UHB.

7.1.3 Administration requiring two registrants

It is recognised that all healthcare professionals can make human errors. For the following types of medicinal products an independent full process two-person check is recommended practice to reduce the risk of adverse drug events. In C&V UHB this is required in the following processes

- All medicines administered to a child less than 16 years of age (with the exception of Teenage Cancer Trust where oral medicines are administered with a single nurse check to patients of 14 years and upwards).
- Controlled Drugs see Chapter 9.9
- All intravenous, epidural injections and infusions.
- Where a calculation is involved

By definition the independent check must not be controlled or influenced by any other person. The independent check must include that the medicine matches the prescription, that the correct

strength, dose and form has been selected, including any calculations that must be clearly documented, that the product has not expired and the patient is not allergic to the particular medicine. The process must include a check of the patient's identity at the bedside and the administration or start of the administration. Accountability for the preparation and administration remains with both professionals. The checking of medicines by a second healthcare professional does not apply in areas of anaesthesia and resuscitation where the doctor or dentist can administer medicines alone. The checking of medicines by a second healthcare professional may not apply in community practice e.g. at a patient's home. However independent checking is required for any medicine which the primary administrator is unfamiliar with, in particular**,** those medicines that are to be administered parenterally regardless of the professional group.

7.1.4 In the absence of a registered second checker

In certain clinical areas, and exceptional circumstance, if a second registrant is not available to act as a second checker, the Clinical Board can approve a process for a member of staff e.g. healthcare support worker, Assistant Practitioners, to undergo suitable preparation and assessment for acting as a second checker.

N.B. First year student nurses/midwives or student operating department practitioners, cannot act as a second checker for IV preparation and administration, however first, second and third year student nurses/midwives or student operating department practitioners can act as second or third checker for Controlled Drugs. Refer to the All Wales Practice Learning Framework.

7.1.5 Selection and administration

7.1.5.1 Selection of medicines

When a health practitioner is selecting a medicine for administration it is vital that the process results in the correct medicine to be given in the prescribed dose by the prescribed route and at the required time.

To support this process all medicines supplied from the pharmacy will be labelled by the original manufacturer or by the pharmacy in a manner that will allow identification of the medicine contents against the patient's prescription.

If the pharmacy repackages an original manufacturer pack, the pharmacy label will then identify the contents of the dispensed container. If the container is a box containing a strip of tablets it is good practice to confirm identity marked on the label with the tablet/capsule name and strength printed on the strip. This is necessary to ensure that a wrong strip has not been returned to another container box at a previous administration time. If the name and strength of a medicine is not clearly printed on a medicine strip, or a label seek advice from another health practitioner. If there is any ambiguity it is advisable to check with the local pharmacy to confirm identity of the medicine.

7.1.5.2 Safe Administration of medicines

Remember in order to administer medicines safely the person administering must

- Establish the identity of the patient in accordance with the UHB Patient Identification Policy.
- Check the prescription is clearly written, unambiguous and appropriate for the condition being treated
- Check that the patient is not allergic to medicine to be administered.
- Check the medicine against the prescription to ensure correct dosage, route and timing of the administration.
- Check the expiry date of the medicine to be administered.
- Ensure that the patient takes the medication.
- Make a clear and accurate recording of initials on medicines administration chart, of all medicines administered, intentionally withheld or refused by patient. Where necessary an entry into the patient's notes must also be made

It is the responsibility of the Ward Sister / Ward Unit Manager/ Unit Lead to ensure that standards of medicines practice are adhered to and ensure that the person administering medicines has received the relevant training and education to enable them to safely administer medicines.

To ensure medicines are safely administered the administrator must:

- Know the therapeutic use of the medicine to be administered, its normal dose, side effects, precautions, contra-indications and monitoring requirements. In the event that the administrator is not aware of this information, they must be able to locate the information before administration. (Sources include BNF and Medusa).
- Be aware of the patients care plan, the patient's condition, in particular with regards to their medication needs.
- Be alert to potential errors in prescribing or dispensing.
- Contact the prescriber without delay if:
    a) Contraindications to the medicine are identified
    b) The patient develops a reaction to the medicine
    c) Assessment of the patient indicates that the medicine may no longer be suitable for the patient

7.1.5.3 Non- administration of medicines

In some circumstances it may be appropriate for the administrator not to administer the prescribed medicine either because they are unable to administer (e.g. patient refuses) or because the administrator feels there is an appropriate reason to withhold (e.g. with holding anti-hypertensive medication if the patient's blood pressure is too low). In the event of the non-administration of

medicines the administrator must annotate the medicines administration chart with the appropriate code. i.e.

X – Prescribers request.	2- Patient not on ward.
3 – Patient unable to receive/no access.	4 – Patient refused.
5 – Medicines unavailable.	6 – See notes.

It is the administrator's responsibility to inform the patient's medical team, or the ''on call' medical team, that the medicine has not been administered, the reasons why, and to discuss the need for alternative action. The patient's condition must be considered to determine the urgency with which this information needs to be passed onto the medical team. Discussion with the pharmacist may facilitate this. If for any reason it is not possible to administer the medicine then the following guidance should generally be observed, but if the administrator has any concerns they should seek further advice, from the prescriber, pharmacy or the BNF, especially where the prescription is for four hourly administrations.

Prescription	Guidance
Once a day medicines	Administer the missed dose as soon as possible, up to 12 hours after the prescribed time.
Twelve hourly medicines.	Administer the missed dose as soon as possible, up to 6 hours after the prescribed time.
Eight hourly medicines	Administer the missed dose as soon as possible, up to 4 hours after the prescribed time.
Six hourly medicines	Administer the missed dose as soon as possible, up to 3 hours after the prescribed time.
Four hourly medicines	Administer the missed dose as soon as possible, up to 2 hours after the prescribed time.

7.1.5.4 Administration of medicines to adults with swallowing difficulties

This section offers guidance for safe administration of medicines to patients with swallowing difficulties, it covers oral and tube administration of medicines. If a patient has difficulty swallowing tablets/capsules the prescriber must consider the need for treatment. Consider- benefit of treatment, non-formulary request, potential long-term availability and cost implications. If available an

assessment by Speech and language therapist (SLT) should be completed and recommendations followed. Consideration should be given to the following:

- Is the swallowing problem likely to be short or long term?
- Is a licensed, formulary liquid formulation available?
- Is an alternative route (rectal, parenteral) available/appropriate?
- Does an alternative drug from the same class help address any of the above?
- Is enteral access available/needed?

Contact pharmacy to discuss if crushing tablet/opening capsule or use of enteral route is appropriate. Some advice is detailed below

Standard tablets

Ordinary release tablets are usually made by one or two methods, direct compression or wet granulation. A variation in the excipients used in the tablet formulation will affect the disintegration time of the tablet when it is placed in water. Several devices are available for crushing tablets. Use one per patient and care should be exercised to minimise risk of exposure to drug powder.

Soluble Tablets

A soluble tablet dissolves completely when placed in water to give a solution of the drug

Effervescent tablets

These tablets will effervesce and disperse when placed in water and must be fully dispersed before administration to allow gases to escape. Care must be taken with sodium content.

Dispersible tablets

Although designed to be given orally, dispersible tablets disintegrate in water to give particles that may or may not suspend in water. Not all are suitable for administration via fine bore tubes. Care with sodium content.

Buccal/Sublingual tablets

These medications are designed to be absorbed through the oral mucosa and therefore bypass the first-pass metabolism effects of the liver. These formulations are a useful alternative for patients who are nil by mouth or are unable to swallow, providing the patient is able to produce normal quantities of saliva. They are not suitable for administration via enteral feeding tubes as significantly reduced drug absorption will occur.

Modified Release Tablets

As a rule, these are not suitable for crushing or administration via enteral feeding tubes as the pharmacokinetic profile of the drug may change and result in excessive peak plasma concentrations and side –effects.

Hard Gelatin Capsules

Some capsules can be opened and the powder mixed with water. Some capsules contain granules rather than powder.

Soft Gelatin Capsules

These drugs are usually poorly soluble in water and are therefore contained in an oily solution within the capsule. These are not suitable for administration via an enteral feeding tube. It may be possible to pierce the capsule shell using a pin and squeeze out the contents, however, accurate dosing cannot be guaranteed. The volume contained in the capsule can vary depending on the brand used.

Enteric coated tablets

These tablets are given an enteric coating to protect the drug from degradation by the acidic conditions of the stomach or to reduce the incidence of gastric side-effects. Crushing these tablets and administering via enteral tubes in highly likely to cause tube blockage. Stomach irritation and a decrease in effectiveness may occur.

Cytotoxic tablets - Do not crush – avoid contact

Where the enteral route is appropriate – use the procedure below (section 3). Reassess the patient and their treatment as the patient's condition changes e.g. daily. Note- the implications of crushing tablets or opening capsules include:

- Modifying the product, rendering it unlicensed and therefore the UHB accepts liability for any adverse effects. N.B. Liability will rest with the person administering the medicine unless UHB procedures are followed.
- Change in stability of the product
- Change in drug absorption and therefore amount of drug that the patient receives
- Potential increased risk of adverse effects
- Health and safety risks to staff and/or patient handling the medicine
- Cross-contamination or infection risk if appropriate procedures are not followed.
- Administering Medicines in Soft Food

Crushed medicines or capsule contents may be administered with a small amount of cold soft food such as a teaspoon of yoghurt (care with dairy products and drug interactions e.g. quinolones, tetracycline) or jam. A small amount should be used to ensure the full dose is taken. Crushed tablets or capsule contents may taste very bitter; it can be helpful to mask the taste for patients taking these medicines orally by using strong flavours such as jam or blackcurrant cordial. Medicines should only be administered in food with the patients' knowledge and consent. Hiding medication in food is considered "covert administration" and is only permissible in certain circumstances following a defined process (see 7.2)

Procedure: administration of medicines by crushing tablets or opening capsules

N.B The use of an oral syringe or standard medicine pot is contraindicated for administering medicines to dysphagic patients (see below)

Obtain pharmacy advice on suitability and implications of crushing tablets/opening capsules for each medicine. Advice is available from ward pharmacist, medicines information (UHW Ext 42979) or if urgently required out-of-hours, the on-call pharmacist.

- Advice on preparation and administration must be documented on the drug chart (or supplementary chart if necessary- attached to the drug chart)
- Confirm dose (adjust if necessary) resulting from change in form.
- Where capsules are opened or an injection is to be given orally use a clean receptacle reserved for the specific patient.
- Where tablet is to be crushed use a tablet crusher reserved for the specific patient (and wash thoroughly between uses). Crush to a fine powder.
- Add 10-15ml sterile water to the crushed tablet, capsule powder or viscous injections to make an appropriate solution or slurry. Check the appropriate consistency that Speech and Language assessment advised e.g. normal/syrup/custard thickness.
- Consider whether administering medication from a medicine spoon or Kapi cup is most appropriate for the patient (obtain advice from speech and language therapist if necessary). N.B syringing medication orally is contraindicated in dysphagic patients as it can increase risk of aspiration. The standard medicine pots are also contraindicated in dysphagic patients due to increased risk of aspiration associated with tilted back head position.

Unless advised by pharmacy otherwise, administer each medication separately. Do not mix any medications prior to administration. Administer immediately after preparation and ensure the full dose has been taken.

Procedure: administration of medicines via enteral feeding tubes

Do not administer medicines via tubes that are being used for aspiration or are on free drainage.

- Where a multi-lumen tube is in use, ensure the medicine is administered via the lumen with the correct output position. Ensure any other ports are closed and airtight.
- Ensure the prescription chart indicates the appropriate route of administration (if not- contact the prescriber).
- Ensure the enteral feeding tube is patent.
- Stop/suspend any enteral feed which is running. Consult pharmacy for advice on appropriate timing intervals
- Flush the feeding tube with 30ml sterile water.
- Draw medicine into an oral/enteral syringe of suitable volume. A parenteral syringe must not be used.
- Ensure an airtight connection of syringe to the enteral tube.
- Administer each medicine in turn, flushing the tube with 10-20ml of water between medicines. The volume used should reflect the diameter of the lumen to prevent build up on the inner wall of the tube but take care with fluid-restricted patients.
- Flush the tube with 15-30ml of water on completion.
- Restart the enteral feed where appropriate

7.1.5.5 Administering cytotoxic medication

Cytotoxic chemotherapy can only be administered to patients by those specific health professionals authorised to administer cytotoxic chemotherapy by the C&V UHB**.**

7.2 Administration via the intravenous route

Practitioners (including doctors, dentists, nurses and other health professions) are permitted to administer intravenous medicines provided they have received UHB delivered or endorsed appropriate education, training and assessment of competence. All intravenous medicines and fluids should be prepared and administered in accordance with C&V UHB approved local procedures (**See Chapter 8**). Practitioners can only administer intravenous cytotoxic chemotherapy as set out in Chapter 8.

7.3 Covert administration

The covert medication guidance, decision tool and record is on SharePoint in 'Resources for Nurses' and can be located via the following link:

FINAL_V 1.2 COVERT MEDICATION ADMINISTRATION GUIDANCE AND DECISION TOOL.doc (sharepoint.com)

The flowchart can be located via the following link:

COVERT MEDS FLOWCHART 28SEPT.doc (sharepoint.com)

There may be times when a patient needs to be given medication covertly – i.e. without the patient's knowledge. It may be lawful to do this where:

- The patient is detained under the Mental Health Act 1983, the treatment is for a mental health disorder and the Consultant considers that it is necessary for the medication to be administered covertly, or
- The patient lacks mental capacity either to consent to, or to refuse medical treatment, but will not accept it. In these circumstances, treatment can be given to the patient covertly if the decision to give it has been made in accordance with the Mental Capacity Act 2005 (MCA).

The impact on the patient of the covert administration of medicine must be considered carefully, as part of the best interests' decision-making process. This is because the patient may regain capacity, understand what has been happening and lose trust in staff.

Given the risk of a breakdown in trust, the covert administration of medicines is likely to be appropriate only when the patient is unlikely to regain capacity to consent to or refuse the medicine. Covert administration of **any** medication (not just sedatives) can only be given in exceptional circumstances This applies to all employees of the UHB who may be involved in decisions about and/or the administration of covert medicine to patients of all ages. This includes locums and staff on honorary contracts.

A recent Court of Protection case regarding Deprivation of Liberty Safeguards (DoLS) considered at length the issue of covert administration of medication. This case has implications for all Clinical Boards within the UHB, Primary Care and the Supervisory Body (DoLS). The ruling from the Judge with regards to the covert administration of medicines to a 92-year-old woman in a care home included

- that covert medicines were being administered without any proper reviews or safeguards being in place, and
- the administration of covert meds contributed to the situation where the patient was being deprived of her liberty

He went on to say that:

- Covert medication can only be given after a best interest decision has been made, by involving relevant professionals and family members, and
- If the decision is made to give medication(s) covertly, a management plan to do this must be drawn up, including provision for regular reviews

The following sets out the issues to be considered/action taken when clinicians believe that covert medication may need to be given.

1) Covert medication can only be administered (except under Mental Health Act 1983) where
    - the patient lacks mental capacity to consent to/refuse the medication, and
    - does refuse it, and
    - it is felt to be essential for the patient's health, and
    - the circumstances are exceptional (see Nice Guidance)

2) Before the medication can be administered covertly (unless in an emergency), a best interest decision must be made involving the relevant healthcare professionals and the patient's family/friends. If the patient already has a DoLS authorisation, then the Relevant Person's Representative (RPR) must also be involved and the Supervisory Body informed in order to carry out a review.

3) If the patient (in a hospital or care home) is not already subject to a DoLS authorisation, clinicians must assess, using the DoLS Proforma whether an application for DoLS authorisation should be made, as the use of covert meds is an aspect of *continuous supervision and control*. If the patient is in their own home, Local authority legal advice must be sought.

4) If it is agreed that covert administration of medication is in the patient's best interests, then this decision, together **with details of the individual medication**(s), must be clearly and fully recorded in
    - the medical and/or care home records
    - any best interests assessment (DoLS)
    - any DOLS authorisation

5) If there is disagreement, then legal advice must be sought.
6) A management plan must be agreed and drawn up, to include timeframes and review frequency. It must specify that if medication is to be changed, a further review of the use of covert medication must be held and the Supervisory Body informed.
7) Reviews must involve the relevant healthcare professionals, the patient's family/ friends and the RPR (if in place).
8) Conditions should be included in any DoLS Standard Authorisation regarding the use of covert medication and timescales of reviews.

7.4 Self-administration – Patient Orientated Medicines System (POMS)

Cardiff and Vale UHB is committed to the continued improvement of patient care. The POMS is regarded as the model for best practice in medicines management for hospitals. It provides substantial benefits for patients and hospitals. The opportunity for self- and/or supervised administration of medicines allows: -

- Improved opportunity to clarify regular medication and inform the therapeutic management plan.
- Difficulties with self-administration of medicines to be identified during the hospital stay.
- Improved opportunity to educate patients on their drug treatment
- Increased patient understanding and reduced potential for re-admission due to medication error.

POMS facilitate and support the appropriate use of patients own medicines and self-administration whilst in hospital. The aims of the POM system are:

- To ensure that the patient, where able, understands their medication plan and is involved in their medicines administration at the appropriate level whilst an inpatient.
- To ensure that the patient is fully prepared for discharge.
- To avoid duplication of prescription dispensing and reduce waste.
- To facilitate continuity of prescribed medicines between primary and secondary care settings.
- To limit unnecessary changes to long term medicines treatment.
- To improve the quality of information to the patient and all relevant parties within the medicines management process

Most of the medicines brought into hospital by patients, where POMS is not in place, are destroyed due to a lack of storage facilities or the systems to ensure they are safely returned to the patient. Utilising patients own medicines whilst in hospital can help to reduce prescribing errors as well as avoiding duplication of supply. Costs are kept to a minimum and waste reduced. People at home usually administer their own medicines. With the appropriate assessment it is logical for patients to have access to and administer their own medicines. Nurses play a major part in education of these patients to ensure the safe and effective use of the medicines, to allow self-medication in hospital to develop further. For the purposes of this procedure, the word medicine describes any medication that the patient has already used or, with appropriate support would reasonably be expected to use at home.

Using Patients own medicines

Patients should be encouraged to bring in their own medicines. All patients should be asked if they have brought any medicines with them, any medicines remaining at home should where possible be brought in. All medicines must be locked in the patient's bedside cabinet, or temporarily in another secure location e.g. in admissions areas where cabinets are not available.

Medicines brought in from home remain the patients property and consent must be sought and given for their continued use in hospital or, where appropriate, destruction.

Patients have the right to refuse consent for continued use or destruction. Where destruction is advised, due for example to medicines being no longer required or expired, patients should be advised of the associated risks.

Medicines will be assessed for continued use using the suitability criteria set out below. This can be done by a pharmacist or medicines management technician on their next routine visit.

A nurse may administer patient's own medicines prior to them being assessed formally by pharmacy if they are satisfied of their suitability using the criteria below.

- Medication must be clearly labelled with, the name of the patient, the name and strength of the medicine the date dispensed (this should be less than 3 months ago)
- Where dosing instructions are given they should be current and correct.
- If the medication has not got a patient specific label, it should not be used unless it is a) in a blister pack with a clearly marked expiry date or b) is a clearly identifiable medicine in an original container, with an expiry date.
- If the medication has a short shelf life (e.g. GTN tablets, eye drops) or if they require storage in a fridge, check their use with the patient and use individual judgment.
- Appearance of the container, label and medicine should be acceptable, i.e. intact, clean, with no visible signs of deterioration.
- Check with patient that the medication has been stored properly. If in doubt do not use.
- If patient's medication is provided in a compliance aid, e.g. Dosette, the medicines may only be used if the patient is self-administering at level 3 and there have been no changes to the medicines regime.
- Medicines should be discarded and returned to pharmacy with the patients consent if, the expiry date has been reached, medicines are in poor condition or mixed in one container.

Professional discretion should remain the overriding factor in assessing suitability of medicines.

Storage of medicines on POMS wards.

Supplies of oral medication for all patients are kept in a locked cabinet attached to their bedside locker. Each cabinet will have a lock operated by a single key, or key code. A master key/ master code system will be in place for nurse administration/ stock renewal etc.

It is the responsibility of the registered nurse to remove medicines no longer required from the patient's medicine cabinet.

Overall responsibility for the safety and security of patient medicines cabinets and medicine cupboard keys/codes, lies with the ward manager. The nurse in charge will hold the master key/be responsible for code system.

Each ward may have up to 4 master keys, for use by team nurses at the discretion of the ward manager nurse. These master keys must be on the nurse's person or locked away at all times. Ideally a shift by shift handover of keys should be done to account for the whereabouts of the keys. Procedures must be in place in order to ensure code systems remain secure, this includes identifying which staff have access to the codes, and when codes need to be changed, and who's responsible for change.

Patients assessed as self-medicating (level 3 discussed in section 4) can be given the individual key/code to their patient medicines cabinet. They must be made aware of the need to keep the key/code out of sight and to return it to the nurse on discharge; however, it remains the responsibility of the nurse to retrieve the key/code from the patient on discharge.

Patients at Level 1 and 2 must not be given access to the key/code to their medicines cabinet.

If keys are lost or the code system is breached, every effort must be made to ensure the system remains secure. If this is not achievable this must be reported via the clinical incident process

Ordering of replacement/duplicate keys/code systems must be made via the appropriate source, please discuss with the Nurse Advisor Medicines Management.

Supply of medicines from pharmacy will occur in the following ways:

Stock

A technician will be assigned to top up the stock cupboards at least once a week, there will be two types of stock:

- Labelled POMS pre–packs of medicines used frequently in the area. The nurse must complete the label with the patient's name and date and then place in the patient's medicine cabinet.
- Stock packs – frequently used medicines, these are for use in one off or PRN dose administration, (and issuing a pre-pack may be wasteful). The stock packs do not have patient's labels on them and must never be placed in the patient's medicine cabinet.

Patient's own medicines

If a patient has brought medicines into hospital that are deemed suitable for continued use they will be placed in the cabinet and used to administer. When re-supply is indicated, if the medicine is not

available as a POMS pre-pack a supply will be dispensed from pharmacy with a label with patients name and dosing instructions. There will be at least 7 days supplied.
NB when individual supplies arrive from pharmacy it is the registrant's responsibility to place the item in the patient's medicines cabinet.

Staff Education.
It is the responsibility of the Ward Manager/Clinical Lead, to ensure that the registered staff working in their ward have been appropriately trained to work within POMS.
It is the responsibility of the registrant to identify to the Ward Sister/Charge Nurse/Clinical Lead if they require training or updates. A register of staff who have received training should be kept locally.

Medicines Administration on a POMS ward
All patients admitted to an area where POMS is in place must be assessed using the identified assessment chart (in the UHB risk assessment document). A patient specific plan for appropriate re-assessment must also be identified. NMC Standards for Medicines Management, states that the responsibility for this assessment lies with the registrant. The assessment process ensures that the patient is placed at the right level and this minimises risks associated with self-administration.

- Level 1: Registered Nurse Administration.
  Registrant administers medicines giving full explanation to patient. The patient does not have access to the key. The registrant initials the drug chart as appropriate at time of administration.
- Level 2: Patient Administration under Supervision.
  The patient administers medicines but under the supervision of the registrant.
  The patient does not have access to the key. The registrant initials the drug chart as appropriate at time of administration.
- Level 3: Patient Administration without Supervision.

The patient is happy to self-administer their medicines, signs consent and continues to administer their own medicines without supervision and is given a key to their cabinet. The registrant is responsible for checking that the patient is aware of any changes to regime and is compliant and happy to continue. The registrant is required to sign the prescription chart at least once in 24 hours to demonstrate this has been done. The registrant is responsible for acting upon a patient's changing condition and move the patient to the appropriate level – NB Patients can move up or down a level.

Patient Education.
The NMC state that patient education is the professional responsibility of the nurse, in conjunction with the pharmacy and medical team. All patients must receive information regarding correct use of their medicines before commencing a self-administration scheme and prior to discharge. Knowledge should be checked and reinforced throughout the process. The information can be verbal, written and where appropriate a combination of both, it should include

- The name of the medicine.
- The purpose of the medicine.
- The dose and frequency of the medicine.
- Any special instructions Possible side effects.
- Duration of treatment.

The Medicines Reminder Card is designed as a prompt to patients and is important when patients are self-medicating and at discharge to aid compliance. It is not a prescription, and patients must be encouraged to refer to the medication label for instruction.

The Medicines Reminder Card should be completed by the registrant caring for the patient. The content of the card must be fully discussed with patients who have been assessed as Level 3 before starting self-medication. The card must then be checked and, where required, updated at least once in 24hrs, and after every prescribing change. The medicines reminder card should be made available with the patients in patient medicines chart, for checking by the Pharmacist. On discharge the card should be discussed with patients as their condition allows.

At discharge wherever possible the card should be available with the TTH to be checked and signed by the Pharmacist. If the card is not present with the TTH or unavailable then a check against the TTH and drug chart must be made by the registrant responsible for discharge and signed accordingly.

Controlled Drugs

Patients assessed as being at Level 1 or 2 follow the UHB Policy for Safe Ordering, Storage and Administration of Controlled Drugs. Patients assessed as being Level 3 can self-administer oral controlled drugs if their regime is stable. CD's brought in by patients can be assessed for suitability for continued use. If a hospital supply is required for self-administration a TTH must be generated and a maximum of 14 days will be supplied. Whilst the CD are the patient's own medicines and they are responsible for them, appropriate assessment will minimise associated risks. A dose by dose record will not be made in the ward CD register.

Transferring Patients.

Lockers with medicines cabinets attached should not be transferred to another ward as the assigned master keys for the receiving ward may be different.

When a patient is moved to another ward please follow the following steps:

- The registrant must remove all the medicines from the patient's medicine cabinet.
- The medicines should be placed in a pharmacy bag. These are available on POMS wards and usually used when patients are going home.
- The medicines should be taken with the patient and given to the registrant receiving the patient on the new ward.

- The medicines should then be placed in the patient's medicine cabinet if a POMS ward, or in the ward medicines trolley.

Discharge Medicines.

A TTH must be written when a patient is being discharged, this must be clinically checked by a pharmacist. Pharmacy staff will then check the patient's medicines on the ward for suitability and length of supply. This process will normally be instigated by your ward pharmacist, or by bleeping the discharge pharmacist for your area.

- You may occasionally (e.g. at weekends, or for unplanned discharges) be asked to send the discharge advice letter (DAL, or TTH) with all medicines from the patient cabinet and the in-patient drug administration record and any associated supplementary charts to Pharmacy, but you should only do this if specifically requested to by pharmacy staff.

NB – It is the responsibility of the discharging registrant to complete a final check of the discharge medicines against the TTH before the patient leaves. This check should be done with the patient wherever possible.

Non-availability of medicines

If the pharmacy department is advised by a supplier of the unavailability of a medicine it will communicate this information to medical and nursing staff as soon as possible. The pharmacy department will seek availability of any alternative that could be used. It is helpful to medicine users to know if the supply interruption is short or long term so that all avenues can be considered for temporary or long-term therapeutic options.

Medication is an essential part of a patient's treatment and it is important that they receive their prescribed medication in a timely manner. This Code also covers those instances when the medication is not on the ward for administration at that appropriate time.

7.5.1 Non-availability during pharmacy department opening hours

When medicines are newly prescribed for any patient, ward staff should consider if the medicines are on the ward stock list or not. If not, then they should bring this fact to the attention of the pharmacy staff providing services to the ward. If the item is urgently required, and no pharmacy staff are available, then ward staff should order the medicine from the pharmacy dept by using the appropriate medicines requisition form or local hospital pharmacy ordering system.

Newly admitted patients should have their medicines reconciled by a member of the pharmacy staff, which will include an assessment of which medicines need to be supplied. If any medicine is unavailable from the pharmacy department, then it is the responsibility of the pharmacist to inform the ward staff of that fact, and to discuss the options e.g. wait for the original patient's medication to be brought into the hospital or arrange for a prescription change to a formulary medicine.

7.5.2 Non-availability when pharmacy is closed

If a medicine to be administered to a patient is unavailable, then a decision must be made by the staff looking after that patient as to the urgency and necessity of the patient having that medication. If a decision is made that the medication is required to be given before pharmacy reopens, then the ward staff must ensure that every effort is made to find an alternative way of obtaining it.
Medications which are likely to be urgent are:

- Intravenous Medicines
- Medicines to treat acute symptoms e.g. chest pain and agitation
- Antibiotics
- Steroid
- Anticonvulsants

Check the stock holding in the hospital's emergency room/cupboard on the intranet/printed list, then follow the local procedure for access to this supply. Take full packs from the emergency medicines room/cupboard and make a record what has been taken.

Ask the advice of the senior nurse on duty within the hospital to check about the possible availability of that medication on other wards or units within the hospital. Obtaining a supply of medication from one ward to another should only be carried out with the consent of the senior nurse on duty within the hospital. For Controlled Drugs Record (see Section 9.8.1). If neither of the two options above enables supply of the urgent medicine then contact the Emergency on call Duty pharmacist in accordance with local procedures, who may recommend an alternative, or make a supply.

For the community hospitals a WP10 (HP) can be written and dispensed locally, or in exceptional circumstances the Emergency Duty pharmacist may be contacted in accordance with local arrangements.

7.5.3 Administration error – see 6.2.6

If a medicine is administered in error, the person administering the medicine must report the incident to the medical team responsible for the patient's care so that the situation can be assessed and determine that any appropriate medical action is taken. The medical team will inform the patient of the incident. The person administering the medicine must report the incident to their line manager. A clinical incident entry on Datix must be completed

Chapter 8 - Administration of Intravenous Medicines

The National Patient Safety Agency (NPSA) issued guidelines to promote the safer use of injectable medicines resulting from reports made to NPSA of errors and incidents in the use of injectable medicines. Developments in intravenous medicines have introduced precise reconstitution and administration techniques to ensure maximum efficiency of the medicine and minimise harm to the patient. The essential theme of these guidelines is that all staff involved with intravenous medication should be trained and sufficiently knowledgeable and competent in dealing with intravenous medication. The staff should also have guidelines, information and support in respect of the medication to ensure the correct prescribing, preparation, administration and monitoring of injectable medication at all times.

Epidural injections are clearly not for intravenous use, but the principles applied to training, prescribing, preparation, labelling and administration of IV medicines apply.

8.1 Professional responsibilities and accountability

Practitioners holding registration with their professional regulatory body are accountable for their actions and omissions. When administering intravenous medication staff must exercise their professional judgment as to their knowledge and experience in dealing with each individual medication. Where an individual member of staff is unfamiliar with a particular medicine and/or has little or limited experience in administration of the medicine the individual must refer back to the prescriber or the pharmacy department for more detailed information. This information is also available from the electronic source The Injectable Medicines Guide (Medusa). Practice set out within this policy will apply to all practitioners/ staff who are involved in the prescribing, administration and safe handling of intravenous medication within the Health Board.

Each Clinical Board must ensure that all staff that are or may be involved in intravenous medication are:

- Able to access all policies, procedures and guidelines approved by C&V UHB for the use of intravenous medication.
- Given the appropriate level of training, retraining and competence assessment which must be recorded for their involvement with intravenous medication.
- Given information as to any medicine or device alert concerning intravenous medication, device or consumable which may be used in administering intravenous or parenteral medication within C&V UHB.
- Staff that administer cytotoxic intravenous chemotherapy and cytotoxic medication by other routes, must demonstrate that they have undertaken approved training.

8.2 Training and competency for IV and other routes of parenteral administration

All staff involved in the use of intravenous and other routes of parenteral medication must be trained and competent in all roles that they may undertake concerning parenteral medication. Within C&V UHB training programmes are in place to ensure that all aspects of intravenous medication usage are covered to include:

- Prescribing
- Preparation (including calculations)
- Labelling
- Administration
- Checks involved throughout the process (who and when)
- Devices used for administration
- Monitoring requirements
- Disposal of waste material
- Risks of using intravenous medication and how to minimize them
- Standard information sources available to Health Board staff concerning intravenous medication

C&V UHB, through its Learning and Education Department, has set up a scheme to ensure that all staff involved in any aspect of intravenous medication has undergone the training and is deemed competent. The names of those deemed competent can be recorded on a database, but as a minimum will be recorded in the staff members personal file. As part of the All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal a review of competence will take place every three years and where there has been a practice gap of 12 months or more.

Competence for administration of adult chemotherapy will be set out in standard operational procedures of the C&V UHB. Administration of intravenous chemotherapy is limited to professionals who have completed the identified training and demonstrated competence.

8.3 Prescribing intravenous medication

Medicines should only be given by the intravenous route when the practicality and appropriateness of other routes has been excluded. The use of this route should be regularly reviewed in favour of switching to oral administration (or another route) as soon as clinically appropriate. When two or more patient medication records (prescription charts) are in use, it is essential that they are cross referenced so that practitioners are aware of all prescribed medicines. To ensure safe practice prescriptions for intravenous medication must specify the following:

- The allergy status of the patient
- Patient's name
- Prescribers signature

- The medication using approved name (in certain circumstances the brand and formulation
- The dose and frequency
- Date of initiation and route of administration
- Concentration or total quantity of medication in the final infusion container or syringe
- Name and volume of diluents and/ or infusion fluid to be used
- Rate and duration of administration
- Stability information to determine expiry date of the final product
- Type of pump or device number being used
- For children the age and weight should be specified
- Date for treatment review
- What clinical monitoring should take place, how often and for how long, (See product characteristics and e- Injectable Medicines Guide)

The use of a normal saline flush (sodium chloride 0.9%) (only), is considered an essential part of cannula care and intravenous medication/fluid administration. It should therefore be considered as inclusive in the prescription of intravenous medication/fluid and a separate prescription is not required.

8.4 Storage of intravenous medication

The storage of intravenous and other parenteral medication (except large volume infusions) stocked on a ward or department must be in the appropriate locked pharmacy cupboard or fridge. Any medication issued for individual patients that require special storage will have this highlighted on the pharmacy label.

8.5 Preparation of intravenous medication

Whenever possible ready prepared injections, infusions or Centralised Intravenous Additive Service products (CIVAS) should be used. If any extra manipulation or medication addition is required then the staff involved must ensure that they are familiar and competent to carry out the preparation of this particular intravenous medication. Preparation and administration requires two registrants, (see section 7.1.3).

8.5.1 Student Nurses

For guidance, refer to the All Wales Practice Learning Framework (2023). The student Nurses scope of practice for all medications including the reconstitution and administration of IV medications under the direct supervision of a registrant following in-point assessments can be located in Appendix 2 .

- Read all the prescription details carefully and confirm that they relate to the patient to be treated
- Confirm that the details on the prescription are correct e.g. dosage, diluents, concentration rate of administration and that the patient is not allergic to the medicine or any of its components
- Ensure that the area to be used for the preparation is clean and clear of clutter. Ideally this should be a dedicated area just for the preparation of intravenous medication
- Assemble all the equipment and infusion devices required including flushes if they are required. Process the preparation using a non-touch technique (ANTT), i.e. avoid touching areas where bacterial contamination may be introduced e.g. syringe tips, needles and vial tops.
- Prepare the label (see below)
- Beware of confusion due to similar names and/ or packaging, by reading the labels carefully.
- Check expiry date of all the materials and medication used Check for damage to containers, vials, ampoules and packaging Confirm that the materials have been stored correctly Complete any calculations. These should be written in the patient's notes and checked by an independent practitioner who is competent in the administration of that intravenous medication.
- Hands must be cleaned according to the control of infection guidelines
- If a giving set is required it should be attached using the technique appropriate for the type of container. The line must be primed in accordance with nursing procedures.

8.6 Labelling of intravenous medication

All injections and infusion additives must be labelled after preparation. Under no circumstances should a practitioner have in their possession or vicinity two or more unlabelled syringes at the same time. If the syringe is to be administered via a pump device then it must be labelled in a manner not to conceal the syringe calibrations or as to otherwise affect the function of the pump device. In Line with NPSA Guidance Labels for intravenous medicines should clearly state the following information

- Name of the medicine
- strength
- route of administration
- diluent and final volume
- patient's name
- expiry date and time
- name of the practitioners preparing the medicine.

8.7 Infusion devices for intravenous medication

All infusion devices in use within C&V UHB must be of a type that has been approved. Staff who use a particular device must be familiar with the function and limitation of each device that they need to use and ensure that the device is suitable for administration of the medication or diluent that is being used. Additionally, staff must be aware of the compatible giving set/s which can be used safely with that device. All staff using infusion devices must have received appropriate training for use of that particular device and have been shown to be competent in the use of that device.

8.8 Administration of intravenous medication

Before administering any intravenous medication a practitioner should be aware of any monitoring of the patient that is necessary after the medication is administered, and then check the following:

- Patient's name and hospital/NHS number
- Prescriber's signature
- The medication using the approved name (in certain circumstances the brand and formulation)
- The dose and frequency
- Date and route of administration
- The allergy status of the patient
- Check that the medication is free of haziness, particles and discoloration.
- Concentration or total quantity of medication in the final infusion container or syringe.
- Name and volume of diluents and/ or infusion fluid to be used
- Rate and duration of administration
- Stability information to determine expiry date of the final product
- Type of pump to be used
- For children the age and weight should be specified
- Date for review of treatment
- That the medication is due at that time and has not already been administered.

The person administering the medication must record the administration as soon as possible after the event in the appropriate patient record and a 3rd signature should be obtained from a student nurse if they have been involved in the reconstitution/administration process. Ask the patient to report any soreness at the injection site or any change in their well-being. When an infusion is running, it should be regularly monitored by a competent member of staff who has undertaken the appropriate competence training. Administration of intravenous medication requires two registrants see section 7.1.3.

8.9 Patient monitoring with intravenous medication

Prior to the administration of any intravenous medication the staff that will subsequently be looking after the patient must be made aware of any specific clinical requirements as to the monitoring of the patient, preferably this should be in the form of written details. Any of the results or findings from the monitoring must be documented within the patient's notes and the prescriber informed of any deviations from the expected findings. The patient should be involved in helping staff by being made aware that they should inform staff of any changes in their well-being. The nurse who is looking after the patient will make frequent checks for:

- Signs of leakage from site or infusion bag
- Signs of infection or inflammation at the infusion site.
- Remaining contents of the infusion bag
- Rate of infusion.

Where particular risks are identified, these need to be clarified with the prescriber prior to administration of any intravenous medication.

8.10 Infection control and personal protective equipment

As parenteral medication is accessing the body directly bypassing the normal infection barriers, it is imperative that the control of infection and the maintenance of the medicines sterility are made a high priority by staff that are undertaking the preparation and administration of the product.
Guidance on Personal Protective Equipment is set out in the local Infection Prevention and Control Procedures.

8.11 Disposal of waste material

All waste must be disposed of in line with the C&V UHB policy on waste which must concur with current environmental legislation. Any material that has been in contact with the patient should be classed as hazardous clinical waste and disposed of via the standard method for clinical waste.
Any item deemed as 'sharps' should be disposed of by being placed in a 'sharps' bin even if they have a small amount of medication left inside them.
Non-controlled and non-cytotoxic medicines that remain in their original foil packaging, should be disposed of in a blue box waste bin – all patient identifiers must be removed and the cardboard boxes can be discarded in a recycling bin.
Empty infusion sets can be placed in the yellow/orange clinical waste bags or in 'sharps' boxes.

For guidance on disposal of Controlled Drugs see chapter 9. or Guidance on disposal of Cytotoxic Chemotherapy Agents see Management of Parenteral Cytotoxic Chemotherapy Policy.

8.12 Responsibilities of the pharmacist and the pharmacy department

The Pharmacist providing clinical services to a clinical area and its patients shall:

- Ensure that a risk assessment is carried out on every new intravenous medication and, whenever possible a ready to use dosage formulation of the medicine is purchased in preference to any injection that needs manipulation prior to administration.
- Provide Information and advice is provided to all health care professionals on the administration of intravenous medication.
- Assist with the training of staff.
- Ensure that staff are aware of how to access the agreed standard references for intravenous medication.
- Ensure that all guidance produced for the prescribing and administration of any intravenous medication has been approved appropriately

8.13 Identifiable risks with intravenous medication

The following list is not exhaustive but includes some common general risks:

- Incomplete and unclear prescriptions that do not contain vital information concerning
- the dose, preparation or administration which can lead to possible errors and
- increased risk to patients.
- Administration of medication by the wrong parenteral route i.e. giving medication by
- the epidural route when the correct route should be intravenous.
- Absence of relevant and accurate information concerning intravenous medication
- Complex calculations needed for prescribing the correct dose, infusion rate or
- preparation of dilution for intravenous medication. Calculations should be
- independently double checked by a second registrant.
- Involvement of inexperienced staff (e.g. registrant or students in training) in some
- parts of the process.
- Selection of wrong medication or diluent.
- Use of expired items.
- Unsafe handling of toxic medication or non-aseptic technique leading to infection.
- Failure to correctly identify and confirm identification of intended patient incompatibilities between medication, diluents, other medication and infusion sets or devices.

Chapter 9 – Controlled Drugs

This chapter will ensure that the UHB has a robust framework in place for the management of controlled drugs (CDs) in secondary care.

9.1 Accountability

C&V UHB has identified the Executive Medical Director as Accountable Officer to be responsible for all aspects of the safe and secure management of CDs.

9.2 Roles and responsibilities

It is the responsibility of the Clinical Boards to ensure that their staff are trained and competent to carry out the tasks required of them in the management of CDs.
The registered nurse, midwife or clinical lead in charge of a ward or department is responsible for the safe and appropriate management of CDs in that area.
The practitioner in charge can delegate control of access (i.e. key-holding) to the CD cupboard to another registered nurse, however, legal responsibility remains with the practitioner in charge. Whilst the task can be delegated, the responsibility cannot.

On occasions, for the purpose of stock checking, the CD key may be handed to a pharmacist or pharmacy technician on production of a current UHB ID badge.

If CD keys go missing, urgent efforts must be made to contact staff who have just gone off duty. The senior nurse on duty must be informed immediately and the pharmacy department when they next open if the keys are not located.

A duplicate set of CD keys must be supplied to the pharmacy department who will keep them secure. In the event that a set of keys goes missing and cannot be located the practitioner in charge should contact the pharmacy department or on-call pharmacist for advice. If necessary the duplicate set can be issued by the pharmacy or site practitioner.
The senior nurse on duty must sign for the duplicate set.

If the original set of keys is located, the duplicate must be signed back into the pharmacy. If the original keys are not found, the locks must be changed as soon as practical, and a duplicate set of the new keys given to pharmacy. An entry of the incident should be completed on Datix.

When the locks on the CD cupboard need changing for reasons other than lost keys, a duplicate set must also be provided to pharmacy. An authorised signatory is a qualified nurse, midwife or operating department practitioner (ODP) whose signature has been provided to pharmacy.

9.3. Controlled Drug Stationery

All stationery which is used to order, return or distribute controlled drugs must be stored securely and access to it must be restricted.

CD stationery (i.e. requisition books and registers) will be issued from pharmacy against a requisition that will be written by an authorised signatory from that ward or department.
Stationery will not be issued against a signature that is not on the authorised signatory list.

A record will be made of CD stationery supplied by pharmacy.

The record will include:

- Date
- Ward/department
- Name of person ordering the stationery
- Type of stationery issued
- Quantity
- The serial numbers of the stationery – to be added at the time of issue
- Signature of the member of pharmacy staff making the supply
- Signature of the member of ward staff receiving the stationery

Loss of any CD requisition books must be reported to the pharmacy and an incident form, eDatix completed by the area responsible for the loss of the requisition book as soon as possible following recognition of the incident.

When a new CD register is started, the balance of CDs in stock must be written into the new book promptly by a registered nurse and witnessed by a second nurse or another registered health professional. It is good practice to write the start date on the front cover.

Completed ward requisition books and CD registers must be retained for a minimum of two years from the date of the last entry by the ward or department. When the CD register is complete, write on the cover a date 2 years on from the last entry. This is the date that the register can be appropriately disposed of as confidential waste.

Other requirements for the retention of CD records are listed below:

- Aseptic Worksheets (paediatric) – 26 years
- Aseptic Worksheets (Adult) – 13 years
- Clinical trials – 5 years

- Destruction of CDs – 7 years
- External Orders and delivery notes – 2 years
- Extemporaneous preparation worksheets 13 years
- Prescriptions (inpatients and outpatients) 2 years

9.4. Storage of Controlled Drugs

Ward CD cupboards must conform to the British Standard reference BS2881 or be otherwise approved by the pharmacy department. This is a minimum-security standard and may not be sufficient for areas where there are large amounts of drugs in stock at a given time, and/or there is not a 24-hour staff presence, or easy control of access. In this case, a security cabinet that has been evaluated against the SOLD SECURE standard SS304 should be used (www.soldsecure.com)

Where a ward or department is to be closed for greater than 5 days, Controlled Drugs, requisition books, registers and keys must be removed from the ward and stored in pharmacy. The stock should be reconciled against the levels in the register by 2 qualified members of staff. Either 2 ward staff or a member of ward staff and a pharmacist or pharmacy technician can undertake this role. A record stating “Number returned to pharmacy XX” for each drug held in stock. The CDs will be stored in a sealed box securely in the pharmacy. When the ward or department reopens the stock will be returned and reconciled immediately against the register and an entry made in the register “Number returned to ward XX”.

The measures below must be observed for the storage of CDs:

- Cupboards must be kept locked when not in use.
- The lock must not be common to any other lock in the hospital.
- Keys must only be available to authorised members of staff and at any time the key holder must be readily available.
- The cupboard must be dedicated to the storage of CDs.

9.5. Ordering and Delivery of CDs

Controlled drugs must be requisitioned using the controlled drug order book and the requisition must be signed in full by the nurse who is an authorised signatory for that ward or department. The name of the nurse must also be printed on the requisition. A copy of the signature of each authorised signatory should be available in the pharmacy department for validation. Ward or department managers will be responsible for ensuring that new members of staff provide a specimen signature to pharmacy and inform pharmacy when members of staff leave in order that their names can be removed from the approved list. Pharmacy will coordinate an annual update of the records held.

Each order must be in duplicate, with the white page as the top copy and one item ordered per page. Requisitions must contain the following:

- Name of the hospital
- Ward/department
- Drug name, form, strength, ampoule size if more than one is available
- Total quantity required e.g. 5, 10 etc – not a number of boxes (i.e. one box). When quantities ordered do not correspond to a complete box the quantity will be altered by pharmacy to the nearest appropriate number.
- Signature and printed name of the registered nurse
- Date
- Signature of the person issuing from the pharmacy

The order book must be kept in a locked cupboard or drawer when not in use. Spare CD stationery must also be kept secure.

Each ward/department should only have one order book in use at any given time. If a ward/department has more than one controlled drug cupboard then a separate book may be used for each cupboard.

Orders for stock controlled drugs from the agreed ward stock list must be sent to the pharmacy before 10:00 a.m. Controlled drugs will normally be delivered to the wards by a porter at UHW and UHL.

Controlled drugs for departments or wards may be collected by a messenger who must be a member of UHB staff and bring an official organisational ID badge for identification. The messenger need not be a qualified nurse.
The messenger or porter transporting the controlled drug to the ward/department is responsible for the safe custody of the drug and must report straight to the ward/department when in possession of CDs, e.g. must not go and carry out another task until the CDs have been delivered to their destination. They must be received and signed for by the qualified member of staff.

Controlled drugs delivered by a messenger or porter must be checked immediately on arrival at the ward/department by a qualified member of staff. The pink copy of the requisition must be signed to accept the CDs onto the ward. On receipt, the CDs must be entered into the controlled drug (CD) register immediately.

The following details must be recorded on the appropriate page in the CD register:

- Date of entry
- Name and signature of nurse making the entry
- Name and signature of the witness
- Balance in stock
- The serial number of the requisition
- Quantity received
- New balance total

9.6. Emergency supply of Controlled Drugs

Under normal circumstances all supplies of CDs must be through the pharmacy department. If a controlled drug is required urgently for a patient when the relevant pharmacy is closed, the drug is not available on the ward and no other drug is a suitable alternative, then one dose may be obtained from another ward.

The ward requiring the dose must take their CD register to the ward providing the dose. The dose of the drug required should be signed out of the CD register on the providing ward and into the CD register of the receiving ward by 2 qualified members of nursing staff. The following must be recorded in both CD registers:

- Date and time when dose is transferred
- Name of patient
- Names & signatures of nurses who transferred the dose
- Quantity transferred
- Balance in stock in both CD registers

9.7. Return of Controlled Drugs to Pharmacy

Controlled drugs are returned to pharmacy for two purposes, safe destruction or recycling and re-use. The following must be recorded in the ward CD register when CDs are returned to the pharmacy

- Date
- Name and Signature of the nurse.
- The name and signature of the pharmacist or pharmacy technician accepting the CDs for return.
- The quantity of drug being returned.
- Reason for return e.g. out of date, excess stock Balance remaining.

On return to the Pharmacy, the pharmacist or technician who accepted the CDs for return and re-use must enter the CDs into the appropriate page in the pharmacy CD register immediately. The

stock must be booked back into the computer stock balance and a reconciliation of the balance on the shelf, the balance in the register and the balance on the computer be made. All 3 levels must tally. Any discrepancy must be investigated immediately.

The following details must be recorded on the relevant page of the pharmacy CD register:

- Date
- Ward from which the return is being made.
- The amount of preparation being returned
- The name and signature of the pharmacist or technician making the return.
- Balance in stock.

If the CDs are for destruction an entry must be made in the appropriate destruction register in the pharmacy - i.e. patient’s own or returned stock registers.

Patient’s own returns can be destroyed without the presence of an Authorised Person. The details required in the register are:

- Date
- The ward & the name of patient, if appropriate
- The preparation and quantity being returned
- The name & signature of the pharmacist/technician making the return
- The next reference number for destruction

If the CD is “date expired stock” for destruction it must be entered in the destruction register for this purpose and the above details recorded as appropriate

9.8. Prescribing Controlled Drugs

Inpatient Prescribing

For hospital inpatients, CDs can be prescribed on the inpatient medicines chart or the anaesthetics card in line with local policies and procedures.

The written requirements for controlled drugs on these charts are the same as for other medicines: if prescribed “when required” e.g. for breakthrough pain, a minimum interval for administration should be specified e.g. every six hours; and a total quantity to be administered in 24 hours.

Prescribing for Outpatients or discharge prescribing

Prescriptions for CDs for outpatients or discharge must comply with all the requirements of the Misuse of Drugs Act. Prescriptions must be written on a discharge form or an outpatient form. Doctors who have not achieved full registration with the GMC are permitted to prescribe CDs for patients on discharge but not for out-patients. Under normal circumstances a maximum of 30 days only should be prescribed. If there are compelling circumstances for the prescription of more than this duration then the reasons must be documented in the patient’s notes. A prescription for a controlled drug is valid for a period of 28 days from the date of issue.

Documentation and Prescription The prescription must be indelible i.e. written by hand, typed or computer generated. Addressographs may be used. If an addressograph is used, it must be tamper evident. Prescribers should also sign across a corner of the addressograph. This is a further safeguard to ensure addressographs are not tampered with or another addressograph is not placed on top of the one that the prescriber signed for.

The prescription must include the following details:

- The patient's full name, address and, where appropriate age
- The patient's hospital number
- The name and form of the drug e.g. tablets, capsules even if only one form exists
- The strength of the preparation, where appropriate
- The dose to be taken
- The total quantity of the preparation (liquids) or the number of dosage units (tablets, capsules, ampoule, patches) to be supplied in both words and figures

The prescription must be signed by the prescriber with his/her usual signature, in his/her own handwriting (this must be handwritten) and dated by him/her (the date does not have to be handwritten).

A pharmacist is authorised to dispense a prescription for a Schedule 2 or 3 controlled drug if it specifies the total quantity only in words or in figures, or if it contains minor typographical errors, provided that any amendments are indelible and clearly attributable to the pharmacist dispensing.

Nurse Independent Prescribers

Nurse Independent Prescribers are now able to prescribe any licensed medicine for any medical condition within their competence, including some CDs for specific conditions. Nurse Independent Prescribers are permitted to prescribe, administer, or direct anyone to administer as prescribed.

9.9 Administration of CD

Controlled drugs must only be administered against a prescription signed by an appropriately qualified prescriber, or in the case of midwives a relevant drug protocol. Two practitioners must be involved in the administration of CDs; one of them must be a registered nurse, midwife, ODP or doctor. The second can be one of these groups or a 2nd or 3rd year student nurse, except when checking intravenous drugs. The exception to using student nurses is in paediatrics where 2 registered nurses must administer the CD. Both practitioners must be present during the whole of the administration procedure.

They should both witness:

- The preparation of the CDs to be administered
- The CD being administered to the patient (except in the administration of CDs by Midwives attending a home birth where a midwife has collected the CD form the

Midwifery Led Unit, and single nurse practitioners in the community) The destruction of any surplus drug e.g. part of an ampoule not required

A record must be made in the ward or department CD register when a CD is removed from the CD cupboard. The following details must be recorded on the relevant page in the CD register:

- Date and time when dose administered
- Name of patient
- Quantity administered
- Name and signature of nurse who administered the dose
- Name and signature of the witness
- Balance in stock

If part of a vial is administered to the patient, the registered nurse must record the amount given and the amount wasted e.g. if the patient is prescribed 2.5 mg diamorphine and only a 5mg preparation is available, the record should show, "*2.5mg given and 2.5mg waste"* This must be witnessed by a second registered nurse who must also sign the record. If a second registered nurse is not available, the administration can be witnessed by any of the staff listed as appropriate checkers.

Individual doses of CDs which have been prepared for immediate administration but not administered must be destroyed by a registered nurse midwife or registered health professional on the ward or department in the presence of a witness who can be another registered nurse, doctor, pharmacist or pharmacy technician. The reason must be documented and signed in the CD register by the practitioner and the witness.

9.10. Disposal/Destruction of Controlled Drugs

CDs must be destroyed in such a way that the drug is denatured or rendered irretrievable so that it cannot be reconstituted or reused. Where denaturing is carried out on the wards, the methods used should be those currently recommended by the Royal Pharmaceutical Society. Any pharmacy held stock of obsolete, expired or unwanted Schedule 2 CDs, other than those returned by patients, which require destruction, may only be destroyed in the presence of an authorised person. Authorised witnesses currently include inspectors of the Royal Pharmaceutical Society, Police constable, the Accountable Officer and the Chief Pharmaceutical Officer to Welsh Government.

The Accountable Officer for the UHB can also nominate Executives of the organisation to witness destruction.

Until they can be destroyed, obsolete, expired and unwanted stock CDs requiring safe custody, must be kept segregated from other CDs in the CD cupboard. Stock CDs awaiting destruction should be clearly marked in order to minimise the risk of errors and inadvertent reissue or administration.

Small amounts of CDs, for example, the surplus when a dose smaller than the total quantity in an ampoule or vial is drawn up or when a dose is drawn up but not used, must be rendered irretrievable by emptying into a yellow top sharps bin. The emptied vial or ampoule must then be placed in the

sharps bin. When the bin is sent for destruction it should be labelled “contains mixed pharmaceutical waste and sharps – for incineration”.

Larger quantities of CDs, for example, discontinued infusions or patient-controlled analgesia (PCA) syringes, must be denatured on the ward using denaturing kits.

All destruction must be documented in the appropriate section of the CD register. It must be witnessed by a second professional such as a registered nurse, midwife or ODP. If any of the previously listed staff are not available to witness the destruction then a doctor, pharmacist or pharmacy technician may witness it. Both persons must sign the CD register.

Individual doses of CDs which have been prepared but not administered must be destroyed by a registered nurse, midwife or registered health professional on the ward or department in the presence of a witness and the reason documented in the CD register.

Controlled drugs that are time-expired or otherwise unfit for use (e.g. opened liquids) or are excess stock must be returned to the pharmacy for safe destruction.

If it is necessary to destroy the contents of a PCA/PCEA syringe that has been transferred to the ward, the destruction must be recorded in the CD register

9.11. Controlled Drug Registers and reconciliation of balances

The CD register must be bound with sequentially numbered pages and it should have separate pages for each drug, formulation and strength of formulation, so that a running balance can be easily kept. Entries must be made in chronological order, in ink or be otherwise indelible.

- If a mistake is made it must be bracketed in such a way that the original entry is still clearly legible. No crossings out or alterations are allowed. The entry must be signed, dated and witnessed by a second registered nurse, midwife or other registered professional. The witness must also sign the correction.
- On reaching the end of a page in the CD register, the balance must be transferred to another page. The new page number must be added to the bottom of the finished page and the index updated.
- The stock balances of all controlled drugs on all wards must be reconciled a minimum of once daily and a record of the check recorded. The registered nurse in charge is responsible for ensuring that the CD stock check is carried out by staff in the ward or department
- Original packs of CDs with intact tamper evident seals, do not need to be opened for checking purposes.
- If stock reconciliations do not balance, the matter must be reported immediately to the appropriate senior nurse manager who will inform a principal pharmacist/senior member of pharmacy team e.g. PSG bleep, or deputy at the earliest convenient opportunity. An investigation to confirm the loss will be undertaken by the senior nurse in conjunction

with the ward pharmacist if necessary. A formal incident form must be completed with advice to the Accountable Officer on escalation.

- The pharmacy department will carry out a full stock reconciliation on the wards and departments at a minimum of every six months. The quality of record keeping will also be assessed at that time and feedback on the quality of record keeping will be discussed with the nurse in charge. If necessary, recommendations for improvements will be agreed.
- All controlled drugs in the pharmacy must be checked every 12 months. This check may be undertaken by any competent person approved by the pharmacist with operational responsibility for CDs or a suitable deputy approved by the chief pharmacist.
- This check is in addition to the rolling checks on the CD register.

9.12 Use of a Patient's Own Controlled Drug on the ward

Temporary storage of patients' own controlled drugs on the ward may be necessary whilst they are awaiting collection and removal to the pharmacy or to the patient's home. In this situation, they must be placed in the CD cupboard but should be marked and kept separate from ward stock. An entry detailing the patient's CD must be made on Patients Own record of the administration of a dose must be documented in the CD register.

If patients' own CDs are not required for use during the patient's admission then one of the following actions should be followed and recorded in the CD register.

- If the patient or the patient's representative agrees, medicines may be sent to the pharmacy for safe destruction. The pharmacist must take responsibility for destruction. Document the agreement to destroy the drugs in the patient's notes.
- If the patient wishes, the medicines may be returned home via an identified adult. Responsibility for security is given to that adult and this action documented in the patient's notes. If the medicines are not safe and/or appropriate for use, then the patient and/or patient's representative should be advised and they should be encouraged to send them to the pharmacy for safe destruction. This must be documented as for any other CD returned to pharmacy.
- If a patient has brought in CDs and is awaiting assessment of competence for self-administration, the CDs should be held in the ward CD cupboard until the assessment is completed. A record of the CDs must be made on a page of the ward CD register headed Patients' Own CDs.
- In areas where the UHB Patients Own Medicine procedure (POMS available on Cav. Web) operates, self-administration of CDs is acceptable providing the following steps are undertaken:

- The patient must be assessed as competent to level 3 for self-administration in the POMS procedure
- Where patients require extra supplies, they must be dispensed as for discharge i.e. using a TTH form – discharge prescription form.
- Patients receiving CDs for self-administration should sign for receipt of the specified number of doses. A separate page of the CD register can be used for this purpose.
- The CDs for patients who self-administer their medicines must be kept locked in their bedside locker. It is not acceptable for patients self-administering CDs to keep them in any other place.

9.13. Controlled Drug discharge medicines (TTHs) and receipt of CDs by outpatients

When Schedule 2 CD TTHs are collected from the Pharmacy, the person collecting them will be asked to sign for receipt. They may be signed for by a healthcare professional, porter or a healthcare assistant.

The following details will be recorded in the CD collection register:

- The date, the name, form and strength of the drug and the patient's name
- The name and address of the healthcare professional collecting the CDs
- The form of identification provided by the healthcare professional e.g. identity badge or whether the messenger is known to the dispenser.
- The name of the member of pharmacy staff handing out the prescription

When an outpatient prescription is being given to the patient or their representative or relative the following details must be recorded:

- Whether the person who collected the drug was the patient, the patient's representative or a healthcare professional acting on behalf of the patient
- If the person who collected the drug was a healthcare professional acting on behalf of the patient, that person's name and address (as above)
- If the person who collected the drug was the patient or their representative, whether evidence of identity was requested. As a matter of good practice, a note as to why the dispenser did not ask may be included but this is not mandatory.

9.14. Transfers between clinical areas

When a patient on a PCA/PCEA containing a CD transfers between 2 clinical areas the following steps must be taken:

- The nurse/practitioner transferring the patient must make an entry on the PCA/PCEA observation sheet detailing the amount left in the syringe. He/she must sign and date the entry.

- A second practitioner must sign and date the entry as a witness.
- The nurse/practitioner accepting the patient in the new clinical area must check the contents of the syringe on receiving the patient and sign and date an entry on the PCA record which must be countersigned by the nurse/practitioner transferring the patient.

A patient transferring between 2 clinical areas on a sub-cutaneous syringe driver containing a CD must have a similar record of the amount remaining in the syringe made on the Sub Cutaneous Syringe Driver Chart.

Patients' own CDs stored in a ward CD cupboard should be transferred with the patient. The CDs must be signed out of the first CD register by two registered practitioners and into the second CD register by two registered practitioners.

9.15. Controlled Drugs for Midwives

Midwives working in the Consultant Led Unit on UHB sites must follow all the elements of this policy.

A registered midwife may possess diamorphine, morphine, pethidine and pentazocine in their own right so far as is necessary for the practice of their profession.

Midwives providing care for women during a home birth where pethidine is required will acquire the pethidine from the Midwifery Led Units (MLU) where stock for community use is stored. The procedures for administration will be followed. Midwives will carry the pethidine in a locked box on route to the woman's home. If the pethidine is not used the midwife will return it to the MLU stock and record this in the relevant CD register.

9.16. Receipt and handling of CDs by pharmacy

The is responsible for the safe and appropriate management of CDs in the pharmacy. Day-today management of CDs in the pharmacy will normally be delegated to a suitably-trained, competent registered pharmacy technician or pharmacist. However, legal responsibility for CDs remains with the Director of Pharmacy.

On receipt of a CD order from a wholesaler, the CDs must be brought to the member of staff in the purchasing section with responsibility for processing CD orders. He/she will take the following action:

- The delivery will be checked against the order and delivery note for accuracy.
- The delivery will be locked in the CD cupboard/room at the first opportunity.
- The quantity delivered will be checked against the delivery note and added to the balance in the register. The new total must be reconciled with the CD register and pharmacy computer system balance. All balances must be reconciled.
- When the balance is reconciled, the CD delivery must be entered into the CD register and onto the pharmacy computer system balance.
- If there is a discrepancy between the order and the delivery, the delivery should be locked in the CD room/cupboard until the discrepancy has been investigated. This should be done

within 24 hours when practical but at the earliest opportunity at times such as weekends or Bank Holidays.

9.17. Transfer of CDs using messengers

A person who conveys CDs between sites is acting as a messenger and is responsible for delivering a sealed or locked container. The seals or locks used must be tamper evident.
The messenger is responsible for the delivery of a sealed intact container.

A transport log will be used to provide an audit trail for the transport of CDs and will require a signature at each point of transfer. See Appendix 3.
The procedure below will be followed:

- The CDs will be sealed in the container for transport along with the CD requisition book.
- The white copy of the CD requisition will be annotated with “Into bag/container” rather than being signed and if a numbered seal is being used the number of the seal will be recorded on the white copy.
- The sealed bag/envopak/box will be signed for on the transport log by the messenger.
- On delivery to the receiving ward the transport log will be signed by a member of staff who is qualified to handle CDs.
- This member of staff will break the seal and verify the contents of the bag and match it the order. They will enter the CDs into their CD register in the normal way.
- Any discrepancies must be reported to the duty pharmacist immediately
- The white copy of the CD requisition and the transport log will be returned to the issuing pharmacy as soon as possible by the receiving clinical area.
- All members of UHB staff signing for CDs to transport must show a valid ID badge.
- If taxis are being used to transport CDs, a record of the taxi-drivers’ car registration or taxi licence number must be obtained.
- If, at any site, the sealed bag is to be left for collection, a signature from a member of UHB staff (e.g. a porter at the porters’ lodge) must be obtained on the transport log.

Also if the driver is required to leave the sealed bag at a porter’s lodge for onward delivery to the ward it must be signed for. The person signing to accept the bag for onward delivery must also obtain a signature from the destination ward/department staff on the transport log when they deliver the bag.

9.18. Controlled drugs within anaesthetic rooms

- A specific controlled drug record book is available for use in Theatres/Anaesthetic rooms within the UHB.

- Controlled drug supplies may be received directly from pharmacy or from theatres suite central CD stock.
- Receipt of controlled drugs may be undertaken and witnessed by a registered nurse or registered ODP
- The quantity supplied to a doctor for a specific patient must be recorded against that specific patient name in the controlled drug record book, signed for by that doctor and signed for by an authorised witness. The quantity administered to the patient must be recorded and signed for by the doctor. The quantity destroyed must be recorded, signed for by the doctor and signed for by an authorised witness.
- The doctor is responsible for this supply whilst in their possession.
- The stock balance must be confirmed at the end of each transaction i.e. receipt, issued to doctor and recorded in the relevant column.
- The stock balance must be checked at the beginning and end of each operating list. Stock reconciliation should be recorded in the stock checks section at the back of the controlled drug record book, which the checker and witness must sign.

Chapter 10 – Return, Disposal and Destruction of Medicines

Medicines that are no longer needed retain their legal status as medicines until such time as they are assessed and destroyed when their legal status becomes controlled under Waste Regulations. It follows that the management and handling of excess or unwanted medicines requires equal diligence to the management and handling of other medicines in current use.

10.1 Return of excess or unwanted medicines

10.1.1 Acute and community hospitals

All excess or unwanted medicines must be held within the ward or clinical area until such time as safe arrangements has been made for their disposal. Wards receiving stock control by pharmacy staff must not make returns without prior agreement with the pharmacy. Pharmacy staff will return stock to pharmacy at the time of stock control. Wards who order their own stock should notify pharmacy of any excess or unwanted medicines usually by email.

Safe arrangements should be made for the return of these excess or unwanted medicines to pharmacy during normal pharmacy opening hours, using hospital transport or a porter with an auditable record of dispatch. It would be considered good practice for wards to have a record of items returned.

10.1.2 Community nurses

Community nurses requested to return medication of patients in the community should encourage the patient or a carer to take them to the supplying pharmacy for destruction.

10.1.3 Medicines brought into hospital by patients

These medicines remain the patient's property, and when they are bought into hospital they should be identified and those products that are appropriate to be continued, are to be retained in the patient's PODs cupboard. Medicines not required should be sent home, or with the patients permission to pharmacy for disposal.

10.2 Disposal of cytotoxic medicines

Arrangements for the disposal of cytotoxic medicines should be in accordance with the recommendations contained in the current policy on the disposal of clinical waste. For the management of cytotoxic spills, staff must follow UHB 201 Procedure.

10.3 Disposal of Controlled Drugs

Excess or unwanted CDs must be returned and disposed of in accordance with the Medicines Code Chapter 9.

10.4 Disposal of part used syringes and injections

Syringes that are not fully discharged and partly used infusion bags containing prescription only medicines (POMs) should be disposed of utilising an appropriate 'sharps' container. They must not be returned to pharmacy.

10.5 Disposal of medicines by the pharmacy

All disposal and destruction of medicines within the pharmacy must be in accordance with departmental procedures and in line with current Waste Regulations and guidelines from the Professional Regulatory body for pharmacy.

Chapter 11 – Errors, Defects, Hazards, Adverse Reactions and Incidents Involving Medicines

A medication error can be defined as an incident where an error has occurred during the process of prescribing, preparing, administering, monitoring and omissions, irrespective of whether such errors lead to adverse consequences or not (DoH, 2018).

11.1 Losses and discrepancies

Loss or suspected loss or misuse of medicines should be reported to the Sister/charge nurse/clinical lead or nurse-in-charge and the senior pharmacist who can then decide on a further course of action. A Datix entry must be submitted

11.2 Management of medication errors

In order to prevent medication errors, it is the individual responsibility of all practitioners to adhere to their Code of Practice, Regulatory Guidance, National and Local Policy and Procedures and to the C&V UHB Hospitals' Medicines Code at all times. Adhering to this guidance will maximise patient safety and minimise risk.

A medication error may cause or lead to inappropriate medication use or patient harm while medication is in control of the health care professional or patient. Such events may be related to professional practice, health care products, procedures and systems including prescribing; order communication, product labelling, packaging and nomenclature; compounding; dispensing; administration; omission, counselling and monitoring. Health practitioners should learn from any medication error, near miss or adverse outcome in order to prevent repetition. A balanced approach is required to protect patients and staff alike. Staff must be given adequate support by their line manager as applicable to the circumstances specific to the medication error. The over-riding concern is to protect patient care and the immediate clinical action that may be required to reverse or negate any adverse clinical consequences.

11.2.1 Action to be taken in event of medication error

Action is to be taken following a medication error (this includes omission, administration, dispensing or prescribing errors) that has led to inappropriate medication administration to a patient: - Patient safety must be maintained. Inform a member of the patient's medical team.

The patient must be reviewed and a medical action plan produced specific to the nature of the medication error.

The ward/department manager/nurse/clinical lead in charge must be informed.

In the event of a dispensing error that has led to inappropriate medication administration, inform a senior member of the pharmacy staff. If an error occurs that involves a medical devise e.g. infusion pump set at incorrect rate etc, continue with BESS reporting tool in Appendix 3 of this Code and complete flow chart in Appendix C or the error pathway.

11.2.2 Duty of Candour and reporting a medication error

The Duty of Candour is a legal requirement for all NHS Organisations in Wales to be open and honest with service users receiving care and treatment. This applies if the care provided has or may have contributed to unexpected or unintended moderate or severe harm, or death.

All incidents involving medicines that have led to inappropriate medication administration must be reported using a Datix entry. This is to ensure that the Patient Safety Team is informed of all incidents in a timely manner, delivery of the incident information should not be delayed until all proposed actions have been carried out. Instead, simply specify the actions proposed.

- When completing the report, the staff member involved in, or witnessing an incident must ensure that the details recorded are concise, a true version of events and complete. An appropriate record must also be made in the clinical notes, medical / nursing. This is not duplication since all events relating to the patient need to be clearly stated, as the incident report does not form part of the medical record. It is important for the person reporting the incident to confine themselves absolutely to the facts. There is no place for an expression of opinion however well meant. No reason for events is required, even if the person reporting the incident is implicated. Merely state the facts as they are. Further information may be required at investigation, statements from staff, number of patients, dependency, staffing levels, time of day and any other circumstances which might impact on the issues.
- The Bennion Error Scoring System tool for use in the discovery of a medication error is available in Appendix 3 of the Medicines Code.

A senior member of the multi-disciplinary team must inform the patient / relative and this should be recorded in the clinical notes. Where equipment is involved in the medication error, staff must ensure that the item is removed from use immediately and defects are reported to Clinical Engineering.

11.2.3 Serious medication errors

A serious medication error is when patient harm occurs or is anticipated. In the event of a serious error the consultant must be informed as soon as possible. If this is outside normal working hours, the Site Practitioner must be contacted via switchboard. They will then contact the on-call manager / consultant as appropriate. It is important that the Executive Medical Director, the Director of Nursing, the Director of Pharmacy, the Nurse Advisor for Medicines Management and the Patient Safety Team are informed of the error and the relevant circumstances at the earliest opportunity. Serious incidents may be deemed notifiable to the Welsh Government and this is required within 24 hours of the incident or the next working day.

In the event of a serious medication error, the Patient Safety Team will facilitate the preliminary investigation under the guidance of the Executive Medical Director and Medicines Safety Executive All serious medication errors along with patient related incidents will be reported to the National Recording and Learning System (NRLS) via the Patient Safety Team. Error analysis and recommendations will be conducted in accordance with local procedures.

11.3 Near misses

Any event that would have led to an error but did not actually happen due to last minute intervention should be reported as a ‘near miss’. In clinical risk management terms, reporting a near miss is just as important as reporting an actual error. Medication errors are rarely the ‘fault’ of individual practitioners and are commonly the result of poor processes/systems. The collation of information on near misses can provide valuable data that may indicate poor system design.

It is important that the continued reporting of errors and near misses is seen as a means of learning in order to minimise future risk.

11.4 Medicines Safety Executive a sub group of the Corporate Medicines Management Group

Will review medication errors and pharmacy intervention data and undertake trend and root cause analysis. The group will co-ordinate actions required in the event of national safety alerts and produce and issue to the clinical areas any local safety alerts deemed appropriate. The group has the authority to initiate action, which may involve system redesign and improvement and/or education, training and competency assessment of healthcare professionals on any aspect of medicines use.

11.5 Management of staff involved in medication errors.

All medication errors should be investigated locally to determine whether the incident is due to a system failure or inappropriate action(s) by a member of staff. This procedure (Appendix 3) will only be used if it is determined that the incident is the result of inappropriate action(s) by a member of staff.

The Bennion Error Scoring System (BESS) should be utilised in order to identify if this is the first or subsequent time(s) the individual/individuals have been involved in such an incident and the time span in which the incidents have occurred. Consideration should be given to the circumstances surrounding the incident and the individual's previous practice and performance.

In the event of a culpable individual making an initial error, the recommendation will be to provide guided supervision to the staff member by their line manager/Practice Educator/Practice Development Nurse. This will involve explaining the relevant area of the UHB Medicines Code. The error will be documented via the BESS error reporting form and score result will remain live in the staff members personal file for 12 months. The BESS form will also determine if the severity of the error was a 'Minor', 'Moderate' or 'Major' and indicates what actions need to be taken.

In the event of a sentinel event involving medication errors a comprehensive investigation and its subsequent findings will be used to determine the management of staff involved.

If however an individual continues to make errors and has been fully supported with education and deemed competent following previous errors consideration of whether implementation of the UHB's Capability and/or Disciplinary Policies is appropriate at this point must be discussed.
Each profession will need to interpret this guidance according to their Professional Code of Practice.

If a UHB bank member of staff makes a drug error they may be limited to where they can work until such time that training has been instigated and assessed.

If an agency member of staff makes an error they will be referred to their manager for training. Evidence of that training will be required by the UHB. If any subsequent errors are made, consideration will be given as to whether placement within the UHB is appropriate.

11.6 Reporting and recording adverse drug reactions and defective medicinal products

11.6.1. Adverse drug reactions

All suspected and confirmed adverse reactions to medicines including contrast media should be reported to the Commission on Human Medicines (CHM), Medicines and Healthcare Regulatory Agency (MHRA) using the "Yellow Card system", or available on line. These can be found in the back of each copy of the British National Formulary www.yellowcard.mhra.gov.uk The nature of the adverse reactions and the medicine involved should be accurately recorded in the patients' case notes. A clearly visible statement to the effect that the patient has suffered an actual or suspected adverse reaction to a given medicine should be permanently imprinted inside the front of the case notes and/or the electronic patient record and also on the in-patient chart (patient medication record) and out-patient and discharge prescriptions, either in large lettering or using specially prepared label.

11.6.2 Defective medicinal products

The Medicines and Healthcare products Regulatory Agency (MHRA) investigates all reports of defective medicines. Where the results of investigations have implications for other patients or users, the MHRA will issue a Hazard or Medicines Alert, which advises of hazardous products or unsafe practices.

Healthcare staff must report their concerns to a duty pharmacist or emergency duty pharmacist (if out of normal working hours) if a defective or potentially defective medicine is suspected. Examples of defective medicines include defective products themselves, wrong products contained in outer packaging, poor or incorrect product labelling, poor or incorrect instructions for use. If a health professional has concerns regarding a potentially defective medicinal product they should contact the pharmacy department. The pharmacy department is responsible for informing the MHRA of defective or potentially defective products. During normal working hours the senior pharmacist on site must be informed of the defect or potential defect. Details should be discussed with a member of pharmacy quality control prior to transmission of details to the MHRA.

Outside of normal working hours the emergency duty pharmacist should contact the Director of Pharmacy or a senior pharmacist prior to a decision to inform the MHRA. When a decision has been made to inform the MHRA, the Director of Pharmacy or other senior pharmacist should complete the Medicinal Product – Suspected Defect Report Form available online at www.yellowcard.mhra.gov.uk

Chapter 12 - Unlicensed Medicines and Unlicensed Indications

Note: Cardiff and Vale University Health Board's procedure for the use of unlicensed medicines and medicines outside their product licence, and the Welsh Risk Pool Services' Technical note on prescribing of unlicensed drugs or using drugs for unlicensed indications are under review. The information contained in this chapter will be updated in line with any changes in the above guidance when available.

12.1 What is a product licence?

A medicine must be granted a product license or marketing authorisation from the Medicines and Healthcare products Regulatory Agency (MHRA) or the European Medicines Agency (EMA) before it can be widely used within the UK (1). Licenses are granted only if acceptable standards of efficacy, safety and quality are met (1,2).

A licensed product must work for the purpose for which it is intended. The product license defines the medicine's terms of use and is detailed in the manufacturers Summary of Product Characteristics (SPC). Information is provided on the indication(s), recommended dose(s), contraindications, special warnings and precautions for use (3).

The licensing process therefore reduces risk in medicines usage. Occasionally there may be a clinical need for a patient to be treated with an unlicensed medicine (a medicine with no UK product license) e.g. midodrine or mexilitine; or with a licensed medicine outside the terms of the license ("off-label") e.g. vitamin K intravenous formulation administered via the oral route for the reversal of over anticoagulation in warfarinised patients (2).

The use of unlicensed medicines or medicines outside their product licence is indemnified by the All Wales Risk Pool only if supported by an appropriate policy (4). Cardiff and Vale University Health Board requires that this Procedure for the Use of Unlicensed Medicines and Medicines Used Outside their Product Licence is followed so that they may take vicarious liability for healthcare staff involved in any aspect of unlicensed medicines procurement, prescribing, supply or administration.

12.2 Healthcare professionals' responsibilities in prescribing, supplying and administering medicines

The responsibility that falls on healthcare professionals when using an unlicensed medicine or a medicine off-label may be greater than when prescribing a licensed medicine within the terms of its license. Prescribers have a duty to ensure they are aware of the legal status of the medicines they prescribe. Prescribers should pay particular attention to the risks associated with using unlicensed medicines or using a licensed medicine off-label. These risks may include: adverse reactions; product quality; or discrepant product information or labelling (e.g. absence of information for some unlicensed medicines, information in a foreign language for unlicensed imports, and potential

confusion for patients or carers when the Patient Information Leaflet is inconsistent with a medicine's off-label use) (3).

The General Medical Council's Good Practice in Prescribing Medicines (2013**)** document provides guidance on prescribing unlicensed medicines and prescribing medicines for use outside the terms of their licence (off-label). In either situation the prescriber must:

- Be satisfied that an alternative, licensed medicine would not meet the patient's needs.
- Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy.
- Take responsibility for prescribing the unlicensed medicine and for overseeing the patient's care, including monitoring and any follow up treatment, or arrange for another prescriber to do so.
- Make a clear, accurate and legible record of all medicines prescribed and, where common practice is not followed give reasons for prescribing the medicine.
- Give patients (or their parents or carers) sufficient information about the medicine to allow them to make an informed decision. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population.
- Answer questions from patients (or their parents or carers) about medicines fully and honestly (4).

Where an unlicensed medicine or a medicine used for an unlicensed indication is prescribed the prescriber is to inform the nurse administering the medicine (where appropriate) and the patient/carer of the unlicensed use. Pharmacists supplying the medicine must consider the need to ensure the prescriber, the nurse administering the medicine (where appropriate) and the patient/carer concerned are aware of the risks of such use

The methods used for the administration of licensed medicines may in some circumstances lie outside the product license. It is important to note that for example the crushing or dispersing of a licensed solid dosage form for ease of administration may mean that the use of the medicine becomes unlicensed. In situations where the medicine is manipulated in a way that is not covered by the product license prior to administration there should be discussion and agreement between the prescriber and the person who will administer the medicine. Discussion should also take place with the pharmacist to check the administration method is appropriate and that the efficacy of the medication is not changed as a result. The patient/carer should also be involved in the decision to use the medicine in this way. Refer to chapter 7 for further information.

Medicinal products covered by this procedure include:

1. **Medicines which do not have a UK product licence (an unlicensed medicine).** These may include medicines manufactured by a licensed manufacturer but which are awaiting a UK product licence, are manufactured for export, have been withdrawn from the UK market or where the manufacturer does not intend to apply for a UK licence.

These products are usually obtained on a “named patient basis”. The pharmacy will purchase such products, usually on a named patient basis, on receipt of a written request from a consultant. In an emergency this may be supplied retrospectively.
Acceptance of liability by the UHB will also depend on “peer group support” as above

2. **Unlicensed medicines prepared by a manufacturer with a Specials Manufacturing Licence.** These are widely referred to as “specials”. They are not usually obtained for a named patient. The responsibility for establishing the quality of the product lies with the pharmacist. A certificate of analysis will be obtained where appropriate. Where the quality of the product is judged to be unsuitable or cannot be established the prescriber will be informed.

3. **Use of licensed products outside their product licence**. The indication may be unlicensed, the dose range or age of the patient may be outside the licence, the route or method of administration may be unlicensed. In some circumstances the product may require unlicensed reformulation before administration. The UHB will accept liability for problems associated with such use if the use would have “peer group support”. Peer group support for the use of unlicensed medicines or medicines outside of product licenses will be determined by a variety of means for example by reference to literature which contains evidence, standard texts, specialist texts, and that which is currently accepted as reasonable clinical practice.

Prescribers have a duty to ensure that they are aware of the legal status of their use of medicines. Where pharmacists are aware of unlicensed use they must consider the need to ensure that the Prescriber is aware of the risks and benefits of such use.

12.3 Monitoring and Recording

Supplies of unlicensed medicines ordered at the request of a consultant will be recorded by the pharmacy. Supplies made to individual patients will be recorded manually and on the pharmacy computer system. The issue of “specials” will be recorded on the pharmacy computer system.

The pharmacy will report on the purchase and issue of unlicensed drugs annually to the Central Risk Management Committee.

12.4 Unlicensed Medicines Risk Assessment Form

Prescribers wishing to use an unlicensed medicine or a medicine outside of the terms of its product license must complete an unlicensed medicines risk assessment form giving details of the product and purpose for its use. The top section will be completed by the Pharmacist and sent to the Prescriber/Consultant who should complete the remaining sections, providing evidence from standard texts/publications or "peer support" i.e. Clinical Director's signature.

The completed form should be returned to Pharmacy and will be entered into the Unlicensed Medicines database

12.5 Non-Medical Prescribing

Nurse or Pharmacist prescribers may prescribe outside the terms of the manufacturer's product license ("off-label") as either independent or supplementary prescribers. Since

December 2009 Pharmacist IP's and Nurse IP's can prescribe unlicensed medicines for their patients on the same basis as doctors and provided they are competent and take responsibility for doing so. All Non-Medical prescribers must adhere to the UHB's NMP Framework.

12.6 Packaging

On receipt of the medication, pharmacy will confirm that the pack is appropriately labelled with an English generic drug name, form, strength, expiry date and has an English version of the SPC. Where necessary the pack will be over labelled and an English SPC will be sourced to reduce the risk of dispensing errors and errors during administration.

12.7 Prescribing interface with GPs for unlicensed medicines and medicines outside of license

Hospital prescribers wishing to transfer the care of a patient for whom they prescribe an unlicensed medicine or a medicine outside of its product license must first seek agreement from the patient's GP. The GP may refuse to undertake ongoing prescribing. Information supporting the prescribing of the unlicensed medicine concerned must be provided where appropriate.

Chapter 13 - Medicines in Clinical Trials

13.1 Cardiff and Vale Research Review Service (CaRRS)

All clinical trials involving Investigational Medicinal Products (IMPs) are governance reviewed by the Cardiff and Vale Research Review Service (CaRRS), a pharmacy assessment forms part of this service.

All clinical trials involving IMPs that are sponsored by Cardiff University or Cardiff and Vale UHB, are also reviewed by the pharmacy clinical trials team as part of the sponsored assessment process (SAP).

The sponsor should provide copies of Research Ethics Committee, Medicines and Healthcare Products Regulatory Agency (MHRA) and UHB Research and Development Department approvals to the pharmacy clinical trials team, before a clinical trial involving medicines can commence.

13.2 Clinical trial storage, prescribing and supply

All medicines used in clinical trials within C&V UHB should be stored and dispensed by the Pharmacy department and managed to the same standards as other medicines used therapeutically.

- IMP must not be stored in offices, clinics or ward areas unless by prior arrangement with pharmacy and only where appropriate risk management processes and standard operating procedures (SOPs) are in place.
- IMP must only be used in patients recruited to the trial.
- All IMP deliveries will be correctly received and recorded by a member of the pharmacy clinical trials team.
- Temperature records will be maintained for all IMP storage locations as specified by the trial sponsor.

A prescription for a clinical trial medicine must be signed by an approved prescriber and member of the investigational team on a trial specific prescription form. The IMP will be dispensed following a trial specific pharmacy dispensing procedure. Accurate accountability records will be maintained for all IMPs, this level of support may vary between trials. The clinical trial prescription will be retained in the pharmacy.

13.3 Unblinding a clinical trial medication

Pharmacy will ensure that a trial specific emergency unblinding procedure is written for all blinded trials before the trial commences. Occasionally copies of the unblinding code breaks or trial randomisation codes may be kept in pharmacy. Pharmacy will ensure that the blind is maintained throughout the trial. Code break envelopes or codes will be returned to the sponsor or investigator at the end of the trial. Code break envelopes or randomisation lists will only be released to the trial sponsor (or investigator) when written evidence from the sponsor has been provided to the clinical trials pharmacist that the final locked dataset has been verified.

13.4 Disposal or return of clinical trial medicines

Any unwanted clinical trial study medication must be returned to the hospital pharmacy. Returned clinical trial study medication should be reconciled and recorded in the pharmacy site file as set out by the clinical trial sponsor. Returned clinical trial medicines or any unissued clinical trial medication must be returned to the sponsor or disposed of in accordance with the clinical trial sponsors instructions.

This procedure is not applicable to clinical trials involving blood products or wound healing products.

Chapter 14 Strong Potassium Injections, Ordering, Storing, Prescribing and Administration

The information in this chapter reflects the requirements set out by the National patient Safety Agency in an alert aimed to minimise the risk of accidental overdose of intravenous (IV) Potassium. This information recognises the need to ensure that seriously ill patients in critical care areas who require intravenous strong Potassium as part of their treatment continue to receive it promptly.

The definition of Strong Potassium injections includes:

- Solutions of Potassium Chloride of 10% or more (i.e. 1gram of potassium in 10ml) Solutions of Potassium Hydrogen Phosphate and Potassium Dihydrogen phosphate in ampoules and vials.

Prescribing

IV treatment of hypokalaemia should only be instigated when the oral/enteral route is unavailable or will not achieve the required increase of serum Potassium within the clinically acceptable time.
Wherever possible prescribed ready mixed infusions. Prescriptions must be expressed as mmols of Potassium and must include rate of infusion and carrier fluid.
The rate of administration in adults should not normally exceed 10mmols/hour. ECG monitoring is recommended for higher rates.
Further guidance on dosing of Potassium is given in the UHB Good Prescribing Guide. Pharmacy and/or your ward Pharmacist will be able to provide information on the ready mixed preparations available.

Ordering and Storage

Strong Potassium injections as defined above will be treated as a controlled drug. Ordering, supply, storage and administration must follow the procedural guidance set out in Chapter 9.

Wards required to keep a supply of strong Potassium injection are:

UHW Site	**UHL Site**
ICU-B3, ICU-A3, ICU/HDU Cardiac, A3 HDU, CCU	ICU, ECU, MEAU
CAU, PICU, Rainbow, Neonatal	Hafan Y Coed
B4 Haematology, B5, CAPD Unit, RTU (T5) EU Resus.	ECT
ICU, ECU, MEAU	

Wards other than those named above will only be provided with a supply of strong Potassium Chloride on receipt of a prescription chart for the individual patient, it is likely that the pharmacist will wish to discuss this individual prescription with the prescriber. If authorised the ward will again need to follow the CD process.

Administration

A two registered person independent whole process check is required for the administration of strong Potassium. As per CD procedure discussed in chapter 9. Infusions prepared with strong Potassium must be thoroughly mixed with repeated inversion and agitation of the container.

NB Wards must not obtain supplies of strong Potassium from other wards. In normal working hours supplies should be obtained from pharmacy. Outside normal hours supplies must be facilitated via the H@N Co-ordinator/Site Practitioner.

Chapter 15 - Oral Methotrexate

The purpose of this chapter is to ensure the safe use of methotrexate. It reflects good practice guidance issued by the National Patient Safety Agency (August 2004 and updated June 2006). This Guidance applies to all staff who are involved with the prescribing, supplying or administration of methotrexate. It is the responsibility of every professional group to ensure that this guidance is followed

PRESCRIBING

Before initiating methotrexate,

- discuss the indication, dosing and monitoring with the patient,
- provide a patient information leaflet and confirm patient understanding and consent
- provide a patient-held monitoring booklet and explain its use to patient.
- confirm who will prescribe and monitor the methotrexate (refer to shared care guidelines) and frequency of monitoring.
- explain this to the patient, including who will communicate necessary dosage changes to the patient and who will record test results in patient-held monitoring booklet.

ALL prescriptions must state the specific dose and highlight the specific day to be taken **("as directed" is not acceptable).**

On the hospital in patient drug administration charts,

- state the day of the week when the methotrexate dose is to be given (in the "special instructions" box).
- strike through the six days of the week when the dose must not be administered.
- prescribe folic acid rescue as a single weekly dose separated from methotrexate. However a small number of patients require folic acid for six days per week to minimise nausea. Folic Acid must not usually be taken on the day methotrexate is administered.
- Ensure discharge summary information includes the form, strength, dose and directions in full and who will prescribe and monitor. This will not be the GP unless the initiation process is

complete, the patient stable and the shared care/near patient testing process has been followed, ie requested and agreed.

- Only prescribe multiples of 2.5mg methotrexate; 10mg strength tablets are deliberately not supplied from C&V pharmacy

DISPENSING/PHARMACIST SCREENING

Check that the patient has been given a patient-held monitoring booklet.

- if yes, and they have it with them, check dose against dose prescribed.
- if yes but don't have it with them, check their usual dose and day of week taken.
- if they don't have a booklet, provide one and either arrange for the patient to see appropriate specialist nurse (for outpatients) or refer to pharmacist to go through the key points with the patient (for inpatients).
- Check prescribed dose- **"as directed"** is not acceptable.
- Label the medication as follows with the number of tablets and day of week to be taken. *Take .....tablets on each .....for .....weeks*
- Communicate the dose as quantity of tablets and weekly frequency with the patient. I if the patient is also taking folic acid tablet, ensure the patient can easily tell the difference.
- Refer to prescriber/specialist nurse if the patient's dose has changed and the booklet needs updating.

ADMINISTRATION

- **NEVER** administer methotrexate daily without confirming with the prescriber or pharmacist that this is intended.
- Wherever possible administer methotrexate on the day of the week the patient usually takes it.
- If you have concerns regarding infection, including wound issues, discuss with Medical/Surgical team before administering methotrexate
- Ensure administration is recorded on the inpatient medication chart correctly.
- Report any issues, concerns or non-administrations to the patient's medical team and/or pharmacist in a timely manner

NB patients attending with or reporting new symptoms e.g. breathlessness, dry persistent cough, vomiting and diarrhoea, consider if these may be signs of methotrexate toxicity or intolerance.

Delivery notes accompanying ward/department stock deliveries

Once items delivered have been checked against the delivery note, and there are no apparent discrepancies by way of delivery error or costing error, the delivery note is to be kept on the receiving ward for 3 months and then may be destroyed

Controlled Drug order book

These are to be kept on the ward/department for 2 years after the date of the last order entry in the book. The CD order book can then be destroyed.

Controlled Drug record book

These are to be kept on the ward/department for 2 years after the date of the last entry of receipt or administration, whichever is the later. The CD record book can then be destroyed.
If the CD Controlled Drug Record Book contains a record of destruction it must be retained for 7 years.

Medicines transit records

Upon completion of signature of the receipt, the delivery driver/ porter must return the record of receipt to the dispatching pharmacy as soon as possible.
The delivery record will be kept for 3 months and then may be destroyed.

Pharmacy records

The pharmacy will retain records of orders, receipt and supply as set out in WHC (2000)/71 which details document retention as follows:
3 months - Picking records/ delivery notes to wards & departments

1 year - Stock-take reports plus current year worksheets for resuscitation boxes (one year after expiry of longest dated item)

1 year - Orders/requisitions for medicinal products supplied by the pharmacy including all dispensing

- Top Copy of Discharge Prescription (TTH)
- Controlled Drug Registers and Requisitions (2 years after last date of entry) Hazard Warnings

5 years - Unlicensed medication requests and issues
Worksheets for chemotherapy, aseptic and total parenteral nutrition

- Repackaging
- Certificates of analysis
- Recall Documentation
- Clinical trials records (5 years after end of trial)

5 years - Orders

- Financial records including invoices
- Disposal of waste records

5 years: Records of Controlled Drug destruction (Hospital stock or patient's own)

6 years: Medicines Information questions and answers

(25 years in case of child or obstetrics & Gynaecology)

13 years: Production records including extemporaneous Controlled Drug products and radio pharmacy

Chapter 17 – Nurse Initiation of Symptomatic Relief

Background

Nurse initiated symptomatic relief medicines are those which are used to treat minor ailments and are available to purchase from a pharmacy (Pharmacy [P] medicine) or from any other retail outlet (General Sales List [GSL] medicine). Nurses often have to contact prescribers to write prescriptions for items which patients, if they were self-caring, could purchase "over-the-counter." There is often a delay in patients receiving the required symptomatic relief medicines.

NB permission to implement this procedure must be sought and given by the appropriate directorate quality and safety group before implementation.

Purpose

The purpose of this procedure is to enable nurses to initiate medicines to treat minor symptomatic ailments for adult inpatients. The procedure provides a clear framework to support nurse initiation of symptomatic relief medicines to provide safe, appropriate and timely patient care, and facilitate the smooth running of wards.

Scope

This procedure applies to registered nurses and midwives within adult inpatient areas who have been identified as suitable by the Sister/ Charge Nurse of the inpatient area.In order to be identified as suitable the nurse or midwife must have :

- A minimum of one year post registration experience.
- Have been trained and assessed as competent in using this procedure.

A registered of suitably trained and competent staff will be kept locally within the area/directorate.

Accountability

Each registered nurse, working to the Nursing and Midwifery Council (NMC) Code of Practice and NMC Guidelines, is professionally accountable for his/her practice. In a local context they are required to work to the Health Board policies, protocols, guidelines and meet expected standards.

Responsibilities

Nursing/Midwifery staff identified as appropriate have a responsibility to:

- Only initiate medicines off the agreed list**.**
- Complete the training programme in order to ensure they feel competent and confident when initiating medicines from the agreed list.
- Assess the patient and plan their care.
- Record the assessment, any intervention and arrangements for review in the care plan/care pathway/medical notes.
- Record any medication administered on the medication chart.
- Record the review and reassessment in the care plan/care pathway/medical notes.
- Contact the doctor on call if they are concerned about the patient's overall condition or the medication has been ineffective.
- Report any serious adverse drug reactions via the Medicines Healthcare and products Regulatory Agency yellow card system.

Pharmacy staff have a responsibility to:

- Update and review the protocols and advise on any major changes.
- Ensure safe systems of supply for medicines named in the protocols.
- Ensure patient appropriateness

Directorates have a responsibility to:

- Identify the need for nurse/midwife initiation of symptomatic relief within the directorate and/or ward/unit area.
- Agree a plan to ensure that nurses/midwives identified as appropriate to initiate symptomatic relief are trained and competent to do so.
- Keep a register of nurses who meet the above criteria locally either at ward / unit or directorate level.

The Health Board Medicines Management Group has a responsibility to:

- Include the procedure for nurse initiation of symptomatic relief medicines in the medicines code and review in line with the code.
- Any subsequent request for additions to the nurse-initiated medicines list must be approved by the UHB Medicines Management Group, prior to the medicine being added

to the list. This addition to the list may be agreed as a UHB addition or a Directorate specific addition, where it is a Directorate specific addition the Directorate will be named.

The Medical Team has a responsibility to:

Countersign the nurse-initiated medicine as follows

- Within 24 hours if possible.
- Within a maximum of 48 hours.
- Community hospital setting max of 72 hours.

Training

The Directorate Pharmacist and/or Nurse Advisor Medicines Management and Professional Practice Development Nurse (or nominated deputies) will provide an agreed training programme. This will involve a one-hour workshop. The workshop will include the following:

- Overview of legislative framework (legal classification of drugs – GSL, P, POM, CD).
- Rationale and place of patient group directives and independent prescribing.
- Principles of drug monographs/protocols.
- Questions and answers on the current drug monographs/protocols.
- The nurse/midwife will complete a competence log of medicines they initiate under supervision (minimum of 5), before they are signed off as competent. This should be achieved within a maximum of 3 months from initial training session.

Procedure

a) Identified potential need for nurse/midwife initiated medicine
b) Consider criteria for inclusion/exclusion as stated in the drug monograph
c) If appropriate to proceed, discuss with patient, provide verbal advice, prescribe on the medication chart (as indicated in monograph) and arrange administration.
d) The prescription must state ‘’nurse/midwife initiated’’ and the nurse must sign and print name (if available include bleep number).
e) Refer to the doctor responsible for the patient if medical advice is needed.
f) Document “nurse/midwife initiated medicine” in the care plan/pathway/medical notes.
g) Follow up and monitor the patient as indicated in the monograph.
h) Report any unusual/serious adverse drug reactions via the Medicines Healthcare and products Regulatory Agency yellow card system.

Audit

An audit will be undertaken at six months after implementation by an identified Pharmacist/Nurse/Midwife within the Directorate for a one week period.

Audit criteria will include:

- Patient, ward and drug initiated.
- Review of medication chart to compare documentation and criteria with the monograph and identify the number of doses administered.
- Review any related clinical incidents.
- Feedback from medical, nursing and pharmacy staff involved in the scheme.
- Review of monographs to clarify and ensure ease of use.

Permitted Drug Protocols for Nurse Initiated Medicines for Symptomatic Relief

Protocol for the administration of PARACETEMOL TABLETS/SOLUBLE TABLETS

Clinical Condition	
Criteria for inclusion	Patient consents to treatment under this protocol. Mild to moderate pain. Pyrexia – temperature greater than 38°C (consider need for blood cultures). Includes patients who are pregnant.
Criteria for exclusion (refer to doctor)	Allergy or hypersensitivity to paracetamol. Patient has received the maximum dose of paracetamol containing. product (e.g. co-codamol, codydramol) within the last 24 hours. Patient has past or current history of moderate to severe renal/hepatic impairment. Avoid concurrent prescription with paracetamol containing products.

Description of Treatment	
Name of medicine	Paracetamol
Legal status (POM/P/GSL)	GSL
Form	• Tablet • Soluble tablet (This effervescent preparation has a high sodium content. May be a problem if the patient needs to restrict sodium intake e.g. hypertension, heart failure).
Dosage	Dosage is dependent on body weight 35 – 39kg = 500mg 40 – 49kg = 750mg 50kg or above = 1g
Route of administration	Oral
Frequency of administration	Every four to six hours
Total daily dose	Maximum dosage is dependent on body weight, QDS
Adverse reactions	• Rare but rashes and blood disorders have been reported. • Acute pancreatitis reported after prolonged use. • Liver damage (and less frequently renal damage) following overdose.
Verbal advice for the patient	• Can request further doses at 4-6 hourly intervals if required. • Inform nursing staff if symptoms persist or worsen.
Follow up	• Review patient response to treatment Monitor clinical observations. • Contact doctor if symptoms persist or worsen.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **PARACETAMOL**		PHARMACIST SUPPLY
DOSE **500MG -1G**	ROUTE **PO**	FREQUENCY **4 to 6 HOURLY**	MAXIMUM DOSE IN 24 HOURS **Max 4g in 24hrs**
DOCTOR'S SIGNATURE **Nurse Initiated Nurse signature PRINT name**		INDICATION **PAIN or PYREXIA (STATE WHICH/BOTH)**	

Protocol for the administration of
CO-CODAMOL 8/500 TABLETS/SOLUBLE TABLETS

Clinical Condition	
Criteria for inclusion	Patient consents to treatment under this protocol. Mild to moderate pain.
Criteria for exclusion (refer to doctor)	Allergy or hypersensitivity to paracetamol or codeine. Patient has received the maximum dose of a paracetamol containing product within the last 24 hours. Patient has past or current history of moderate to severe renal/hepatic impairment. Avoid concurrent prescription with paracetamol containing products.

Description of Treatment	
Name of medicine	Co-codamol 8/500 (Codeine 8mg/Paracetamol 500mg)
Legal status (POM/P/GSL)	GSL
Form	• Tablet • Soluble tablet (This effervescent preparation has a high sodium content. May be a problem if the patient needs to restrict sodium intake e.g. hypertension, heart failure).
Dosage	Dependent on body weight because of paracetamol content 35 – 49kg = 1 tablet 50kg or above = 2 tablets
Route of administration	Oral
Frequency of administration	Every four to six hours
Total daily dose	Maximum dose dependent on body weight , QDS
Adverse reactions	• Rare but rashes and blood disorders have been reported. • Acute pancreatitis reported after prolonged use. • Liver damage (and less frequently renal damage) following overdose. • Nausea and vomiting. • Constipation (especially after regular dosing).
Verbal advice for the patient	• Can request further doses at 4 – 6 hourly intervals if required. • Inform nursing staff if symptoms persist/worsen or if nausea or constipation occurs.
Follow up	• Review patient response to treatment. • Monitor clinical observations. • Contact doctor if symptoms persist or worsen.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **CO-CODAMOL 8/500**		PHARMACIST SUPPLY
DOSE **1 OR 2 TABS**	ROUTE **PO**	FREQUENCY **4 to 6 HOURLY**	MAXIMUM DOSE IN 24 HOURS **Max 8 in 24 hours**
DOCTOR'S SIGNATURE **Nurse Initiated Nurse signature PRINT name**		INDICATION **PAIN**	

Protocol for the administration of

ALGINATE BASED ANTACID (GAVISCON ADVANCE)

Clinical Condition	
Criteria for inclusion	Symptomatic relief of heartburn and acid indigestion (dyspepsia) Patient consents to treatment under this protocol. Includes patients who are pregnant.
Criteria for exclusion	Vomiting with/without haematemesis, diarrhoea, rectal bleeding. Allergy to product or excipients
Seek further advice from doctor	History of heart failure (high sodium content – 3mmol in 5ml) Moderate or severe renal failure

Description of Treatment	
Name of medicine	Gaviscon Advance® or generic
Legal status (POM/P/GSL)	GSL
Form	Suspension
Dosage	5-10 ml 20 minutes to 1 hour after meals and at bedtime or as required.
Route of administration	Oral
Frequency of administration	Four times a day
Adverse reactions	None expected when used at this recommended dosage.
Further information	Avoid administration of antacids at the same time of day as tetracyclines, ciprofloxacin, rifampicin, hydroxychloroquine, chloroquine as absorption of these medicines can be reduced. N.B. a complete list is available in the BNF.
Verbal advice for the patient	• Inform nurse if symptoms persist or worsen. • Can request further doses, up to four times a day, if required. • Acid indigestion can be exacerbated by high fat/spicy diet, excess alcohol, smoking, obesity. (Consider reduction of risk factors as appropriate). • Antacid preparations should not be taken at the same time of day as enteric coated (e/c) tablets. The coating is removed so that stomach irritation can occur from the medication in the tablet.
Follow up	• Review patient response to treatment. • Monitor clinical observations. • Consider medical referral if symptoms persist or worsen.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **GAVISCON**		PHARMACIST SUPPLY
DOSE **5-10 ml**	ROUTE **PO**	FREQUENCY **After meals and at bedtime**	MAXIMUM DOSE IN 24 HOURS **10ML FOUR TIMES DAILY**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**		INDICATION **INDIGESTION**	

Protocol for the administration of

PEPPERMINT WATER

Clinical Condition	
Criteria for inclusion	Relief of gastric and intestinal flatulence, and pain associated with these. Relief of griping pains caused by administration of laxatives. If regular irritable bowel syndrome sufferer. Patient consents to treatment under this protocol.
Criteria for exclusion	Patient already prescribed related product e.g. Colpermin® Allergy or hypersensitivity to peppermint. Nausea, vomiting, diarrhoea, severe abdominal pain, history of bowel obstruction, rectal bleeding, haematemesis and other possible reasons for abdominal discomfort e.g. constipation. Patients who are pregnant are excluded.

Description of Treatment	
Name of medicine	Peppermint water
Legal status (POM/P/GSL)	P
Form	Solution
Dosage	10ml well diluted with water
Route of administration	Oral
Frequency of administration	Up to three times a day
Total daily dose	10ml three times a day
Adverse reactions	None expected when used at this recommended dose and diluted.
Verbal advice for the patient	• Inform nurse if symptoms persist or worsen. • Can request further doses up to three times a day if required. • Diet may have been cause of flatulence. Regular diet and avoidance of "trigger foods" may help. • Movement/exercise may assist with relief of pain associated with "trapped wind."
Follow up	• If no relief from symptoms, or symptoms worsen. • Enquire if regularly experience symptoms of this kind e.g. irritable bowel syndrome and consider medical referral if so.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **PEPPERMINT WATER**		PHARMACIST SUPPLY
DOSE **10ML**	ROUTE **PO**	FREQUENCY **THREE TIMES DAILY (DILUTED IN WATER)**	MAXIMUM DOSE IN 24 HOURS **10ML THREE TIMES DAILY**
DOCTOR'S SIGNATURE **Nurse initiated** **Nurse signature** **PRINT name**		INDICATION **e.g. GRIPING PAINS**	

Protocol for the administration of SENNA TABLETS or SYRUP

Clinical Condition	
Criteria for inclusion	Chronic uncomplicated constipation. Acute infrequent constipation (see Good Prescribing Guide) Patient consents to treatment under this protocol.
Criteria for exclusion	Severe abdominal pain, history of bowel obstruction, vomiting, rectal bleeding and/or haematemesis. Patient undergoing investigations to colon/rectum and/or recent gastrointestinal surgery. Allergy or hypersensitivity to senna. Patients who are pregnant are excluded.
Seek further advice from doctor	If patients are thought to misuse laxatives long term.

Description of Treatment	
Name of medicine	Senna
Legal status (POM/P/GSL)	GSL
Form	Tablets or syrup
Strength	7.5mg tablets or 7.5mg/5ml syrup
Dosage	7.5mg to 15mg (One or two 5ml spoonsful)
Route of administration	Oral
Frequency of administration	Once at night
Total daily dose	If needed 15mg (two tablets or 10ml) ON
Adverse reactions	Abdominal cramps/griping pains. Diarrhoea.
Further information	Avoid syrup formulation if diabetic.
Verbal advice for the patient	Inform nurse if symptoms persist or worsen.
Follow up	• Review for effectiveness. • Consider need for regular prescription i.e. 15mg (two tablets or 10ml BD).

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **SENNA**		PHARMACIST SUPPLY
DOSE **ONE – TWO tablets ot 5-10ml**	ROUTE **PO**	FREQUENCY **AT NIGHT**	MAXIMUM DOSE IN 24 HOURS **TWO (1oml) AT NIGHT**
DOCTOR'S SIGNATURE **Nurse Initiated Nurse signature** **PRINT name**		INDICATION **CONSTIPATION**	

Protocol for the administration of LACTULOSE SOLUTION

Clinical Condition	
Criteria for inclusion	Relief of constipation. Patient consents to treatment.
Criteria for exclusion	Severe abdominal pain, history of bowel obstruction, vomiting, rectal bleeding, haematemesis. Patient undergoing investigations to colon/rectum, recent gastrointestinal surgery. Allergy or hypersensitivity to lactulose. Intolerance to lactose Galactosaemia Patients who are pregnant are excluded.
Seek further advice from doctor	If patient is thought to misuse laxatives long term.

Description of Treatment	
Name of medicine	Lactulose
Legal status (POM/P/GSL)	P
Form	Solution
Strength	3.1-3.7g/5ml
Dosage	15ml (Three 5ml spoonsful) BD
Route of administration	Oral
Frequency of administration	BD
Total daily dose	30ml BD
Adverse reactions	Nausea, vomiting, flatulence, cramps, abdominal discomfort
Further information	Can take up to 48 hours to work
Verbal advice for the patient	• Inform nurse if symptoms persist or worsen. • Eat fruit/vegetables and more fibre. • Drink plenty of water and take regular exercise. • Inform nurses if nausea develops (can be reduced by administration with water, fruit juice or meals) • Can take up to 48 hours to work.
Follow up	Review for effectiveness.

AS REQUIRED MEDICINES		
DATE **Today's date**	MEDICINE (Approved Name) **LACTULOSE**	PHARMACIST SUPPLY
DOSE **15ML**	ROUTE **PO**	FREQUENCY **TWICE DAILY**
DOCTOR'S SIGNATURE **Nurse Initiated Nurse signature PRINT name**		INDICATION **CONSTIPATION**

Protocol for the administration of MACROGOL ORAL POWDER (MOVICOL® /LAXIDO)

Clinical Condition	
Criteria for inclusion	• Chronic constipation • Patient consents to treatment under this protocol.
Criteria for exclusion	• Intestinal perforation/obstruction, paralytic ileus, inflammatory conditions of the gastrointestinal tract e.g. Crohn's, colitis, toxic megacolon • Fluid and electrolyte disturbances • Severe abdominal pain, vomiting, rectal bleeding, haematemesis. • Patient undergoing investigations to colon/rectum, recent gastrointestinal surgery. • Allergy or hypersensitivity to macrogol • Patients who are pregnant are excluded. • If the patient is thought to misuse laxatives long term. Patients with heart failure
Seek further advice from doctor	

Description of Treatment	
Name of medicine	Macrogol
Legal status (POM/P/GSL)	P
Form	Powder for solution
Dosage	1 sachet daily or 1 sachet twice daily
Route of administration	Oral
Frequency of administration	OD or BD
Total daily dose	1 sachet BD
Adverse reactions	• Abdominal distension, pain, nausea, flatulence
Further information	• Dissolve the contents of 1 sachet in half a glass of water (125ml) of water. • After reconstitution the solution can be kept in the fridge and discarded if unused after 6 hours. • Patients with cardiovascular impairment should not take more than 2 sachets in any one hour.
Verbal advice to the patient	• Inform nurse if symptoms persist or worsen • Eat fruit/vegetables and more fibre. • Drink plenty of water and take regular exercise. • Inform nurses if nausea develops (can be reduced by administration with water, fruit juice or meals)
Follow up	□ Review for effectiveness

DATE →		**Today's date**		MEDICINE (Approved name)	SPECIAL INSTRUCTIONS	PRESCRIBER'S SIGNATURE	PHARMACIST
ROUTE →		**PO**		**MACROGOL ORAL POWDER**	**Dissolve one sachet in half a glass of water (125ml)**	**Nurse Initiated Nurse signature PRINT name**	SUPPLY
SPECIFY TIME IF REQUIRED ↓		DOSE ↓	SIGN DOSE CHANGE				
MORNING	✓	†					
MIDDAY							
EVENING							
BED TIME	✓	†					

Protocol for the administration of

GLYCERIN SUPPOSITORIES

Clinical Condition	
Criteria for inclusion	Acute infrequent constipation Hard impacted faeces – mild Patient consents to treatment under this protocol.
Criteria for exclusion	Severe abdominal pain, rectal bleeding, intestinal obstruction Vomiting with/without haematemesis Allergy to gelatin

Description of Treatment	
Name of medicine	Glycerin
Legal status (POM/P/GSL)	GSL
Form	Suppositories
Strength	4g (adult)
Dosage	One to two suppositories
Route of administration	Rectal (moisten with water)
Frequency of administration	Stat dose (consider as required prescription)
Total daily dose	Maximum of two 4g suppositories
Adverse reactions	May occasionally cause rectal irritation or stomach cramps.
Further information	Glycerin suppositories also contain gelatin.
Verbal advice for the patient	• Explain procedure to patient and suggest that they lie on their lefthand side. • Explain action of glycerine suppositories is usually within 15 to 30 minutes. • Encourage adequate fluid intake.
Follow up	□ Patient's response to treatment.

PRESCRIPTION FOR ONCE ONLY AND PRE-ANAESTHETIC MEDICATION										
DATE	MEDICINE (Approved Name)	DOSE	ROUTE	TIME TO BE GIVEN	DOCTOR'S SIGNATURE	PHARMACY	DATE	TIME GIVEN	GIVEN BY	CHECKED BY
Today's date	**GLYCERIN SUPPOSITORY**	**4g**	**PR**	**14:00**	**Nurse Initiated** **Nurse signature** **PRINT name**					

Protocol for the administration of

MICRO-ENEMA

Clinical Condition	
Criteria for inclusion	Acute and infrequent constipation (see Good Prescribing Guide) Consider if other treatments have been tried. Includes patients who are pregnant. Patient consents to treatment under this protocol.
Criteria for exclusion	Severe abdominal pain, history of bowel obstruction, rectal bleeding, haematemesis. Inflammatory bowel disease (ulcerative colitis, Crohn's disease)

Description of Treatment	
Name of medicine	Micralax®/Micolette®/Relaxit®
Legal status (POM/P/GSL)	P
Form	As sodium citrate micro-enema
Dosage	Contents of one 5ml enema
Route of administration	Rectal
Frequency of administration	Stat dose, followed by a second enema if there is no result after 20 minutes
Total daily dose	Maximum of two enemas.
Adverse reactions	Side-effects are unusual but occasionally there may be abdominal cramps.
Verbal advice for the patient	• Explain procedure to the patient. • Explain the action of the enema can be within 5 – 15 minutes but that it is preferable to resist the urge to empty bowels immediately and "hold on" for 10 to 15 minutes for maximum effect. Encourage patient to lie on their left-hand side. Encourage adequate fluid intake.
Follow up	• If no relief from symptoms or symptoms worsen. • Consider need for regular laxative (see Good Prescribing Guide).

PRESCRIPTION FOR ONCE ONLY AND PRE-ANAESTHETIC MEDICATION										
DATE	MEDICINE (Approved Name)	DOSE	ROUTE	TIME TO BE GIVEN	DOCTOR'S SIGNATURE	PHARMACY	DATE	TIME GIVEN	GIVEN BY	CHECKED BY
Today's date	**MICRO-ENEMA**	**ONE**	**PR**	**14:00**	**Nurse Initiated Nurse signature PRINT name**					

Protocol for the administration of

SIMPLE LINCTUS

Clinical Condition	
Criteria for inclusion	Dry cough Includes patients who are pregnant Patient consents to treatment under this protocol
Criteria for exclusion	Diabetes (request sugar free formulation) Allergy or hypersensitivity to any of the ingredients (refer to bottle – may contain alcohol) Symptoms such as wheezing or shortness of breath

Description of Treatment	
Name of medicine	Simple Linctus BP (citric acid monohydrate 2.5% in a vehicle with an anise flavour)
Legal status (POM/P/GSL)	GSL
Form	Solution
Dosage	One or two 5ml spoonfulS
Route of administration	Oral
Frequency of administration	Up to four times a day
Total daily dose	10ml four times a day
Adverse reactions	□ Side-effects not expected at this dosage
Verbal advice for the patient	□ Can request further doses, up to four times a day, if required. □ Inform nurse if symptoms persist or worsen.
Follow up	• Review patient response to treatment • Monitor clinical observations • Contact doctor if symptoms persist or worsen.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **SIMPLE LINCTUS**		PHARMACIST SUPPLY
DOSE **5 – 10ML**	ROUTE **PO**	FREQUENCY **FOUR TIMES DAILY**	MAXIMUM DOSE IN 24 HOURS **10ML FOUR TIMES DAILY**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**		INDICATION **DRY COUGH**	

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Protocol for the administration of

WHITE SOFT PARAFFIN

Clinical Condition	
Criteria for inclusion	Dry, sore chapped or cracked lips Dry, sore nose secondary to cold/flu-like symptoms or nasal cannulae use
Criteria for exclusion	Evidence of infection, history of cold sores with symptoms suggestive of a new cold sore e.g. tingling sensation, blistering – seek medical advice for alternative treatment.

Description of Treatment	
Name of medicine	White soft paraffin
Legal status (POM/P/GSL)	GSL
Form	Ointment
Dosage	Apply a small amount to the affected area using clean fingertip or cotton bud.
Route of administration	Topical Caution: Paraffin is flammable
Frequency of administration	Four times a day
Total daily dose	Four single applications to a localised area
Adverse reactions	• Not expected when used at this recommended frequency • Sensitivity reactions and acne have been reported rarely following topical use.
Verbal advice for the patient	• Can reapply up to four times daily to help soothe dry areas. • Avoid contact with eyes. • Keep away from naked flames. • Inform nurse if symptoms persist or worsen.
Follow up	Review the patient's response to treatment.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **WHITE SOFT PARAFFIN**		PHARMACIST SUPPLY
DOSE **SMEAR**	ROUTE **TO LIPS OR AFFECTED AREA**	FREQUENCY **FOUR TIMES DAILY**	MAXIMUM DOSE IN 24 HOURS **FOUR TIMES DAILY**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**		INDICATION **e.g. SORE LIPS**	

Protocol for the administration of
CHOLINE SALICYLATE ORAL GEL (BONJELA®)

Clinical Condition	
Criteria for inclusion	Mouth ulcers Sore mouth secondary to denture irritation Patient consents to treatment under this protocol
Criteria for exclusion	Aspirin hypersensitivity, or allergy to preservative (cetalkonium chloride) Unexplained mouth ulcer of >3 weeks duration (refer to doctor) Bleeding from gums or known oral cancer. Recent or current immunosuppressant drug therapy (refer to BNF), recent chemotherapy or radiotherapy
Seek further advice	Recurrent mouth ulcers or if sore throat also present

Description of Treatment	
Name of medicine	Choline salicylate 8.7% in an oral gel formulation (Bonjela®)
Legal status (POM/P/GSL)	GSL
Form	Gel
Dosage	Apply one clean fingertip or cotton bud of gel to the affected area
Route of administration	Oral Apply to tender areas of mouth and buccal mucosa
Frequency of administration	Up to every three hours
Total daily dose	Maximum 8 applications in 24 hours
Adverse reactions	Excessive application or confinement under a denture irritates the mucosa and can itself cause ulceration
Verbal advice for the patient	• Can reapply up to every 3 hours (avoid application just before food or drink) • Do not apply to dentures. • Leave at least 30 minutes before reinsertion of dentures.
Further information	• Onset of pain relief is usually within 5 minutes and usually lasts approximately 3 hours. • Ulceration of the oral mucosa may be recurrent or caused by trauma (physical or chemical), infection, carcinoma, dermatology disorders, nutritional deficiencies, gastrointestinal disease, drug therapy or blood dyscrasias. • It is important to establish diagnosis and any specific management in addition to local treatment. • Refer to doctor if problem persists.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **BONJELA**		PHARMACIST SUPPLY
DOSE **ONE APPLICATION**	ROUTE **TOPICAL/ BUCCAL**	FREQUENCY **3 HOURLY AS NEEDED**	MAXIMUM DOSE IN 24 HOURS **UP TO 3 HOURLY**
DOCTOR'S SIGNATURE **Nurse Initiated Nurse signature** **PRINT name**		INDICATION **MOUTH ULCERS**	

Protocol for the administration of

CLOTRIMAZOLE 1% CREAM

Clinical Condition	
Criteria for inclusion	Fungal skin infections e.g. nappy rash, ringworm, candida intertrigo, athlete's foot
Criteria for exclusion	Allergy to clotrimazole

Description of Treatment	
Name of medicine	Clotimazole
Legal status (POM/P/GSL)	GSL
Form	Cream
Strength	1%
Dosage	Apply to the affected area(s) two to three times daily
Route of administration	Topical
Frequency of administration	Two to three times daily
Total daily dose	Three times daily
Adverse reactions	Local irritation including mild burning sensation, erythema and itching. Treatment should be discontinued if these are severe.
Verbal advice for the patient	• Apply thinly and evenly to the affected area(s) Continue treatment for at least 2 to 4 weeks. • Inform nurse if symptoms persist, worsen or signs of local irritation develop
Follow up	• Contact the doctor if symptoms persist, worsen or signs of local irritation develop. • If candida vulvitis, ask doctor to prescribe treatment for vaginal infection.

DATE →		**Today's date**		MEDICINE (Approved name) **CLOTRIMAZOLE 1% CREAM**	SPECIAL INSTRUCTIONS	PRESCRIBER'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**	PHARMACIST
ROUTE →		**TOP**				BLEEP	SUPPLY
SPECIFY TIME IF REQUIRED ↓		DOSE ↓	SIGN DOSE CHANGE				
MORNING	✓	†					
MIDDAY	✓	†					
EVENING							
BED TIME	✓	†					

Saunders Nathan 26/09/2023 09:52:26

Protocol for the administration of

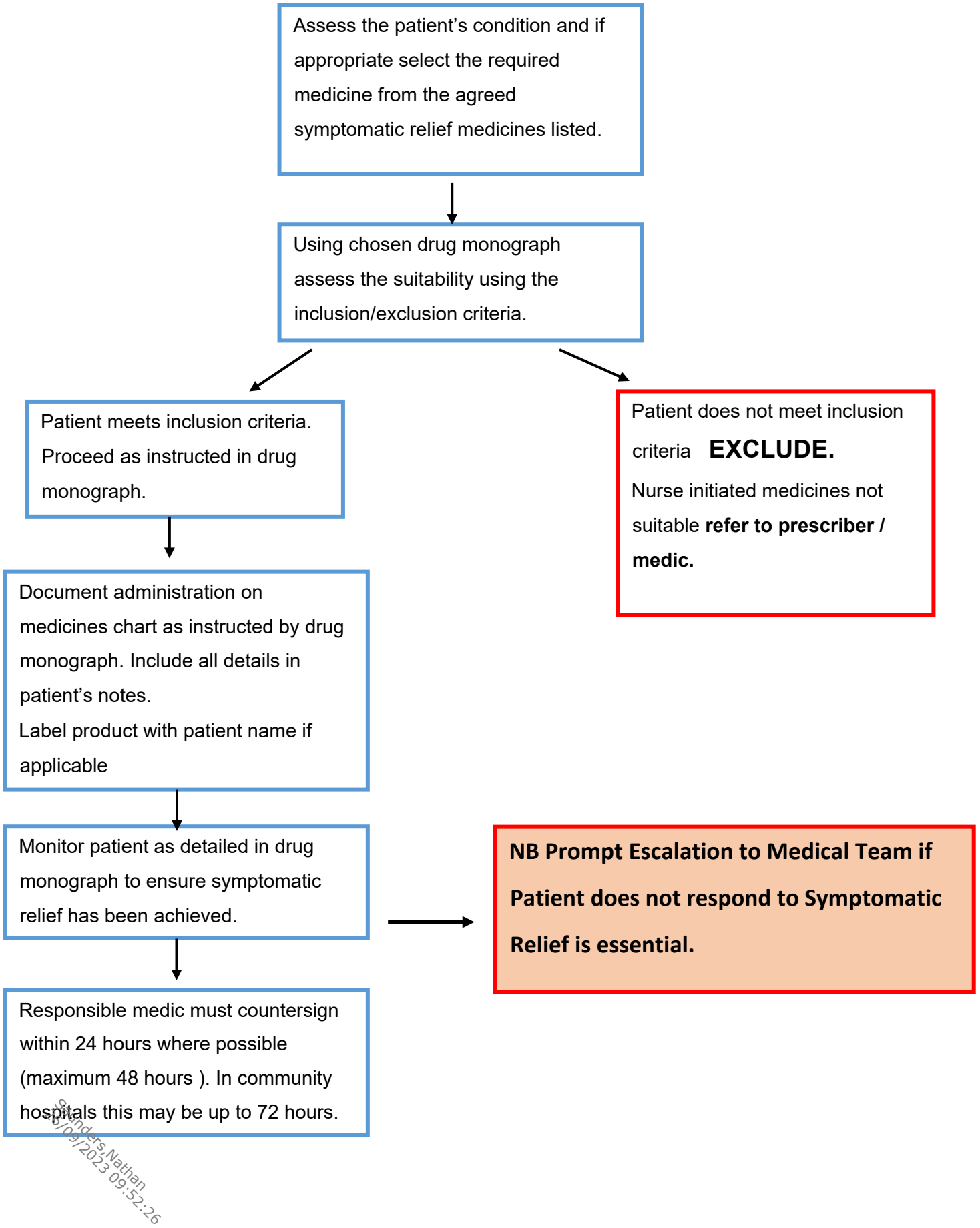
DIPROBASE CREAM ®

Clinical Condition	
Criteria for inclusion	Dry skin
Criteria for exclusion	Hypersensitivity to Diprobase® or any of the excipients (see tube for list of ingredients)

Description of Treatment	
Name of medicine	Diprobase® (Cetomacrogol, cetostearyl alcohol, liquid paraffin, white soft paraffin)
Legal status (POM/P/GSL)	GSL
Form	Cream
Dosage	Apply to the affected area(s) when required
Route of administration	Topical
Frequency of administration	As needed
Total daily dose	N/A
Adverse reactions	Local irritation and sensitisation. Discontinue if irritation occurs.
Verbal advice for the patient	• Apply as often as necessary. • Rub well into the skin. • Apply cream in the direction of hair growth. • Avoid contact with eyes. • Keep away from naked flames. • Inform nurse if symptoms persist or worsen
Follow up	Contact doctor if symptoms persist or worsen.

AS REQUIRED MEDICINES			
DATE **Today's date**	MEDICINE (Approved Name) **DIPROBASE**		PHARMACIST SUPPLY
DOSE **ONE APPLICATION**	ROUTE **TOPICAL**	FREQUENCY **AS NEEDED**	MAXIMUM DOSE IN 24 HOURS **AS NEEDED**
DOCTOR'S SIGNATURE **Nurse Initiated** **Nurse signature** **PRINT name**		INDICATION **DRY SKIN**	

Nurse Administration of Symptomatic Relief Medicines



Chapter 18 Medicines for Discharge Adult Short Stay Areas

Adult patients undergoing short-stay procedures may require new medications postoperatively (e.g. analgesia, antibiotics) for a successful outcome. These medications are often pre-determined and therefore ready labelled packs can be provided from Pharmacy to facilitate their issue by nursing staff.

The purpose of this procedure is to enable medications from an agreed list (identified by pharmacy) to be prepared and issued to patients "To Take Home" (TTH) in a safe manner on adult surgical & gynaecology short stay units dealing with minor procedures and where the stay is ≤ 48 hours

It is a legal requirement that all medicines are labelled with:

- Name and strength of the medicine
- Quantity in the container
- Directions of how and when to take the medicine and any additional instructions
- Patient's name
- Date of supply/issue of the medicine
- Name and address of the pharmacy/hospital from which the medicine was issued
- The words "Keep out of the sight and reach of children"

In addition:

- All TTHs must be prescribed by a doctor or non-medical independent prescriber.
- All of the medications on the agreed list are available as a pre-labelled patient pack.
- Individual areas to decide the range of patient packs available from this list, in consultation with their Directorate pharmacist.
- If the medication is not on the agreed list or the prescriber requires a dose or frequency which does not match the pre-labelled directions this must **only** be dispensed by the pharmacy department (see below).

PROCEDURE

1) Obtain a discharge prescription for the patient. Prescriptions must include as a minimum the name, address, date of birth, Patient's weight (if under 12 years old) and hospital number (e.g. an addressograph).
2) Ensure that the prescription is signed and dated by a doctor/non-medical independent prescriber.
3) Check with the patient that they have not been prescribed any medication they are allergic to; if they have, contact the prescriber.

4) One qualified nurse/midwife should obtain the pack of medication (usually one pack per prescription) and clearly fill in the patient's details on the pack (patient's name and the date).
5) **Paracetamol tablets, Fybogel sachets, Chlorhexidine Mouthwash 0.2%, Gaviscon Advance and magnesium hydroxide suspension**: These are now issued as manufacturer's packs with no added pre-printed label. A hospital address sticker should be attached to each pack and the patient's name and date written on. The directions are as on the pack.
6) **Paracetamol, Paracetamol 500mg soluble , Co-codamol 8/500 & Co-codamol 30/500:** The **maximum** dose for these preparations in patients weighing less than **50kg** is **ONE** tablet up to **FOUR** times a day
7) **Eye drops/eye ointments**: The patients name and the date should be written on to the pre-printed label on the bottle/tube including the frequency and intended eye requiring treatment. A 28 day expiry should be added unless the eye drop/ointment contains an anti-infective when a 14 day expiry should be given. If both eyes are infected, a separate bottle/tube should be provided for each eye.
8) For all items, the following checks should be made:
    i) That the drug name and strength on the box are the same as those on the prescription.
    ii) That the directions on the label are the same as those on the prescription.
    (NB the packs are pre-labelled with standard doses and dose frequencies; if the prescription does not match these, please contact the prescriber. If the prescriber requires a different dose this must be dispensed by pharmacy.
    iii) For antibiotic courses, ensure that the quantity issued will cover the whole course.
9) Endorse the prescription with the quantity of medication supplied. Sign and date the issue.
10) A second qualified nurse should then repeat the above checks and counter-sign the prescription.
11) The patient should be given an explanation of their medication and an appropriate patient information leaflet.
12) The top copy of the prescription should be returned to the pharmacy department, a copy given to the patient for their GP, and a copy filed in the patient's notes.

PRESCRIPTIONS DISPENSED BY THE PHARMACY DEPARTMENT

- If the medication is not on the agreed list or the prescriber requires a dose or frequency which does not match the pre-labelled directions this must be dispensed by the pharmacy department.
- If a patient is admitted for a period of over 48 hours the prescription must be dispensed by the pharmacy department.
- There is a separate procedure on the clinical portal: **Procedure for the Provision of Discharge Prescriptions when the Pharmacy is closed.**
- It is essential that a copy of the prescription is filed in the patient's notes on the unit/ward as this contains important dispensing information. The top copy of the prescription should be returned to pharmacy.

Directorate Pharmacists will ensure implementation in their appropriate areas working with the relevant lead/senior nursing staff to ensure nursing staff are appropriately trained.

Chapter 19 Medicines for Discharge Out of Hours

Under normal circumstances, discharge prescriptions should be written and dispensed during pharmacy opening hours. This should be completed as part of the UHB discharge planning process.

In **exceptional circumstances** e.g. discharge at short notice due to clinical need or bed shortage, the discharge prescription may not have been written and/or dispensed. The senior registered nurse on the ward caring for the patient (hereafter referred to as "the responsible nurse") must be satisfied that there is a need for an out of hours supply of medication at discharge.

The following options should then be considered:

a) For recently admitted patients, is a suitable supply of medication available at home? (N.B. need to ensure patient understands any changes to usual medication e.g. dose changes and has a supply of any new medication),

b) If no medication is due before the pharmacy re-opens, and the patient is then able to return to the hospital, they should be asked to do so. The prescription should be written and sent to pharmacy when re-open. The prescription will then be completed and returned to the requesting ward. The patient should be advised to return to the discharging ward to collect the medication.

c) If neither of the above solutions are appropriate/possible is not possible, the patient may be issued with a labelled medication pack(s)- as detailed below.

Then either :-

MTED

- An e-discharge will need to be written before the patient is discharged from the ward clinical workstation.
- There may not need to be medication added to the e-discharge in all circumstances.
- Medication can be added to the e-discharge by the doctor using the in-hours procedure.
- If an out of hours supply of medication at discharge is needed, then the doctor writing the e-discharge needs to print and sign it.
- The step requiring a pharmacy clinical check is not necessary and will not prevent the e-discharge from being transmitted to the GP.

Hard Copy TTH (where appropriate)

- The prescriber must write the UHB Discharge Advice Letter (TTH) .
- The responsible nurse and the doctor/prescriber requesting discharge must initial the prescription and indicate what was issued i.e. number of tablets (and strength if not as prescribed)..
- The completed Out of Hours TTHs form and the top copy of the prescription and the inpatient Medication Administration Record (inpatients only) and patient notes must be left in the designated area of the ward for a pharmacist to review retrospectively. The second (GP) copy should be given to the patient in a sealed envelope.
- The top yellow/white copy is the legal prescription document and should be kept in the pharmacy for 2 years from dispensing.

Checking Medicines for Take Home

- The doctor/prescriber requesting the discharge and the responsible nurse must check each item on the discharge prescription against the inpatient drug administration record for accuracy of transcription. If the therapy is intended for a discrete course and there is excess in the pack this must be made clear to the patient.

- Medication packs may be either those brought in to hospital by the patient (if fit for purpose), or pre-labelled casualty/patient/ Patient-orientated medicines POMS packs that must be annotated with patient's name and date of supply.

Before any medicines are supplied to the patient each item prescribed must be checked as follows:

- That the medication pack is labelled.
- That the name on the prescription corresponds with the patient name shown on the medication pack label (where applicable).
- That the drug name and details on the pack label corresponds with the drug, route/form and strength required by the prescription.
- The contents should be checked to ensure they match label.
- That the route specified on the prescription is compatible with the medication available and the instructions on the label.
- That the dose volume, and dosing frequency, specified on the prescription match the instructions on the label. For some medicines the dose may need to be completed on the label. Where dose instructions are not specific (e.g. take as directed) ensure that the patient has a completed Medicines Information Card. Ward stock packs with no patient label must NOT be used.
- That the quantity is sufficient to cover the whole period of supply (normally one week). If not, arrangements must be made to complete the supply e.g. patient to return.
- That the medication has not passed its expiry date.
- Where patients own medicines are used, follow this procedure in conjunction with POMS criteria (see chapter 7 point 7.3) for use of patient's own medicines.

- Controlled drugs cannot be issued under this procedure **EXCEPT** the return of the patient's own supplies. In this case, the return must be appropriately documented in the ward controlled drug record book.

- Any drug substitution due to lack of stock must be resolved with the prescriber e.g. choice of analgesia. Any changes must be indicated on the discharge prescription.

- Ensure that the patient and/or the patients' carer understands the following about their medication(s):
  - What it is for
  - How and when to take it
  - What to do if side effects are noticed
  - When to stop taking / get medication reviewed by a doctor

- If any concerns arise during the process, **the on-call pharmacist may be contacted for advice.** Though they will not normally provide a TTH service out of hours.

- Most ward areas in UHW and Llandough have over labelled packs – “POMS packs”. Addition of the necessary information at ward level allows them to be used as part of the TTH. For information on availability of POMs packs etc see WOREQ or seek advice from site practitioner. Supplies are only restocked on receipt of the prescription.

Ward Pharmacist’s responsibility

- The next normal working day the ward pharmacist must review the prescription utilising the patient’s Inpatient Medication Administration Record and notes.
- If there are problems with the prescription, the pharmacist must contact a member of the Consultant team that was responsible for the care of the patient. The pharmacist will document any problems in the notes.
- It is the Consultant team’s responsibility for resolving the problem, including (if necessary) contacting the patient.

  The ward **pharmacist will provide information** for ward staff on this procedure on request by the ward manager.

Resources/ References

- Summary of Product Characteristics (SPC) for each medicine is produced by the manufacture eIV guide is a database accessible via HOWIS Local Hospital Medicines Guide
- Good Prescribing Guide
- British National Formulary (BNF)
- Nursing and Midwifery Council
- General Medical Council
- Royal Pharmaceutical Society of Great Britain
- General Pharmaceutical Council
- Specialist information on medicines can be found from the Medicines Information Centre UHW – number 02920742251

All Wales Guidelines for Delegation (HEIW 2020). Available at: https://heiw.nhs.wales/files/covid-19/delegation-guidelines/ (Accessed on 01/06/2023)

All Wales Practice Learning Framework (2023) Available at: heiw.nhs.wales/files/once-for-wales/documents/all-wales-practice-learning-framework-2023 (Accessed 01/06/2023)

The Pharmaceutical Journal (Vol 285) 24/31 'How to keep proper pharmacy records' NHS Choices. Medicines Information – Licensing Available at: www.nhs.uk/Conditions/Medicinesinfo/Pages/Safetyissues.aspx (Accessed on 20/3/2017)

Medicines and Healthcare products Regulation Agency. Medicines and medical devices regulation: what you need to know Revised 2008. Available at: www.mhra.gov.uk/home/groups/comms-ic/documents/websiteresources/con2031677.pdf (Accessed on 20/03/2017)

Medicines and Healthcare products Regulation Agency. Off-label or unlicensed use of medicines: prescribers' responsibilities. Published 1/4/2009. Available at: https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicinesprescribers-responsibilities. (Accessed on 20/3/2017)

NHS Wales Shared Services Partnership Welsh Risk Pool Services Technical note 14: Prescribing of unlicensed drugs or using drugs for unlicensed indicators. Reviewed 8/11/2004

General Medical Council. Good practice in prescribing and managing medicines and devices. Available at: www.gmcuk.org/static/documents/content/Prescribing_guidance.pdf (Accessed on 21/3/2017)

Appendix 1

The Medicines Code provides concise evidence-based medicines practice guidance. The following list is representative of the policies and procedures that The Medicines Code now replaces the following policies:

Reference Code	Document Title
UHB 219	Policy for Safe and Secure Handling of Medicines.
UHB 046	The Ordering, Storage, Disposal, Safe Prescribing and Administration of Controlled Drugs in Secondary Care Policy.
UHB 125	Prescribing for Staff Policy and Procedure.
UHB 261	Medicines Reconciliation Policy.
Ref 298	Covert Administration of Medicines Policy and Procedure.
UHB 402	Covert Medicines
UHB 176	Access to Medicines When Pharmacy is Closed Procedure.
Ref 280	Disposal of Medicines Procedure
Ref 205	Management of Staff involved in Medication Errors Procedure.
UHB 112	Safe Administration of Medicines. Patient Orientated Medicines Procedure.
UHB 187	Prescribing, Ordering, Storage and Administration of Strong Potassium Injections Procedure.
UHB	Procedure for the Safe Administration of Medicines to Adult Patients with Swallowing Difficulties
UHB 151	Provision of Discharge Prescriptions When the Pharmacy is Closed Procedure.
UHB 195	Safe Administration of Medicines in Secondary Care Procedure
UHB 152	In-patient Prescription Monitoring Endorsement and Supply Procedure expired
UHB 204	Complimentary Medicines Guidelines.
UHB 225	Take Home Medication (TTH) on Adult Short Stay Surgical and Gynaecology Areas Procedure expired Jun 2015
UHB 226	Use of Unlicensed Medicines and Medicines used Outside their Product License Procedure expired Dec 2015
UHB 266	Non-Medical and Dental Prescribing Policy
UHB 270	Use of bed side medicines cabinets for wards without a POM service medicines management procedure
UHB 388	Medicines Management policy

Appendix 2

This section clarifies the scope of practice that the 'future nurse' nursing student must work within. Detailed information is provided regarding medicines management and the enhanced skills. It is vital that supervising registrants recognise that they hold overall accountability for patient care and thus direct supervision of student practice is essential There are a number of clear practice exclusions that must be adhered to.

Student Nurses must NOT
Check, draw up or administer intravenous **opioid** medication or intrathecal medication Undertake arterial blood gas sampling. Administer IM injections as part of the rapid tranquilisation process in Mental Health, Learning Disability and some adult settings. Undertake any aspect of transportation, handling and administration of Systemic Anti-Cancer Therapy (SACT) (all routes including oral). This includes chemotherapy, immunotherapy, antibody treatments and targeted therapies
Administer from Patient Group Directives (PGD). Please note: this means that if the All Wales national protocol supporting non-registrants to participate in the COVID vaccination programme is withdrawn students will no longer be able to vaccinate – administration will revert to registrants administering via the PGD only. Set up or administer total parenteral nutrition (TPN). Student nurses must **not** undertake venepuncture if pre-transfusion blood sampling is required. This means they must not take blood if any of the following tests are requested: a. Crossmatch b. Group and save/group and screen c. Kleihauer d. Direct Antiglobulin Test (DAT) They must also **not** undertake venepuncture for blood cultures. Undertake digital removal of faeces (manual evacuation).
Apply compression bandaging to treat venous leg ulcers, venous disease or lymphoedema.

Student Nurse Scope of Practice

Medicines Administration

Training is provided in the HEI from Part 1 of the programme, and reinforced in Parts 2 and 3. Students can be involved in medicines administration from Part 1.

Supervision requirements:

1. Students from all fields can administer medications as below under the direct supervision of a Registered Nurse (RN) throughout the whole process.
2. Child field students can administer under the direct supervision of two RNs except for Child Health areas that have converted to one RN administration, here the student can be supervised by one RN.
3. Students must **never** be left unsupervised during any part of the medicines' administration process.

Route	Part 1	Part 2	Part 3
Oral medication	Students can undertake oral administration of medicines under direct supervision.	Medicines practice is essential to prepare the student for the In-point Medicines Assessment which has to be completed by the end of Part 2.	In preparation for registration, students must undertake directly supervised medicines administration for an allocated group of patients wherever and whenever possible.
	NB: Oral Systemic Anti-Cancer Therapy (SACT) must **not** be given by student nurses (i.e. chemotherapy, immunotherapy, antibody treatments and targeted therapies)		
Oral, IM and subcutaneous controlled drugs	Students can check and administer CD under the direct supervision of an RN from part 1 and can be the 2nd checker (3rd checker in Child Health). They must **not** administer s/c infusions via an infusion device. The practice assessor or practice supervisor will need to check that the student nurse has the underpinning knowledge re: the CD check and administration process through discussion and questioning. The student can then practice by participating in the process when it is carried out by two RNs. Once the PA or PS has observed the student being able to safely carry out the full process during practice with two RNs they can then become the 2nd checker (3rd in Child Health).		
Per rectum (PR) medication	Can administer under direct supervision from part 1. The student can also undertake the digital rectal examination (DRE) required prior to the administration of suppositories or enemas (needed to support bowel opening) under direct supervision provided that they have received prior training in practice or the HEI.		
Inhaled therapies	Can administer and support patients to self-administer under the direct supervision of RN from Part 1.		

Route	Part 1	Parts 2 and 3
Topical treatment	Can administer under direct supervision of RN from Part 1.	
Nasogastric (NG) tube and Percutaneous Endoscopic Gastrostomy (PEG)	Observation only.	Can administer under direct supervision of RN. Whilst the student can check NG tube position, the RN must also complete an independent check to confirm the position prior to the student administering medication via the NG tube.
Vaccinations Flu and COVID vaccinations only whilst national protocol in place. **No other vaccines can be administered by students.**	Students must **not** administer vaccinations.	Whilst the national protocol is in place to support the COVID vaccination programme, students in part 2 and 3 who are on placement in vaccination centres/vaccination clinics/other appropriate settings where these vaccinations are administered can only administer the COVID and influenza vaccinations (to adults over 18 years old) and intranasal influenza vaccine (to children 2-18) under direct supervision provided that they have: a. Completed the national vaccination training programme which is completed by UHB vaccinators. b. Been assessed as proficient by an experienced registered practitioner immuniser using the UHB vaccination competencies.
Subcutaneous (s/c), intradermal or intramuscular injection	Can administer under direct supervision from Part 1. Administration of insulin must be **via a pen device only**. **Exclusion:** students must not administer rapid tranquilisation in Mental Health and Learning Disability settings or any other adult settings where this is required.	
Priming a S/C or IV infusion giving set	Observation only.	Can prime an infusion giving set under the direct supervision of RN once they can evidence that they have passed the In-point Medicines Assessment.
Replace IV infusion bags **Please note:** Students are not allowed to handle infusion bags listed in the exclusions on page 116.	Observation only.	Once the student can evidence that they have passed the In-point Medicines Assessment they can replace IV infusion bags under the direct supervision of an RN. Two RNs must check the bag and the student undertake a third check for their development. Students will be required to sign the fluid chart along with the two RNs. **NB:** The RN is responsible for ensuring the appropriate assessments have been undertaken before bag change e.g. U&E results, check of fluid balance, assessment for fluid overload/hypovolaemia. Students can participate in these checks.

Route	Part 1	Part 2	Part 3
Participate in the intravenous (IV) administration of medications using: **Bolus** **Intermittent infusion** **Continuous Infusion** **Includes the administration and monitoring of medications using vascular access devices.**	Observation only. Student can be involved in: ✓ patient monitoring ✓ recording of fluid balance ✓ patient assessment ✓ monitoring of IV access site using VIP Score. Students must **not** be involved in the reconstitution of IV medicines.	Observation only - student can be involved in: ✓ patient monitoring ✓ recording of fluid balance ✓ patient assessment ✓ monitoring of IV access site using VIP Score. At the end of part two once student can evidence that they have: a. Passed the In-point Medicines Assessment. b. Completed IV medicines/infusion training and simulation in the HEI. They can undertake: a. reconstitution of IV medications under the constant and direct supervision of two RNs. **Please note:** • Two RNs have to check the medications as per usual process. • The student can undertake a 3rd check as part of their development. • Student will be required to sign the medication chart along with the two RNs.	Once the student can provide evidence that they have: a. Passed the In-point Medicines Assessment. b. Completed IV medicines training and simulation in the HEI. They can undertake the following under constant direct supervision of an RN: a. Reconstitution of IV medications. b. Administration of IV medications. c. Saline flush of cannula. d. Patient monitoring. e. Recording of fluid balance. f. Patient assessment. g. Monitoring of the IV access site. **Please note:** ✓ Two RNs have to check the medications as per usual process. ✓ The student can undertake a 3rd check as part of their development. ✓ The student will be required to sign the medication chart along with the two RNs.

Route	Part 1	Part 2	Part 3
Manage and monitor blood component transfusions **Please note**: Only **RNs** can remove blood from Satellite Fridges. Student nurses can observe. Saunders,Nathan 26/09/2023 09:52:26	In parts 1 and 2 the student can: a. Observe the RN(s) whilst they check: ✓ the patient ID ✓ the written instruction ("prescription") ✓ the blood components NB: Some UHBs have mandated that 1 RN undertake these checks, whilst some mandate the checks must involve 2 RNs. b. Assist the RN with the following (under direct supervision): ✓ Taking & recording transfusion observations ✓ Monitoring the patient for complications or adverse reactions ✓ Monitoring the venous ✓ access site ✓ Monitoring of fluid balance		Once the student can evidence that they have: ✓ Passed their In-point Medicines Assessment. ✓ Completed IV medicines training and blood transfusion training and simulation in the HEI. They can undertake the following practical elements (under direct supervision from the accountable RN/RNs): ✓ Check patency of venous access. ✓ Check availability of component (in accordance with local organisational policy). ✓ Pre-administration checks including: • Patient ID • Written instruction ("prescription") • Blood component quality **Please remember:** the student must **not** act as a second checker for blood components. Whilst students can practice undertaking the checks the registrant, or 2 registrants where local policy requires, must independently undertake all checks as the accountable registrant(s). ✓ Taking & recording transfusion observations. ✓ Complete transfusion documentation with the RN – must be countersigned by the RN. ✓ Run through the blood giving set. ✓ Administration of any concomitant medication – this is medication which, if prescribed alongside the transfusion, must be given as instructed as part of the transfusion process. ✓ Monitoring the patient for complications or adverse reactions. ✓ Monitoring the venous access site. ✓ Monitoring of fluid balance. ✓ Disconnect and dispose of the transfusion. ✓ Complete traceability requirements in accordance with local UHB policy (i.e. return the transfusion label to blood bank or use of electronic fating system). **NB.** The RN will be responsible for ensuring full patient ID check is undertaken, setting up the infusion device if required, connecting the blood to the patient and commencing the infusion.

Appendix 3

Procedure for the Management of Staff involved in Medication Errors

(BENNION ERROR SCORING SYSTEM)

Policy	Procedure	Protocol	Guideline
NO	YES	NO	NO

Classification of Document:	Medicines Management/Corporate
Area for Circulation:	UHB employees
Version Number:	2
Original Reference Number:	205
Author/Reviewee:	Nurse Advisor for Medicines Management
Responsible Officer:	Executive Deputy Nurse Director
Ratified by:	EDoNs, DoNs, CMMG, NMB
Date Issued:	June 2023

Version Number	Date of Review	Reviewer Name	Completed Action	Approved By	Date Approved	New Review Date
1	NA	NA	NA	Clinical Standards and Patient Experience Committee	July 2006	July 2007
2	2023	Nurse Advisor MM	updated	NMB DoNs CMMG	May 2023 June 2023 July 2023	July 2026

Disclaimer

When using this document please ensure that the version you are using is the most up to date either by checking on the UHB database for any new versions or if the review date has passed please contact the author.

CONTENTS

1. INTRODUCTION

Medication is the most common intervention within the NHS and is a critical component of modern healthcare. Whilst every care is taken by individuals and the UHB when managing medication, errors involving medicines are sometimes inevitable due to human components.

A medication error can be defined as an incident where an error has occurred during the process of prescribing, preparing, administering, monitoring and omissions, irrespective of whether such errors lead to adverse consequences or not (DoH, 2018).

This procedure has been designed to support healthcare practitioners that have been involved in a medication error. The involvement in a medication error can often cause stress and anxiety for all individuals involved and this process should act as a guide to ensure the right support is provided and lessons are learnt. This procedure sets out actions to be taken by both the employee and employer.

2. AIM & OBJECTIVES

a) To ensure that lessons are learnt from each clinical incident and that a proactive, open and fair approach with staff is adopted to encourage reporting of incidents within a framework that promotes professional development whilst protecting patient safety.

b) This process will enable standardisation of the management of medication errors across Cardiff & Vale UHB.

3. SCOPE

This process is to be used for any healthcare practitioner within C&V UHB that has been involved in a medication error regardless of the stage at which the error occurred e.g. prescription to administration. Those that will predominantly be involved with medications are as follows but this list is not exhaustive:

- Medical staff
- Non-Medical Prescribers/Independent Prescribers
- Nursing & Midwifery staff
- Assistant Practitioners
- Pharmacy staff
- Allied Healthcare Professionals

4. ROLES & RESPONSIBILITIES

Employees

All staff within the UHB that are involved in medicines management should familiarise themselves with this procedure to assist in the standardisation of how errors are managed.

Employers/Managers
All employers and managers that are operationally responsible for service delivery must ensure the implementation of this procedure within their area when a staff member is involved in a medication error. The employer must ensure that their employees are aware of this procedure.

5. PROCEDURE

As soon as a medication error has been identified and reported to the medical team in charge of the patient, treatment provided if required, patient and family informed and the error has been documented in the medical notes and a Datix submitted, the following steps should be taken:

a) The Medication Error Reporting form is to be completed ideally by the line manager. Dependent on the seriousness of the incident, different mechanisms will be put in place. Using the BESS tool will enable a review of the causal factors, and will provide an error rating score for the individual along with providing suggested actions to be undertaken.

b) Consideration should be given to the circumstances surrounding the incident and the individual's previous practice and performance.

c) Whilst the investigation is to be carried out sensitively and support offered to the staff member involved, if the incident is found to have been malicious, the staff member should be informed that there is potential for disciplinary action.

d) After any error is made, the staff member must complete a reflection about this. Nurses and Midwives should use the NMC Reflective Template. All other professions should be encouraged to use a reflective tool commonly used within their profession or Driscoll's Model template.

e) Identify any systemic issues that may have contributed towards the error and address accordingly.

f) Identify any training needs and learning opportunities for the individual(s) involved

g) This procedure is a guide and should be used with managerial discretion. If there are concerns around the individual's practice regardless of the BESS score, mangers are advised to discuss with their senior managers.

h) If an individual obtains a BESS score of 16 or above, the appropriate senior team members e.g. Senior Nurse should be informed.

i) It is advisable to have a multi-disciplinary approach in managing the outcome/actions should this be deemed a systematic issue e.g. Clinical Board Pharmacist/Lead Nurse etc.

j) Retain the BESS score in the individual's personal file for 1 year, should a subsequent error occur within a 12-month timeframe, the current BESS score must be taken into consideration, however when the 12 months has passed this should be removed.

Temporary Staffing & Agency
Each profession will need to interpret this pathway according to their Professional Code of Practice. If a bank nurse makes a medication error they may be limited to where they can work until training has been instigated and assessed. If an agency nurse makes an error they will be referred to their manager for investigation and training. Evidence of that training will be required by the UHB. If any subsequent errors are made, consideration will be given as to whether placement within the UHB remains appropriate.

COMPLETION OF BESS
Where possible, this process should be undertaken by the line manager in the presence of the member of staff who has made the error, maintaining confidentiality at all times.

6. BESS Error Reporting Form

Area incident occurred/discovered:

Date of Incident: / /	Time of Incident:
Location Incident occurred:	
Date Incident reported / /	Time Incident reported:
Error reported by (circle): **SELF** **OTHER**	

Staff involved: Identify how many people were involved
Banding of staff member(s)
Substantive/Agency/Temporary Staffing

Total number of staff involved in error: _____			
Name	**Profession**	**Band/ Grade**	**Substantive/ Agency**

Staffing levels at time of incident:

Number of Registered staff	
Number of Unregistered staff	

Did staffing levels have an impact on the incident/situation (circle) **YES** **NO**
If 'Yes' explain why:

……

……

……

……

……

……

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Additional Information:

Patient seen by medical staff? (circle)	**YES**	**NO**
Discussed on the phone with medical staff? (circle)	**YES**	**NO**

Brief description of nursing/medical action recommended/taken:

……..

……

……

……

……

Prescription/authorisation clear and legible? (circle) If 'No' enclose a copy	**YES**	**NO**
Pharmacy label clear and legible and match prescription? (circle)	**YES**	**NO**
Drug name, dose and formulation identifiable from manufacturer's box (circle)	**YES**	**NO**
Is the patient wearing a wrist band? (circle) ***Hospital setting only***	**YES**	**NO**
Was a medical device involved in the error? E.g. pump rate set incorrectly. *If yes, continue with this error pathway and complete flow chart in Appendix C*	**YES**	**NO**

Form completed by: *(Name, Job Title and Signature)*	**Date:**

BESS RATING SCALE

ERROR CATEGORY

Circle all that are relevant	Points
Wrong time	**1 Point**
Wrong date	**1 Point**
Wrong patient	**3 Points**
Wrong route	**2 Points**
Wrong medication	**3 Points**
Wrong dose/strength	**2 Points**
Extra dose	**2 Points**
Medication omitted	**2 Points**
Medication given when allergy stated	**3 Points**
Medication given against an unsigned prescription	**1 Point**
Wrong formulation	**1 Point**
Expired drug	**2 Points**
Presence of a known contraindication	**3 Points**
Failure to double pump appropriately **(ITU/CCU only)**	**3 Points**
Medication administered without a prescription	**3 Points**

MEDICATION CLASSIFICATION

Assign Points dependent on the classification
(If in doubt of what classification a drug belongs to, please look up in the BNF / consult with pharmacy staff)

i	ii	iii	iv	v
Topical drugs & ENT Antacids. Anti-motility medicines. Anti-diarrhoeal agents. Laxatives. Vitamins & Minerals. Peripheral vasodilators. Anti-platelets. Lipid-regulators. Leukotriene receptor antagonist. Anti-histamines Mucolytic cough preparations. Orlistat Paracetamol Acamprosate NRT	Anti-dementia drugs. Non-MAOI Antidepressants. Anti-inflammatory agents. Endocrine system drugs (not listed elsewhere). Hypnotics and anxiolytics. Ulcer healing drugs. Diuretics. Nitrates/anti-anginals. Dihidropyridine. Calcium channel blockers. Inhaled bronchodilators and steroids. Oral salbutamol Pseudoephedrine. CNS stimulants Disulfiram. Oral penicillin, cephalosporin and trimethoprim. Contraceptives. Allopurinol/colchicine. Eye preparations	Antibiotics/anti-infectives. (not listed elsewhere) Antipsychotic agents. Barbiturates. Narcotic antagonists. Oral anti-diabetic agents. Oral steroids. Glucose infusion/glucagon Management of inflammatory bowel disease. Beta-blocker Centrally acting vasodilators & anti-hypertensive Alpha-blockers ACEI and ARB Diltiazem Non-antihistamine anti-emetics Drugs for genito-urinary disorders Vaccines	Oral anti-coagulants (except warfarin) LMWH Thrombolytic agents. Anti-arrhythmics including digoxin, verapamil Narcotic analgesics Electrolytes Any IV agents MAOIs Anti-epileptics Parkinsons medication Aminoglycosides Anti-virals Penicillamine/gold Ciclosporin, Leflunomide and tacrolimus Cytokine modulators	Warfarin & Heparin Blood & blood components Chemotherapeutic & Antineoplastic agents. Insulin Clozapine Lithium
1 Point	**2 Points**	**3 Points**	**4 Points**	**6 Points**

ROUTE GIVEN	Points
Epidural / Intrathecal / IV / IM / SC / intra-dermal / articular / lesional	**3 Points**
Oral	**2 Points**
PEG/NG	**2 Points**
Topical	**1 Point**
Inhaled/Intra-nasal	**1 Point**
PR or PV	**1 Point**
Sublingual/Buccal	**1 Point**

ERROR DISCOVERY TO ESCALATION TIME

The moment the error was identified by the individual, how long did they take to escalate this: ***NB:*** *if the individual did not know they made an error e.g. this was noted by another staff member on another shift there is an automatic default of 4 points – this is due to the potential harm that could be caused by a delay in being reviewed. However, if after discussion it is deemed to have not caused harm – you can review the score originally appointed*	**Points**
0 – 30 minutes	**0 Points**
31 – 59 minutes	**1 Point**
1 hour – 6 hours	**2 Points**
6 hours – 24 hours	**3 Points**
24 hours +	**4 Points**

OUTCOME TO PATIENT

Level of monitoring required at time of error above and beyond the existing observation for the patient	**Points**
Minimal monitoring - little or minimal actions required e.g. BP & pulse once only	**0 Points**
Close monitoring – observations to be continued over a period of time e.g. BP & pulse over next 6 hours, BM hourly for 3 hours etc. *(If patient in HDU/ ITU additional monitoring beyond pre-error requirements)*	**1 Point**
Complex monitoring and medical intervention - extended nursing & medical observations, blood tests. Needs further medical opinion. Possible transfer to HDU / ITU. *(If patient in HDU/ ITU additional intervention beyond pre-error requirements)*	**5 Points**
Intensive monitoring & medical intervention – transfer to HDU / ITU for emergency intervention. *(If patient in HDU/ ITU additional EMERGENCY intervention beyond pre-error requirements)*	**10 Points**

Total Score = _____

7. Managing and supporting staff following a medication error

Recording chart Form to be completed post error and retained on individuals file

Name:	
Datix number:	
Location of incident:	Date of Incident
Name and Designation of person completing form:	
Signature of person completing form:	Date:

BESS	**Points awarded**
Error Category	
Medication classification	
Route given	
Following error, time to reporting error	
Outcome to patient	
Previous BESS score if within past 12 months (add to Total)	
Total BESS Score	
Score to remain live on file until	

Staff member managed as indicated below:

Total points scored *(if more than one error in 12 months – accumulate score)*	**Outcome** **Score retained on practitioners file for 12 months**
Minor severity Score 1 - 15	Staff member involved in error can continue to prescribe / dispense / administer / advise on medicines if within their normal scope of practice. NB through reflection the practitioner must demonstrate they are safe. If there is any doubt, the line manager can ask the staff member to undertake supervised practice, even if the points fall in the 'minors' severity category.
Moderate severity Score 16 – 24	Staff member involved in error **SHOULD NOT** prescribe / dispense / administer / advise on medicines. • Carry out reflection • Action plan (moderate / major score will determine detail of action plan) to include: • Supervised practice & Competency assessment Score to be retained on practitioners file for 12 months
Major severity Score 25+ points *(Consider Capability Policy)*	

Staff member to sign as acknowledgement of their BESS Score & Actions

I understand that I have a BESS score on my file for 12 months and actions to be carried out.	**Name:** **Signature:** **Date:**

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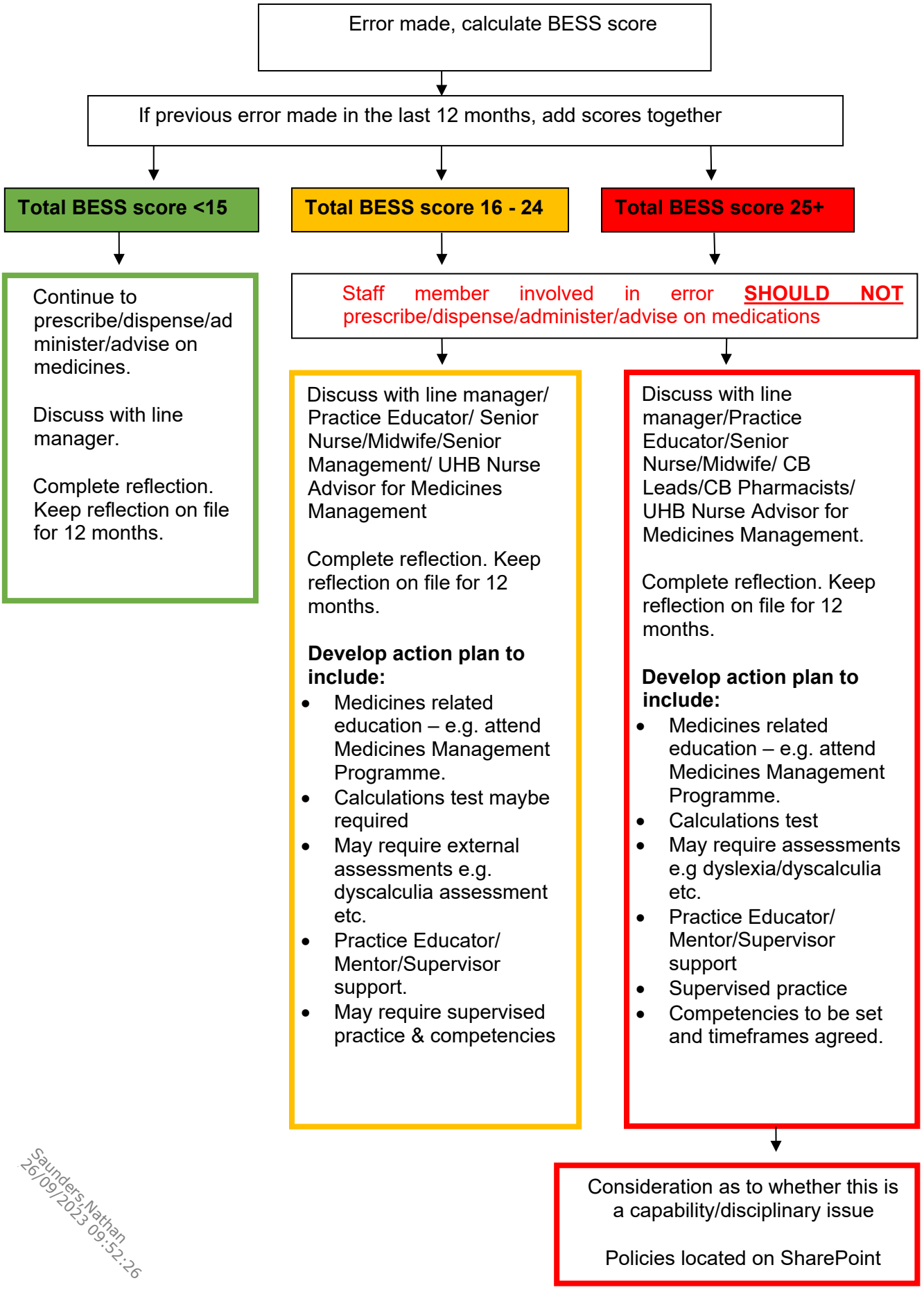
8. Managing and supporting staff following a medication error flowchart



9. Implementation & Training

The procedure will be circulated widely to the appropriate groups and will be re-enforced within Service Groups by local risk management arrangements. Any training needs identified will be addressed locally. A step by step flowchart has been included in this procedure to guide staff in its use. All staff who have made an Insulin related drug error to complete the Diabetes 6 steps to insulin safety online learning module:

10. Equality

This procedure has had an equality impact assessment and has shown there will be no adverse effect or discrimination made on any particular or individual group.

11. Distribution

This procedure will be available for viewing via the UHB Intranet Site. A copy will also be provided to all Directors, General Managers and Directorate Managers for onward distribution and circulation to staff as necessary.

12. Audit

It will be necessary to ensure that Service Groups are adhering to the requirements of this procedure. This will be monitored by the Corporate Medicines Management Group and the Nurse Advisor for Medicines Management.

13. Review

This procedure will be reviewed every 3 years, or more frequently if required.

14. References

Driscoll, J.J. (2007) Supported reflective learning: the essence of clinical supervision? Chp 2 in Practising Clinical Supervision: A Reflective Approach for Healthcare Professionals (2nd edition). London: Bailliere Tindall.

Department of Health & Social Care (2018) The Report of the Short Life Working Group on reducing medication-related harm (Online). Available at: Medication errors: short life working group report - GOV.UK (www.gov.uk)

Nursing & Midwifery Council (2018) Written reflective accounts (Online). Available at: www.nmc.org.uk/revalidation/requirements/written-reflective-accounts

Appendix A

Nursing & Midwifery Council

REFLECTIVE ACCOUNTS FORM

You must use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user, colleague or other individuals. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in *How to revalidate with the NMC*.

Reflective account:
What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?
What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?
How did you change or improve your practice as a result?
How is this relevant to the Code? Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

Appendix B

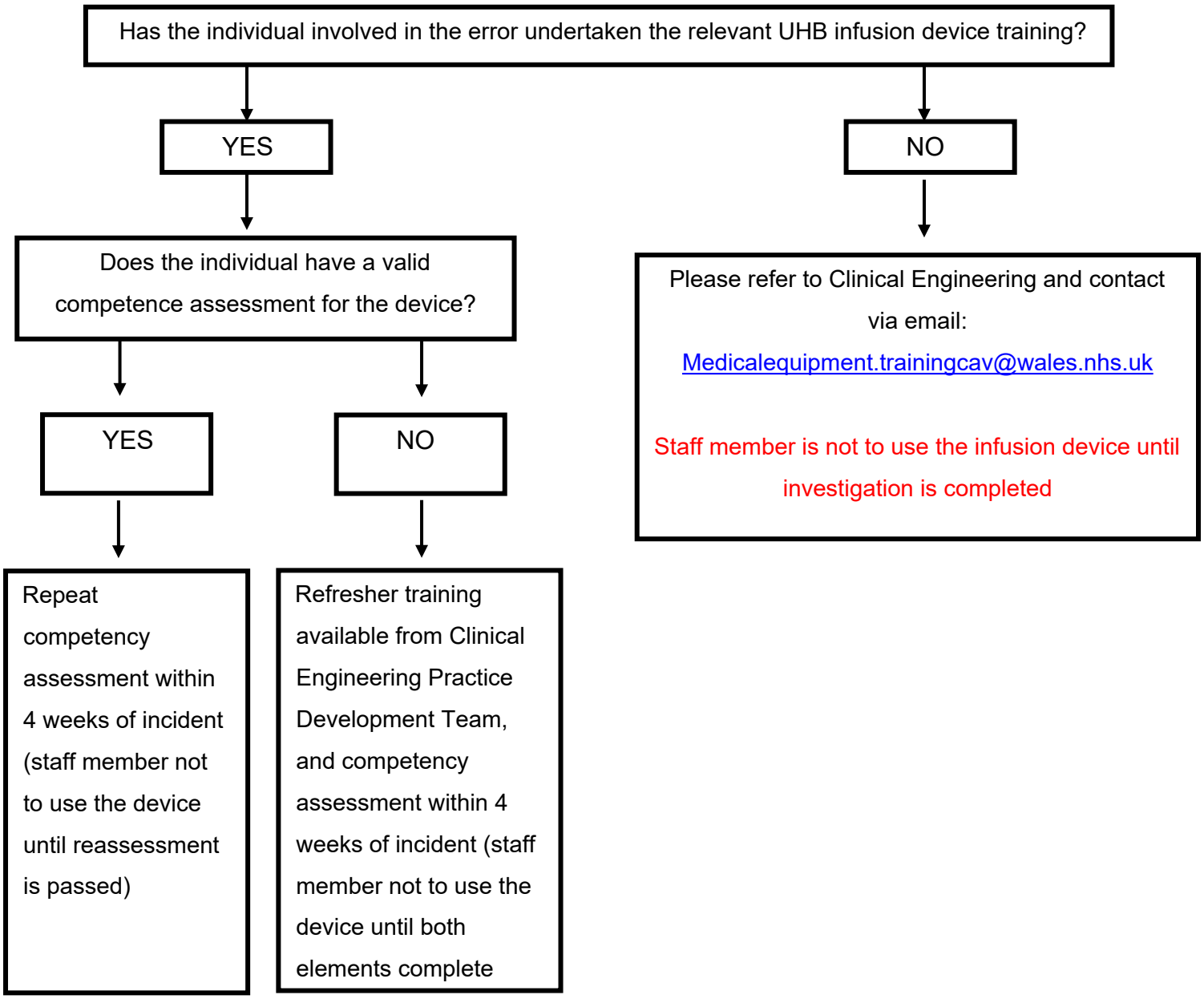
DRISCOLL'S REFLECTIVE MODEL TEMPLATE

What happened?
So What? Explain why the action/event was significant/ what impact it had/could have had
Now What? Explain how you will use this information to inform your future practice
Name: _____ **Date: _____** Saunders,Nathan 26/09/2023 09:52:26

Appendix C

INFUSION DEVICE USED DURING ERROR

This route is for errors with no/minimal patient harm. If moderate/severe harm has occurred please contact the Clinical Engineering Practice Development Team. If an infusion device was in use during the administration error please follow the flow chart. An infusion device includes; Volumetric pumps, Syringe pumps, Subcut pumps, PCAs, PCEAs, NG pumps.



NB: All infusion devices involved in an incident must be sent to Clinical Engineering (clean and with incident number attached) for investigation and checking. The B number must be included in the DATIX report.

Report Title:	Staff Winter Respiratory Vaccination Policy and Procedure			Agenda Item no.	3.1.2
Meeting:	Quality, Safety and Experience Committee	Public	X	Meeting Date:	26/09/2023
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	Information	✓
Lead Executive:	Executive Director of Public Health				
Report Author (Title):	Consultant in Public Health				

Main Report
Background and current situation:

Background:

For 2023/24, the Winter respiratory vaccination will include the active offer of the seasonal influenza (flu) and the COVID-19 Autumn booster vaccination.

The Joint Committee on Vaccination and Immunisation (JCVI) and the World Health Organisation (WHO) advise that all frontline healthcare staff receive an influenza vaccination to protect those they care for. Influenza vaccine has been recommended by JCVI for frontline NHS staff working in the UK since 2000. Prior to the pandemic, uptake had been increasing in a sustained way, but it has now been declining for the past 2 years.

Whilst Winter respiratory vaccinations are strongly recommended for all staff with patient contact, they are not mandatory. The emphasis of this policy and procedure is to ensure all eligible staff have actively received an offer of vaccination, and support to make an informed decision.

The underlying rationale for staff vaccination is at the same time that of reducing infection and transmission to patients, staff and their families, while also contributing to control the pressures experienced by urgent and acute care services. This is especially important due to the seasonality of COVID-19 and Influenza which can lead to a surge in the numbers of patients presentations and admissions, but also be accompanied by significant numbers of staff absences.

Previous efforts at increasing vaccination focused on strategies that had been adopted in organizations reporting high staff vaccination uptake and resulted over the 2021/22 and 2022/23 to the adoption of the following:

- An increase in visible senior leadership
- Implementation of Clinical Board Vaccination leads and Flu Champions and their active engagement
- Myth busting and challenging of incorrect information / misinformation and reinforcement of flu vaccination as routine practice and a patient safety issue
- Ownership and delivery of the vaccination programme distributed across the organisation.

The present policy and procedure aim to build on that experience and further develop our strategic and tactical approach to achieve higher vaccination uptake among staff with direct patient contact within the UHB.

Current situation:

In 2022/23, for the first time, Cardiff and Vale University Health Board (UHB) delivered the flu vaccination programme alongside the Covid-19 Autumn booster vaccination campaign in an effort to maximise uptake and protect as many vulnerable people as possible. Co-administration of flu and

Covid-19 is a key principle outlined in Welsh Government's Winter Respiratory Vaccination Strategy, published July 2022, and remains a key priority for the 2023/24 winter vaccination campaigns. That said, especially among staff there has been variable uptake rates between flu and COVID-19 vaccines.

- **Summary of 2022/23 Staff Flu and COVID 19 Vaccine uptake:**

The overall uptake of flu vaccination for staff with direct patient contact across Cardiff and Vale UHB in 2022/23 was **37.9%** which was lower than the 2021/22 uptake of **52.9%** and lower than in 2020/21 when it was **66.4%**. Flu vaccine uptake, apart from the 65+ cohort has been trending downwards across Wales for the last two years after the pandemic year upward spike of 2020-21.

Whilst the trend is undeniably downwards, with regards to the 2022/23 campaign for Cardiff and Vale UHB it is important to highlight that a significant proportion of vaccinations, over 15%, were delivered to employees unmatched in our records, especially in Medicine Clinical Board where more than 50% of employees vaccinated were unmatched to records (2,600 records required manual validation). The impact of digital records on the ability to match ESR records on WIS was widely highlighted as hampering the ability to accurately report progress in the campaign and target catch-up efforts. Whilst this is still a risk which can affect the accuracy of data in this campaign we are also aiming to mitigate this by using dashboards to more closely monitor the progress of the vaccination campaign progress. For future campaigns we are exploring how to simplify and possibly automate the matching of data across WIS and ESR, potentially with the use of RFID ID badges or other solutions involving unique identifiers.

Uptake for flu vaccination in 2022/23 also varied by Clinical Board from 32.6% (Mental Health) to 45.5% (Clinical Diagnostic & Therapeutics). These were again the Clinical Boards with the lowest and highest uptake in the 2021/22 campaign. (see appendix 1)

With regards to the COVID-19 booster vaccination in the Spring (as or 31st March 2023) we had a higher uptake than flu at 56.8%, but was still short of the Welsh Government ambitions of 80% for frontline staff uptake and this also represented a decline compared to previous booster vaccination campaigns. Cardiff and Vale UHB has also seen the lowest uptake of flu vaccination across Wales. (appendix 2). There is therefore work to be done to improve this Winter.

Over the last two Winter vaccination campaigns a number key issues have been identified which are likely to have contributed to reduced uptake this year amongst healthcare staff:

i) Reduced capacity amongst Clinical Board Flu Champions to offer vaccination in their usual, flexible and opportunistic manner
ii) Vaccine fatigue[1] amongst staff members
iii) Staff prioritising COVID-19 vaccine over flu vaccine
iv) Staff reporting difficulty attending two separate Mass Vaccination Centre appointments for flu and Covid-19 vaccination
v) Staff being vaccinated elsewhere and this not being captured appropriately in the data

In light of two subsequent years of downward trends in uptake among our members of staff, further work will be necessary even to return to the levels of vaccination seen before the pandemic.

Plan for 2023/24 Autumn/Winter Staff vaccination campaign:

On the basis of the insights gained from the 2021/22 and 2022/23 flu programme debrief sessions, qualitative insights published by Public Health Wales on barriers and facilitators to uptake of

[1] Vaccine fatigue is defined as people's inertia or inaction towards vaccine information or instruction due to perceived burden or burnout (Su Z, Cheshmehzangi A, McDonnell D, da Veiga CP, Xiang YT. Mind the "Vaccine Fatigue". *Front Immunol*. 2022;13:839433. Published 2022 Mar 10).

influenza and Covid-19 uptake amongst NHS staff in Wales[2] and the experience of the Covid-19 Spring booster campaign, this years' campaign will focus on:

- Expectation of strong Clinical board, directorate and corporate leadership
- Raising awareness and providing guidance on vaccine-related issues
- Proactively offering vaccination(s) to all eligible staff
- Providing accessible vaccination(s) to our staff, administered in multiple sites across the Health Board and with multiple avenues including UHB's Vaccination Centres, drop-in sessions throughout the season and support in the form of rebranded Vaccination Champions to facilitate vaccinations closer to the workplace
- Providing our staff protected time to review vaccine information, consent to the vaccination(s), receiving the vaccination(s) and, if required, any observation period following vaccination
- Co-administering influenza and COVID-19 vaccinations wherever possible

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Improving staff vaccination uptake against Winter respiratory viruses is of major strategic importance for the Health Board. The Autumn/Winter immunisation campaign, due to start officially on the 11th of September, is a fundamental pillar of our Winter planning strategy.
Key points to note are:

- By reducing spread among patients, staff and their families, a higher vaccination uptake will slow spread in the community, make hospitals a safer place for patients and reduce the rate of staff absences during the Winter season.
- This plan and procedure for staff respiratory winter vaccination builds on the already approved population-level Winter respiratory plan and procedure for the broader and fully integrated Winter Respiratory Vaccination Programme.

- The Plan seeks opportunities to promote more effective and efficient planning, delivery and evaluation strategies/tools which, in turn, will improve vaccine equity and access for citizens and staff.

- Building on our learning from previous campaigns, the campaign will be delivered with a hybrid delivery model that will see the operation of a number of Mass Vaccination Centres (Barry, Maelfa and Rookwood) while leveraging the important role of clinical board leads, local Vaccination Champions and occupational health.
- It is especially the opportunistic vaccination delivery led by vaccination champions that has the potential to achieve significant improvement in uptake and address vaccine fatigue among Health Board staff. This has been subject to limited capacity in recent years
- Leadership across the organization will therefore be pivotal in order to achieve the goal of high rates of Flu and Covid-19 vaccination among our staff. Collaboration among Clinical Board Vaccination Leads can help maximized the number, capacity and effectiveness of their Vaccination Champions.

Recommendation:

The Quality, Safety and Experience Committee is requested to:

- NOTE the content of the 2023/24 Staff Winter Respiratory Vaccination plan and procedure
- APPROVE the 2023/24 Staff Winter Respiratory Vaccination plan and procedure

Provide leadership and support to the implementation of the Plan

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

[2] Public Health Wales (2021) Understanding and addressing the barriers and facilitators for influenza and Covid-19 vaccine uptake among NHS employees in Wales

2. Deliver outcomes that matter to people		7. Be a great place to work and learn	✓
3. All take responsibility for improving our health and wellbeing	✓	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	✓	Long term		Integration	✓	Collaboration	✓	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: Vaccination forms one aspect of improving safety for our patients and our staff
Financial: No
Workforce: Failure to deliver on high uptake rates may impact on staff sickness during Winter
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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APPENDIX 1

Staff COVID-19 Vaccine Uptake by Clinical Board

Last Updated: 12/04/23

Cohort	Total Number Immunised	Uptake %
Capital, Estates & Facilities	647	47.1%
Children & Women Clinical Board	1,268	56.5%
Clinical Diagnostics & Therapeutics Clinical Board	1,707	66.3%
Corporate Executives	633	63.7%
Medicine Clinical Board	1,014	53.1%
Mental Health Clinical Board	786	52.4%
Primary, Community Intermediate Care Clinical Board	707	64.9%
Specialist Services Clinical Board	1,102	53.8%
Surgical Services Clinical Board	1,303	54.3%
All Wales Genomics Service	169	56.3%
Overall Health Board	9,336	56.8%

Source: The Welsh Government target is 75% uptake

Staff Flu Vaccine Uptake by Clinical Board

Last Updated: 12/04/23

Cohort	Total Number Immunised	Uptake %
Capital, Estates & Facilities	335	24.4%
Children & Women Clinical Board	901	40.1%
Clinical Diagnostics & Therapeutics Clinical Board	1,173	45.5%
Corporate Executives	421	42.4%
Medicine Clinical Board	646	33.9%
Mental Health Clinical Board	489	32.6%
Primary, Community Intermediate Care Clinical Board	430	39.5%
Specialist Services Clinical Board	751	36.7%
Surgical Services Clinical Board	962	40.1%
All Wales Genomics Service	115	38.3%
Overall Health Board	6,223	37.9%

Source: The Welsh Government target is 75% uptake

APPENDIX 2

Table 12a. Uptake of influenza immunisation in Welsh Health Board & NHS Trust staff until the end of February 2023

Health Board	Total Staff			Staff with direct patient contact[1]		
	Immunised (n)	Denominator (n)	Uptake (%)	Immunised (n)	Denominator (n)	Uptake (%)
Aneurin Bevan UHB	7495	13852	54.1	5053	9293	54.4
Betsi Cadwaladr UHB	8453	19348	43.7	6074	13435	45.2
Cardiff and Vale UHB	6663	16436	40.5	4737	11543	41.0
Cwm Taf Morgannwg UHB	5825	12472	46.7	3826	8310	46.0
Hywel Dda UHB	5292	11214	47.2	3618	7650	47.3
Powys Teaching HB	1088	2042	53.3	664	1308	50.8
Swansea Bay UHB	5556	12813	43.4	3724	8775	42.4
Velindre NHS Trust	917	1655	55.4	486	852	57.0
Welsh Ambulance Service NHS Trust	1852	4251	43.6	-	-	-
Public Health Wales NHS Trust	1238	2422	51.1	663	1240	53.5
Wales	**44379**	**96505**	**46.0**	**28845**	**62406**	**46.2**

[1] *Combined figures for: Additional Prof Scientific and Technical, Additional Clinical Services, Allied Health Professionals, Medical and Dental, Nursing & Midwifery Registered staff groups.*

Reference Number: UHB 494 **Version Number: 1**	**Date of Next Review:** *June 2026* **Previous Trust/LHB Reference Number:** *UHB 494*

Staff Winter Respiratory Vaccination (Seasonal Influenza (Flu) and COVID-19 Autumn Booster) Policy

Policy Statement

To ensure that the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will protect the health and wellbeing of our staff and population by proactively offering seasonal vaccination(s) in line with Joint Committee for Vaccination and Immunisation (JCVI) advice and Welsh Government policy for the Winter season.

In order to protect our patients, our staff and our families from infection-related morbidity and mortality, and in so doing contribute to the resilience of our health services during Winter, the Health Board is committed to actively offering all eligible staff Winter respiratory vaccinations to include the seasonal influenza (flu) vaccination and the COVID-19 Autumn booster vaccination.

Policy Commitment

As an employer of healthcare staff, Cardiff and Vale University Health Board (hereon referred to as the Health Board) has an occupational health responsibility and commitment to ensuring that all eligible staff are aware that they are eligible, are actively invited to receive the recommended Winter respiratory vaccination(s), are provided and supported with relevant accessible information to make an informed decision and are provided with accessible options to receive the vaccination(s).

To ensure this commitment is met, the Health Board will utilise a number of strategies, including:

- Raising awareness and providing guidance on vaccine-related issues
- Proactively offering vaccination(s) to all eligible staff
- Providing accessible vaccination(s) to our staff, administered in multiple sites across the Health Board
- Providing our staff protected time to review vaccine information, consent to the vaccination(s), receiving the vaccination(s) and, if required, any observation period following vaccination
- Co-administering influenza and COVID-19 vaccinations wherever possible
- Treating staff information as confidential and securely storing that information according to NHS Wales and the Health Board's information governance policies and procedures, and in line with current Data Protection legislation

Supporting Procedures and Written Control Documents

This Policy and the supporting procedures describe the following regarding the Health Board staff Winter vaccination(s):

- The important role that the Health Board has to play in improving the health, safety and wellbeing of its staff
- The expectation that every eligible staff member is responsible for maintaining and improving their own health and wellbeing
- Who is eligible for the staff Winter vaccination (seasonal influenza and COVID-19 Autumn booster) programme
- What eligible staff can expect in terms of offer, information, access, delivery of the vaccinations and data management

Other supporting documents are:

- Employee Health And Wellbeing Policy
- Cardiff and Vale University Health Board Winter Respiratory Vaccination Plan
- CIPD 2023. COVID-19 vaccination: guide for employers. 7 March 2022. Available online at: https://www.cipd.co.uk/knowledge/fundamentals/emp-law/health-safety/preparing-for-covid-19-vaccination [Accessed 19.05.23]
- NICE Guideline [NG103] – Flu vaccination: increasing uptake. 1.7 – Employers of health and social care staff.
- Thorneloe R, Lamb M, Jordan C *et al*. 2021. Understanding and addressing the barriers and facilitators for influenza and COVID-19 vaccine uptake among NHS employees in Wales: Qualitative insights and co-produced interventions. Public Health Wales and Cwm Taf Morgannwg University Health Board.
- UKHSA. 2013 (Updated September 2022). Influenza: the green book, chapter 19: Available online here
- UKHSA 2020 (Updated April 2023). COVID-19: the green book, chapter 14a: Available online here
- Joint Committee on Vaccination and Immunisation Advice & Guidance. Available online here
- Welsh Government. 2023. Welsh Health Circular: The National Influenza Immunisation Programme: Available online here
- Welsh Government. Winter respiratory vaccination strategy: Available online here

Scope

This policy applies to all of our staff in all locations including those with honorary contracts

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed as part of an EHIA. This found there to be a positive impact on the following groups:

	• Older people • People with a disability • Pregnant people • People from a Black, Asian or Other ethnic group • People from areas of disadvantage • People with caring responsibilities There were no direct negative consequences from this policy. Overall no significant impacts requiring improvement or mitigation were identified.

Health Impact Assessment	A Health Impact Assessment (HIA) has been completed as a part of an EHIA. This found there to be a potential negative impact on staff working bank/shift patterns in terms of loss of income from potential side effects affecting their ability to work. Key actions have been identified and these can be found in the accompanying EHIA.
Policy Approved by	TBC
Group with authority to approve procedures written to explain how this policy will be implemented	Strategic Leadership Board
Accountable Executive or Clinical Board Director	Executive Director of Public Health

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Strategy and Delivery Committee *21/09/22* *Link to agenda.*	27/09/2022	New Staff Winter respiratory vaccination policy including seasonal influenza vaccination and the addition of COVID-19 Booster vaccination. Supersedes the Staff Influenza (Flu)

			Vaccination Policy v1.10 September 2020 (Previous reference number unknown).
2	Date approved by Strategic Leadership Board Link to Agenda		Review & update of Staff Winter Respiratory Vaccination Policy including seasonal influenza vaccination and the addition of COVID-19 Booster vaccination (Reference UHB 494).

Contents Page

Appendices *(if required)*

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board	**Reference Number: UHB XXX** **Version Number: 1** **Next Review Date: July 2024** **Previous Trust/LHB Reference Number: N/A**

Cardiff and Vale University Health Board 2023/24 Staff Winter Respiratory Vaccination (Seasonal Influenza (Flu) and COVID-19 Autumn Booster) Procedure

Introduction and Aim

It is the procedure of Cardiff and Vale UHB to ensure that all eligible staff are proactively offered seasonal vaccination(s) in line with Joint Committee for Vaccination and immunisation (JCVI) and advice from Welsh Government policy for the Winter 2023/24 season.

For 2023/24, the Winter respiratory vaccination will include the active offer of the seasonal influenza (flu) and the COVID-19 Autumn booster vaccination.

Whilst Winter respiratory vaccinations are strongly recommended for all staff with patient contact, they are not mandatory. The emphasis of this procedure is to ensure all eligible staff have actively received an offer of vaccination, and support to make an informed decision.

Objectives

The Objectives of the procedure are to: -

- Articulate the scope of the 2023/24 Winter respiratory programme
- Indicate the mechanisms of delivery to improve access across the workforce
- Outline individual, managerial, Clinical Board and UHB responsibilities.
- Acknowledging information governance requirements and in a transparent manner, emphasise the specific uses of any data aligned to the programme.

Scope

This procedure applies to all of our staff in all locations including those with Honorary Contracts.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed as part of an EHIA. This found there to be a positive impact on the following groups: • Older people • People with a disability • Pregnant people • People from a Black, Asian or Other ethnic group • People from areas of disadvantage • People with caring responsibilities

	A Health Impact Assessment (HIA) has been completed as a part of an EHIA. This found there to be a potential negative impact on staff working bank/shift patterns in terms of loss of income from potential side effects affecting their ability to work. Key actions have been identified and these can be found in the accompanying EHIA.
Documents to read alongside this Procedure	Staff Winter Respiratory Vaccination (Seasonal Influenza (Flu) and COVID-19 Autumn Booster) Policy
Approved by	TBC
Accountable Executive or Clinical Board Director	Executive Director of Public Health
Author(s)	Deputy Head of Operations – Mass Immunisations & Testing; Consultant in Public Health Medicine

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	Date approved by Strategy and Delivery Committee *21/09/22* *Link to agenda.*	27/09/2022	New Staff Winter respiratory vaccination policy including seasonal influenza vaccination and the addition of COVID-19 Booster vaccination. Supersedes the Staff Influenza (Flu) Vaccination Policy v1.10 September 2020 (Previous reference number unknown).
2	Date approved by Strategic Leadership Board Link to Agenda		Review & update of Staff Winter Respiratory Vaccination Procedure including seasonal influenza vaccination and the addition of COVID-19 Booster vaccination (Reference UHB 494).

CONTENTS

1. INTRODUCTION

As an employer of healthcare staff, the Health Board has an occupational health responsibility and commitment to ensuring that all eligible staff are aware that they are eligible, are actively invited to receive the recommended Winter respiratory vaccination(s), are provided and supported with relevant accessible information to make an informed decision and are provided with accessible options to receive the vaccination(s).

2. PROCEDURE STATEMENT

To ensure that the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will protect the health and wellbeing of our staff and population by proactively offering seasonal vaccination(s) in line with Joint Committee for Vaccination and Immunisation (JCVI) advice and Welsh Government policy for the Winter season.

In order to protect our patients, our staff and our families from infection-related morbidity and mortality, and in so doing contribute to the resilience of our health services during Winter, the Health Board is committed to actively offering all eligible staff Winter respiratory vaccinations to include the seasonal influenza (flu) vaccination and the COVID-19 Autumn booster vaccination.

3. SCOPE

3.1. For the purpose of this procedure, Health Board 'staff' refers to all staff who deliver services on behalf of the Health Board including clinical and non-clinical roles, and those with honorary contracts, medical and dental students on placement with the Health Board and volunteers.

3.2. Eligibility for the Winter respiratory vaccinations is informed by United Kingdom (UK) and national guidance, including the JCVI, Welsh Government and the Vaccine Clinical Advisory Panel (VCAP).

3.3. *Seasonal influenza (flu) vaccination eligibility 2023/24* - For 2023/24, the seasonal influenza vaccination is recommended for specified high-risk groups including "frontline NHS/primary care services, healthcare workers with direct patient contact", which is consistent with previous years. The Health Board has, in recent years, extended the influenza vaccination offer to all staff in the Health Board where supply and capacity has allowed. Where possible, the Health Board will continue to offer influenza vaccination to all staff members, with priority to those who have face-to-face clinical or social contact with patients if there are supply constraints.

3.4. *Autumn COVID-19 booster vaccination eligibility 2023/24* - For 2023/24, the Autumn COVID-19 booster vaccination is recommended for specified high-risk groups including "frontline health and social care workers", which includes staff involved in direct patient care, non-clinical staff who may have social contact with

patients and hospital-based laboratory and mortuary staff who frequently handle SARS-CoV-2 or collect or handle potentially infected specimens.

3.5. Individuals who do not meet the eligibility criteria for vaccination as a Health Board staff member but are eligible for seasonal influenza and/or COVID-19 Autumn booster vaccination(s) due to another risk factor will be invited in line with that cohort.

3.6. Staff who wish to receive the vaccination(s) will be asked to provide verbal consent at the point of accessing the vaccination(s). The verbal consent will be recorded on the Welsh Immunisation System (WIS).

4. TRAINING

4.1. All staff delivering the vaccinations will have received appropriate training outlined in the National Minimum Standards and Core Curriculum for Immunisation Training for Registered Health Professionals. This includes knowledge on the vaccination(s) and ability to support the individuals to make an informed decision.

4.2. Clinical Boards will support staff working across different clinical areas to train (or maintain their training through annual updates) as a 'Vaccination Champion' and peer vaccinators, to enable them to have supportive conversations about the vaccinations, and to offer influenza vaccination in the workplace.

5. IMPLEMENTATION

5.1. The offer of vaccination will be cascaded to staff via several routes including line managers, Health Board communications (e.g. e-mails, staff newsletters, and social media) and/or through personal invitations. The offers should be provided in a variety of accessible formats.

5.2. The Mass Immunisations Team will offer a blended approach to access vaccination, inviting staff to access their winter respiratory vaccination through drop-in vaccination clinics, within their workplace via peer vaccinators (Vaccination Champions) and/or invitation to one the Health Boards Mass Vaccination Centres. Any specific requests should be directed to the Mass Immunisations & Testing team.

5.3. Co-administration of the influenza and COVID-19 vaccinations should be the standard delivery model where possible, for staff who are eligible.

5.4. New starters joining the Health Board will complete a screening form for their pre-employment occupational health checks, which includes a question on COVID-19 vaccination status. If they have received the vaccination(s), it will be recorded in the Occupational Health system. As part of induction for new starters, if they are joining during the seasonal Winter vaccination period, the new starter should be made aware of the offer of vaccination and the usual process of supporting informed decision making, consent and access to vaccination will then be followed. Supporting information such as this procedure (and accompanying policy) and the Flu for All e-module should also be available.

5.5. Staff who wish to receive the vaccination(s) will be asked to provide verbal consent at the point of accessing the vaccination(s). The verbal consent will be recorded on the Welsh Immunisation System (WIS).

5.6. Staff who consent to vaccination(s) but have/will receive the vaccination(s) elsewhere (e.g. via their GP or community pharmacy) will be encouraged to complete a self-certification process or inform the Mass Immunisations team directly once they have received the vaccination(s). Vaccinations delivered by a Health Board Vaccination Champion, a Health Board Vaccination Centre or the Health Board's Occupational Health Department will be entered directly and recorded on the WIS, thus requiring no further communication internally.

5.7. In the scenario where there is a limited supply of vaccines at any given time, prioritisation of vaccines will be through a risk assessment approach to identify groups of staff or departments with the greatest need.

6. RESPONSIBILITIES

6.1. Clinical Boards and corporate departments in which eligible staff members work have overall responsibility for ensuring every eligible staff member will receive an offer for vaccination and will be able to access the vaccination(s).

6.2. Staff should be allowed time by their line manager during their working day/shift to receive the vaccination(s), where service delivery allows. This includes protected time to review information, consent to the vaccination(s), receiving the vaccination(s), and if required any observation period following vaccination. In cases where line managers are struggling to release staff for vaccination due to service pressures, they should contact the Clinical Board lead for further support.

6.3. Winter respiratory vaccination(s) are strongly recommended for eligible Health Board staff but are not mandatory. Therefore, every eligible staff member is required to make an informed decision as to whether they will receive the recommended vaccination(s). The Health Board will support staff to be able to make these informed decisions, by promoting a supportive culture at all levels in the organisation including executive, senior management, and peer support.

6.4. Accessible information should be provided at the point of offer to allow for time for each staff member to review and process the information, and to make their informed decision. It will be provided in a variety of formats; this includes access to a short e-module on Influenza/COVID-19.

6.5. The content of the information will be evidence-based and up-to-date, and developed in consideration of guidance and research on providing information to support decision making for vaccination uptake. This includes providing information on the rationale for the vaccine and addressing known concerns.

6.6. Line managers are responsible for ensuring that all their eligible staff have received accessible information about the vaccination(s) and can escalate to Vaccination Champions or the Clinical Board lead if there are staff members who are unable to access the information in its provided format.

6.7. Where a staff member is returning to work in the Health Board following a period of leave, a Return-to-Work Interview with the line manager will include the staff member being informed of the offer of Winter vaccinations if during the seasonal vaccination period. The usual process of supporting informed decision-making vaccination will be followed.

6.8. Staff who wish to decline the offer of vaccination(s) will be encouraged to complete an optional anonymous online form to help Public Health/Immunisation teams understand the reasons for declining a vaccination. This **optional** form **only** collects data on Clinical Board and staff group and the reasons why the vaccination(s) has/have been declined. This information can support relevant teams with general campaigns to improve take-up of vaccinations for flu and COVID-19.

6.9. All individual level data on vaccination status will be stored securely according to NHS Wales and the Health Board's information governance policies and procedures, in line with current Data Protection legislation, and will be treated as confidential.

6.10. Information on how an individual staff member's data will be recorded, shared, and stored should be communicated to the staff member prior to consent for the vaccination.

6.11. Individual level data on vaccination status for those who choose to receive the vaccination(s) from the Health Board will only be available to: the practitioner who completes the data entry into the Welsh Immunisation System (WIS) and the Health Board's Data Warehouse.

6.12. Individual level data on those who have declined the vaccination(s) will not be collected.

6.13. To ensure the use of this information will not result in any unfair treatment of employees, whilst data will be collected at an individual level, this will only be used at an anonymised group/cohort level. Status of individual vaccination will not be made available to managers or Clinical Boards.

6.14. The purpose for the data to be transferred from systems, such as, the WIS to the Health Board's Data Warehouse, is to provide reports on Health Board staff vaccination uptake by department, clinical board or staff group (which is not currently possible using the WIS, for COVID-19).

6.15. Uptake reports could help identify areas or staff groups (not individuals) where uptake is lower than expected, and where additional support from the Immunisation Team/Occupational Health could be offered. The reports may also demonstrate trends over previous years, comparisons with different health boards in Wales, and achievement against national and local targets for vaccination uptake.

7.0. REVIEW

This procedure will be reviewed to reflect any changes in guidance. As a minimum it will be reviewed annually after the date of approval.

8.0. REFERENCES/OTHER SUPPORTING DOCUMENTS:

- Employee Health And Wellbeing Policy
- Cardiff and Vale University Health Board Winter Respiratory Vaccination Plan
- CIPD 2023. COVID-19 vaccination: guide for employers. 7 March 2022. Available online at: https://www.cipd.co.uk/knowledge/fundamentals/emp-law/health-safety/preparing-for-covid-19-vaccination [Accessed 19.05.23]
- NICE Guideline [NG103] – Flu vaccination: increasing uptake. 1.7 – Employers of health and social care staff.
- Thorneloe R, Lamb M, Jordan C *et al*. 2021. Understanding and addressing the barriers and facilitators for influenza and COVID-19 vaccine uptake among NHS employees in Wales: Qualitative insights and co-produced interventions. Public Health Wales and Cwm Taf Morgannwg University Health Board.
- UKHSA. 2013 (Updated September 2022). Influenza: the green book, chapter 19: Available online here
- UKHSA 2020 (Updated April 2023). COVID-19: the green book, chapter 14a: Available online here
- Joint Committee on Vaccination and Immunisation Advice & Guidance. Available online here
- Joint Committee on Vaccination and Immunisation Advice on Eligible Groups for 2023 Autumn Booster: Available online here
- WHC (2023) 029 Winter Respiratory Vaccination Programme: Autumn and Winter 2023. Available online: here
- Welsh Government. 2023. Welsh Health Circular: The National Influenza Immunisation Programme: Available online here
- Welsh Government. Winter respiratory vaccination strategy: Available online here

Equality & Health Impact Assessment for
Staff Winter Respiratory Vaccination
(Seasonal Influenza (Flu) and COVID-19 Autumn Booster) Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Staff Winter Respiratory Vaccination (Seasonal Influenza (Flu) and COVID-19 Autumn Booster) Policy Policy Reference no: 494
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Cardiff and Vale University Health Board (All clinical boards and corporate directorates) Accountable Executive Director: Fiona Kinghorn, Executive Director of Public Health Fiona.kinghorn@wales.nhs.uk
3.	Objectives of the policy	**Overarching purpose** • To ensure all eligible staff are proactively offered seasonal influenza (flu) vaccination each year to protect at-risk patients, other staff and themselves from influenza-related morbidity and mortality • To ensure that all eligible staff are proactively offered a COVID-19 Autumn booster as per current JCVI and Welsh Government guidance to protect at-risk patients, other staff and themselves from COVID-19 related morbidity and mortality. The policy outlines the Cardiff and Vale University Health Board (Hereon referred to as the Health Board) offer of Winter vaccinations to all eligible staff in the Health Board, in order to: • Demonstrate who is eligible for the staff Winter vaccination (seasonal influenza and COVID-19 Autumn booster) programme • Outline what eligible staff can expect in terms of offer, information, access, delivery of the vaccinations and support afterwards

		• Outline the important role that the Health Board has to play in improving the health, safety and wellbeing of its staff • Explain the expectation that every eligible staff member is responsible for maintaining and improving their own health and wellbeing The objectives are: - To ensure that all Health Board staff members who are eligible to receive the seasonal influenza and/or COVID-19 vaccination: o are aware they are eligible o are able to access relevant information o are able to make an informed decision for vaccination o are able to communicate that decision o are able to access the vaccine(s) o are supported after receiving the vaccine(s) o are confident in the confidentiality of their data
4.	Evidence and background information considered.	This is an update of the Cardiff and Vale University Health Board 2022/23 Staff Winter Respiratory Vaccination (Seasonal Influenza (Flu) and COVID-19 Autumn Booster) Policy. The policy would apply to all Health Board staff who have regular contact with patients, so access should reflect the make-up of the Health Board staff cohort. This is in line with Welsh Government and UK Government policy for all health and social care staff who have regular contact with patients to be offered the vaccine. **Data on staff influenza vaccination** - There are limited data available on staff influenza vaccination uptake by protected characteristics or other demographic factors. - In discussion with the Project Leader for Employee Health and Wellbeing services, data on uptake by age and gender may be possible as this information is available in ESR, but the processes are not in place to extract and report this data currently.

Whilst there is no local evidence available on whether staff flu vaccination is taken up differentially within equalities groups, staff flu vaccination data is reported at Health Board level and by staff group. Overall in Wales, as of 21/06/23, 46.2% of all NHS staff were recorded as having received the influenza immunisation in 2022/23, compared to 56.0% in 2021/22, and of staff with direct patient contact 46.7% in 2022/23 compared to 57.2% in 2021/22[1]. In Cardiff and Vale Health Board, overall uptake of flu vaccination for staff with direct patient contact for 2022/23 was 37.9% (significantly lower than 2021/22 – 52.9%). Uptake varied by Clinical Board from 24.4% (Capital, Estates & Facilities) to 45.5% (Clinical Diagnostics and Therapeutics).

Data on staff COVID-19 vaccination

There are limited data available on COVID-19 vaccination uptake for Health Board staff. In-house analysis (Data from WIS – filtered by; Alive, P2.2 and Occupation Organisation as 7A4 Cardiff and Vale) showed the following overall coverage of healthcare workers by gender in the Health Board as of 31st March 2023:

- At least one dose 94.5% (male) and 95.4% (female)
- At least two doses 93.9% (male) and 95.0% (female)
- Two doses plus booster = 86.2%(male) and 86.8% (female)
- Autumn Booster '22 = 63.9% (male) and 62.2% (female)

Overall coverage by ethnic group as at 31st March 2023 (in-house analysis) was:

Cardiff and Vale UHB staff coverage by ethnic group for the COVID-19 Autumn booster 2022/23	
Any White Background, including Welsh, English, Scottish, Northern Irish, Irish, British	64%
White and Black Caribbean	48%
White and Black African	42%
White and Asian	59%
Any other mixed background / multiple ethnic background	57%
Indian (Asian or British)	60%

[1] Public Health Wales. Influenza Vaccination Coverage Downloadable data. 21.06.23. Available online at: Weekly Influenza and Acute Respiratory Infection Report - Public Health Wales (nhs.wales) [Accessed 22.06.23]

Pakistani (Asian or British)	47%
Bangladeshi (Asian or British)	53%
Any other Asian background	68%
Caribbean (Black/Black British)	58%
African (Black/Black British)	42%
Any other Black background	53%
Chinese	63%
Any other ethnic group	57%
Arab	25%
Not Given/Recorded/Specified	39%
Overall total	**62%**

Overall, there was lower coverage in the Black African and Arab staff members for the 2022/23 Booster.

Regarding coverage by occupational group (as of 31st March 2023) for the COVID-19 Autumn 2022/23 Booster
Considering occupational group, coverage varied. Groups with consistently lower average coverage were Estates and Ancillary, Nursing and Midwifery and Administrative and Clerical.

When looking at the most recent dose offered to Cardiff and Vale Staff – the Autumn 2022/23 Booster, uptake was highest in Healthcare Scientists, Additional Professional Scientific and Technical, and Administrative and Clerical (with 71.9%, 70.0% and 69.3% uptake respectively.) Average uptake across groups was 62.6%. Lowest uptake was amongst healthcare students, with less than half (42.7%) taking up the offer of an Autumn Booster, and staff who did not report their occupational group.

More information on protected characteristics and COVID-19 vaccination equalities uptake data is available for the whole population of Cardiff and Vale. The most recent, covering the period up to June 2023, has demonstrated gaps in coverage by age, ethnicity, deprivation and sex.

Overall uptake in Cardiff and Vale Health Board population:
Age and sex: There is a general trend in COVID-19 coverage in that as age decreases, vaccination coverage also reduces. For the Autumn 2022/23 Booster, coverage for 50-59 year-olds in Cardiff and

		Vale males was 55.6% and in females this was 61.3%. In contrast, for aged 80 plus coverage was 83.6% in males and 83.4% in females [2]. **Ethnicity**: A gap in coverage is present in all age groups when comparing combined White ethnic groups to combined Black, Asian, Mixed and Other ethnic groups, where White ethnic groups are more likely to have received COVID-19 vaccinations. This was consistent across all age ranges. For Cardiff and Vale the coverage for all eligible age groups for the 2022/23 COVID-19 booster for Black ethnic groups was 31.4% compared to 71.7% for combined White ethnic groups [2]. **Deprivation:** Overall, a deprivation gradient is present where the proportion of individuals vaccinated decreases with increasing deprivation. For example, for the Autumn 2022/23 Booster, the coverage in the most deprived quintile was 47.6%; whereas for the least deprived quintile it was 77.3% in our eligible Cardiff and Vale population [2]. The benefit of vaccination for individuals who have received the vaccine (as opposed to other people they interact with) is known to be greater among those with pre-existing risk factors, such as people with long-term conditions, carers, people aged over 65, and pregnant women[3,4] **Summary** Although data relating to uptake of flu and COVID-19 vaccination among staff with protected characteristics is limited and therefore a gap, this Health Board policy is the local implementation of Welsh Government (WG) policy, to ensure all eligible staff are offered vaccination(s). Recording and evaluating data on offer of vaccination in relation to protected characteristics would not affect the policy or its implementation, as vaccination would continue to be offered to all eligible staff for them to make an individual informed decision on uptake. **Supporting documents:**

[2] Public Health Wales. Wales COVID-19 Vaccination Enhanced Surveillance, Health Board Level Equality Report (March 2023)

[3] Department of Health & Social Care. 2021. Making vaccination a condition of deployment in health and wider social care settings – Equality Impact Assessment. 9th November 2021

[4] The Green Book (Immunisation against infectious disease) Chapter 14a – COVID-19 – SARS-CoV-2

		Chartered Institute of Personnel and Development (CIPD). 2022. COVID-19 vaccination: guide for employers. 7th March 2022. *(This document includes general advice to all employers (not just healthcare employers) but discusses planning for employees with protected characteristics)* Department of Health & Social Care. 2021. Making vaccination a condition of deployment in health and wider social care settings – Equality Impact Assessment. 9th November 2021. *(This document considers the equality impact of the introduction of mandatory COVID-19 vaccinations for health care staff. Whilst the Health Board policy does not mandate vaccination, the document considers equality impact in terms of uptake and access to vaccination which may be relevant to the Health Board's population)*
5.	Who will be affected by the policy	The policy will directly affect all Health Board staff to whom the policy applies, as they will all receive a proactive offer of vaccination. • Some eligible staff may not be aware of the offer of vaccination and that they are able to access it. • Individual staff members who are vaccinated against influenza are less likely to develop seasonal influenza. • Individual staff members who are vaccinated against COVID-19 are less likely to experience severe illness, hospital admission and death, and may be less likely to transmit the COVID-19 infection.[5] The policy will indirectly positively affect: • Vulnerable patients and contacts of staff members who are eligible for and receive staff vaccinations, where vaccinations are obtained and the route of transmission therefore reduced. • The Health Board workforce as a whole where vaccination reduces staff sickness and absence, and supports maintenance of the service.

[5] Stokel-Walker C. 2022. What do we know about covid vaccines and preventing transmission? BMJ 2022;376:o298 Available online at: https://www.bmj.com/content/376/bmj.o298 [Accessed 05.07.22]

6. EQIA: How will the policy impact on people?

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy applies to all eligible staff members regardless of age. **Influenza vaccination offer:** Positive impact on older patients and staff, and children. These groups of individuals are more likely to be adversely affected if they catch seasonal influenza, so reducing the risk of exposure will have a positive impact on this age group. **COVID-19 vaccination offer:** Positive impact on older patients and staff. These groups of individuals are more likely to be adversely affected if they catch COVID-19, so reducing the risk of severe illness and exposure will have a positive impact on this age group. Vaccine hesitancy may be higher in the younger age groups – ONS data has shown for COVID-19 vaccination, compared to 4% of the general population, 9% of 22-25 year olds were hesitant.[6] However, all age groups will be provided with an equal offer of vaccination as per the policy.	None required	None required

[6] ONS 2021. Coronavirus and vaccine hesitancy, Great Britain: 9 August 2021. Available online at: Coronavirus and vaccine hesitancy, Great Britain - Office for National Statistics (ons.gov.uk) [Accessed 05.07.22]

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The offer of vaccination will be to all eligible staff regardless of whether they have a disability. **Influenza vaccination offer:** Positive impact on staff and patients with a disability, in contact with vaccinated Health Board staff. Many individuals with disabilities are more likely to be adversely affected if they catch seasonal influenza, so reducing the risk of exposure will have a positive impact on this group. Although staff with a disability may be eligible anyway for flu vaccination from their GP, being offered vaccination at work as well increases the opportunity to be vaccinated **COVID-19 vaccination offer:** Positive impact on staff and patients with a disability in contact with vaccinated Health Board staff. Many individuals with disabilities are more likely to be adversely affected if they catch COVID-19, so reducing the risk of exposure will have a positive impact in this group. Whilst some eligible Health Board staff members may also be in another eligible risk group for COVID-19 vaccination, being offered vaccination at work increases the opportunity to be vaccinated.	The operational delivery of the vaccination offer is outside the scope of this policy, but the policy states that any information should be provided in an accessible format, and that delivery of the vaccination should be accessible to all staff who are eligible.	None required

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
	Some disabled staff may experience access issues for the vaccinations, including receiving information in an accessible format and accessing vaccination venues.[7]		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to	The vaccinations will be offered to all eligible staff regardless of gender and whether they have undergone gender reassignment. Positive impact on males for COVID-19 vaccination as global data suggests they are more likely to have hospitalisations, ICU admissions and death from COVID-19.[8] Positive impact on females for COVID-19 vaccination as UK data suggests females are more likely to be diagnosed with long COVID.[9] It is recognised that women may have more barriers to accessing the vaccines (for example, more likely to have caring responsibilities, childcare, part-time working).[8]	The policy offers vaccination to all staff regardless of gender, and reflects the need for accessible and flexible delivery of the vaccination programme to support all eligible staff to be able to access vaccination.	None required

[7] Department of Health & Social Care. 2021. Making vaccination a condition of deployment in health and wider social care settings – Equality Impact Assessment. 9th November 2021

[8] Global Health 50/50. The Sex, Gender and COVID-19 Project. Available online at: The Sex, Gender and COVID-19 Project | Global Health 50/50 (globalhealth5050.org) [Accessed 05.07.22]

[9] Global Health 50/50. The Covid-19 sex-disaggregated data tracker. November Update Report. November 2021. Page 10. Available online at: November tracker update 2021 (globalhealth5050.org) [Accessed 05.07.22]

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
as Trans or Transgender			
6.4 People who are married or who have a civil partner.	No impact on staff because of marriage or civil partnership. Vaccination is offered to all eligible staff regardless of whether they are in a marriage or civil partnership	None required	None required
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Vaccination will be offered to all eligible staff, including those on maternity or parental leave, regardless of pregnancy or breastfeeding status[10] **Influenza vaccination offer:** Positive impact on staff who are pregnant. Being pregnant is a risk group for developing severe influenza, and these individuals are also offered vaccination through their GP practice. Offering the influenza vaccination in the workplace increases the opportunity for uptake. **COVID-19 vaccination offer:** Positive impact on staff who are pregnant. COVID-19 significantly increases the risk of pregnancy complications.[11] Offering the	None required	None required

[10] Individual staff members will be assessed for contra-indications to the vaccination(s) as per the Green Book guidance prior to receiving the vaccination(s)
[11] Lacobucci G. 2022. COVID-19: Severe infection in pregnancy significantly increases risk, study shows. BMJ. 376:0480. doi: https://doi.org/10.1136/bmj.o480

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
	COVID-19 vaccination in the workplace will increase the opportunity for uptake. Positive impact on patients who are pregnant. These patients are more likely to be adversely affected if they catch seasonal influenza, and are at higher risk of pregnancy complications and severe disease from COVID-19, so reducing the risk of exposure will have a positive impact.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Vaccination will be offered to all eligible staff members regardless of race, nationality, colour, culture or ethnic origin. **COVID-19 vaccination offer.** Positive impact of COVID-19 vaccination for ethnic minority groups, as UK data has demonstrated they are more at risk of complications from COVID-19.[12] Prior to vaccination roll-out, UK survey data indicated higher COVID-19 vaccine hesitancy in certain ethnic groups including black (71.8% reported being hesitant), Pakistani/Bangladeshi (42.3%), Mixed (32.4%) and non-UK/Irish white (26.4%) ethnic	Employees should not be identified based on their race, nationality, colour, culture or ethnic origin or stereotyped based on these characteristics as this could lead to potential discriminatory treatment[14]. The policy applies to all eligible staff members individually, regardless of	None required

[12] Scientific Advisory Group for Emergencies (SAGE). COVID-19 Ethnicity subgroup: Interpreting differential health outcomes among minority ethnic groups in wave 1 and 2, 24 March 2021. Available online [Accessed 05.07.22]
[14] CIPD 2022. COVID-19 vaccination: guide for employers. 7 March 2022. Available online [Accessed 04.07.22]

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
	groups.[13] Coverage of COVID-19 vaccinations in Black, Asian, Mixed and Other ethnic groups compared to combined White ethnic groups was lower across all age ranges in the Cardiff and Vale population in the Autumn 2022/23 Booster campaign [2].	race, nationality, colour, culture or ethnic origin.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No impact on staff or patients because of their religion, belief or non-belief. Vaccination is offered to all eligible staff regardless of religion, belief, or no religion or belief. **Influenza vaccination offer:** Concerns which have been raised relating to gelatine in the nasal flu vaccine for children which might affect some individuals in certain religious groups, do not impact on adults receiving the vaccine because the adult vaccine does not contain gelatin. **COVID-19 vaccination offer:** COVID-19 vaccines used in the UK do not contain pork gelatine. There is potential for some individuals to object to the use of ethanol or host cell lines in the production of some of the vaccines[14]. However, religious organisations have produced statements to support informed decision-making.	Choice to be vaccinated is individual and religious beliefs can vary within a religion. Employees will not be identified by their religion or belief, or stereotyped based on this, as this could lead to potentially discriminatory treatment. The policy states sufficient accessible information will be provided to enable an individual's informed decision. This information should include ingredients and the production process	To be considered in the operational delivery (outside scope of the policy).

[13] Robertson E, Reeve KS, Niedzwiedz CL, *et al.* 2021. Predictors of COVID-19 vaccine hesitancy in the UK Household Longitudinal Study. Available online.

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
		of the vaccinations where requested. Signposting to organisations of the individual's religion at their request could support the individual further in their informed decision making.	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	No impact on staff or patients because of their sexual orientation. Vaccination is offered to all eligible staff regardless of sexual orientation. It is recognised that LGBTQ+ staff may be less likely to be vaccinated, with an explanation being fear of discrimination due to their sexual orientation[15], however there is limited data on this and all eligible staff will receive an equal offer for vaccination to then make their informed decision.	None required	None required
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets,	No impact on staff or patients because of their preferred language. Vaccination is offered to all eligible staff regardless of their preferred language. Posters used to publicise the vaccine are produced in English and Welsh versions.	Booking line is bilingual and communication is offered in Welsh and English. All patient information is bilingual.	None required

[15] Department of Health & Social Care. 2021. Making vaccination a condition of deployment in health and wider social care settings – Equality Impact Assessment. 9th November 2021.

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	All eligible staff will be offered vaccination regardless of their income group. This includes volunteers. Individuals employed by the Health Board but off work will be eligible for the vaccines but would need to attend a Health Board site to receive the vaccinations. There may be concerns from those on low income, particularly if working bank shifts, that there may be an associated loss of income where side-effects from the vaccination are experienced affecting their ability to work. "Addressing concerns about side-effects and their impact" was identified as a key factor in the work by Cwm Taf Morgannwg University Health Board looking at vaccination uptake in healthcare staff.[16] Positive impact:	The policy aims to address this by promoting a supportive culture for vaccine uptake, line manager support to access the vaccinations, and accessible supporting information on the vaccinations including the risk and severity of any side effects to allow for an informed decision.	To be considered in the operational delivery (outside scope of the policy).

[16] Thorneloe R, Lamb M, Jordan C *et al.* 2021. Understanding and addressing the barriers and facilitators for influenza and COVID-19 vaccine uptake among NHS employees in Wales: Qualitative insights and co-produced interventions. Public Health Wales and Cwm Taf Morgannwg University Health Board.

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
	There are higher rates of COVID-19 diagnosis and death in areas of higher deprivation, so vaccination could give staff from these areas greater protection against morbidity and mortality.	Discussions have been raised with the workforce organisational department regarding the All Wales 'Managing attendance at work' policy to consider individuals who are unable to work due to short-term vaccine side-effects.	
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities 	All eligible staff will be offered vaccination regardless of where they live. Offer of vaccination for staff will include multiple options and times at Health Board sites. Employees such as those who do not live within the Health Board area and employees without access to transport may find access to vaccination more difficult when not delivered directly at their workplace. Employees who work from home/remotely, or who are on leave from work, may be negatively impacted in being able to access the vaccinations. Positive impact:	The policy promotes a supportive culture for vaccination and for line managers to allow the employee time to access the vaccination(s) during their working day where this is possible. The policy supports consideration to making the vaccination venues accessible – the operational delivery of the	To be considered in the operational delivery (outside scope of the policy).

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
	There are higher rates of COVID-19 diagnosis and death in areas of higher deprivation, so vaccination could give staff from these areas greater protection against morbidity and mortality.	vaccinations is outside the scope of this policy, but should include identification of venues which are in an accessible location.	
6.12 Any other groups relevant to the strategy **Caring responsibilities**	Positive impact on staff and patients with caring responsibilities. Although vaccination is offered to all eligible staff regardless of whether they are an informal carer outside work, the added benefit of vaccination through work is that the risk of passing on infection to those in receipt of care will be lowered. Although voluntary carers are eligible in their own right for flu vaccination through their GP surgery, and may be eligible for the COVID-19 vaccination through their caring role, having an offer through work as well is likely to increase vaccine uptake in this group. Positive impact on older people in the local population. These groups of patients are more likely to be in receipt of care and adversely affected if they catch seasonal influenza and/or COVID-	None required	None required

How will the policy impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate.
	19, so reducing the risk of exposure will have a positive impact on this age group.		

7. HIA / How will the policy impact on the health and well-being of our population and help address inequalities in health?

How will the policy impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
7.1 People being able to access the service offered: Well-being Goal - A more equal Wales	All staff will be offered access to the vaccination free of charge, delivered by the Health Board. The offer of vaccination will be accessed through the workplace. Therefore, it is anticipated the majority of eligible staff will be able to access it at their usual place of employment or in a nearby vaccination centre. Positive impact: There are higher rates of COVID-19 diagnosis and death in areas of higher deprivation, so vaccination could give staff from these areas greater protection against morbidity and mortality.	None required	None required
7.2 People being able to improve /maintain healthy lifestyles: Well-being Goal – A healthier Wales	The policy covers eligibility and access to vaccination promoting access to support disease prevention.	None required	None required

How will the policy impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
7.3 People in terms of their income and employment status: Well-being Goal – A prosperous Wales	The policy is accessible to all eligible Health Board staff (including volunteers and bank staff) regardless of income, banding or seniority. Some staff members may have concerns around missing work due to side-effects of the vaccination. This may be a greater concern for those working temporary or bank shifts, or for those with a high sickness absence record. Some staff may have concerns about access to vaccinations where additional travel is required, due to the additional cost of travel.	The policy promotes a culture of support for receiving vaccination, and that should include supporting staff members who may suffer side effects from the vaccination affecting their ability to work. The policy supports access to vaccination. Where travel is required, staff should be supported by their line managers in accessibility, including awareness and assessing eligibility for travel reimbursement as per the All Wales 'NHS Wales Travel and Subsistence Policy'.	None required
7.4 People in terms of their use of the physical environment: Well-being Goal – A resilient Wales	The staff vaccination policy relates to the offer of vaccination. The operational delivery of the vaccination programme will be considered separately. However, the policy emphasises the need for accessible venues to be used.	None required	None required
7.5 People in terms of social and community influences on their health:	The policy aims to promote a positive and supportive culture in the workplace towards the vaccinations.	None required	None required

How will the policy impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
Well-being Goal – A Wales of cohesive communities	The policy supports informed decision making, with the information provided and the role of Flu and vaccine champions to provide support whilst avoiding pressure towards accepting the vaccination. Vaccination status will remain confidential to the individual and occupational health, unless the individual chooses to share it.		
7.6 People in terms of macro-economic, environmental and sustainability factors: Well-being Goal – A globally responsible Wales	The policy does not directly address environmental or sustainability factors, but it is expected that the operational delivery (outside the scope of this policy) will take into account these factors.	None required	None required

8.1 Summary of the potential positive and/or negative impacts of the policy	Overall, no significant impacts requiring improvement or mitigation have been identified. The policy applies equally to all eligible staff irrespective of any protected characteristics the staff member may have. The following groups have potential positive impacts: • Older people • People with a disability • Pregnant people • People from a Black, Asian or Other ethnic group • People from areas of disadvantage • People with caring responsibilities The following groups may have negative impacts: • Staff working bank/shift patterns in terms of loss of income from potential side effects affecting their ability to work Some groups have also been identified who may have increased difficulty in accessing the vaccinations, including staff members with certain disabilities, staff who work part-time, staff with caring responsibilities and staff who have lower income. The role of this policy is to outline the offer of vaccination, and expectations for delivery i.e. that vaccinations will be made accessible. The operational delivery will be managed separately, where these potential issues should be considered.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	The findings from this EHIA should be considered in the operational planning and delivery of the policy.	Staff Winter Vaccination operational planning group	September 2023	N/A
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required?	No, it is not necessary to complete a more comprehensive Equalities Impact Assessment or Health Impact Assessment. The policy is to be delivered universally to all employees of the Health Board, and no significant issues were identified in this assessment.	N/A	N/A	N/A
8.4 What are the next steps?	The proposal is for no changes to this policy in view of the findings from the EHIA, as no significant negative impacts were identified. The outcomes of the policy will be monitored in terms of uptake data for vaccinations.	Consultant in Public Health, Local Public Health Team.	September 2023	N/A

Report Title:	Clinical Effectiveness Committee Bi-annual Report				Agenda Item no.	4.1	
Meeting:	Quality Safety and Experience Committee	Public	x		Meeting Date:	26th September 2023	
		Private					
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Executive Medical Director						
Report Author (Title):	Deputy Head of Quality Assurance						

Main Report
Background and current situation:

Background and current situation:

This provide provides oversight of some of the headline results and improvements associated with national clinical audits presented to the clinical effectiveness committee Between March and July 2023.

The Health Board Clinical Effectiveness Committee was established in December 2019 and has strengthened since 2022 to ensure greater involvement from Clinical Boards, specialties and clinical audit leads. The National Clinical Audit and Outcome Review Programme is a mandated programme of 40 national clinical audits that support measurement of quality against defined evidence-based standards, national benchmarking and quality improvement. All national audits are scheduled to be presented at the clinical effectiveness committee with specialist meetings arranged around cancer, cardiology, maternity and perinatal services etc. Further development is required to ensure the group is able to provide robust assurance and oversight performance and improvement and this is reliant on engagement from all specialties and Clinical Boards.

The scope of the Clinical Effectiveness Committee will expand to include oversight of National Institute of Clinical Effectiveness (NICE) and Health technology Wales guidance in the next quarter.

Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries (MBRRACE) 2018-2020. Saving Lives, Improving Mother's Care report November 2022.

This ninth MBRRACE – UK annual report of the confidential enquiry into the maternal death of mothers and morbidity and includes surveillance data on women who died during and up to one year after pregnancy between 2018 -2020. The report explores a number of causes of deaths including cardiovascular disease, hypertensive disorders, diabetic ketoacidosis (DKA), early pregnancy disorders and accidents and the care of women who died from mental health related causes in 2020.

The report identified that Black and Asian women remain at greater risk of maternal mortality with more than a three-fold difference amongst women from Black ethnic background and two-fold increase amongst women from Asian background when compared to white women. The report also identified that 11% of women who died during and up to 1 year after pregnancy were considered to be at severe and multiple disadvantage including factors such as mental health diagnosis, substance misuse and domestic violence.

Maternal deaths from psychiatric disorders and cardiovascular disease now represent 30% of maternal deaths combined, with nearly 40% deaths are related to mental health causes as a whole (suicide and substance misuse).

Some key messages from MBRRACE include:

- Maternal mortality is 19% higher than 2017-2019 (excluding covid-19 maternal deaths)
- 9 women un the UK died as a direct result of Covid-19

- 1 in 9 women that died had severe and multiple disadvantage (mental health, substance misuse, domestic violence).
- In 2020 women were 3 times more likely to die by suicide

No local or organisational data is presented in this report, however, the Health Board has considered the findings and has implemented a number of initiatives to enhance and improve maternity care for the more vulnerable women.

The Elan team of midwives is unique to Cardiff and includes a team of skilled midwives who provide antenatal and postnatal care to the most vulnerable women across Cardiff and the Vale of Glamorgan. The Elan team provides person centered care to women who require additional support in relation to substance misuse, domestic violence, safeguarding and homelessness. The Elan team has created an exemplary collaborative working with external stakeholders, who include social services, housing, substance misuse team, NSPCC to name a few. The team provides individualised and accessible maternity care.

Cardiff and Vale have also appointed a specialist midwife for equality and inclusion who currently leads on two clinical projects. A specialist antenatal clinic is run as part of the Cardiff and Vale Health Inclusion Service (CAVHIS) based at Cardiff Royal Infirmary, where support and advice is provided to women who are seeking sanctuary and those who are survivors of harmful practices, In addition a Women's Well Being Clinic for women who have experienced female genital mutilation (FGM) is delivered. These clinics also supports pregnant sex workers and the clinic is also supported by the charity Safer Wales, Street Life Project, enabling more flexibility for woman to access maternity services.

The Inclusion specialist midwife has established working relationships with third sector agencies that support asylum seekers/refugees, these include; BAWSO, Red Cross, the Birth Partner Project and national referral mechanism to provide enhanced maternity support, antenatal education and identify supports needs for women. Care can be provided through the use of interpretation services throughout the antenatal, intrapartum and postnatal period. Cardiff and Vales maternity services have successfully secured Welsh Government funding for a specialist psychologist to provide mental health support to women who may have been trafficked and experienced harmful practices.

To enhance communication for non-English speaking women, translation carts have been purchased and distributed within maternity services, with the aim to ensure interpretation is accessible for every clinic appointment. Translation cards have also been implemented across the maternity unit, these allow women to communicate with staff, these cards have been translated into the top 5 spoken languages. Access to emergency services has been reviewed for non-English speaking women, the unit has implemented a call back service, women can play a message to staff via their mobile requesting call back with an interpreter of their language. Steps to raise staff awareness is ongoing. Improved access to outpatient clinic has also undergone a review, where increased efforts are made to ensure multiple appointments are scheduled for the same place on same day. Induction of labour information leaflets has also been translated in the different languages, work is ongoing to increase the number of other information leaflets in this way.

A recent clinical audit has identified **100%** compliance with aspirin assessment during booking appointments for women who are predisposed to hypertension disorders, DKA and cardiovascular disease. There has been increased inclusion for Gestational Diabetes Mellitus (GDM) assessment and the development of a multi-disciplinary joint cardiovascular-obstetric clinic.

The maternity service has an established perinatal mental health service for women who have been identified to require additional mental health support. The team includes a psychologist, psychiatrist, pharmacist, community psychiatric nurse and a specialist mental health midwife and all women will be allocated a named consultant obstetrician to ensure continuity of care.

National Maternity and Perinatal Audit (NMPA), Clinical Report 2022

The National Maternity and Perinatal Audit (NMPA) is a large-scale audit of NHS maternity services which aims to evaluate a range of processes and outcomes in order to identify good practice and areas for improvement. The data provides an understanding of the way in which maternity services care for women and birthing people. The 2022 NMPA report is the forth clinical report which measures births in England, Scotland and Wales from April 2018 to March 2019.

Induction of labour (IOL) rates in Cardiff and Vale during the reporting period were **32.5%** comparable with the national rate of **33.5%.** Approximately one third of women giving birth in England and Wales undergo induction of labour, an increase from the previous reporting period. This increase is associated with the initiatives highlighted within the Saving Babies' Lives Bundle (March 2016) including assessment of fetal movement and fetal growth.

Nearly half of all small for gestational age (SGA) babies were born on or after their due date and this rate was noted to be higher in Wales than in England. When SGA babies are identified, national guidance advises that an induction of labour is offered at 37 weeks of gestation. In Cardiff **56.9%** of SGA babies were born at 40 weeks or after compared with **48.9%** nationally. The introduction of the midwife sonographer services has is grown in strength over the past 6 years. The additional resource of the midwifery sonography services allows additional scanning capacity to ensure women with predisposed risk factors for SGA babies received serial growth scans throughout their pregnancy. The Health Board has implemented the GAP and GROW programme which is designed to monitor potential problems and support the identification of small for gestational age babies. There are plans this year to implement electronic measurement plotting to reduce growth plotting variation.

Mode of Birth – the annual report highlighted that nationally there has been a decrease in the number of unassisted vaginal births and therefore an increase in assisted vaginal birth and overall cesarean birth. **62.5%** of women have spontaneous vaginal births in the Health Board compared with **60%** nationally. Currently there is no 'ideal' caesarean rate, however the physical and psychological harm associated with assisted and emergency caesarean are known to be higher when compared to unassisted vaginal birth. Within Cardiff and Vale UHB a consultant midwife lead birth choices clinic is available to provide appropriate counselling support negative birth experiences which is in addition to an obstetric outpatient feedback clinic.

Neonatal National Perinatal Mortality Review Tool (PMRT) – September 2022

The PMRT is a standardised multidisciplinary review of care undertaken for all babies that die from twenty-two weeks gestation to twenty-eight days after birth. The mortality review is undertaken to provide answers for bereaved parents and their families about why their baby died and to ensure local and national learning results from review findings to improve care and prevent future baby deaths.

The Health Board ensures the perspective of parents are considered when undertaking the mortality review. Summary reports and action plans are generated and shared with families to promote organisational learning and benchmarking through the publication of annual reports. The reports include details relating to performance, trends, themes and barriers.

Cardiff and Vale is one of 26 organsiations that have a level three neonatal unit and undertake neonatal surgery. The National mortality rate for neonatal units in similar originations, excluding congenital anomalies is 1.48 per 1000 births. The Health Board rate is 1.81 deaths per 1000 births.

Trends in Neonatal Mortality 2017-2021

Rate	2017	2018	2019	2020	2021
UK	1.67 (1.58, 1.77)	1.64 (1.54, 1.73)	1.62 (1.53, 1.71)	1.53 (1.44, 1.62)	
Wales	1.93 (1.45, 2.41)	1.95 (1.46, 2.44)	2.32 (1.78, 2.87)	1.64 (1.17, 2.11)	
C&V UHB (All)	3.14 (2.07, 4.67)	2.64 (1.72, 3.99)	3.55 (2.35, 5.39)	2.63 (1.81, 3.86)	3.00 (2.05, 4.43)
UK Level 3 NICU & Surgery (All)	2.40 (1.66, 3.50)	2.45 (1.66, 3.63)	2.63 (1.75, 3.95)	2.39 (1.65, 3.49)	2.62 (1.83, 3.75)
C&V UHB (excluding congenital anomalies)	1.79 (1.04 to 3.04)	1.36 (0.86 to 2.22)	1.81 (1.12, 2.86)	1.44 (1.03, 2.06)	1.81 (1.11, 2.88)
UK Level 3 NICU & Surgery (excluding congenital anomalies)	1.28 (0.81, 2.01)	1.27 (0.82, 2.02)	1.39 (0.90, 2.16)	1.40 (1.00, 1.99)	1.48 (1.01, 2.15)

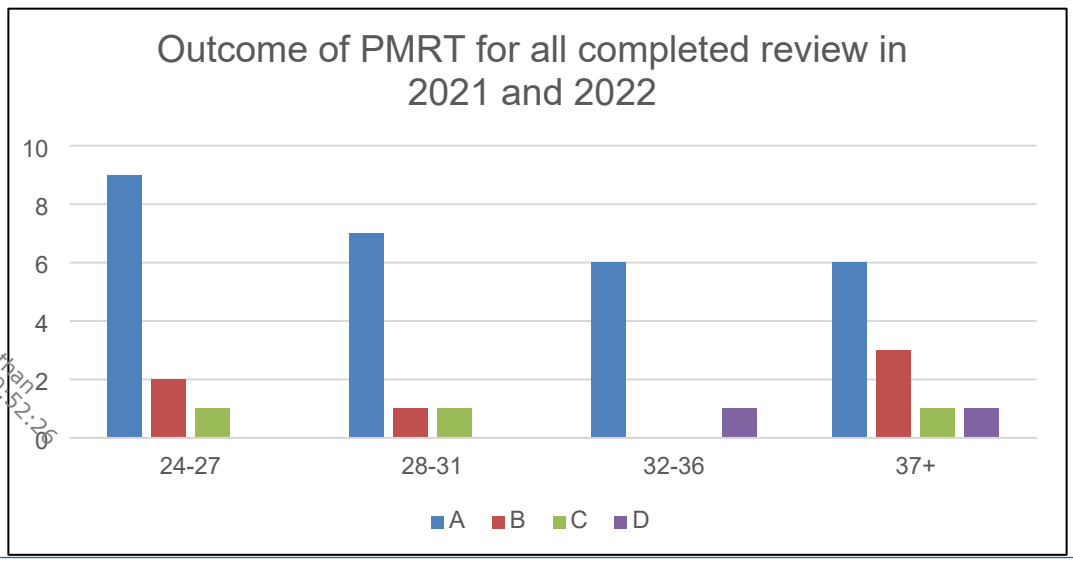
All PMRT outcomes are classified from A-D
A – No issues identified
B – some care issues identified, however, this would have made no difference to the outcome
C - Care issues identified which could have contributed to the outcome
D – Care issues that were likely to have contributed to the outcome

The neonatal care of sixteen babies was reviewed in 2021 and identified that in **50%** of cases there were no issues identified with the care provided and in **31%** of cases the was learning identified, however it was established that this did not impact on the outcome of the babies. **19%** of mortality reviews identified issues in care that might have contributed to the outcome of the babies.

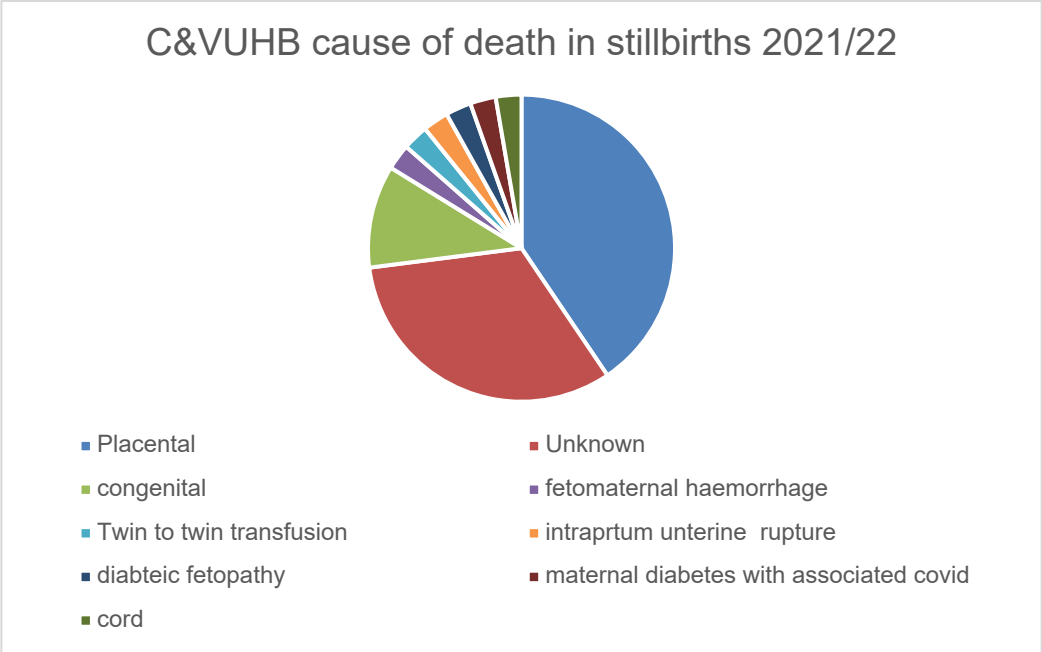
Learning from PMRT reviews has been combined with learning from the National Neonatal Audit to deliver the required improvements and is detail is included in the next section.

The outcomes of maternity PMRT reviews for 2021 and 2022 were categorised by gestation. **72%** of mortality reviews not identifying an issue in care and a further **15%** identifying learning that did not impact of the outcome of the pregnancy.

Aspirin assessment and administration and growth monitoring were identified through the PMRT as areas that required improvement. The process for undertaking asprin assessment at booking has been strengthened and was subject to audit that identified **100%** compliance. The appointment of additional sonographer roles and electronic growth monitoring (as previously discussed in relation to NMPA improvements) strengthens serial growth scan arrangements and supports the Gap and Grow programme. In addition, improved compliance with Cardiotocography (CTG) monitoring training (intrapartum monitoring of the fetal heart rate) and the appointment of a CTG training midwife has strengthened intrapartum monitoring.



Maternity PMRT reviews identify a causes of death where possible. The most common causes of fetal death are placental causes, Unknown causes and conenital anomolies which mirrors the the most frequesantly recorded cause of death recorded nationaly in 2020.



National Neonatal Audit Programme (NNAP) – November 2022

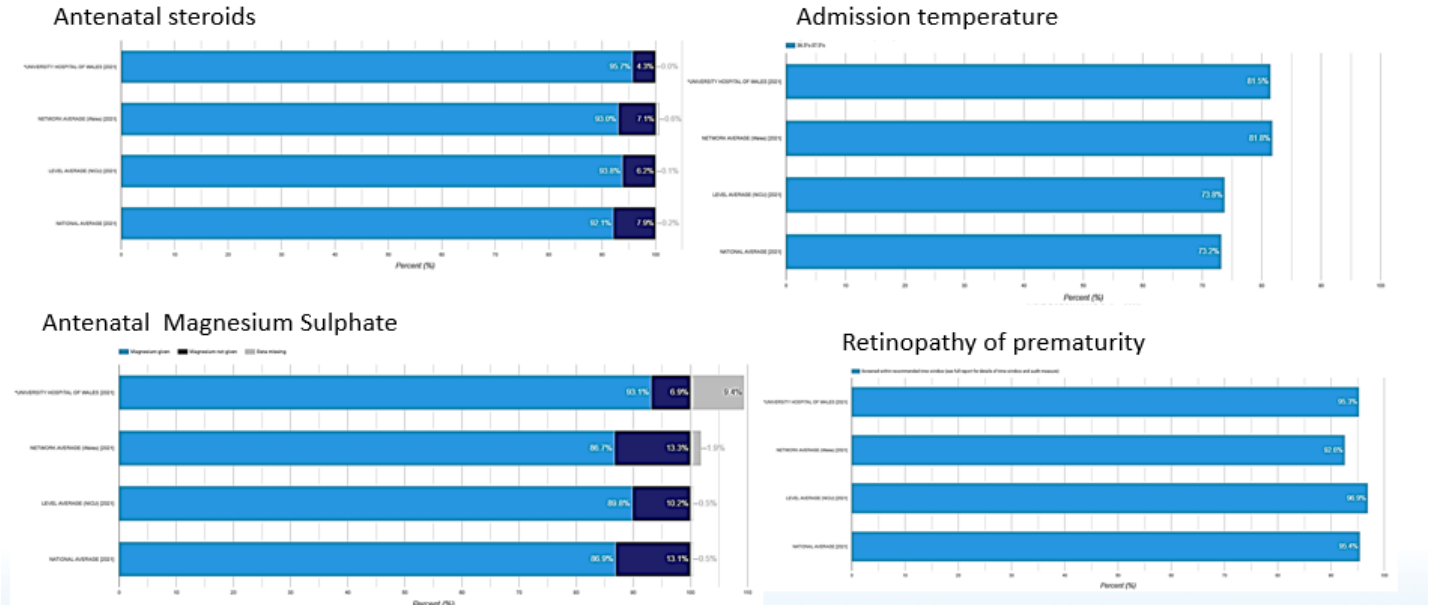
The National Neonatal Audit Programme (NNAP) assesses and benchmarks the care of babies admitted to neonatal units, in relation to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes.

The audit reports key outcomes of neonatal care, measures of optimal perinatal care, maternal breastmilk feeding, parental partnership, neonatal nurse staffing levels and other important care processes.

The key outcomes of the audit include:

- Neonatal care (mortality, bronchopulmonary dysplasia, late onset bloodstream infection, necrotising enterocolitis and preterm brain injury)
- Measures of optimal perinatal care (birth in the right place, antenatal steroids, antenatal magnesium sulphate, deferred cord clamping and normal temperature on admission), maternal breastmilk feeding (during admission and at discharge)
- Parental partnership
- Neonatal nurse staffing levels
- Care processes (screening for retinopathy of prematurity and follow-up at two years of age).

Health Board performance against these standards was comparable with UK performance and often exceeded the national standard. In relation to antenatal steroids, **95.7%** of women received at least one dose of antenatal steroids (target standard 85%), **93.1%** of women received antenatal magnesium sulphate (target standard 85%) and **95.3%** babies born at less than 32 weeks gestation with a birth weight of less than 1501g receive on-time screening for retinopathy (Wales Network average 92.6%).

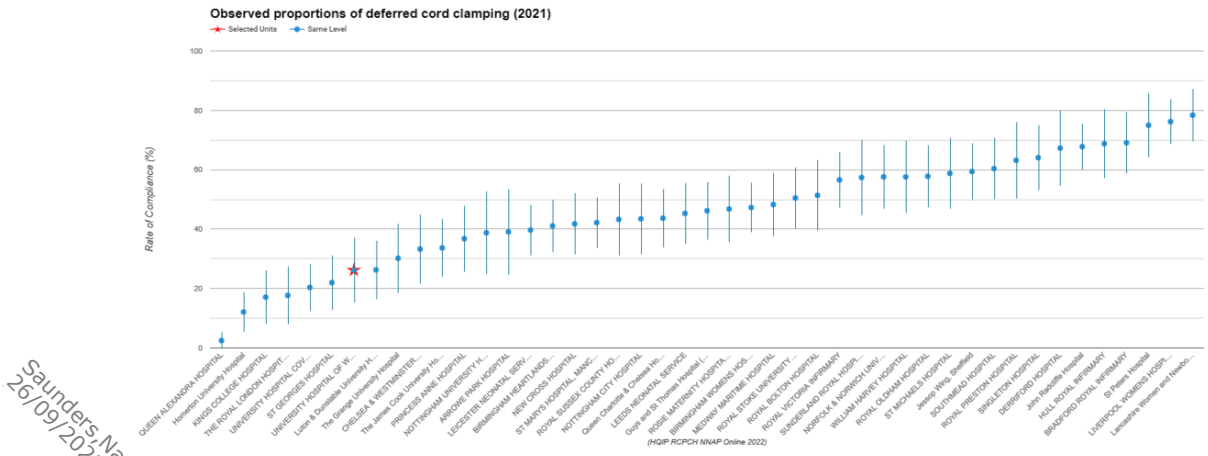


The Health Board did not achieve the target standard of 90% of babies who were born at less than 32 weeks gestation having a temperature range of 36.5-37.5 degrees Celsius 1 hour after birth, Cardiff and Vale was below the national target range (Cardiff **81.5%**).

In response the neonatal team have implemented a number of improvements that includes:

- Provision of Thermometers in all delivery rooms
- Dated/older Incubators replaced
- Initial training has been undertaken with the perinatal team around the importance for thermoregulation
- Follow up simulation training is planned

Deferred cord clamping allows extra blood to be transferred from the placenta, increasing the amount of iron transferred to the baby and the measure is associated with improved outcomes for pre-term babies. The Health Board were identified an outlier in relation to deferred cord clamping. In response to the outlier notification the neonatal team has introduced a quality improvement project to increase compliance, early measurements of this improvement projects are promising and will be subject to ongoing audit.



Additional improvements currently ongoing include:

Perinatal Optimisation:

- Introduction of probiotics for extreme preterm babies is now complete

- A new breastfeeding lead nurse has been appointed to support increases in breastfeeding at discharge and early administration of colostrum

Infection:
- Aseptic non-touch technique training planned for August 2023 with audits developed and ongoing
- Lead infection prevention and control neonatal nurse has been appointed part time
- Consultant and nurse lead for IP&C have been appointed
- A review of workforce against British Association of Perinatal Medicine standards

Patient Flow:
- Increasing timely discharge investment has been approved
- Posts will be created for a transitional care unit ward manager, discharge coordinator, additional band 4 posts to support the nursery and outreach team, and a neonatal nurse per shift on the transitional care ward.
- Investment in allied health professional - Speech and language therapist, physio, dietician and occupational therapy roles

Workforce:
- Workforce reviews against British Association of Perinatal Medicine Standards
- Nursing workforce establishment is under review
- A planned review of consultant workforce is required to deliver 24-hour residence
- A planned expansion of the Physician Associate role and tier two rota
- A member of the neonatal team is now present at the completion of the WHO checklist for all high-risk deliveries.

National Clinical Audit of Seizures and Epilepsies for Children and Young People - Epilepsy 12

Epilepsy is the most common significant long-term neurological condition of childhood and affects an estimated 112,000 children and young people in the UK. Epilepsy12 seeks to help improve the standard of care for children and young people with epilepsies.

Epilepsy 12 focuses on 12 key indicators:
1. Paediatrician with expertise
2. Epilepsy specialist nurses
3. Tertiary involvement

3a. Epilepsy surgery referral

4. Appropriate first paediatric assessment
5. Seizure formulation
6. ECG
7. MRI
8. Accuracy in diagnosis

9a. Sodium valproate prescribing in females 9 years and older

9b. Sodium Valproate prescribing in all females

10. Comprehensive Care Plan agreement
11. Comprehensive Care Plan content
12. School individual Healthcare Plan

Cardiff and Vale first participated into Epilepsy12 in 2021 the cohort of patients were identified via the EEG Department; their care was followed-up for a twelve-month period. The Health Board has not had a robust to support full participation in the audit. This is a risk to the organsation and means that the care provided to this patient group does not benefit form bench marking and the systematic scrutiny of performance to inform improvement.

In May 2023 the Clinical Board appointed an epilepsy lead who will also be the responsible lead for the Epilepsy12 clinic audit and to progress compliance with this mandated audit

National Lung Cancer Audit

The National optimal lung cancer pathway was published in 2019 and updated in 2022 and sets out a number of standards that should be achieved from the time that lung cancer is clinically suspected, that includes radiological investigations, specialist review, biopsy and MDT discussion with an aim to support commencement of treatment within 62 days. The

The National Lung Cancer Audit State of the Nation Report was published in April 2023 and was presented to the Clinical Effectiveness Committee in June 2023. The report is based on patients diagnosed with lung cancer in England during 2021 and in Wales in 2020-2021 and summarises performance.

It is noted that Covid-19 has had an impact on the number of patients being diagnosed with advanced disease with a negative impact of outcome associated with delays in presentation.
In Wales 50% of patients presented with stage IV disease (stages I-IV) and in England 48% while in Cardiff this figure was **43%.** It is noted that 65% of referrals are received from primary care, 25% from the Emergency Unit (England 35%) and 10% are incidental findings.

The pathway determines that patients should have a specialist outpatient review within 7 days, however the average in the Health Board is **14 days**. The Clinical Nurse Specialists have been fundamental in improving this process and an additional 2 consultants have been appointed and there are plans to develop a one stop clinic where patients.

There is a national standard that 17% of patients with non-small cell lung cancer should have surgical treatment for their condition. In Wales this is achieved for 13% of patients and in Cardiff this is **16%.**

The national standard requires 70% of patients with non-small cell carcinoma should be treated with chemotherapy, in Wales this is achieved for 71% of patients (England 70%) and in Cardiff **76%,** exceeding the standard.

The proportion of patients with non-small cell lung cancer receiving treatment with a curative intent is subject to monitoring with a national target of 80% applied to patients with stage I and II disease. Cardiff achieved this for **65%** of patients. The main constraints in increasing the number of patients being treated with curative intent includes the stage of cancer at presentation, the fitness of patients to tolerate treatment and delays in the diagnostic pathways.

One-year survival rate for patients in Wales diagnosed between January - June 2021 was 40% (England 45%) . The last full NCLA audit report provided one-year survival data for Wales and Guernsey for 2019 and In England for 2019 and 2020. The National survival rate was noted to be 42.19% and the Welsh rates was 42.21% while in Cardiff this was **36.53%.**

National Oesophageal Gastric Cancer Audit (NOGCA)

The latest NOGCA report was published in January 2023 and reported to the clinical effectiveness committee in June 2023. The report focuses on the care received by patients diagnosed with invasive epithelial cancer of the oesophagus, gasto-oesophageal junction or stomach between April 2019 and March 2021.

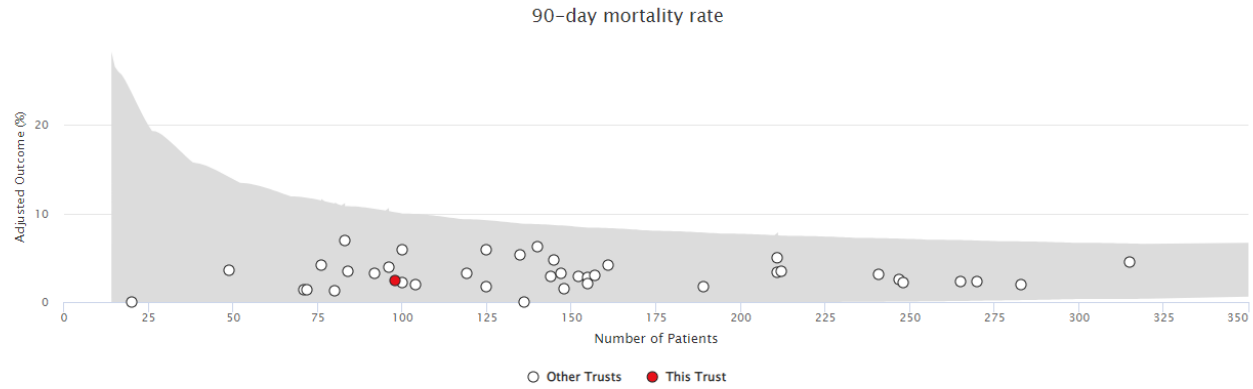
Patients that present as an emergency for the first time generally have more progressed disease and therefore treatment options are more limited and outcomes worse. 19.6% of patients in Cardiff were diagnosed after an emergency admission compared to the national rate of 12.5%,. The proportion of patients diagnosed with stage IV disease increased from 41.6% nationally in 2019/20 to 44.9% in 2020/21.

The use of non-invasive staging scans was noted to increase nationally during this audit period reducing the need for staging laparoscopies. Patients with a staging CT scan recorded 84.9% in line with the national rate of 85.7%.

The proportion of patients who had a plan for curative treatment declined from 38.9% nationally in 2019/20 to 37.5% during the audit period with Cardiff recording a rate of 37.7% of patients have a plan for curative treatment and 30.3% of patients with non-curative plans receiving chemotherapy compared with 38.5% nationally.

The 90-day mortality for the Health Board for the audit period was within the normal range and below the average with an adjusted rate of 2.49%.

90-day mortality rate



Trust	Number	Adjusted %
Cardiff and Vale University Health Board	98	2.49

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- The Clinical Effectiveness Group has developed to include clinical audit leads and clinical board representation, however further development is required to ensure all national audits are presented at the group following publication of an audit report.
- Nationally there are significant variation in maternal outcomes associated with ethnicity and deprivation. While local data Is not generated as part of the MBRACE Saving Lives, Improving Mother's Care report November 2022 a number of initiatives are in place reduce variation including the Elan team, Health Inclusion Service and the Health Access Midwife. In addition, the development of a maternity dashboard support oversight of variation.
- The National Perinatal Mortality programme reviews all stillbirths from 22 weeks gestation and neonatal deaths up to 28 days after birth. The reviews seek to identify areas of concerns that might have contributed to the outcome of the baby or might support wider learning. Contributions from the wider Multi-disciplinary team improve the rigor of the process, however, there is variation between the membership in the maternity and neonatal mortality reviews. Addressing this variation will be a priority of the Maternity Neonatal oversight group in quarter 3
- The Neonatal unit meets or exceed many of the standards included in the National Neonatal Audit, however, it was identified as an outlier for deferred cord clamping and infection rates. An improvement plan has been developed to support the required improvements and will be subject to ongoing monitoring through the Maternity and Neonatal Oversight Group.
- The Health Board is not fully participating the in Epilepsy12 National Audit although an audit lead was identified in May this year to progress this.
- Covid-19 has had a detrimental impact on the timeliness of diagnosis of lung cancer with more patients being diagnosed at with greater disease progression both nationally locally.

This has an impact on the treatment options available to these patients and their outcomes. Work is underway to develop a one stop outpatients clinic that will combine stages of the diagnostic pathway in an attempt to improve compliance with the 62 days pathway.

- Again Covid-19 has had a detrimental impact on the timeliness of diagnosis of upper gastrointestinal cancers both nationally and locally.

Recommendation:

The Board / Committee are requested to: **NOTE** the assurance provided by the national audit results and oversight of the improvements.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: n/a

Safety: n/a

Financial: n/a

Workforce: n/a

Legal: n/a

Reputational: n/a

Socio Economic: n/a

Equality and Health: n/a

Decarbonisation: n/a

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Report Title:	Compliance against PSA008 – Nasogastric tubes			Agenda Item no.	4.2
Meeting:	QSE Committee	Public	X	Meeting Date:	
		Private			
Status (please tick one only):	Assurance	Approval	X	Information	
Lead Executive:	Executive Medical Director, Executive Nurse Director				
Report Author (Title):	Interim Head of Safety, Quality and Organisational Learning				

Main Report
Background and current situation:

This paper gives a summary of the Health Board's actions taken in response to Patient Safety Alert 008 – 'Nasogastric tube misplacement: continuing risk of death and severe harm'.

In May 2017, Welsh Government issued a Patient Safety Alert following incidents of harm and a Coroner's report to prevent future deaths (Regulation 28). The alert contained a number of actions, which are detailed below. The PSA originally had a compliance deadline of 30th November 2017. Nationally, achieving compliance with the alert has been challenging due to the requirement for a standardised national response to NG tube education for all relevant clinical staff including medical staff and implementation of a standardised pH strip used to confirm NG tube placement. In May 2023, a letter was issued by the Deputy Director Quality Safety Assurance in NHS Wales Executive (formerly NHS Wales Delivery Unit) regarding the PSA and providing a new compliance deadline of 29th September 2023.

Since the PSA was issued in 2017, there has been extensive work across the organisation to improve and ensure the safe use of nasogastric (NG) tubes.

Action 1. Identify a named Executive Director who will take responsibility for the delivery of the actions required in this alert.

As with all Patient Safety Solutions, executive oversight is given by the Executive Nurse Director, with support from the Executive Medical Director. This has been provided by the current END and EMD, as well as their predecessors in these roles.

Action 2. Provide local policies and protocols that reflect all the safety critical requirements summarised in the resource set.

The original resource set linked to from the PSA is available from the National Archives:
https://webarchive.nationalarchives.gov.uk/ukgwa/20171102111258/https://improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes/

The resource set provides safety-critical requirements for confirmation of NG tube position. For example, a requirement not to use the 'whoosh test' – listening with a stethoscope for the sound of air injected via the NG tube.

The Health Board has an extensive and updated procedure for the insertion and care of NG tubes in adults, children, infants and neonates: cavuhb.nhs.wales/files/policies-procedures-and-guidelines/patient-safety-and-quality/i-j-patient-safety/ng-2012-pdf/. The procedure includes the safety-critical requirements outlined in the resource set.

Action 3. Ensure the supply and use of safe equipment. Nasogastric tubes used for feeding should be radio-opaque throughout their length and have externally visible length markings. pH paper should be CE marked for use on human aspirate.

Compliant NG tubes are used throughout the Health Board. The pH testing strips used are CE marked for use on human aspirate (Avanos 'aspHirate' testing strips).

Action 4. Ensure the provision and uptake of competency-based training which needs to reflect all the safety-critical requirements summarised in [the] resource pack. Training in the X-ray interpretation and pH testing should be provided for staff who will undertake these procedures, regardless of the level of seniority.

A well-established training programme for nursing staff is in place, which is supported by the Education, Culture and Organisational Development Team (ECOD). The programme includes practical training on NG insertion using a manikin, which is followed by supervised practice to gain competence. There is a requirement to update and demonstrate competence every 3 years with a ward-based assessor. The following topics are covered as part of the training:

- Professional and legal issues
- Associated risks and hazards
- Anatomy and physiology
- Inserting the nasogastric tube
- Methods to obtain gastric aspirate
- Nasogastric tube aftercare
- Nasogastric tube removal
- Medications via nasogastric tubes
- Unblocking feeding tubes
- Practicalities of feeding

For medical staff, the Health Board has been informed by NHS Wales Executive that NG tube training will be included in the first/second year foundation programme by Heathcare Education and Improvement Wales (HEIW) from August 2023. This training will be recorded in the individual's e-portfolio.

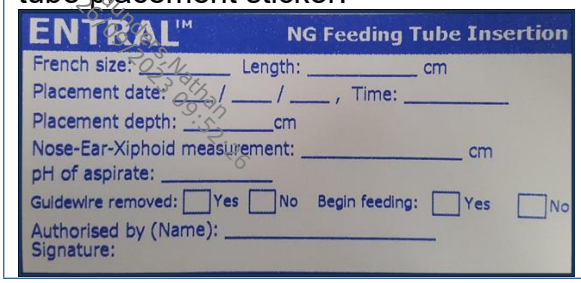
The Health Board's Medical Education Department provides training as part of their education programme. This includes:

- Practical skills sessions for Foundation Year 1 trainees, including NG insertion and X-ray interpretation. Held in August, October, January and April.
- Practical skills sessions for Foundation Year 2 trainees, including NG insertion and X-ray interpretation. Held in September, November and February.
- Procedural skills sessions for Internal Medicine Training (IMT) doctors, held in September, December, March and May.

NG insertion is also included as part of the nutrition course, which is offered to all medical trainees. Additionally, should any member of medical staff, regardless of grade, wish to have refresher training on NG insertion and interpretation, this can be arranged by contacting Medical Education.

Action 5. Ensure that clinical documentation reflects all the safety-critical requirements summarised in [the] resource set. This should also include an assessment of whether naso/orogastric feeding is the most appropriate plan for the patient.

Required documentation is included as part of the training and is supported by the use of an NG tube placement sticker:


ENTRAL™ NG Feeding Tube Insertion
French size: ____ Length: _____ cm
Placement date: ___/___/___, Time: _____
Placement depth: _____cm
Nose-Ear-Xiphoid measurement: _____ cm
pH of aspirate: _____
Guidewire removed: Yes No Begin feeding: Yes No
Authorised by (Name): _____
Signature:

Training includes the assessment and balance of potential risks from the insertion of an NG tube against the need to provide nutrition. The procedure for the insertion and care of nasogastric tubes (linked in Action 2) directs that placement should be delayed if there is not sufficient support available to accurately place and confirm the position of the NG tube, such as at night, unless it is clinically urgent.

Action 6. Implement an ongoing audit of compliance to assess the sustainable implementation of the safety critical measures in [the] resource set.

The Nutrition and Dietetics team undertake ad-hoc audits of compliance with guidance for insertion and management of NG tubes. The team are working with the Corporate Nursing team to develop an NG tube audit, which will be hosted on Tendable. This audit will be ongoing and results reportable from the Tendable system.

A baseline central audit is being planned by the Patient Safety and Quality team, in conjunction with Nutrition and Dietetics to assess compliance with guidance and identify any areas requiring specific support.

Action 7. Share the findings of audits with the organisation's Quality and Safety Committee and ensure action plans agreed and implemented.

Findings of the baseline and ongoing Tendable audits will be reported to QSE. Where necessary, action plans will be shared with local QSE meetings and/or the Nutrition and Hydration group.

In view of the response to the actions set out in the original Patient Safety Alert and subsequent letter to Health Boards, it is considered that Cardiff and Vale UHB is in a position to report compliance with the PSA.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Health Board is now in a position to declare compliance with PSA008- Nasogastric tubes. Actions to achieve compliance include:

- An identified Executive lead for overseeing compliance with this alert
- A comprehensive procedure for the insertion and management of NG tubes
- The use of a standardised CE marked pH strip for use on human aspirate and compliant NG tubes.
- The provision of competency base NG tube training
- Clinical documentation methods that reflect the safety critical requirements.
- Arrangements for ongoing audits of compliance

Recommendation:

The Committee is requested to:

APPROVE the reporting of compliance with Patient Safety Alert 008 – 'Nasogastric tube misplacement: continuing risk of death and severe harm'.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	

3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: n/a
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
26/09/2023 09:52:26

Report Title:	Chair's Report Radiation Protection Group				Agenda Item no.		
Meeting:	UHB QSE Committee	Public			Meeting Date:		
		Private	x				
Status *(please tick one only):*	Assurance		Approval		Information	x	
Lead Executive:	Fiona Jenkins, Executive Director of Therapies and Healthcare Sciences						
Report Author (Title):	Lesley Harris, Professional Head of Radiography UHL/Chair of Radiation Protection Group						

Main Report
Background and current situation:

This report is a summary from the UHB Radiation Protection Group held on 25th July 2023

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

A further update has been made to The Best Available Techniques Document. This will be circulated to the Group.

Discussions are being held on the need for the Radiation Protection Group to be more proactive and action driven, and set itself achievable goals, as opposed to receiving information. As part of this a table is being collated from areas where Radiation is in use to establish the status of radiation risk assessments and receive assurance that they have been reviewed and signed off by the Radiation Protection Service. Areas to also include a list of their employer procedures and local rules.

A framework for the management of employer procedures has been produced. The framework sets out the need for information sharing and transparency of where Employer Procedures can be accessed in departments and that they are visible to all stakeholders.

A discussion was held around the process for Entitlement and how this can be made more robust and improve compliance. This is an issue across all Health Boards in Wales. The Chair queried whether it would be appropriate to change Health Board documentation so that there is automatic entitlement to refer with referral being covered by GMC and GDC registration and details. The Head of the Radiation Protection Service stated that if a blanket approach was implemented, the Health Board would need to demonstrate to HIW inspectors that the procedure is effective at reducing risk and also how this process is being robustly managed. A further suggestion was that a staff group approach is taken in terms of entitlement to referrers as opposed to issuing individual letters. This is possibly the best compromise on a way forward. All members to give consideration as to whether they can suggest a better process that can be implemented and feedback at the next meeting.

Support has been provided to the Radiopharmacy from an MPE perspective. To ensure there is a return to some level of imaging capacity, some DRL patient dose audits have been undertaken for UHW and UHL for Nuclear Medicine. Those reports cover aspects around Radiopharmacy, as well as the clinical and administration to patients aspects. These reports have been issued and will be followed up with the service leads to implement any actions.

Laser audits had been postponed due to staff shortages. These are now in the process of being resumed.

Final amendments were made to the review of the Laser Risk Management Policy and Procedure and based on these changes, the Group ratified the documents.

Recommendation:

The QSE Committee are requested to:

Note the summary of the key issues from the meeting.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term	x	Integration		Collaboration	x	Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Safety: Yes

Financial: No

Workforce: Yes

Legal: /Yes

Reputational: Yes

Socio Economic: /No

Equality and Health: Yes

Decarbonisation: Yes

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
26/09/2023 09:52:26

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Minutes of the Medicine Clinical Board Quality, Safety & Experience Committee Meeting Held on 18 May 2023 14:30 – 16:00, Via MS Teams

Present:	
Sian Rowlands	Head of Quality and Clinical Governance (Chair)
Lyndsey MacDonald	Consultant, Acute & Emergency Medicine
Diane Walker	Interim Deputy Director of Nursing, MCB
Suzie Cheesman	Patient Safety Facilitator, Patient Safety & Quality Team
Cari Randall	Interim General Manager, Acute & Emergency Medicine
Emma Keen	Deputy General Manager, Integrated Medicine
Derek King	Clinical Nurse Specialist, Infection Prevention & Control
Liz Vaughan	Professional & Practice Development Nurse, Integrated Medicine
Barbara Davies	Lead Nurse, Specialised Medicine
Ceri Richards-Taylor	Interim Lead Nurse, Integrated Medicine
Ceri Martin	Interim Lead Nurse, Acute & Emergency Medicine
Jenna McLaren	Senior Nurse, Acute & Emergency Medicine
Natasha Whysall	Senior Nurse, Specialised Medicine
Eli Gerrard	Senior Nurse, Acute & Emergency Medicine
Harriet Foley	Senior Nurse, Integrated Medicine
Sarah Cornes-Payne	Senior Nurse, Diabetes, Integrated Medicine
Rhian Cottrell	Professional & Practice Development Nurse, Surgery Clinical Board
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Alun Tomkinson	Clinical Board Director, MCB
Jane Murphy	Director of Nursing, MCB
Angela Jones	Senior Nurse, Resuscitation Service
David Pitchforth	Interim Lead Nurse, Integrated Medicine
Marianne Jenkins	Emergency and Acute Consultant Nurse
Kath Prosser	Quality & Governance Lead, Medicine
Louise Platt	Director of Operations, MCB
Craig Davies	Interim Service Manager

Item No	PRELIMINARIES	Action
MCBQSE/ 2023/0081	**A1. Welcome & Introductions** – were undertaken.	
MCBQSE/ 2023/0082	**1.1 To receive the minutes of the previous meeting** The group resolved: the minutes were agreed and accepted.	
MCBQSE/ 2023/0083	**1.2 Matters arising**: for outstanding actions, please see the action log.	
MCBQSE/ 2023/0084	**1.3 Directorate QSE minutes** - only Gastroenterology minutes received to date. The group resolved: minutes from other areas are required monthly. **Action from discussion** – minutes from other areas are required monthly.	
6 DOMAINS OF QUALITY		
SAFE		
MCBQSE/ 2023/0085	**2.1 Concerns and Compliments Report** **Compliments** **Respiratory –** 'to Sophia & Jade: thank you so much for the numerous visits to assess my dear husband during his stay on Duthie ward and ITU. Although he does not remember too much you were very kind explaining everything to me and showing me the USS as you were scanning him. I had no idea you were able to perform such procedures	

	on the ward, and was very surprised to see you on the ward with all your equipment, rather than carting a poorly patient down to X ray. It really is such an excellent service with immediate reports rather than waiting! Thank you again for your kindness to me and sorting out my husband. Keep up the good work'. **Memory Team** – **'**five years ago my wife was diagnosed with Dementia. From the Memory Team we were allocated Michelle Norman, a link worker. What a stroke of good fortune that was. Michelle has been a rock for us, usually at the end of the telephone but occasionally face-to-face. Michelle is very kind, compassionate, knowledgeable and a thoroughly dedicated professional. She has made the path through this horrible disease easier to navigate than it might have been'. The group resolved: note the action below. **Actions from discussion:** SR will acknowledge the compliments.	Sian Rowlands
MCBQSE/ 2023/0086	**6. National Reportable Incidents, updates and closures** There are 6 open NRI's at present. SR is capturing themes and learning from NRI's. **Integrated Medicine, ID27623** presented by Natasha Whysall. Relating to a patient who had an unwitnessed fall from a chair on a medical ward. The patient 'X' sustained a fractured neck of femur and required surgical intervention. X had been in hospital since Nov/Dec 22. X had dementia, some challenging and impulsive behaviour and required enhanced supervision. On the day of the fall, X had a 1-2-1 Health Care Support Worker (HCSW) with her and asked for a commode. The HCSW left X for a short time to get the commode and had advised another staff member she was doing so, however, X had fallen by the time the other staff member got to her. **Learning**: the multi-factorial risk assessment had last been reviewed 17 days prior to the fall. The HCSW should not have left X unattended until another member of staff took over. The enhanced supervision document was well completed. The post falls procedure was completed. A read about me document was not in the notes. **Recommendations**: staff were reminded that if assigned 1:1 supervision, not to leave the patient until cover in place. Staff were reminded to complete all multi-factorial risk assessments. **Actions**: staff were reminded in safety briefings as per recommendations. An audit in April 23 showed 100% compliance with falls risk assessments and their timely completion. 100% compliance with the 'Read about Me' documentation. X is at UHL having rehab. Next of kin have been informed. The group resolved: duty of candour is triggered at the point that it is considered the event was avoidable. Duty of candour must be included in all NRI meetings. **Actions from discussion** – none.	

MCBQSE/ 2023/0087	**7. Infection Prevention and Control up-date**
	262 days since last MRSA bacteraemia (UHL E7)
	14 days since last MSSA bacteraemia (UHL E8)
	8 days since last *C difficile (UHL E6)*
	5 days since last E. *Coli* bacteraemia (UHW A1L)
	2 days since last Pseudomonas bacteraemia (UHW A7)
	12 days since last Klebsiella bacteraemia (SDH Lansdowne)
	
	There are three ongoing incidents/ outbreaks within MCB. Two of which are Norovirus and one is Covid 19.
	• DMT scores – all wards within MCB are compliant for the last 4-week period.
	• Awaiting 2023-2024 reduction goals.
	• HCAI reduction goals, MCB position based on same period 2022-2023:
	  ○ 66% (-2) reduction with *C. difficile.*
	  ○ 0% reduction with *E. coli.*
	  ○ -1% reduction with *Pseudomonas.*
	  ○ 0% reduction with SAUR Bacteraemias.
	  ○ 80% increase has been seen *with Klebsiella*
	• 34 RCA's remain outstanding.
	• Audit: Environmental audits in March were above MCB average. Hand Hygiene audits very poor (70% or less). PVC audits above average.	

	• IP&C 'back to basics' teaching 25/05/2023 in pharmacology seminar room 1-2pm.
	• IP&C at MCB induction commenced.
	• C. Difficile RCA themes:
	  ○ Recurrent CDI in many cases, antibiotics main precursor, but antibiotic review is common through all cases.
	  ○ Early isolation established in majority of cases, stool chart updated in most cases.
	  ○ Action points were listed in some RCA's received. Common action points were: delay in stool sampling, delay in reviewing results when samples sent.
	• Covid community cases have fallen again this month, the number of cases within CAVUHB has also fallen.
	• Influenza rates are at baseline levels. RSV is increasing.
	
	The group resolved: see actions below.
	Actions from discussion
	Action 1: DW, LV and DK to liaise regarding more ANTT assessors are required.
		Diane Walker, Liz Vaughan, Derek King

MCBQSE/ 2023/0088	**3.3 Patient Safety Alerts/MDA's/ISN's**: SBAR – Nebuliser Mouthpieces May 2023 The group resolved: all to read. **Actions from discussion** – all to read.	
MCBQSE/ 2023/0089	**Duty of Quality Statutory Guidance 2023 and Quality Standards Update** The group resolved: no update. **Actions from discussion** – SR will liaise with Angela Hughes with a view to having an update at the June 2023 MCB QSE meeting.	Sian Rowlands
MCBQSE/ 2023/0090	**Medical Device/ Equipment Point of Care Testing** **Point of Care testing (PoCT)** – ward staff were the only people who could carry out PoCT on their ward, however, with the industrial action in December 22, Gemma Taylor arranged for a period of 7 months for any new staff assigned to wards to be able to use PoCT. This is due to expire. The group resolved: to carry out the action below. **Actions from discussion** – need to see what impact this will have and if an extension to this agreement or something different is required.	Diane Walker Liz Vaughan
MCBQSE/ 2023/0091	**Safeguarding update** The group resolved: no update. **Actions from discussion:** no update.	
MCBQSE/ 2023/0092	**Health and Safety Issues** - Riddors are analysed by the H&S department. Updates on historic incidents are required. The group resolved: see the action below. **Actions from discussion**: SR will email the relevant areas requesting updates. SR will look to capture themes and feedback for this meeting and clinical areas.	Sian Rowlands
TIMELY		
MCBQSE/ 2023/0093	**Initiatives to improve access to services** The group resolved: no update. **Actions from discussion** – no update.	
MCBQSE/ 2023/0094	**Performance with National Targets** The group resolved: no update. **Actions from discussion – no update.**	
EFFECTIVE		
MCBQSE/ 2023/0095	**Feedback from UHB QSE Committee** **Update on the Pressure Damage Collaborative -** a goal was set for 25% reduction of health care acquired pressure damage. C&VUHB have exceeded that target and achieved a 27% reduction. The group resolved: the reduction in health care acquired pressure damage was noted. **Actions from discussion** – none.	
MCBQSE/ 2023/0096	**Service Improvement Initiatives** **Diabetes Safety Week this week** - programme of events is running this week at UHW, UHL, Barry and St David's. SC-P has updated staff on three new forms/charts which are: new incident prescription charts; new variable rate infusion charts; new treatment for hypo charts. Raising the profile regarding diabetes and letting staff know of the	

	support that can be provided to staff. Study days are run frequently. Approximately a quarter of patients in any area will have diabetes, so important for all staff. The group resolved: diabetes training is mandatory for all new starters. **Actions from discussion** – SC-P, LV and CR-T to discuss diabetes training further.	Sarah Cornes-Payne Liz Vaughan Ceri Richards-Taylor
MCBQSE/ 2023/0097	**HIW/CHC reports and improvement plan updates** – On the agenda to highlight action plans in place following two CHC visits to: 1. Emergency Department 2. Alcohol Treatment Centre. Action plans are stored on AMaT. Inspections were mostly positive. **Ombudsman Report Ref: 202206106** – action plan captured on AMaT relates to an Ombudsman case where C&VUHB was questioned on why an MRI was not done for a patient with back pain. Looked at the pathway and guidance at the time of the case. A further question is being discussed regarding if a patient cannot have an MRI. The group resolved: this case was previously discussed at MCB QSE. **Actions from discussion** – none.	
EFFICIENT		
MCBQSE/ 2023/0098	**Transforming care through sustainability** – update delivered by Rhian Cottrell (RC) RC is looking at what sustainability is within nursing. The aim is to adopt the 'Gloves Off' campaign. To achieve a sustainable healthcare system the following is required: - Disease prevention and health promotion. - Quality. - Institutionalisation of environmental concerns. - Institutional accountability and individual responsibility. - Long term strategic perspective and innovation. Pharmaceutical waste is a huge issue. The main carbon emitters in healthcare are medicines, medical equipment and other supply chain. A project is planned regarding the admission to discharge process and the overlap of medications being prescribed. Saving money on waste, could mean more nurses could be employed. **Adopting sustainable practices**: better productivity; ease of use; reduces errors; reduces cost; better time management; less mess, less paperwork; better waiting lists; improve car parking; reduces hospital footfall. **Welsh six step plan**: carbon management; buildings; transport; procurement; estate planning and land use; **Waste Management** - the aim is to increase recycling facilities. The main nitrous oxide manifold has been decommissioned. Housekeeping modernisation tool is in place. **Gloves off campaign** – PPE usage increased since the pandemic. The cost of gloves has increased from £7.58 to £18.26 for 2021-2022. C&VUHB spent £3.3m on gloves from 2021-2022. Great Ormond Street Hospital carried out a glove usage project and saved 90% financially, had a reduction in infections and had better productivity of staff. **Gloves on** – chemical exposure; infection exposure; bodily fluid exposure; mucous membrane exposure **Gloves off** – bed making (risk assess this); transferring patients; injections; observations; mobilising patients; feeding; ward rounds; completing documentation. The group resolved: RC's presentation was excellent and informative. **Action from discussion** – email RC if there are any questions.	
EQUITABLE		
MCBQSE/ 2023/0099	**Feedback from Clinical Board Inclusion Ambassador Group** **Age Resource Pack** – all to read. The group resolved: see action below. **Actions from discussion** – SG will email the group of the list of Inclusion Ambassadors.	Sheryl Gascoigne
MCBQSE/ 2023/0100	**Equality and Diversity Issues** The group resolved: none. **Actions from discussion** – none.	
PERSON CENTRED		

MCBQSE/ 2023/0101	**Patient Story, Acute & Emergency Medicine**, delivered by Jenna McLaren Dorothy (D) (pseudonym) a 90-year-old female who was a smoker, had COPD, essential hypertension, osteoarthritis and hypothyroidism. In 2019 D had an incidental finding of an aneurysm, however, no intervention at that time. **14:30pm** D was at a bus stop when she had sudden onset of right sided weakness. **14:32pm** bystander phoned 999. **14:37pm** WAST car arrived. D's symptom's had worsened. **15:00pm**: ambulance arrived and collected D, pre-alerted UHW, stroke call was activated pre-hospital. UHW was at a risk rating of 4:20 and a typical busy day, resus was full. At the same time as this, two other pre-alerts were received. Ongoing estates work was taking place. A full capacity protocol was activated. **15:16pm** crew arrived. D was taken straight from WAST to CT to ensure no delay to scan, whilst waiting for a space to become vacant in Majors. Radiology was advised of D upon arrival and created capacity. **15:20** D had undergone a CT head and a CT Angiogram. It was confirmed D was having a significant stroke. D was returned to Majors and had an experienced Acute and Emergency nurse, 2 Stroke Clinical Nurse Specialists and a Medical Registrar caring for her. Thrombolysis equipment was prepared. D scored 22 on the National Institutes of Health Stroke Scale (NIHSS) which was significantly high. D was deemed unsuitable for Thrombolysis. Contact was made with the C&VUHB Interventional Neuroradiologist. **15:45** swallow screen completed. **16:26** D arrived on C4 Stroke. **Notable Practice** - door to ward in 1 hour 16 minutes. Time of onset to ward in 1 hour and 56 minutes. No delays in delivery of care. Experienced A&E nurse. Two stroke CNS nurses were available. Access to a stroke consultant. Access to CAVUHB Interventional Neurologist. The stroke pathway was driven by the Stroke CNS, D arrived in working hours and there was a bed on C4S available. D remains in stroke rehab. The group resolved: the value of the CNS role was apparent. Having an experienced team enabled the efficient progress of the patient through the pathway. Stroke CNS's are not available out of hours. **Actions from discussion** – none.	
MCBQSE/ 2023/0102	**Initiatives to promote the health and wellbeing of patients and staff** **Winter Vaccination Profile** **MSE Meeting notes April 2023** The group resolved: N/A. **Actions from discussion** – none.	
ITEMS TO BE RECORED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE		
MCBQSE/ 2023/0103	- **MCB Quality, Safety and Experience Committee – Workplan** - **MCB Quality, Safety and Experience Committee – Terms of Reference and Operating Arrangements** The group resolved: all to read. **Actions from discussion** – all to read.	
MCBQSE/ 2023/0104	**AOB** **Patient Safety Team** - Cath Evans will be taking on Medicine and this is Suzie Cheesman's last MCB QSE meeting. Thanks were given to SC for the work done over the past years. SC will now work with Mental Health and WAST. This is DW's final meeting today, prior to commencing a new role.	
MCBQSE/ 2023/0105	**7.3 Date & time of next Meeting –** 2.30pm to 4pm on 15/6/23.	

Action Log

Item	Subject	Action	Allocated to	Date allocated	Date to be completed	Completed Y/N
MCBQSE/ 2023/0003	Stroke bed protection SOP	Check if this needs to come back to MCB QSE following sign off at MCB Formal Board	Diane Walker	16/2/23	Carry over to 20/4/23 May meeting	EK will email SR an update

MCBQSE/ 2023/0019	Infusion Charts	Contact Dave Mcrae re potentially using the infusion charts elsewhere in MCB	Diane Walker & Dave Pitchforth	16/2/23	Carry over to 15/6/23 meeting	Update: no progress to date
MCBQSE/ 2023/0055	Concerns/ Compliments	SR will liaise with Angela regarding obtaining patient feedback to be discussed at MCB QSE.	Sian Rowlands	20/4/23	20/7/23	Carry over to next meeting (June)
MCBQSE/ 2023/0063	Initiatives to improve access to services	NT will deliver a Stroke update at next month's meeting	Niki Turner	20/4/23	18/5/23	IM QSE is at same time as MCB QSE
MCBQSE/ 2023/0069	Yellow Card Centre Wales Survey Results	SR to contact Manon Richards to arrange to discuss what learning could be shared with staff	Sian Rowlands	20/4/23	20/7/23	SR will follow up on this
MCBQSE/ 2023/0076	Patient Story, Specialised Medicine	BD/Jenna M to liaise about uploading detailed plan to clinical portal, to be accessible to all clinicians, in case the patient comes back to ED.	Barbara Davies/ Jenna McLaren	20/4/23	20/7/23	To be progressed
MCBQSE/ 2023/0085	Compliments	Acknowledge compliments shared at this meeting.	Sian Rowlands	18/5/23	15/6/23	
MCBQSE/ 2023/0087	Infection Prevention & Control	DW, LV and DK to liaise regarding more ANTT assessors are required.	Diane Walker Liz Vaughan Derek King	18/5/23	15/6/23	
MCBQSE/ 2023/0089	Duty of Quality Statutory Guidance 2023	SR will liaise with Angela Hughes regarding having an update at the 15/6/23 MCB QSE meeting.	Sian Rowlands	18/5/23	15/6/23	
MCBQSE/ 2023/0090	Point of Care Testing	Dec 22 Gemma Taylor arranged for a period of 7 months for any new staff assigned to wards to be able to use PoCT. This is due to expire. See what impact this will have and if an extension to this agreement or something different is required.	Diane Walker Liz Vaughan	18/5/23	15/6/23	
MCBQSE/ 2023/0092	Health and Safety Issues	Updates on historic Riddor incidents is required. SR will email relevant areas requesting update. SR will look to capture themes and feedback for this meeting and clinical areas.	Sian Rowlands	18/5/23	15/6/23	
MCBQSE/ 2023/0096	Diabetes safety week	New starters have mandatory diabetes training. SC-P, LV, CR-T to discuss diabetes training further.	Liz Vaughan Sarah Cornes-Payne Ceri Richards-Taylor	18/5/23	15/6/23	
MCBQSE/ 2023/0099	MCB Inclusion Ambassadors	SG to share the list of Inclusion Ambassadors	Sheryl Gascoigne	18/5/23	15/6/23	

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Minutes of the Medicine Clinical Board Quality, Safety & Experience Committee Meeting Held on 20 July 2023 14:30 – 16:00, Via MS Teams

Present:	
Jane Murphy	Director of Nursing, MCB (Chair)
Sian Rowlands	Head of Quality and Clinical Governance
Aneurin Buttress	Consultant, Integrated Medicine
Tom Hughes	Consultant, Integrated Medicine
Derek King	Clinical Nurse Specialist, Infection Prevention & Control
Wayne Parsons	Lead Nurse, Integrated Medicine (IM)
Dave Pitchforth	Interim Lead Nurse, Specialised Medicine (SM)
Ceri Martin	Interim Lead Nurse, Acute & Emergency Medicine (A&E)
Angela Jones	Senior Nurse, Resuscitation Service
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Rachael Maiden	Senior Nurse, Integrated Medicine
Harriet Foley	Senior Nurse, Integrated Medicine
Sarah Cornes-Payne	Senior Nurse, Diabetes, Integrated Medicine
Beth Jones	Senior Nurse, Specialised Medicine
Suzanne Braithwaite	Service Manager, Integrated Medicine
Niki Turner	Stroke Service Manager, Integrated Medicine
Andrew Brown	Ward Manager, A7
Manon Richards	Pharmacist
Secretariat	
Sheryl Gascoigne	MCB Secretary/Project Support Officer
Apologies:	
Alun Tomkinson	Clinical Board Director, MCB
Louise Platt	Director of Operations, MCB
Cath Evans	Patient Safety & Quality Team
Lisa Green	Senior Nurse, Acute & Emergency Medicine
Kath Prosser	Quality & Governance Lead, Medicine
Ceri Richards-Taylor	Interim Lead Nurse, Integrated Medicine
Liz Vaughan	Professional & Practice Development Nurse, Integrated Medicine
Lyndsey MacDonald	Consultant, Acute & Emergency Medicine
Barbara Davies	Deputy Director of Nursing

Item No	PRELIMINARIES	Action
MCBQSE/ 2023/0106	**Welcome & Introductions** – were undertaken.	
MCBQSE/ 2023/0107	**To receive the minutes of the previous meeting** The group resolved: the minutes were agreed and accepted.	
MCBQSE/ 2023/0108	**Matters arising**: for outstanding actions, please see the action log. Completed actions as below: **Yellow Card Centre Wales Survey Results** – completed. **Compliments** – completed.	
MCBQSE/ 2023/0109	**Directorate QSE minutes** – received from Integrated Medicine and also from Emergency and Acute Medicine. **Action from discussion** – minutes are required monthly.	
6 DOMAINS OF QUALITY		
SAFE		
MCBQSE/	**Concerns and Compliments Report**	

2023/0110	**Royal College of Nursing, Wales Awards** – congratulations to Tara Rees for winning the Nurse of the Year and the Advanced and Specialist Nursing Awards from the RCN. MCB are delighted to see Tara receive this accolade and appreciate all the work she puts into the Hepatology Team. **Clinical Audit Champion** – congratulations to Dr Benjamin Jelley, Consultant in Stroke and Geriatric Medicine who was identified as the Clinical Audit Champion for his audit and quality improvement (QIP) work since joining the UHB. Dr Jelley mainly works with patients and colleagues in the Stroke Rehabilitation Centre at Llandough Hospital and has utilised QIP and audit to improve the care provided there. **Compliments** **Lakeside Wing** (LSW) – to note 'how impressed we were with all the staff who cared for my father during his last days of life. Without exception all staff of LSW Ward 2; the cleaning staff, the dieticians, the nurses of all grades and Doctors were caring and humane. Communication between staff and the family was always clear and considerate and the care given to my father was outstanding. It was reassuring to know that we could visit at any-time and we did often. We always found him looking clean and comfortable and in safe caring hands. Please convey our sincere thanks to all the staff'. **Endoscopy** – 'I went through a colonoscopy at Llandough hospital and wanted to share feedback regarding your staff. Quite simply they were fabulous - kind, approachable, informative and professional are a few words to describe them. From Natalie Fumis actually doing the procedure to Hanna Abrahams sorting out info and providing a welcome cup of tea & biscuits thereafter. People are often quick to criticise and slow to praise and so it gives me genuine pleasure to be able to do the latter – please send them my thanks and keep up the good work'. **B7** – 'our daughter was a patient (discharged 05/06/2023) initially to the Assessment ward and transferred to B7. Her 10-day stay was a very positive experience for all the family and our daughter! The care for the entire stay was excellent and despite the business and often challenging nature of the staff workload, everyone caring for our daughter was courteous, respectful and simply really kind to all patients, visitors and each other! They ensured that as a family we were part of 'the team' keeping us well informed and reassured. The eventual discharge process was seamless and well organised! I was an employee (nursing) within the trust for over 50 years, retiring at 70 and enjoyed every moment of my working life and I have never been more-proud of a profession'. **C4 Stroke** – 'I would like to recommend Ward Sister Sarah Fergusson for the highest award the NHS can give, together with the amazing team on C4 Stroke Unit. My husband suffered a major stroke early February, the ambulance arrived within 8 minutes and the Emergency Unit had thrombolysis treatment ready promptly when he arrived. Michael was transferred to the Stroke Unit where he received exceptional care under the guidance of Dr Hughes. When Michael's condition deteriorated it was Dr Hughes swift action in alerting surgeons and arranging a craniotomy procedure. This undoubtedly was the reason for my husband's amazing progress, and possibly instrumental in saving his life. Dr Hughes was extremely generous with his time, and was there for me to contact whenever I had concerns. Following surgery, my husband spent 2 months on C4 where he received the highest level of care and support. The amazing leadership of Sarah Fergusson seemed to inspire a wonderful caring attitude in all her staff. Through difficult times when my husband suffered frightening nightmares, confusion and mental conflict the staff were tireless with their reassurance and understanding. I should also mention Dr Shetty, who also inspired my husband and gave him hope of recovery through the principles of neuro-plasticity, and the work of the Early Discharge Team who have given such care and support since his discharge at the end of March. **East 2 –** a compliment was also received for East 2. Not included in the meeting papers. The group resolved: to keeping noting compliments and share with teams. **Actions from discussion:** none.	
MCBQSE/ 2023/0111	**National Reportable Incidents, updates and closures** There are 10 open NRI's at present of which 3 are in IM; 1 in SM and 6 in A&E. **Common themes from Pressure Ulcer Scrutiny Panel:**	

	- incorrect mattress selection is the most common theme. There are so many mattresses to choose from and the criteria in the pathway overlaps. TVN to provide good education to ward staff regarding mattress selection. - omission in good documentation, there were some incidents where care had been implemented, however, not documented. - passport was used, however, a little too far into the patient's journey. **Integrated Medicine**: (no update provided on the ID numbers below) ID32885; ID10038; ID13851; ID24484; ID28694; ID31171; ID31499; ID33286. **Actions from discussion** Action: East 4 prepared excellent action plans following RCA's. DP to share these with Senior Nurses for learning. Action: DP and SR to liaise to create an action plan on AMAT from the common themes.	Dave Pitchforth Sian Rowlands/ Dave Pitchforth
MCBQSE/ 2023/0112	**Infection Prevention and Control up-date** 354 days since last MRSA bacteraemia (UHL E7) 7 days since last MSSA bacteraemia (UHW LSGF1) 31days since last *C difficile (UHL ECU)* 12 days since last E. *Coli* bacteraemia (UHW LSGF1) 67 days since last Pseudomonas bacteraemia (UHW A7) 26 days since last Klebsiella bacteraemia (UHL ECU) • There is currently only 1 outbreak within the MCB, two cases of COVID currently occupying a 2 bedder and 9 bedder. • DMT scores – All wards within MCB are compliant for the last 4-week period. • Awaiting 2023-2024 reduction goals, probably be a 10% reduction on last year's figures. • HCAI reduction goals, MCB position based on same period 2022-2023: o 60% increase with *C. difficile.* o 140% increase with *E. coli.* o 0% increase / reduction with *Pseudomonas.* o 25% reduction with SAUR Bacteraemias (100% less MRSA). o 300% increase has been seen *with Klebsiella* • Applied an RCA amnesty to those outstanding prior to April 2023. • 3 RCA's outstanding (note for RCA's sent before the end of May 2023 only). Please review the tables. There has been an excellent response to returned RCA's recently with no outstanding RCA's for May 2023. • Audit: Hand hygiene audits in June were disappointing and below MCB average, however, C7 had a very good joint environmental audit. • IP&C 'back to basics' teaching continues on 3rd August. • IP&C at MCB induction continues. • Increased cases of group A Strep recently both in community and hospitals. • Increases cases of Measles recently. **Winter preparedness meeting in August** – DK is arranging this meeting and requires a MCB rep per site to join this meeting to ensure stocks and training is up to date. The group resolved: note the actions below. **Actions from discussion** Action: DK will find out information about the Public Health Wales organised High Consequence Infectious Disease (HCID) meeting and update JM. It may be that the invite did not get to MCB, JM will look into this. Action: Winter Preparedness Meeting - the following are to send names of reps to DK. HF/DP to liaise regarding a rep for UHW; CM for ED/AU; WP for UHL.	Derek King Harriet Foley/ Dave Pitchforth Ceri Martin Wayne Parsons
MCBQSE/ 2023/0113	**Patient Safety Alerts/ MDA's/ ISN's** ISN 2023 004 – Defibrillator pad placement Safety Memo – Falls Sensors, June 2023 Safety Memo – Oxygen Flow meters, June 2023 Safety Memo Aurum branded pre-filled syringes SBAR VR111 Fluids, May 2023	

	The group resolved: note the action below. **Actions from discussion** – all to read and share with teams.	
MCBQSE/ 2023/0114	**UHB IRMER incidents April 22 – March 23** Collated by the Radiology Department. For information, however, key reading of the important learning points. The group resolved: all to read. **Actions from discussion** – all to read.	
MCBQSE/ 2023/0115	**Medical Device/ Equipment Point of Care Testing/ Medicines** Medicines Safety Briefing for Healthcare Staff May 2023 The group resolved: all to read. Lots of learning to be noted. **Actions from discussion** – all to read and share with teams.	
MCBQSE/ 2023/0116	**Safeguarding update** – performance has improved. The group resolved: JM appreciated all the work done in closing cases down. **Actions from discussion:** SR will find out who the Safeguarding representative is and invite them to join this meeting and deliver an update.	Sian Rowlands
MCBQSE/ 2023/0117	**Health and Safety Issues** – Terms of Reference for the Health and Safety Committee have been sent to JM to review. **Health and Safety Report to Execs, representing MCB** – DP provides a report and has asked MCB staff to provide info. Email JM to follow up on this. **Violence and Aggression (V&A) training** - compliance is poor. This is a corporate risk and it on the MCB Risk Register of staff exposure to violence and aggression. The group resolved: to note the actions below. **Action from discussion:** Action: DP is preparing the MCB Health and Safety Report and would appreciate updates to add to the report. JM will follow up on this. Action: SR will follow up on identifying key areas where V&A training is needed most and has been advised that these will be prioritised with face-to-face training.	Dave Pitchforth Jane Murphy Sian Rowlands
TIMELY		
MCBQSE/ 2023/0118	**Initiatives to improve access to services** **Get up, Get Dressed, Get Moving** – starting a pilot at UHW, taking an MDT approach. The group resolved: to note the action below. **Actions from discussion:** JM will discuss further with Lead Nurses regarding getting a clear timeline and to see a growing plan.	Jane Murphy
MCBQSE/ 2023/0119	**Performance with National Targets** **Stroke Thrombolysis Review** – patients were selected who had not been thrombolysed in whom possibly there was the option of thrombolysing them. If a patient is thrombolysed within 4 hours, their risk of being less dependent is reduced. Stroke consumes 5% of the NHS budget. The review did not review patients who had been thrombolysed. Most cases were acceptably not thrombolysed with the exception of two patients. One was an in-patient at CAVOC, UHL, the other was at UHW and was dysphasic (lost capacity for the written and spoken word), he was a tri-lingual person. All cases were well assessed. **Report Recommendations:** 1. Diagnostics at the front door and senior decision makers who have seen the benefits of thrombolysis and the dangers of not using it. Integration with the front door and the Stroke Service. 2. Difficulty of appreciating that mild deficits that score low on rating scales, may still be profoundly handicapped. Education and training needed regarding both these points. **Stroke Performance June 2023** Feb 23 – 20% of patients thrombolysed. Out of 60 stroke patients, 12 were thrombolysed.	

	March 23 - thrombolysis performance dipped. Patient cohort was very different to Feb 23's patients. **Challenge in thrombolysis**: target timeframe is <45 minutes. In the past 8 months have only thrombolysed 1 patient <45 minutes. **CT scan within 1 hour** – CT scanner broke down and needed a part replaced. This category is being monitored. **Swallow screen** - doing well in this area. A lot of staff training has taken place and this is showing an improvement in this area. The group resolved: the amount of work that staff have been doing is appreciated. The next Stroke Summit will take place on 31/7/23. Thanks to all in ED and the Patient Flow Team for their assistance. **Actions from discussion**: none.	
EFFECTIVE		
MCBQSE/ 2023/0120	**Feedback from UHB QSE Committee** The group resolved: no issues were raised. **Actions from discussion** – none.	
MCBQSE/ 2023/0121	**Service Improvement Initiatives** The group resolved: no issues were raised. **Actions from discussion** – none.	
MCBQSE/ 2023/0122	**HIW/CHC reports and improvement plan updates** **HEIW visit Report Gastroenterology** – revisit taking place next week. **A7 inspection visit feedback** – following the unannounced 2-day inspection, it was noted that a treatment room door was not working, this was raised as an immediate action and has been rectified. A very good, positive inspection. Happy with patient and staff feedback. Some areas needed to be re-decorated. The inspection team liked the dementia care on the ward. Relatives were happy with care given. Need more robust drug cupboards. A deep clean and de-clutter of the ward was suggested. The full report is awaited. **HEIW visit Report Integrated Medicine** and action plan. **LFE 3802/RED 54 RS** – relates to a bronchoscopy patient in the endoscopy unit. The patient's front tooth was knocked out during the procedure. **Learning** – ensure all patient information aligns with consent. CR-T is looking at the patient information leaflet. The Legal Team advised that the patient was not appropriately consented and a payment was made. **LFE CN/UHW/DCQ908 AL** – regarding a patient attending the medical assessment unit. Did not identify scaphoid fractures in relation to the patient. The Unit is undergoing training. The group resolved: to note the above. **Actions from discussion** – none.	
EFFICIENT		
MCBQSE/ 2023/0123	**Sustainability** The group resolved: no issues raised. **Action from discussion** – none.	
EQUITABLE		
MCBQSE/ 2023/0124	**Feedback from Clinical Board Inclusion Ambassador Group** **Age Resource Pack** – all to read. **Disability Inclusion Ambassador** – SG is currently holding this role, along with other Ambassador roles. All to consider finding a volunteer for this role. If no volunteer found, JM will nominate a representative. The group resolved: to note the above. **Actions from discussion** – none.	
MCBQSE/ 2023/0125	**Equality and Diversity Issues** The group resolved: to note the action below. **Actions from discussion** – JM will change this on the agenda and be more precise on what needs to be discussed.	Jane Murphy

PERSON CENTRED		
MCBQSE/ 2023/0126	**Patient Story, Acute & Emergency Medicine**, delivered by Claire O'Keeffe, IM 6/4/23 – a gentleman was admitted following a fall and was being treated for decompensated heart failure. 7/4/23 the patient fell from a trolley in EU and had a temple laceration. He had a CT head scan and had sustained a haemorrhage and bi-lateral haematomas from the fall. 10/4/23 admitted to C7. 12/4/23 physio assessed the patient, who was confused, not orientated to place or year. 13/4/23 – the patient had an unwitnessed fall and was sent for another CT head scan. 14/4/23 – real time documentation of the care on the ward at 14.20pm. No medical documentation of therapy documentation. The next documentation was from East 2 in the night. The patient had been transferred to the annexe without a handover from C7. Moved to East 2 and 1-2-1 care was assigned to him. No changes were seen on the CT head scan. 16/4/23 – the patient's confusion had increased. 17/4/23 – test results showed the patient was Covid positive. East 6 – remained there until 3/5/23. The patient had deconditioned for a time and was rehabilitated back to assistance of one and was using a Zimmer frame. 3/5/23 – returned back to East 2. 17/5/23 – another unwitnessed fall and sustained a laceration to his elbow. Between 22 and 28 May multiple 222 calls had gone out for the patient. The patient never recovered from the hospital acquired Pneumonia. 29/5/23 – the patient died. 3/7/23 – staff received a compliment from the family advising they wanted to 'express thanks on behalf of the family to the staff of East 2 who cared for my Dad in the final days of his life. Such a distressing time in our lives, we are thankful to come away from our experience with such positive memories of the care and dedication of the staff. The professionalism shone through and the care he received gladdened all our hearts. We are reassured as a family that when we needed the service the most, the NHS was there'. **Learning** – this case was discussed on the ward. The teams worked really well together to give the patient and his family a better experience. The group resolved: thanks for sharing this story. **Actions from discussion** – none.	
MCBQSE/ 2023/0127	**Initiatives to promote the health and wellbeing of patients and staff** **Barry Hospital –** received funds from the staff lottery fund and have created a Chapel for patients and staff, following a bid submitted from the Ward Sister. The group resolved: an excellent initiative with significant benefits for staff and patients. **Actions from discussion** – none.	
ITEMS TO BE RECORED AS RECEIVED AND NOTED FOR INFORMATION BY THE SUB-COMMITTEE		
MCBQSE/ 2023/0128	**Wound Care Chronicle Summer 2023.** **Resuscitation Team Newsletter** from Angela Jones. **Flow chart for issues considered by MMG** – version 4. The MCB Medicine Management Group was paused earlier in the year. The group will be rebranded to look at other governance issues. **Quality decision making tool** – part of the Duty of Quality, this tool has been released. The group resolved: note the above. **Actions from discussion** – none.	
MCBQSE/ 2023/0129	**AOB** **Inquests** and learning from inquests. Need to know how many are open. Action: CM will give an update of the recent inquest at the next MCB QSE meeting. **Cancers** – need to get this on the agenda, to ensure patients are being seen within the recommended timescale and the impact on patients if the timescales are not met and how MCB can support these patients. Action: add this to future MCB QSE agendas. Discuss impact of delayed care affecting patients.	Ceri Martin
MCBQSE/ 2023/0130	**Date & time of next Meeting –** 2.30pm to 4pm on 17/8/23.	

Action Log

Item	Subject	Action	Allocated to	Date allocated	Date to be completed	Completed Y/N
MCBQSE/ 2023/0003	Stroke bed protection SOP	Check if this needs to come back to MCB QSE following sign off at MCB Formal Board	Diane Walker	16/2/23	Carry over to April 23 meeting	SR will follow up with EK
MCBQSE/ 2023/0019	Infusion Charts	Contact Dave Mcrae re potentially using the infusion charts elsewhere in MCB	Diane Walker & Dave Pitchforth	16/2/23	Carry over to 15/6/23 meeting	JM will follow up on this action
MCBQSE/ 2023/0055	Concerns/ Compliments	SR will liaise with Angela regarding obtaining regular patient feedback to be discussed at MCB QSE	Sian Rowlands	20/4/23	20/7/23	SR meeting Angela and will update
MCBQSE/ 2023/0076	Patient Story, Specialised Medicine	BD/Jenna M to liaise about uploading detailed plan to clinical portal, to be accessible to all clinicians, in case the patient comes back to ED.	Barbara Davies/ Jenna McLaren	20/4/23	20/7/23	To be progressed. JM will discuss with BD.
MCBQSE/ 2023/0090	Point of Care Testing	Dec 22 Gemma Taylor arranged for a period of 7 months for any new staff assigned to wards to be able to use PoCT. This is due to expire. See what impact this will have and if an extension to this agreement/something different is required.	Diane Walker Liz Vaughan	18/5/23	15/6/23	Keep on action log. JM will follow up with Liz Vaughan
MCBQSE/ 2023/0092	Health and Safety Issues	Updates on historic Riddor incidents is required. SR will email relevant areas requesting update. SR will look to capture themes and feedback for this meeting and clinical areas.	Sian Rowlands	18/5/23	15/6/23	Need a forum for H&S. SR will check how many meetings should be held annually
MCBQSE/ 2023/0096	Diabetes safety week	New starters have mandatory diabetes training. SC-P, LV, CR-T to discuss diabetes training further.	Liz Vaughan Sarah Cornes-Payne Ceri Richards-Taylor	18/5/23	15/6/23	Awaiting Liz to get back to SC-P
MCBQSE/ 2023/0111	National Reportable Incidents, updates and closures	East 4 prepared excellent action plans following RCA's. DP to share these with Senior Nurses for learning. DP and SR to liaise to create an action plan on AmAT from the common themes.	Dave Pitchforth Dave Pitchforth/ Sian Rowlands	20/7/23		
MCBQSE/ 2023/0112	Infection Prevention	DK to find out information about the	Derek King Jane Murphy	20/7/23		

	and Control up-date	Public Health Wales organised High Consequence Infectious Disease (HCID) meeting and update JM. It may be that the invite did not get to MCB, JM will look into this. Winter Preparedness Meeting - the following are to send names of reps to DK to attend the meeting. HF/DP to liaise regarding a rep for UHW; CM for ED/AU; WP for UHL.	Harriet Foley/ Dave Pitchforth Ceri Martin Wayne Parsons			
MCBQSE/ 2023/0116	Safeguarding update	SR to identify the Safeguarding and invite them to join this meeting and deliver an update.	Sian Rowlands	20/7/23		
MCBQSE/ 2023/0117	Health and Safety update	DP is preparing the MCB Health and Safety Report and would appreciate updates to add to the report. JM will follow up on this. SR will follow up on identifying key areas where V&A training is needed most and has been advised that these will be prioritised with face-to-face training.	Dave Pitchforth/ Jane Murphy Sian Rowlands	20/7/23		
MCBQSE/ 2023/0118	Initiatives to improve access to services	**Get up, Get Dressed, Get Moving** – starting a pilot at UHW, taking an MDT approach. JM will discuss further with Lead Nurses regarding getting a clear timeline and to see a growing plan.	Jane Murphy	20/7/23		
MCBQSE/ 2023/0124	Feedback from Clinical Board Inclusion – Inclusion Ambassador for Disability	**Disability Inclusion Ambassador** – SG is currently holding this role, along with other Ambassador roles. All to consider finding a volunteer for this role. If no volunteer found,	Jane Murphy	20/7/23		

		JM will nominate a representative.				
MCBQSE/ 2023/0125	Equality and Diversity Issues	JM will change this on the agenda and be more precise on what needs to be discussed.	Jane Murphy	20/7/23		
MCBQSE/ 2023/0129	AOB – Inquests AOB - Cancers	Inquests - CM will give an update of the recent inquest at the next MCB QSE meeting. **Cancers** – JM to add this to future MCB QSE agendas. Discuss impact of delayed care affecting patients.	Jane Murphy Jane Murphy	20/7/23		

Minutes of the Specialist Services Clinical Board
Quality, Safety and Experience Committee

Held Monday 30 March 2023 at 9:30am

Via MS Teams

Chair:		
Claire Main	CMain	Interim Director of Nursing, Specialist Services CB
Present:		
Aled Lewis	AL	
Alex Scott	AS	Assistant Director of Quality and Patient Safety
Angela Jones	AJ	
Beverley Oughton	BOu	Senior Nurse, Cardiac Services
Catherine Evans	CE	Patient Safety Facilitator
Caroline Burford	CB	Consultant in Critical Care
Claire Mahoney	CM	CNS Infection Prevention & Control
Colin Gibson	CG	Consultant Clinical Scientist, ALAS
Gareth Jenkins	GJ	
Gayle Sheppard	GS	
Glynis Mulford	GM	Corporate Governance Officer
Guy Blackshaw	GB	Clinical Board Director, Specialist Services
Helen Thomas	HT	Lead Pharmacist for Specialist Services Clinical Board
Jessica Castle	JessC	Director of Operations for Specialist Services
Jo Clements	JC	Lead Nurse, Critical Care
Kevin Nicholls	KN	
Kirsty Britton	KB	Senior Nurse, Nephrology & Transplant
Lisa Higginson	LH	
Mat Davies	MD	Consultant Nephrologist, Quality and Safety Lead SSCB
Mark Davies	MkD	
Melissa Rossiter	MR	
Nicola Carter	NC	
Rachael Sykes	RS	Assistant Head of Health and Safety
Rachel Long	RL	Directorate Manager for Nephrology & Transplant
Richard Parry	RP	Q&S Facilitator
Rose Lewis	RL	Duty of Candour Lead
Vicky Stuart	VS	Complaints Manager
Secretariat		
Mandy McGee		
Apologies:		
Bethan Ingram		Senior Nurse, Teenage Cancer Trust
Caroline Burford		
Claire Mahoney		
Colin Gibson		
Jane Morris		Senior Nurse, PaRT
Rachel Long		
Sian Williams		Senior Nurse, Cardiac Services
Tom West		Critical Care Consultant

Tracey Skyrme		Head of Inquests

Item No	Agenda Item	Action
1.1	**Welcome & Introduction** CMain welcomed all to the meeting.	
1.2	**Apologies for Absence** **The Committee resolved that:** a) The apologies given were noted.	
1.3	**Duty of Candour** CMain introduced Vicky Stuart, Complaints Manager and Rose Lewis, Duty of Candour Lead who gave a presentation on the Duty of Candour. Discussions were held around the presentation.	
1.4	**Minutes of the Meeting Held 16 March 2023** **The Committee resolved that:** With the amendment made the minutes were recorded as a true and accurate record.	
1.5	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** CMain introduced Debbie Jones, Deputy Head of Quality Assurance & Clinical Effectiveness Lead who presented an update of the audit management and tracking system, which was originally piloted with the Children & Women CB and went live across the UHB from November- Debbie said that she was happy to have further conversations with people outside of this forum if they would like extra support using the system. CMain thanked Debbie for her presentation.	
	Safe Care	
2.1	**Open Nationally Reportable Incidents** RP reported that there are ten NRI's in progress at the moment, of these four have documents that are completed or very near to	

	completion and are expected to close very soon. There are some new NRI's which will be reported here after the first meetings. CE suggested that it may be beneficial to see the closure forms which contain a summary of the incident and recommendations along with learning from the event rather than the closure report which only provides numbers. **Potential NRI's** Nothing to report **The GROUP resolved:** It was agreed to continue reviewing all complex cases following the NRI structure in order to share learning **Open Inquests** Nothing to report **The GROUP resolved:** a) To review inquest information as appropriate	
2.2	**Closure Forms** RP reported on the findings for the Investigation of Concerns in Care of MG L066988L, the case of a 25year-old pregnant lady who was found dead at her home by her mother. RP said that there is a second similar case which will be reported on in a future meeting. MD commented that there were a large number of inquests in the report sent out and noted that some date back to Summer of 2021 which would make it difficult to get closure for both the families and medical professionals involved. He asked if this was usual or something which has worsened following the pandemic. CE replied that the situation has worsened, MD said that he would follow this up with Tracey Skyrme outside of this meeting. AS replied that inquests have been subject to the same pressures experienced by the HB as a result of Covid, all face to face inquests ceased at the onset of Covid and it took some time to move to virtual inquests resulting in a significant backlog nationally. RP reported that there are also significant delays in receiving post mortem results which causes significant delays with investigations. MD replied that the pathologists are extremely understaffed at present and experiencing difficulties in being allowed to recruit to these university posts due to financial constraints.	
2.3	**Alerts / Patients Safety Notices** The following notices which have been disseminated to the Group, to share as appropriate: • CPhO MedsLet 2023 002 - Norditropin (somatropin) Flexpro solution for injection pre-filled pens (002)	

	• 23-01-11 - CMO letter providing update on TB services (vA83349546) • PSA015 Oxygen cylinder FINAL • Guidance Sensitive Oxygen Cylinder FINAL1 Wales • SBAR aspHirate PH testing strips Potential batch issue • CAV Antimicrobial Management Group SSTF audit report **The GROUP resolved:** • All documents shared at this meeting to be shared within the Directorates. The antimicrobial audit report will be brought back to the next meeting for further discussion.	
2.4	**Healthcare Associated Infections** No report received CMain reported that she was unaware of any significant infection issues across the area. There are a number of respiratory and Covid issues generally across the HB which are being worked through on an individual basis.	
2.5	**Health Care Standard 2.9 Medical Devices** Nothing to report	
2.6	**Health and Safety** CMain introduced Rachael Sykes from the H&S Team, she will be covering in the interim period as Caroline Murch has moved to a new role. Rachael and Claire will be meeting to discuss H&S within the CB 17 February.	
2.7	**Vaccination Update** KB reported that uptake has not been as successful as previously but this may be due in part of problems in data capture with staff receiving their vaccinations from outside the HB. It is hoped to have a more accurate picture later this month.	
	Governance, Leadership and Accountability	
3.1	**Feedback from UHB QSE** AS reported that there was nothing significant to report. The 2 main topics are the Duty of Quality and the Duty of Candour. AS would like to present on the Duty of Quality at the next meeting and explained that there is a significant process to be implemented by the beginning of April in order to meet our statutory duty with regards to the Duty of Candour.	

	The main principles of Duty of Quality require the improvement of governance across the HB in relation to how Clinical Governance groups interlink with the CB's in order to share lessons learned. It is expected that standard agendas will be amended to include quality in the broader sense using the 6 domains of quality. More information will be provided in March. It is expected that a quality summit will be arranged for later in the year. **The GROUP resolved:** To invite AS to present overview of Duty of Quality at the next meeting	
3.2	**Mortality Review** CMain asked everyone consider the recent email sent out by Caz Burford looking at the Mortality Review Group and the triggers for enhance mortality review. There has been a recognition that parameters in certain departments are more concerning than others and that there are some nuanced specialty-related outcomes within Specialist Services. CB had asked for representatives from each directorate to look at any opinions on hard triggers for stage 2 mortality reviews that would be recommended to specialities to support the process. Replies by end of February in order for CB to present at the next Mortality Review Group meeting. AS informed that a Learning from Death Framework Is being developed across the HB and added that within the next couple of months all in-patient deaths will be reviewed.	
3.3	**Exception Reports and Escalation of Key QSE Issues from Directorate QSE Groups** <u>Nephrology and Transplant</u> Nothing to report <u>Haematology</u> KW reported that the key issue affecting the Department is staffing, both Nursing and Medical. The Department is currently not running at a safe level which is having a significant impact o staff morale and retention. The new lead nurse is currently drawing up action plans to try and resolve the situation. The estate situation is long standing, there is a plan in place to improve facilities but tangible progress has yet to be made. JACIE accreditation is due 2024, KW expressed his concern that the deficits found in the previous inspections remain. MD asked if there were any obvious blockages to recruitment which could be addressed. KW replied that most of the problem is due to the high level of training staff require to work within the Department. CMain informed the Group that there is a very in-depth plan around both spreading the skill mix we have and using the entire workforce and working very differently within the Directorate, this is something that a lot of the other Directorates have already done. The staffing	

	is reviewed on a daily basis and through a new system, SafeCare, the safety of all wards is reviewed and mitigation is put in place in those areas which may not be working at the establishments the are designed to be. CMain has met with the staff from B4 to talk through the specific issues they are experiencing and with them an action plan has been put together which comes into effect immediately in terms of how they can work differently, prioritise workloads and work with different teams. There is a lot of work being undertaken to help ensure that there is a robust plan to grow the Haematology Service back to where it needs to be but there an investment and training period that needs to be undertaken before we can get the staff up to the competency that has been lost due to retirement, people changing priorities and work being undertaken differently. It is anticipated that there will be significant changes seen in terms of day to day practice and the staff feel supported and have a different view on how they can also support themselves through this period. CMain added that further details will be shared with the Team at the next Directorate Performance meeting. SL reported on the plans around the infrastructure issues, it is planned for a strategic outline case to be presented to the Senior Leadership Board in March. This will then go to the Executive Board in May for sign off and from there it will go to Welsh Government. It is hoped that at the time of the JACIE inspection there will be an approved strategic outline case and work will be on-going on a full business case. SL shared KW's concerns around the JACIE inspection and added that it is hoped that the next few months are key in terms of receiving assurance that WG are committed to working with the UHB on this. <u>Critical Care</u> HV reported recurrent problems in getting APTT results back and asked if others were experiencing the same problem. She also informed that a large number of staff are unable to carry out blood sugar testing as the POCT clearance seems to be lapsing with no explanation. POCT are unable to resolve this problem. HV an update on the Critical Care Topic of the Month initiative where incidents on Datix are reviewed and collated into common themes in order to feedback to the staff using a multidisciplinary approach on a monthly basis. CMain thanked HV and the Team for their work in developing this and asked that it be presented to this Group. MD asked for an update on the current staffing levels in CC, HV and JC replied that the situation has greatly improved since the end of last year, department are currently at establishment overall with an over-establishment of Band 5 nurses and under on Band 6 nurses. Throughout all of the winter pressures there was no doubling up nor working with reduced zone leaders. However, it is anticipated that this number may reduce as a lot of the overseas nurses have indicated that they are looking to move to Australia. AS asked if HV would be happy to meet with her to discuss promoting the Topic of the Month initiative across the HB.	

	CE reported that it has been 12 months since the weekly Pressure Damage Scrutiny Panel was set up, at the time there were approximately 55 cases but this has significantly reduced to 18. This is going to be entered in the HSJ Patient Safety Awards as Pilot Project of the Year. <u>Cardiac Services</u> BO reported that an issue was raised at the Cardiac Services Q&S meeting around the emergency transfer of patients from the Cath Lab over to Llandough, this is going to be investigated further. <u>MTC</u> Nothing to report <u>Neurosciences</u> Nothing to report <u>PaRT</u> FD reported that the Management of the Deteriorating Patient study days have been very well received with every one fully booked. The Team are looking to add further dates. <u>ALAS</u> Nothing to report	
	Items to be Recorded as Received and Noted for Information by the Committee	
4.1	Fire Safety – Computers on Wheels Fire Risk	
4.2	Medication Safety – Briefing for Healthcare Professionals	
4.3	Fire Safety Drop-In Session Dates	
5.1	**Any Urgent Business**	
	KW informed the Group that 1 March 2023 will be the 40th anniversary of the first transplant in Wales, a Patient and Family day to celebrate this is planned for later in the year. The annual meetings to benchmark UHW results against other organisations is planned along with one and all who are interested are invited. The Haematology Department have been successful in 3 separate research bids for increased funding. KW announced that he has resigned for his Q&S Medical Lead role with effect from 1 April 2023.	

	AJ reported that as of 17 February there will be standardisation of Zol defibrillators across the HB.	
6.1	**Date & time of Next Meeting**	
	Monday 17 April 2023 9:30am via Teams	