

Medicines Safety Assurance Tool (MSAT)

Authors and affiliation

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Introduction

NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) provide a full range of medicines management and optimisation (MMO) services to integrated care systems, NHS England, local authorities and primary care networks. The MLCSU Safety team have developed an innovative systematic tool (MSAT) that offers a unique, easy-to-use solution for the management of monthly safety drug alerts, all in one place.

MLCSU supports organisations in reducing avoidable medication-related risk and preventing patient harm. MSAT identifies actions for learning and implementation, provides assurance, and can be used to meet the organisations' quality and safety requirements in line with CQC. MSAT facilitates information sharing across many organisations and can be used to track implementation on a regular basis.

Process

The tool is delivered via a standardised process under the direction of the MMO safety lead pharmacist. The MLCSU Safety team carry out systematic horizon scanning of medicines safety information from a defined list of resources each month.

The MSAT is peer reviewed to ensure high quality standards and is produced monthly

BNF and BNF for Children

Methylphenidate hydrochloride long-acting (modified-release) preparations: caution if switching between products due to differences in formulations [MHRA/CHM advice].

Nebulised asthma rescue therapy in children: home use of nebulisers in paediatric asthma should be initiated and managed only by specialists [MHRA/CHM advice] (advice in ipratropium bromide, salbutamol, terbutaline sulfate; see example in [ipratropium bromide](#)).

Buprenorphine [update to indications and dose for transdermal patches].

BNF and BNF for Children Significant changes

Proposed action

- Newsletter Optimise Rx/Script/Switch
 Practice audit/search Other (please specify)

Methylphenidate - comms and Tablets newsletter. SS messages links to shared care guidance re brands. Nebuliser - on the techs workplan checking patients under the hospital. Buprenorphine - no action needed at this time. Information shared in Tablets

Action taken

Methylphenidate - as above. Nebuliser - as above Buprenorphine - as above

Status	Action due date	Date completed
Green	02/02/2023	02/02/2023

Figure 1: Snapshot of completed actions related to MSAT safety alert

Implementation

The MSAT has been used by the Wirral Place Medicines Management Committee to support 46 practices serving a population of 337,000 people.

From April 2022 to March 2023, 49 safety alerts were identified, with all safety alerts being tabled for review at the medicines management meeting. 100% of these were published to the prescribing newsletter, 31% were added to the Prescribing Support Tool, 12% were cascaded to other Allied HealthCare Professionals, and 8% resulted in Clinical Audits/Clinical System searches.

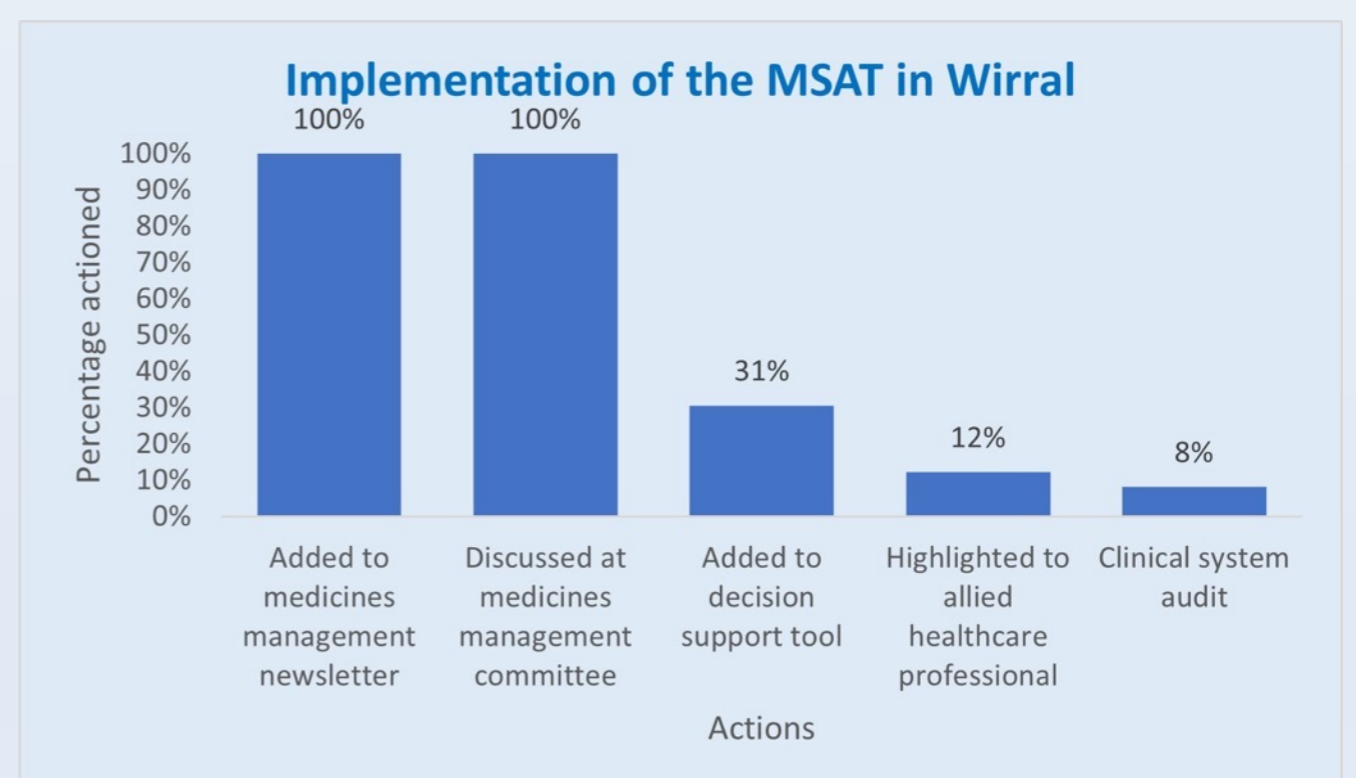


Figure 2: Implementation of the MSAT in Wirral

Conclusions

There is considerable scope in primary care and across the interface with secondary care for consistent and assured implementation of safety alerts.

MSAT is an efficient way for an organisation to support its assurance responsibilities in accordance with CQC in order to manage medicines related risk to patients.

“We regularly review the MSAT at the Wirral Medicines Management Committee. It is a good way to keep up to date with safety issues, and is a starting point for safety review work at practices. The MSAT highlights safety issues which the Medicines Management Team can then take forward and action.”

Sr Diane Atherton | Prescribing Lead GP

Wirral Place, Cheshire and Merseyside Integrated Care Board

References

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2. NICE Medicines Awareness Service, <https://www.nice.org.uk/news/nice-newsletters-and-alerts> (accessed July 2023)
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