

**Dr Jim Livingstone**  
Director of Safety, Quality and Standards



Department of  
**Health, Social Services  
and Public Safety**

[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

AN ROINN  
**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O  
**Poustie, Resydènter Heisin  
an Fowk Siccar**

## **Patient Safety Alert**

### **Subject:**

Safer Lithium Therapy

### **For action by:**

Chief Executive, HSC Board for cascade to:

- *Director of Commissioning*
- *Assistant Director of Pharmacy & Medicines Management*

Chief Executives, HSC Trusts for cascade to:

- *Medical Directors*
- *Directors of Pharmacy*
- *Directors of Nursing*
- *CSCG leads*

Chief Executive RQIA for cascade to:

- *Independent hospitals and clinics*

General Medical Practitioners

### **For Information to:**

- Chief Executive, Public Health Agency
- Director of Public Health, Public Health Agency
- Director of Nursing, Public Health Agency
- Director of Primary Care, HSC Board
- Director of Performance Management & Service Improvement, HSC Board
- Assistant Director of Performance Management, HSC Board
- Professor David Woolfson, Head of School of Pharmacy, QUB
- Professor Linda Johnston, Head of Nursing & Midwifery, QUB
- Professor Hugh McKenna, Head of Life and Health Sciences, UU
- Dr Owen Barr, Head of School of Nursing, UU
- Professor Paul McCarron, Head of School of Pharmacy, UU
- Staff Tutor of Nursing, Open University
- Director, Safety Forum
- Lead, NI Medicines Governance Team

### **Summary of Contents:**

The purpose of this circular is to highlight the importance of safer lithium therapy

### **Enquiries:**

Any enquiries about the content of this Circular should be addressed to:

Safety & Quality Unit  
DHSSPS  
Room D2.4  
Castle Buildings  
Stormont  
BELFAST  
BT4 3SQ

Tel: 028 9052 2239

[qualityandsafety@dhsspsni.gov.uk](mailto:qualityandsafety@dhsspsni.gov.uk)

**Circular Reference: HSC (SQSD) 84/09**

**Date of Issue: 7 January 2010**

### **Related documents**

National Institute for Clinical Excellence. Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care. *Clinical Guideline 38*, 2006. <http://www.nice.org.uk/nicemedia/pdf/CG38fullguideline.pdf>

### **Superseded documents**

N/A

### **Status of Contents:**

For completion of actions and assurance template by:  
31 December 2010

### **Implementation:**

Immediate

SQSD material can be accessed on:

<http://www.dhsspsni.gov.uk/index/phealth/sqs.htm>

**Working for a Healthier People**

**Chief Medical Officer Group**



INVESTOR IN PEOPLE

Dear colleagues

## **SAFER LITHIUM THERAPY**

The National Patient Safety Agency (NPSA) has reported that there have been deaths, severe harm and a substantial number of reports relating to lithium therapy. An analysis of errors reported suggests lithium therapy is an error-prone process. Some patients taking lithium have been harmed because they have not had their dosage adjusted based on recommended regular blood tests. If patients are not informed of the known side effects or symptoms of toxicity, they cannot manage their lithium therapy safely.

NPSA/2009/PSA005: *Safer lithium therapy* is available on <http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=65426> This Patient Safety Alert supports the National Institute of Clinical Excellence (NICE) guidance and requires that patients are monitored in either primary care, secondary care or both according to its instruction. Communication between healthcare providers is essential and may be facilitated by patient-held records.

The content of the attached circular at Annex A has been reviewed by relevant professional colleagues in the Department and approved for regional dissemination.

I would ask you to bring this to the attention of relevant practitioners and key health and social care staff within your organisation. They should consider the best practice for their setting and take appropriate steps to minimise the risks to patients.

I would also draw your attention to the attached 'assurance template' which has been designed as a means of recording the response from the Trusts and Board in circumstances where SQSD Circulars require action to be taken by a given date.

Yours sincerely



**Dr J F Livingstone**  
Director, Safety, Quality & Standards

## **SAFER LITHIUM THERAPY**

### **Issue**

1. There have been deaths, severe harm and a substantial number of reports relating to lithium therapy. Analysis of errors reported to the National Patient Safety Agency (NPSA) Reporting and Learning System suggests lithium therapy is an error-prone process. Monitoring of lithium therapy is a specific issue. A recent audit demonstrates less than optimal monitoring of lithium and a failure to adequately prepare patients to recognise therapy-induced side effects or toxicity. Some patients taking lithium have been harmed because they have not had their dosage adjusted based on recommended regular blood tests. If patients are not informed of the known side effects or symptoms of toxicity, they cannot manage their lithium therapy safely.
2. Regular blood tests are important. Clinically significant alterations in lithium blood levels occur with commonly prescribed and over-the-counter medicines. The blood level of lithium is dependent on kidney function and lithium has the potential to interfere with kidney (renal) and thyroid functions.

### **National Context**

3. The NPSA received 567 incident reports (October 2003 to December 2008) relating to lithium use. Two reports were of severe harm, 34 moderate and 531 low or no harm. The most common error was 'wrong or unclear dose or strength' (124 incidents).
4. The NHS Litigation Authority dealt with two fatal and 12 severe harm incidents involving lithium therapy and the Medical Defence Union has been involved with 15 incidents directly related to lithium toxicity and monitoring.
5. An audit by the Prescribing Observatory for Mental Health found that only 42 per cent of patients on initiation of lithium therapy were documented to have been informed of risk factors for toxicity. For patients maintained on lithium therapy in the previous year, the audit found:
  - i. one in 10 patients had no documented lithium blood level. (NICE standard: one blood level measurement every three months. Not met for 70 per cent of patients);
  - ii. one in five patients had no renal function tests documented (NICE standard: assessment every six months. Not met for 46 per cent of patients);

- iii. one in six patients had no thyroid function tests documented (NICE standard: assessment every six months. Not met for 51 per cent of patients).

### **Local Context**

6. All HSC organisations and independent sector organisations should put arrangements in place, by **31 December 2010**, to ensure that where lithium therapy is initiated, prescribed, dispensed and monitored:
  - i. patients prescribed lithium are monitored in accordance with NICE guidance;
  - ii. there are reliable systems to ensure blood test results are communicated between laboratories and prescribers;
  - iii. at the start of lithium therapy and throughout their treatment patients receive appropriate ongoing verbal and written information and a record book to track lithium blood levels and relevant clinical tests;
  - iv. prescribers and pharmacists check that blood tests are monitored regularly and that it is safe to issue a repeat prescription and/or dispense the prescribed lithium;
  - v. systems are in place to identify and deal with medicines that might adversely interact with lithium therapy.
7. NPSA has developed a patient information booklet, lithium alert card and record book for tracking blood levels. Further information is available on <http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=65426>

### **Action Required**

8. You will wish to bring the contents of this document to the attention of staff, particularly those involved in governance and risk management within your organisation. Organisations need to be aware of this document in order to assist in complying with the Quality Standards for Health and Social Care –
  - Criteria 4.3(i) and 5.3.1(a) (the appropriate management of risk);
  - Criteria 5.3.3(f) (implementation of evidence-based practice through guidance), and
  - Criteria 8.3(i) (effective communication and information)
9. HSC Trusts should take immediate action to implement this Patient Safety Alert as outlined above by **31 December 2010**. Trusts should provide assurance on this action to the HSC Board by completing **Section 2** of the attached template.
10. The HSC Board should complete **Section 1** of the attached assurance template and forward to the Department by **28 January 2011**.

## **SQS CIRCULARS: ASSURANCE TEMPLATE FOR HSC TRUSTS**

### **Circular number: HSC (SQSD) 84/2009: *Safer Lithium Therapy* For Implementation by: 31/12/2010**

(Section 2 is to be completed by HSCT and forwarded to HSCB for consideration. Section 1 should then be completed by HSCB and forwarded to DHSSPS)

---

#### **SECTION 1:**

To: Director, Safety, Quality & Standards Directorate, DHSSPS

I note the response from the Trust and –

I can confirm that the HSC Board is content the action(s) taken referred to in Section 2 below, complies with the requirements of the above circular.

I can confirm that the HSC Board is monitoring compliance with the above circular and has requested that further action is taken as follows:

I confirm that the Chief Executive and designated senior manager have been advised of this response and are content that it should be submitted to the Department.

Response submitted by: \_\_\_\_\_ (Name & contact details of person submitting response) on behalf of HSC Board. Date: \_\_\_\_\_

---

#### **SECTION 2:**

To: Chief Executive, HSC Board

I can confirm that the required actions set out in the above circular have been implemented in full by the due date.

I can confirm that the actions in the above correspondence have been partially implemented by the due date. Work is ongoing in the following areas:

I can confirm that the organisation has been unable to implement any actions of the above circular for the following reasons:

I confirm that the Chief Executive and designated senior manager have been advised of this response and are content that it should be submitted to the HSC Board.

Response submitted by: \_\_\_\_\_ (Name & contact details of person submitting response) on behalf of \_\_\_\_\_ HSC Trust. Date: \_\_\_\_\_