NHS Lothian

Internal Audit 2024/25

Medicines Management Follow Up Review

January 2025

Final report

Emily Mayne
Head of Internal Audit
T 0121 232 5309
E emily.j.mayne@uk.gt.com

Pippa Jackson
Senior Manager
T: 0121 232 3567
E: pippa.g.jackson@uk.gt.com

Hannah McKellar
Audit Manager
T: 0141 223 0000
E: hannah.l.mckellar@uk.gt.com

Contents

This report is confidential and is intended for use by the management and directors of Lothian NHS Board. It forms part of our continuing dialogue with you. It should not be made available, in whole or in part, to any third party without our prior written consent. We do not accept responsibility for any reliance that third parties may place upon this report. Any third party relying on this report does so entirely at its own risk. We accept no liability to any third party for any loss or damage suffered or costs incurred, arising out of or in connection with the use of this report, however such loss or damage is caused.

It is the responsibility solely of Lothian NHS Board management and directors to ensure there are adequate arrangements in place in relation to risk management, governance, control and value for money.

Section	Page
Executive summary	03
Headline messages	05
Summary of findings	07
Detailed findings & action plan	08
Appendices	**17**
Appendix 1: Areas visited Testing	18
Appendix 2: Progress on 2023 Recommendations	26
Appendix 3: Staff involved & Documents reviewed	33
Appendix 4: Our Assurance Ratings	34

Report Distribution

Executive Lead:

- Scott Garden – Director of Pharmacy

For action:

- Melinda Cuthbert – Associate Director of Pharmacy
- Gillian McAuley – Director of Nursing –Acute
- Jane McNulty – Associate Nurse Director
- Katy Ruggeri - **Associate Midwifery Director**
- Debbie Alexander - Lead Pharmacist Controlled Drug Governance and Medicine Safety | Deputy Controlled Drug Accountable Officer

For Information:

- Caroline Hiscox - Chief Executive
- Craig Marriott – Director of Finance
- Audit Committee

Executive summary

Background

Safe and effective management of medicines is essential to the safe performance of every health and social care organisation. All health and social care organisations that deal with patient medication are required to have appropriate medicine management processes and policies in place that are aligned to national guidance to support and guide staff in the safe management of medicines.

An internal audit of NHS Lothian's Medicine management in 2023/24 provided a limited assurance rating following visits to nine pre-selected areas of the organisation. There was noted to be variable compliance with NHS Lothian Board's policies and procedures relating to the safe and secure storage of medication across the areas visited, and the oversight and monitoring of compliance with the Board's medicines policies and procedures required strengthening.

In response to the audit, NHS Lothian introduced a multidisciplinary Medicines Safety & Risk Group which is chaired by the Director of Pharmacy and is responsible for monitoring and reporting the progress in addressing the actions raised by the 2023/24 internal audit report.

This is a follow up review to assess arrangements in place and provide assurance that actions to address identified gaps in compliance have been appropriately addressed and the associated learning shared across the wider organisation. This audit will focus on reviewing the safe and secure storage arrangements for medication and assess if the processes introduced have been sufficient to achieve the progress required.

Executive summary

Objectives

Our review focussed on the following key risks:

- Are staff complying with the Board's policies in the safe and secure handling, storage, disposal, ordering and receipt of medicines and stationery , including that related to Controlled Drugs?
- Does the Board have adequate arrangements in place to monitor compliance with its medicines management policy and take action where compliance is sub-standard?
- Does the Medicines Safety & Risk Group have appropriate arrangements in place to monitor and gain assurance on the progress in addressing the original recommendations; to strengthen the management of medicines across the Organisation ?
- Has the Board made sufficient progress in addressing the recommendations raised in the 2023/24 internal audit review of medicines management.

Limitations in scope

Our findings and conclusions will be limited to the risks identified above. The scope of this audit does not allow us to provide an independent assessment of all risks and controls linked to the Medicines Management review.

Where sample testing is undertaken, our findings and conclusions will be limited to the sample tested only. Please note that there is a risk that our findings and conclusions based on the sample may differ from the findings and conclusions we would reach if we tested the entire population from which the sample is taken.

This report does not constitute an assurance engagement as set out under ISAE 3000.

Acknowledgement

We would like to take this opportunity to thank your staff for their co-operation during this internal audit.

Headline messages

Conclusion

Limited Assurance

We have undertaken a follow up review of compliance with the processes and controls around medicines management, specifically focusing on recommendations raised in our previous 2023/24 review to assess progress in made in addressing the actions agreed with management. We have concluded that the processes have provided a rating of **LIMITED ASSURANCE.** This was confirmed through testing in specific areas of the organisation and through discussions with management.

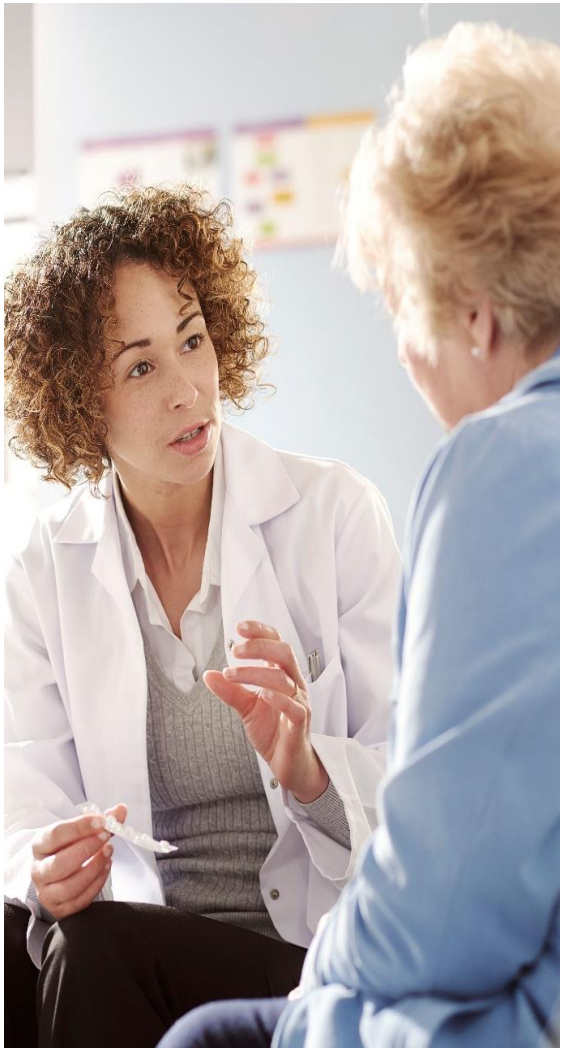
The objectives reviewed are set out on the following page with the assurance rating we have assessed for each one and the number of recommendations raised. We have reported by exception against the areas where we consider that Management and the Audit Committee should focus their attention.

We would like to acknowledge that NHS Lothian is a large organisation with multiple sites. Our initial visit in September 2023 resulted in recommendations which were accepted by management and reported to the Audit & Risk Committee in February 2024, so this review, undertaken in October 2024, is only 8 months after actions were formally agreed. These factors may have contributed to the limited progress achieved in addressing some of the recommendations raised and the lack of sustained improvement with some aspects of medication management that we have identified across the sites.

Testing was undertaken at 10 areas selected by NHS Lothian. Three of these were follow up visits to areas where we had previously highlighted concerns and seven areas were new to our audit process. The visits were spread across three sites: Western General, the Royal Infirmary and St John's Hospital in Livingston. At the clients request these visits had been previously announced to the Clinical Nurse Managers and at both the Western General and St John's Hospital, staff were expecting us.

Improvement has been achieved in the strengthening of staff training associated with the management of medicines and in compliance with the management of Controlled Drugs (CD). However, overall, there remains variable compliance with NHS Lothian's policies and procedures relating to the safe and secure storage of medication in many of the areas that we reviewed, and this remains a potential area of risk for the organisation.

There has been limited progress achieved in strengthening the Board's internal assurance tools (LACAS) due to work needed to update the system's medicines managements template. In addition, further work is required to strengthen assurance that appropriate and sufficient action is taken to address issues related to medicines safety and security that are identified by the audits and to ensure staff at a ward level are familiar with the outcome of the CD and LACAS audits. This is key component of the audit cycle, so staff are aware of what needs to improve and change which drives a culture of excellence around the management of medicines.



Headline messages

Conclusion

We have raised 9 recommendations. The grading of these recommendations, based on risk, is summarised in the table below.

Objectives	Assurance rating	Number of recommendations			
		High	Medium	Low	Imp
Are staff complying with the Board's policies in the safe and secure handling, storage, disposal, ordering and receipt of medicines and stationery , including that related to Controlled Drugs?	Limited Assurance	1	2	1	-
Does the Board have adequate arrangements in place to monitor compliance with its medicines management policy and take action where compliance is sub-standard?	Limited Assurance	-	2	1	-
Does the Medicines Safety & Risk Group have appropriate arrangements in place to monitor and gain assurance on the progress in addressing the original recommendations; to strengthen the management of medicines across the Organisation	Limited Assurance	-	1	-	-
Has the Board made sufficient progress in addressing the recommendations raised in the 2023 internal audit review of medicines management.	Moderate Assurance	-	-	1	-

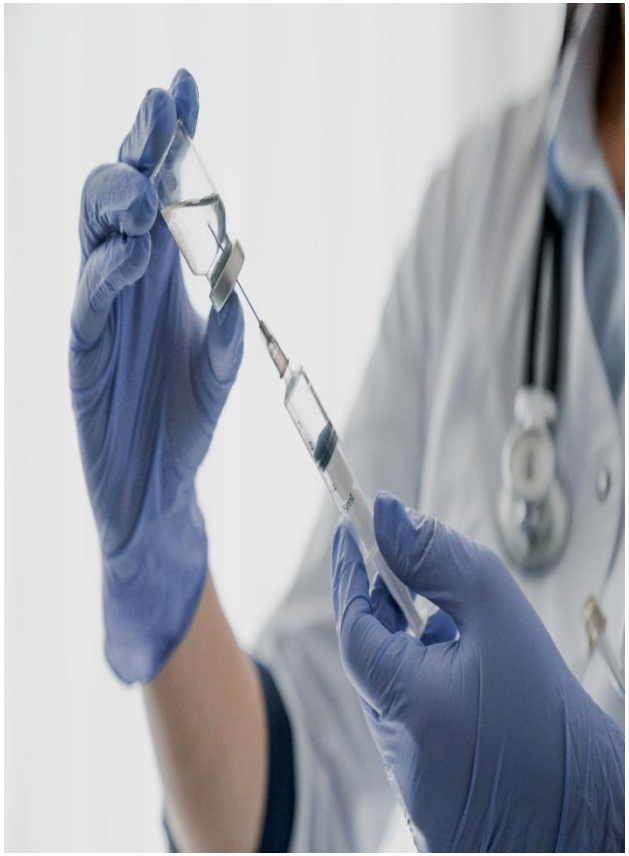
Summary of findings

Examples of where recommended practices are being applied

- There is good compliance with the completion and recording of the daily CD checks in most areas and CD stationery was consistently stored securely in the CD cabinets.
- There is consistently good compliance with the monitoring and recording of emergency equipment and resuscitation drugs.
- There are effective arrangements in place to ensure medical gases are monitored and replaced in a timely manner.
- There is good separation of medicines in accordance with the varied strength and route of administration, and medication is generally being stored in its original packaging.
- Patient POD lockers were all secured, ensuring access is limited to authorised personnel.

Areas requiring improvement

- Access to Clean Utility Rooms remains unrestricted to unregistered staff and provides a potential opportunity for unauthorised personnel to access medicines and drug keys being stored in unsecured cupboards, key safes and drug fridges.
- Further improvement is required in the safe management of elixirs, insulin and of medicines stored within drug fridges.
- Work to strengthen the existing internal assurance tools LACAS needs to be prioritised to allow improved oversight of staff compliance with the safe and secure storage of medication.
- Formalised processes need developing to provide assurance that issues identified by audits as requiring improvement are appropriately addressed in a timely manner.
- Collaboration with estates services is required to allow issues that impact the safety and security of medication to be prioritised.



Detailed findings

Objective 1.	Are staff complying with the Board's policies in the safe and secure handling, storage, disposal, ordering and receipt of medicines and stationery , including that related to Controlled Drugs?	Limited Assurance

Finding and implications	Audit recommendation	Management response, including actions
At the time of our visits no medication had been left out or unattended in the Clean Utility rooms we viewed and the Computer on Wheels drawer's that previously contained medication have been removed to mitigate the risk of drugs inadvertently being left accessible in unlocked drawers. However, access to the Clean Utility rooms is not restricted to registered personnel and there remains variable staff compliance with the Board's 'Safe Use of Medicines' procedure in most of the 10 areas we visited. We continued to find medicine keys, drug fridges, IV fluids and cupboards containing medication unsecured in the Clean Utility rooms thus providing unrestricted access by non-registered staff to medicines. **(Recommendation 1) (See Appendix 1 for details of compliance)** In addition, we have noted that in several areas there were broken locks on cupboards containing medication that had not been responded to and resulted in medication being potentially accessible to unauthorised personnel. **(Recommendation 1)**	**Recommendation 1** To improve compliance with the secure storage of medicines NHS Lothian should: • Review access rights to clinical rooms where medication is stored across all sites and restrict access to non-clinical staff and those not involved in the medication aspect of patient care. • Update the 4 monthly Controlled Drug audit tool to incorporate medicines safety and security. • Collaborate with Estates services to allow priority responses to estates issues that compromise the safe and secure storage of medicines.	**Actions:** LACAS questions for 6 monthly assessment have been drafted that includes these items and will be updated in Q4 24/25 to go live for 25/26 cycle. Controlled Drug 4 monthly audit for each clinical area will be used to inform the 6 monthly LACAS assessment for each area. Nurse/Midwife in Charge all to be communicated the recommendation for improvement from this audit and the awareness that spot checks will be introduced as part of senior managers walk around. **Responsible Officer:** Melinda Cuthbert, Debbie Alexander, Gillian McAuley' Jane McNulty & Katy Ruggeri **Executive Lead:** Alison MacDonald **Due Date** March 2025 Discussion with Morag Campbell, Director Estates & Facilities to agree process to prioritise estates issues related to medicines safety and governance with the associated resource. **Responsible Officer:** Gillian McAuley, Jane McNulty & Scott Garden **Executive Lead:** Alison MacDonald & Tracey Gillies **Due Date** March 2025

Detailed findings

Objective 1.	Are staff complying with the Board's policies in the safe and secure handling, storage, disposal, ordering and receipt of medicines and stationery , including that related to Controlled Drugs?	Limited Assurance

Finding and implications	Audit recommendation	Management response, including actions
In several areas we found storerooms housing IV fluids that had unrestricted access and in three areas we identified IV fluids that were out of date. These were removed and disposed of at the time of the review. (Recommendation 2)	Recommendation 2 To improve compliance with the safe management and storage of IV fluids the Board should ensure that random spot checks of IV storage cupboards are undertaken to ensure that the stock is in date and securely stored.	**Actions:** LACAS questions for 6 monthly assessment have been drafted that includes this item and will be updated in Q4 24/25 to go live for 25/26 cycle. Nurse/Midwife in Charge all to be communicated the recommendation for improvement from this audit and the awareness that spot checks will be introduced as part of senior managers walk around. **Responsible Officer:** Gillian McAuley, Jane McNulty & Katy Ruggeri **Executive Lead:** Alison MacDonald **Due Date** February 2025

Detailed findings

Objective 1.	Are staff complying with the Board's policies in the safe and secure handling, storage, disposal, ordering and receipt of medicines and stationery , including that related to Controlled Drugs?	Limited Assurance

Finding and implications	Audit recommendation	Management response, including actions
CD keys were kept separate to other drug keys and were held by the nurse in charge. All CD stationary was securely stored and there was no backlog of CD medication awaiting disposal found in any areas we visited. However there remains a lack of clarity regarding the correct process for disposing of small amounts of CD medication and some variance in the frequency of CD medicines checks. In 2 areas we noted some missed daily checks that staff attributed to periods of low staffing and high activity. We identified that in several areas there is limited evidence that staff consistently sign the CD order book to confirm the receipt of new CDs being delivered to the ward. **(Recommendation 3)** Furthermore, in one area we were told a discrepancy had been identified in the quantity of methadone elixir during a reconciliation check. This had been reported to Pharmacy but there had been no response on what action to take at the time of our visit. Staff and Pharmacists lacked clarity on how frequently CD elixirs should be reconciled across the sites. We were told these arrangements have recently been updated in the procedures and our finding may indicate further work is needed to familiarise staff with the new arrangements. **(Recommendation 3)**	**Recommendation 3** To improve compliance with CD governance further work is required to embed the recent updates to the Safe Use of Medicine Procedure related to liquid balance checks and the embedding of the ward CD audits and the four monthly Pharmacy CD audits.	**Actions:** Raise awareness of updates to CD section of Safe use of Medicine Procedure within pharmacy and nursing leadership teams Raise awareness of CD Governance Team resources and intranet pages Review trends from updated 4 monthly CD check and share with pharmacy and nursing teams **Responsible Officer:** Debbie Alexander **Executive Lead:** Scott Garden **Due Date:** December 2025

Detailed findings

Objective 1.	Are staff complying with the Board's policies in the safe and secure handling, storage, disposal, ordering and receipt of medicines and stationery , including that related to Controlled Drugs?	Limited Assurance

Finding and implications	Audit recommendation	Management response, including actions
In 8 out of the 10 areas we found opened bottles of elixir that did not display the date they had been opened, and, in several areas, there were out of date drugs that required disposal, and were removed from circulation at the time of our visit. **(Recommendation 4)** In 5 out of the 10 areas visited we noted compliance with the completion of the daily drug fridge temperatures was variable. In one of the areas there was no process in place to monitor the drug fridge temperature and we were told this had not been identified previously. In addition, we noted in one area, staff food was being stored in a drug fridge. This was disposed of at the time of our visit. **(Recommendation 4)** There is evidence NHS Lothian has undertaken work to increase staff awareness of appropriate cold chain management, however our testing indicates this may not have had the required impact and requires further work to gain assurance that actions implemented have achieved the required outcomes. (see Recommendations 7 & 9)	**Recommendation 4** To improve compliance with Lothians' 'Safe Use of Medicines' procedures ' The Board should introduce a process that allows formal spot checks of medicine management arrangements: ▪ Monitoring the completion of drug fridge temperature checks, appropriate storage and timely disposal of expired and unused medication and compliance with appropriate labelling on elixir bottles and insulin with the date of opening. ▪ Embedding the formal monthly oversight of completed temperature monitoring records for drug fridges and the Clinical Nurse Manager should report non-compliance by exception to the appropriate oversight group.	**Actions:** LACAS questions for 6 monthly assessment has been drafted that includes these items and will be updated in Q4 24/25 to go live for 25/26 cycle. Nurse/Midwife in Charge all to be communicated the recommendation for improvement from this audit and the awareness that spot checks will be introduced as part of senior managers walk around. The findings of the 6 monthly LACAS cycle and any themes will go through the Nursing and Midwifery Care Assurance Oversight Board using a formal report. The SCN would be the first line for checking compliance with fridge temperatures. Spot check findings by the CNM will be reported to the nurse or midwife in charge and taken through local governance as required. **Responsible Officer:** Gillian McAuley, Jane McNulty and Katy Ruggeri **Executive Lead:** Alison MacDonald **Due Date:** March 2025

Detailed findings

Objective 2.	Does the Board have adequate arrangements in place to monitor compliance with its medicines management policy and take action where compliance is sub-standard?	Limited Assurance

Finding and implication	Audit recommendation	Management response, including actions
NHS Lothian has two established monitoring tools that provide oversight of medicine management compliance: • A Patient Care Assurance Tool (PCAT), completed by the Charge Nurse each month, and • The Lothian Accredited Care Assurance Standard (LACAS), undertaken biannually by the Charge Nurse and the Clinical Nurse Manager. The PCAT / LACAS tools have a series of standardised questions to provide assurance that patient medication is reviewed, appropriately reconciled and administered. Staff told us, and review of the PCAT & LACAS medication question templates confirmed that, the internal audit tools have not yet been updated to incorporate additional questions that will provide assurance of the safe and secure storage medication since the review of arrangements in 2023/24. We were told this work will be undertaken by the recently introduced Care Assurance Oversight Board, but this work is in its infancy. **(Recommendation 5)**	**Recommendation 5** To improve oversight and compliance with the safe and secure management of medicines the Lothian NHS Board should: ▪ Prioritise the work of incorporating a medicines security module into the PCAT and LACAS audit tools to allow regular oversight of compliance with medicines management. ▪ Consider the implementation of a peer review process to gain improved objectivity of an areas medicine management arrangements.	**Actions:** LACAS questions for 6 monthly assessment have been drafted that includes these items and will be updated in Q4 24/25 to go live for 25/26 cycle. Controlled Drug 4 monthly audit for each clinical area will be used to inform the 6 monthly LACAS assessment for each area. **Responsible Officer:** Melinda Cuthbert, Debbie Alexander, Gillian McAuley, Jane McNulty & Katy Ruggeri **Executive Lead:** Alison MacDonald **Due Date:** March 2025

Detailed findings

Objective 2.	Does the Board have adequate arrangements in place to monitor compliance with its medicines management policy and take action where compliance is sub-standard?	Limited Assurance

Finding and implication	Audit recommendation	Management response, including actions
A review of some LACAS audits indicates that the ward observations tool in some areas has identified gaps in the safe and secure management of medicines. However, staff reported there is no formalised process in place to monitor that actions to address issues raised in the PCAT / LACAS audits are sufficiently addressed and embedded. **(Recommendation 6)**	**Recommendation 6** The Board should formalise the process for gaining assurance that actions identified in PCAT/LACAS audit are appropriately addressed and sustained.	**Actions:** Medicines Management focused agenda to be planned for the Nursing and Midwifery Care Assurance Oversight Board in 2025 using quality improvement data, including LACAS cycle results to inform discussions and any agreed actions. The Nursing and Midwifery Care Assurance Oversight Board provides a process for measuring, improving, assuring and accrediting nursing and midwifery care across NHS Lothian. It provides a forum for sharing data / reports relating to patient care so that learning can be taken beyond operational ward / management / Business Unit boundaries. It provides a governance structure for nurse leadership to report the level of assurance on care standards within individual services and across NHS Lothian. It provides a clear process for the commissioning of work from NHS Lothian programme boards, groups, services, teams or individuals related to the safe, effective and person-centred delivery of care within NHS Lothian **Responsible Officer:** Gillian McAuley, Jane McNulty and Katy Ruggeri **Executive Lead:** Alison MacDonald **Due Date:** December 2025

Detailed findings

Objective 2.	Does the Board have adequate arrangements in place to monitor compliance with its medicines management policy and take action where compliance is sub-standard?	Limited Assurance

Finding and implication	Audit recommendation	Management response, including actions
• A Patient Care Assurance Tool (PCAT), completed by the Charge Nurse There is evidence to support that the outcome of the audits is shared widely with the Associate Directors of Nursing, Clinical Nurse Managers and the Hospital Management Group, allowing themes and trends to be shared. However, the staff we spoke to on the wards often had limited awareness of the outcomes from PCAT /LACAS audits . This indicates further work is required to ensure the learning from audits is effectively cascaded at a ward level. (Recommendation 7)	Recommendation 7 The Board should undertake further work to ensure the arrangements for sharing the outcome of audits related to medicines with staff and pharmacy services is strengthen at a ward level.	Actions: The following groups will be utilised to share learnings and recommendations from audits: Nursing and Midwifery Care Assurance Programme Board, Area Drugs & Therapeutics Committee and subcommittees, Medicines Safety & Risk Group, Acute Clinical Management Group, HSCP Care Governance Committee, Pharmacy Senior Leadership Forums. Datix reports will be monitored along with results of the 4 monthly Controlled Drug audits and 6 Monthly LACAS assessments **Responsible Officer:** Scott Garden, Melinda Cuthbert, Gillian McAuley, Jane McNulty, Debbie Alexander & Katy Ruggeri **Executive Lead:** Alison MacDonald & Tracey Gillies **Due Date:** March 2026

Detailed findings

Objective 3.	Does the Medicines Safety & Risk Group have appropriate arrangements in place to monitor and gain assurance on the progress in addressing the original recommendations; to strengthen the management of medicines across the Organisation.	Limited Assurance

Finding and implication	Audit recommendation	Management response, including actions
The Medicines Safety & Risk Group operates under an established Terms of Reference; however, a review of meeting minutes revealed limited nurse representation. Additionally, nurses in the areas we visited were unaware of the forum's existence. An action plan to address the recommendations raised in the 2023/24 medicines management internal audit report has been developed and that actions have a nominated action owner. However, we note attendance by the action owners at the Medicines Safety & Risk Group has been limited due to their conflicting priorities and this is reported to have delayed the progress in addressing the actions specifically aimed at strengthening the oversight and assurance that medication is safely and securely managed. In addition, we are told that updates provided have on occasion only been verbal. **(Recommendation 8)** In August 2024, the Board's Audit & Risk Committee received a progress update in addressing the action plan that incorporated the action plan and updated RAG ratings driven by progress. The action plan has been reviewed and the Board's assessment on the progress against actions is generally aligned to our own assessment. See Appendix 2 page 20) To date only one low level recommendation has been closed and six of the remaining actions are overdue. We note an update to the action plan in May 2024 indicating that draft wording for the additional questions to be integrated into the Medicines Management module on LACAS was in progress via the NHS Lothian Medicines Safety Committee. However, we have been told this action now sits with the Care Assurance Oversight Board and it is anticipated that work to review medicine management oversight and arrangements will not be progressed until the new year. **(Recommendation 5)** We acknowledge the Medicines Safety & Risk Group is still in its infancy and remains under review.	**Recommendation 8** To improve the assurance provided to the Medicines Safety & Risk Group of progress in addressing specific actions on the internal audit action plan the actions owners should provide a formal written update on the progress that has been achieved in addressing the action. Outlining any barriers to the progress of the action and demonstrating how effective the action has been in addressing the recommendation.	Actions: The Medicines Safety and Risk Group (MSRG) will structure agendas to receive formal written updates from action owners as detailed in the audit action plan. They will be expected to attend to discuss the updates to ensure there is an appropriate level of discussion, holding to account and opportunity for timely escalation of issues. MSRG will commission work aligned with outstanding actions as required. MSRG will report progress to the Area Drug and Therapeutics committee. **Responsible Officer:** Debbie Alexander **Executive Lead:** Scott Garden **Due Date:** February 2025

Detailed findings

Objective 4.	Has the Board made sufficient progress in addressing the recommendations raised in the 2023 internal audit review of medicines management.	Moderate Assurance

Finding and implication	Audit recommendation	Management response, including actions
The number of recommendations raised in our 2023/24 Medicines Management report and the number of separate sites where actions require cascading provides a significant challenge for the Board. The elapsed time from our visit, to the report being agreed by Management, and actions starting to be addressed is also a consideration. Overall, the Board has made some progress in addressing each of the recommendations raised in the 2023/24 Medicines Management report. However, the pace is reported to have been slower than planned in addressing some actions and a number of the actions cannot be completed until the work to update the PCAT / LACAS template has been finalised. Work to address this is being taken forward by the Care Assurance Oversight Board. There is evidence of some improved compliance with the NHS Lothian's Medicine Management standards related to the management of CDs and staff education, and although we can see some limited improvement in staff compliance with the Safe Use of Medicines Procedures, the overall compliance remains variable in most of the key areas visited. Focus should be on targeting processes, training and embedding a culture of sustained improvement. The Board then needs to put in place a process where they can receive assurance that actions are still having the required impact to mitigate and address risk. Nationally we have seen a project of this size can take several years to embed. We have identified that even where actions have been addressed to improve compliance this has not achieved an improved level of compliance. An examples of this is the monitoring and management of drug fridge temperatures where the introduction of refresher medicines management training, the inclusion of cold chain management into the New Staff's induction pack, and the clinical skills courses related to medicines enhancing staff awareness has not had the required impact. This may indicate further action is required to strengthen arrangements and that greater scrutiny and assurance is needed by the Medicines Safety & Risk Group that actions once addressed are achieving the required outcome. **(Recommendation 9)**	**Recommendation 9** **The** Medicines Safety & Risk Group should review the IA action plan and assess the effectiveness of the actions that have been put in place to address the gaps in compliance with the Board's Safe Use of Medicines procedures. In addition, the action plan should be updated to include a column that documents how assurance will be gained than an action has been effectively addressed.	**Actions:** The detailed action plan in response to this audit will be cross referenced to the outstanding actions from the audit conducted in 2023 to ensure that all remaining actions will be taken forward. As described in recommendation 8 the MSRG will assess progress against the detailed action plan as a standing agenda item at all meetings. **Responsible Officer:** Debbie Alexander **Executive Lead:** Alison MacDonald **Due Date:** February 2025

Appendices

Appendix 1:
Sample testing – medicine management compliance – St John's

2 or more breaches found | Single breach | Compliant

We have undertaken visits to 3 nominated areas at the St John's Site. We have RAG rated the compliance with the Board's medicines management policy and best practice using our RAG rating definitions below. We saw variable compliance with the management of medicines in all areas visited.

Area visited	Secure Storage	Safe Storage	CD Management	Storage of IV fluid	Cold Chain management	POD Arrangement	Emergency Equipment	Medical Gases	Stationary storage	Staff knowledge
MAU	Cupboard not lock	Elixir	CD receipt book							
ED	Cupboards drug fridge in clean utility not all locked and smaller room on latch Triage cupboard lock not working storing medication	All Pin codes same Elixir Found variety of Out-of-date medication in decommissioned cupboard	Receipt & Some missed checks	Lock ineffective on store Out of date bag of fluid	Variable temp checks	N/A				Limited awareness of CD or LACAS audit results
Ward 11	No Door Fridge not locked	Elixir		Stored in open room	Variable temp checks					

Appendix 1:
Medicine management compliance – St John's

We visited 3 pre-selected areas at the St John's Hospital Site. ED, MAU & Ward 11 . These were all new areas and staff on MAU and Ward 11 were expecting us.
Our key finds are listed below.

- Compliance with the Management of Medicines policy at St John's Hospital was variable. Staff reported they are well supported by pharmacy services with each area having a nominated Pharmacist and regular visit from Pharmacy Technicians to help maintain supply and rotate medication stock.
- The Clean Utility rooms were accessed by a swipe access or a Digi locks in. However, all areas allowed access to the Clean Utility room by unregistered staff.
- In the Clean Utility room in ED the drug fridge and two cupboards containing medication were not secured and all the cupboards with Digi locks have the same code that is not routinely updated. The cupboard used to store medication in triage cannot be locked providing unrestricted accessed to unauthorised personnel and it was unclear if this had been reported. **(Recommendation 1)**
- In MAU a cupboard had a broken dig lock that we were told had been broken for a long time and it was unclear if this had been reported. These arrangements could potentially allow access to medication by unauthorised personal. **(Recommendation 1)**
- On Ward 11 the cupboards storing medication were all secure. However , there is no door securing access to the area where medication is stored and the drug fridge containing insulin was unlocked. Staff told us this is normal practice to allow quick access to the emergency drugs that are stored in the fridge.,
- IV fluids in all areas were well separated and generally stored in their original boxes . However, restriction of access to IV fluids requires improvement on Ward 11 and ED as IV fluids could be potentially accessed by unauthorised personnel. **(Recommendation 2)**
- The opened bottles of elixir did not consistently display the date of opening in all areas we visited, and this may result in staff being unaware of when the contents of the bottle should be discarded. Furthermore, in ED we identified an out-of-date bag of IV fluids and a decommission cupboard containing a variety of out-of-date medication. **(Recommendation 4)**
- CD and Medication stationary was securely stored in all the areas visited however, there was variable compliance with staff signing the order book to confirm the receipt of CD medication. **(Recommendation 3)**
- CD medication is checked twice daily at St John's Hospital, and we noted in ED and on Ward 11 there were some occasions the CDs had only been checked once . This we were told was due to staffing capacity or the level of activity . There is good compliance with the completion of documentation to demonstrate where However, quantity of a CD has been wasted However, there remains some variance in the way a part dose of a CD would be disposed of. **(Recommendation 3)**
- There was good compliance with the completion of the emergency trolley checks and all medications were in date. However, there is evidence to support that the daily completion of drug fridge temperature checks in ED and Ward 11 are variable and there is evidence that the Clinical Nurse managers do not consistently review the completed temperature monitoring forms at the end of each month and the limited consequence of poor compliance may contribute to persistence in the variable levels of completion. **(Recommendation 4)**

Appendix 1:
Medicine management compliance – Royal Infirmary

2 or more breaches found | Single breach | Compliant

We have undertaken visits to 4 nominated areas at the Royal Infirmary Site. We have RAG rated the compliance with the Board's medicines management policy and best practice using our RAG rating definitions below

Area visited	Secure Storage	Safe Storage	CD Management	Storage of IV fluid	Cold Chain management	POD Arrangement	Emergency Equipment	Medical Gases	Stationary storage	Staff knowledge
Combined Assessment Unit	Key safe not locked Fridge not secure	Out of date insulin elixir	CD receipt book	Not locked	Staff food in drug fridge	N/A				Not aware of fridge needing to be secure
Ward 202 (MOE)	Door unlocked Fridge unlocked	Elixir Out of date insulin	CD receipt book	IV fluid store unlocked Out of date IV fluids	Temp not reg monitored Out of date antibiotics					Limited awareness of CD or LACAS results Lack of clarity regarding escalation of discrepancy in methadone

Appendix 1:
Medicine management compliance – Royal Infirmary

We visited 2 pre-selected areas at the Royal Infirmary Hospital site. We re visited Ward 202 and visited one new area Acute Medical Assessment Unit, Our key finds are listed below.

- Compliance with the management of medicines policy at the Royal Infirmary Hospital site was more variable. A return visit to ward 202 demonstrated that medication was no longer being stored in the drawers of the Computer on Wheels (CoW) and medication was generally stored in its original packaging , reducing the risk of administration error. However, the door to the Clean Utility area was not locked on our arrival and we were told this was because staff were in the middle of drug rounds. We noted that not all the cupboards storing medication, were secured and in addition, the drug fridge was not locked, and this was reflective of what had been found when we visited the ward in 2023. **(Recommendation 1)**
- We noted there had been limited improvement in compliance with the completion and documentation of daily fridge temperature checks with only six temperatures being documented in September 2024 and there remains limited compliance with the requirement to record the date of opening on elixir bottles. **(Recommendation 4)**
- In addition, we noted there was a vial of out-of-date insulin and an out-of-date bottle of antibiotics left in the drug fridge that were disposed of at the time of our visit. **(Recommendation 4)**
- A review of the CD register on Ward 202 indicated the CD register had a completed index page and that there was good compliance with the completion of daily CD checks. However, we noted there was variable compliance with the staff signing the order book to confirm receipt of new CDs. **(Recommendation 3)**
- Our visit to the Combined Assessment Unit provided assurance that medicines in the Clean Utility Room were securely stored and we were told the pin code for the Digilock had recently been changed. However, the lock for the key safe in the Clean Utility room that contained the keys for the individual drug cupboards was broken allowing unrestricted access to unauthorised personnel who have access to the Clean Utility Room. Furthermore, the drug fridges in the Clean Utility and Base 6 were not kept locked and staff told us this was not a requirement. Furthermore, the cupboard containing drugs for return to Pharmacy were not secured allowing potential access to medication by unregistered staff who have unrestricted access to the room. In addition, the door to the room containing IV fluids was not locked. **(Recommendation 1 & 2)**
- There was good compliance with the completion of daily monitoring of the drug fridge temperature and evidence to demonstrate the daily monitoring of CDs is being completed. However, we identified an open vial of insulin and several elixir bottles that did not display the date they had been opened. **(Recommendation 4)** and there was an item of staff food being stored in the drug fridge in Base 6 drug fridge.
- There was variable compliance by staff in signing the CD order book on receipt of new CDs being delivered to the ward. **(Recommendation 3)**

Appendix 1:
Medicine management compliance – Royal Hospital for Children & Young People site

2 or more breaches found | Single breach | Compliant

We have undertaken visits to 2 nominated areas at the Royal Hospital for Children & Young People. We have RAG rated the compliance with the Board's medicines management policy and best practice using our RAG rating definitions below

Area visited	Secure Storage	Safe Storage	CD Management	Storage of IV fluid	Cold Chain management	POD Arrangement	Emergency Equipment	Medical Gases	Stationary storage	Staff knowledge
Castle Mey		elixir								
Dunvegan				Out of date IV fluid						

Appendix 1:
Medicine management compliance – Royal Hospital for Children & Young People site

We visited 2 new pre-selected areas at the Royal Hospital for Children & Young People site Castel Mey and Dunvegan within the site. Our key finds are listed below.

- There was good compliance with the safe and secure management of medicines on the two paediatric wards at the Royal Hospital for Children & Young People site (Castle Mey and Dunvegan). There was swipe access to the Clean Utility areas with access restricted to registered staff only and the cupboards and drug fridges storing medication. There is good compliance with the completion and recording of drug fridge temperatures and minimum stock levels of medicines are held with clear separation of medication aligned route of administration and strength. All medication, was securely stored and the twice daily check of CDs are routinely completed and documented. On Castle Mey we identified that opened bottles of elixirs did not consistently have the date of opening recorded on them and on Dunvegan we identified some out of date IV fluids that were removed during the visit. **(Recommendation 4)**

Appendix 1:
Medicine management compliance Western General

2 or more breaches found | Single breach | Compliant

We have undertaken visits to 3 nominated areas at the Western General Hospital. We have RAG rated the compliance with the Board's medicines management policy and best practice using our RAG rating definitions below

Area visited	Secure Storage	Safe Storage	CD Management	Storage of IV fluid	Cold Chain management	POD Arrangement	Emergency Equipment	Medical Gases	Stationary storage	Staff knowledge
MAU	Fridge not locked	Elixir date	Receipt Missed checks		Variable Out of Date antibiotic					
Ward 23	Key safe open no door		Receipt not all signed							Limited awareness of CD or LACAS results
Ward 2		Elixir Out of date insulin		Store unlocked	No temp check					

Appendix 1:
Medicine management compliance – Western General

We visited 3 pre-selected areas within the Western General site. We revisited Ward 23 & the Medical Assessment Unit and visited Ward 2 for the first time. Staff in all areas were expecting us. Our key finds are listed below.

- Compliance with the Management of Medicines policy at the Western General Hospital remains variable although we noted the there had been some improvement in the arrangements for maintaining safe and secure storage of medication on the Medical Assessment Unit. (MAU)
- The Clean Utility Room on MAU was secured by a Digilock , and we were told the code for this lock had recently been changed. Medicines for return to Pharmacy were now securely stored, all medication was stored in its original packaging and there was no backlog of patient own CD medication awaiting disposal as we had identified on the previous visit. However, access to the Clean Utility remains open to some nonregistered staff and the drug fridge was not locked, allowing potential access to medication by unauthorised staff. **(Recommendation 1)**
- There was variable compliance with the completion of the daily fridge temperature checks on MAU and we were told completion is person dependant. We also noted that the opening dates on elixir bottles are not consistently recorded on elixir bottles and there were out of date antibiotics in the drug fridge, This indicates arrangements for managing the drug fridge require further improvement. **(Recommendation 4)**
- CD stationary was securely stored and there was improved documentation in the CD register. However, there was variable consistency with staff signing the CD order book in line with policy and we noted 3 occasions when CD checks had not been completed. **(Recommendation 3)**
- On Ward 23 there remains unrestricted access to the area where medication is stored due to environmental constraints. On this visit no medication had been left out and medication for return to pharmacy was now securely stored . Opened elixir bottles consistently had the date they had been opened recorded on them and the drug fridge was secured and compliance with the completion of daily temperature checks on the drug fridge was generally good.
- The cupboards storing medication are fitted with self securing locks and we identified two cupboard had broken locks that we were told had been reported the previous week but had not yet been addressed. In addition, the key safe that held keys for the POD lockers and drug fridge was not locked and the door left open allowing potential access to medication by unauthorised personal. **(Recommendation 1)**
- We also noted that there was variable evidence to provide assurance that staff consistently signed the CD order book on receipt of the order being delivered to the ward. **(Recommendation 3)**
- On Ward 2 we were told access to the Clean Utility room was restricted to registered staff and the pin code for the Digilock on the door was due to be changed. There was clear separation of medication aligned route of administration and strength and medication was stored within its original packaging. However, the daily monitoring of the fridge temperatures was not being routinely undertaken and we identified an out-of-date vial of insulin , and a box of out-of-date IV fluids still available for use. That were removed at the time of our visit. Furthermore, the opened bottles of elixirs did not have the date of opening routinely recorded on them and this may result in staff being unaware of when the contents of the bottle should be discarded.**(Recommendation 4)**
- IV fluids were consistently well separated and where storage allowed they were kept in their original packaging in. However, on Ward 2 the access to IV fluids was unsecured allowing potential access to unauthorised personnel.. **(Recommendation 2)**
- CD and Medication stationery and order books were securely stored in all the areas we reviewed at the Western General however we noted in the CD order book that the receipt of CD medication was not consistently recorded (MAU & Ward 23) **(Recommendation 3)**

Appendix 2:
Progress against 2023/24 recommendations

No progress	Partially addressed	Action addressed and embedded

Recommendation	Management response	GT assessment	Progress
• Review access rights to clinical rooms • Introduce regular spot checks of areas used to store medicines to monitor the security and ensure duplicate set of medicines keys are securely stored • Ensure that when areas replace a drug fridges, the fridge adheres to pharmaceutical specification. • staff should be aware of the need to implement mitigation to restrict the access to the drug fridge by unauthorised personnel.	• single communication with key messages for all staff across all hospital sites sent to Site Associate Nurse Directors on 15th December 2023 to share and ensure actioned within all clinical areas with medicines stored. • Future compliance will be monitored via integrate LACAS audits and the CD Support Audit.	There is evidence that the key messages from the 2023 audit were shared along with a presentation of the 2023 Medicines Management Report with the Assistant Directors of Nursing (ADON) and the pharmacy teams in December 2023. However, not all the nursing staff we spoke to in clinical areas were aware of the findings from the 2023 audit. Some of the newly built or refurbished areas reported that access to the clean utility rooms is restricted to registered staff only . However, In those areas where access cannot be restricted to registered staff only, we continued to note variable compliance with the safe and secure storage of medicines finding medication keys being stored in unsecured key safes and cupboards and drug fridges storing medication that were not locked. In the 2023 medication review we identified medication was securely stored in 1 out of the 9 areas we visited and in 2024 we found that in in 3 out of 10 areas medications were securely stored. We note in the areas revisited at the Western General there had been some improvement but the area we revisited at the REI site continues to require significant improvement. **(Recommendation 1)** Staff reported the LACAS template had not been updated and a review of the electronic LACAS audit tools indicates the focus of the audit remains on Patient safety. A review of the Internal Audit Action Plan and the Medicines Management update to the Audit & Risk Committee indicates work has been undertaken to identify additional questions that will be incorporated into the internal assurance tools to provide oversight on medicine security . However, this work has not yet been implemented and will now be undertaken by the recently introduced Care Assurance Oversight Board that is Chaired by the Director of Nursing for Acute services and attended by Associate Directors of Nursing.	

Appendix 2:
Progress against 2023/24 recommendations

No progress	Partially addressed	Action addressed and embedded

Recommendation	Management response	GT assessment	Progress
Ward and Department Managers and Matrons should ensure all IV fluids are securely stored and undertake frequent random spot checks of cupboards storing IV fluids to monitor the security, and storage arrangements.	Single communication with key messages for all staff across all hospital sites Work will be undertaken to develop the informal local monitoring processes routinely undertaken in clinical areas. Future compliance will be monitored via integrate LACAS audits.	Due to limiting environmental factors and a lack of secure storage space in many Clean Utility rooms stocks of IV fluids continued to be kept on unsecured shelving allowing unrestricted access to unauthorised personnel in those wards where access to the Clean Utility room is not restricted to registered staff. In 2024 we focused on the security of the cupboards or rooms where excess fluid stock was being stored and found in 6 out of the 10 areas reviewed IV fluids were not secured and allowed access to non-registered staff. **(Recommendation 2)** The staff we spoke to reported they do not routinely complete informal monitoring of medication security. The Biannual LACAS audit includes a ward observation and evidence demonstrates these observation visits highlight security issues . However, not all the staff we spoke to were familiar with the results from previous LACAS audits in their area. **(Recommendation 7)** There are plans to strengthen the LACAS template and incorporate questions to provide assurance that medicine management arrangements are being complied with. However, the work to address this remains in its infancy.	

Appendix 2:
Progress against 2023/24 recommendations

No progress	Partially addressed	Action addressed and embedded

Recommendation	Management response	GT assessment	Progress
• Review and report compliance with the completion of the quarterly CD audits and incorporate a review of the CD order book to monitor compliance with the CD policy. • Include an action to the quarterly CD audit to gain assurance that areas of previous limited compliance have been sufficiently addressed. • Embed a feedback process to allow the outcome of CD audits to be cascaded.	• Centralised collation of completed 4 monthly Controlled Drug Check for Schedule 2 Controlled Drugs completed by the pharmacy teams will support a review of common themes and identify area where these checks have not been completed within the expected timeframe. • A review of the questions within this check will also be completed to ensure this supports the updates to the controlled drug section within the SUMP which is due to be launched March/April 2024. • A data will be located in a digital library and reviewed and reported monthly by the CD Governance Team to the Accountable Officer for Controlled Drugs.	Progress has been made updating the Safe Use of Medicine Procedure (SUMP)in May 2024 to address issues such as: secure storage of spare CD keys; Transfer of medication between wards; The denaturing arrangements and the liquid balance checks. However, we noted some of these updates such as the liquid balance checks were not yet embedded in staff awareness. A Ward CD Audit Tool has been introduced however; this was not mentioned by any of the staff we spoke to indicating the use of this tool may not yet be embedded. **(Recommendation 3)** In addition, a quarterly Pharmacy Audit of CD has been introduced using a standardised tool. This model has been piloted and is now looking to expand. This data is recorded electronically via MS Teams and provides an excel report. Work is now being undertaken to analyse this data to strength oversight od CD management and will be reported into Clinical Pharmacy Group .	

Appendix 2:
Progress against 2023/24 recommendations

No progress	Partially addressed	Action addressed and embedded

Recommendation	Management response	GT assessment	Progress
Formal spot checks of medicine management arrangements: ▪ Monitoring the completion of drug fridge temperature checks, appropriate storage and timely disposal of expired and unused medication and compliance with appropriate labelling on elixir bottles , insulin and eye drops with the date of opening. ▪ To improve staff awareness of Lothian's 'Safe Us of Medicines' procedure. The Clinical Skills Team should develop mandatory medicine safety update training	Single communication with key messages for all staff across all hospital sites sent to Site Associate Nurse Directors on 15th December 2023 to share and ensure actioned within all clinical areas with medicines stored. Work will be undertaken to develop a sub -Committee of the Medicines Poly Committee . This will be attended by nurse leadership to gain oversight on progress to address actions. Future compliance will be monitored via integrate LACAS / PCAT audits The clinical education team will add cold chain management to RNRM induction and to the medicines management session with reference to the storage of elixirs, eye drops, insulin and other cold chain medicines. The clinical education team will promote further awareness of the safe use of medicines policy and procedures on the intranet on ALL clinical skills and education courses involving medicines.	There is evidence that the key messages were shared along with a presentation of the 2023 Medicines Management Report with the Assistant Directors of Nursing (ADONs) and the pharmacy teams in December 2023. A multi-disciplinary Medicines Safety & Risk Group chaired by the Director of Pharmacy has been established and is responsible for monitoring and reporting the progress in addressing the actions raised in the audit report. However, we were told there has been limited Nurse engagement with this forum and to progress the development of the PCAT / LACAS tools a Care Assurance Oversight Board has been established that will be responsible for reviewing and updating the internal assurance tool . It is anticipated this will allow improved assurance in key areas such as medicines management. The new nurse's induction pack has been updated and includes cold chain management covering and has also been included in the Medicines and Associated Medicines Supply Processes Assessment of Patients' Own self assessment document and all the clinical skills courses related to medicines. However, the compliance with the monitoring and recording of drug fridge temperature remains variable as is the evidence to demonstrate assurance is gained internally .and this may indicate further action is required. **(Recommendation 4)**	

Appendix 2:
Progress against 2023/24 recommendations

No progress	Partially addressed	Action addressed and embedded

Recommendation	Management response	GT assessment	Progress
Clinical Skills Team should develop mandatory medicines management refresher training.	There are three overarching medicines management modules will be regularly updated by the medicines management nurses . Regular themes from incidents and audits will be added to the modules following review at the medicine's safety and governance forum. The three medicines modules will now be included in the relevant categories of the 2 yearly essential learning list for nurses and midwives. In addition, the key medicine management messages will be incorporated into future medical staff medicine updates and their induction.	A Refresher Medicines Management training module has been developed that is delivered on staff induction and will be used as biannual refresher via Learnpro. We are told refresher training cannot be made mandatory as this is only for legally required training. However, it is marked as desirable and will be accessible via the intranet. It is anticipated the training can also be used in response to support individual following medication incidents and strengthen competencies. The new Medicines Management training module has been tested on all sites and is due to launched following discussions with the Associate Directors of Nursing . In addition, key medicine management messages have been incorporated into new Medicine Matters updates that can be accessed via the intranet and have also been added to the FY1 learning from prescribing sessions and induction.	
To improve attendance at the Newly Qualified Nurses and Midwives Program and at bespoke training developed in response to incidents the Trainer should be provided with a list of all staff who are eligible or required to complete the training to allow assurance it is being appropriately cascaded.	All newly qualified practitioners will attend medicines management as part of induction and will have access to attend additional sessions open to all NMC registrants. This will be in addition to their essential medicines management e-learning. Compliance will be monitored and escalated as appropriate by the Clinical Skills and training Team.	The Clinical Skills team has developed a comprehensive suite of training for staff that are new to NHS Lothian that this is supported by a Skills Passport that includes medicines competencies being signed off. There are additional courses that require completion to demonstrate and provide assurance of the effectiveness of the training. Such as IV training The Clinical Skills team also has a list of specialist courses with a medicines management component and new Medicine Matters sessions have been introduced that are available to all registered staff that covers sharing learning from adverse events. Compliance monitoring of training is managed locally by Charge Nurse and Education Leads.	

Appendix 2:
Progress against 2023/24 recommendations

No progress	Partially addressed	Action addressed and embedded

Recommendation	Management response	GT assessment	Progress
▪ Strengthen process for sharing the outcome of audits related to medicines and the associated learning with staff and Pharmacy services. ▪ Incorporate a medicines storage module into the PCAT and LACAS audit tool . ▪ Board should consider the implementation of a peer review process to gain improved objectivity ▪ Develop a formalised spot check template that can be completed on any environment walk around	National Acute Pharmacy Service (NAPS) Group have an existing Task & Finish Group developing the core actions related to medicines governance and management that are routinely identified from HIS visits to acute hospital sites into a checklist for audit. This check list of required elements will be delivered April 2024 to NAPS and Directors of Pharmacy for approval and engagement with SEND/ Acute Nurse Leads of how to best implement in Health Boards. In NHS Lothian, the preferred option is to integrate into LACAS ad PCAT for a single approach to governance and assurance. Any necessary themes and improvements can then be managed through the same single process	In response to common themes relating to the management of medicines identified by Healthcare Improvement Scotland (HIS) a National Acute Pharmacy Group has a Task & Finish group that is developing a standardised checklist that will be used to audit medicines standards as a regular monitoring tool or in responses to a Datix incident . It is anticipated this tool will be used nationally and is currently in draft but not yet rolled out. However, NHS Lothian report that the information from the checklist will be integrated into the LACAS tool to maintain a single line of assurance. However, the work to update LACAS remains on going and it is anticipated the national checklist will be utilised to undertake a deep dive investigation of medicine management arrangements and assist in gaining greater clarity of the areas that require improvement, and it is anticipated this will help inform the development of additional questions to be incorporated into the LACAS template. **(Recommendation 5)**	

Appendix 2:
Progress against 2023/24 recommendations

No progress	Partially addressed	Action addressed and embedded

Recommendation	Management response	GT assessment	Progress
Quality Lead should develop a process to monitor the completion, sustainability and effectiveness of actions implemented to address areas of non-compliance. In addition, further improvement is required to establish a formal process to allow the learning and outcome of audits to be effectively shared.	This will be incorporated into the LACAS and PCAT tools with responsibility sitting with the Quality Improvement Resource allocated to these programmes. The responsibility for monitoring through PCAT and LACAS sits with the professional nursing teams on the site, the quality leads take a role in leading the process, validating data, collating reports making recommendations and supporting improvement, but the results and actions are owned by the teams	The results of the biannual LACAS and monthly PCAT audits are shared widely through the Associate Directors of Nursing and reported to the Hospital Management Group . However, the response to identified gaps in PCAT and LACAS audits is managed locally, and it is acknowledged the formalisation and oversight in managing these actions remains an area for further improvement as assurance that identified action has been sufficiently addressed is not formally monitored and lack of improvement may not be evident until the next audit. **(Recommendation 6)** A Care Assurance Board has been established which is supported by a Terms of Reference that outlines the purpose of the forum as providing a process for measuring, improving, assuring and accrediting nursing and midwifery care. The forum is in its infancy, but it is anticipated this forum will be responsible for updating the PCAT / LACAS medicine management questions to cover the themes and those previously identified in critical incidents . In addition, the forum is due to undertake a deep dive into medicines management to capture greater insight of issues at a service level . This will allow them to enhance the audit tools to provide greater assurance . There is evidence the effective communication of audit results to the Board and to Associate Directors of Nursing and Charge Nurses. However , there remains limited awareness among ward staff of the results of LACAS audit results and this is an area that requires further improvement. **(Recommendation 7)**	

Appendix 3:
Areas visited staff involved and documents

St John's site

- Medical Assessment Unit
- Emergency Department
- Ward 11 – Maternity

Royal Infirmary site

- Combined Assessment Unit
- Ward 202 (MOE)

Royal Hospital for Children & Young People

- Castle Mey – Paediatric
- Dunvegan – Paediatric

Western General site

- Medical Assessment Unit
- Ward 23 - Clinical Surgery
- Ward 2 - Oncology

Staff Involved

- Scott Garden – Director of Pharmacy
- Melinda Cuthbert – Associate Director of Pharmacy
- Gillian McAuley – Nurse Director Acute
- Debbie Alexander – Lead Pharmacist Controlled Drug Governance and Medicine Safety | Deputy Controlled Drug Accountable Officer;
- Lead Pharmacy for MAU & ED St John's Hospital
- Jenny Scott - Lead Clinical Pharmacist, Acute, Chair, Medicines Policy subcommittee
- Fiona Pollack – Clinical Skills Team Leader
- Nurse in Charge of Clinical Areas visited.

Documents Reviewed

- Safe Use of Medicines Procedures 2022
- Safe Use of Medicines Policy 2019
- PCAT –Medicines template
- LACAS – Medicines template
- Terms of reference for the Medicines Safety & Risk Group
- Medicines Safety & Risk Group Action Log
- Medicines management Internal Audit Action Plan
- Medicine Management Audit – Update to Audit & Risk Committee Aug 2024
- Care Assurance Oversight Board Terms of reference
- LACAS Overview Jul 2024
- SUMP changes Presentation
- Ward CD Audit Tool
- Pharmacy 4 month CD Audit Tool

Appendix 4:
Our assurance levels

The table below shows the levels of assurance we provide and guidelines for how these are arrived at. We always exercise professional judgement in determining assignment assurance levels, reflective of the circumstances of each individual assignment.

Rating*	Description
Significant Assurance	The Board can take reasonable assurance that the system(s) of control achieves or will achieve the control objective. There may be an insignificant amount of residual risk or none at all. There is little evidence of system failure and the system appears to be robust and sustainable. The controls adequately mitigate the risk, or weaknesses are only minor (for instance a low number of findings which are all rated as 'low' or no findings)
Moderate Assurance	The Board can take reasonable assurance that controls upon which the organisation relies to achieve the control objective are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk. In most respects the "purpose" is being achieved. There are some areas where further action is required, and the residual risk is greater than "insignificant". The controls are largely effective and in most respects achieve their purpose with a limited number of findings which require management action (for instance a mix of 'medium' findings and 'low' findings)
Limited Assurance	The Board can take some assurance from the systems of control in place to achieve the control objective, but there remains a significant amount of residual risk which requires action to be taken. This may be used when: • There are known material weaknesses in key control areas. • It is known that there will have to be changes that are relevant to the control objective (e.g. due to a change in the law) and the impact has not been assessed and planned for. The controls are deficient in some aspects and require management action (for instance one 'high' finding and a number of other lower rated findings)
No assurance	The Board cannot take any assurance from the audit findings. There remains a significant amount of residual risk. The controls are not adequately designed and / or operating effectively and immediate management action is required as there remains a significant amount of residual risk (for instance a number of HIGH rated recommendations)

Appendix 4:
Our recommendation ratings

The table below describes how we grade our audit recommendations based on risks:

Rating	Description	Possible features
High	Findings that are fundamental to the management of risk in the business area, representing a weakness in the design or application of activities or control that requires the immediate attention of management	• Key activity or control not designed or operating effectively • Potential for fraud identified • Non-compliance with key procedures/standards • Non-compliance with regulation
Medium	Findings that are important to the management of risk in the business area, representing a moderate weakness in the design or application of activities or control that requires the immediate attention of management	• Important activity or control not designed or operating effectively • Impact is contained within the department and compensating controls would detect errors • Possibility for fraud exists • Control failures identified but not in key controls • Non-compliance with procedures/standards (but not resulting in key control failure)
Low	Findings that identify non-compliance with established procedures, or which identify changes that could improve the efficiency and/or effectiveness of the activity or control but which are not vital to the management of risk in the business area.	• Minor control design or operational weakness • Minor non-compliance with procedures/standards
Improvement	Items requiring no action but which may be of interest to management or which represent best practice advice	• Information for management • Control operating but not necessarily in accordance with best practice