Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Communication Care Bundle Guide

The Scottish Patient Safety Programme (SPSP) is a unique national initiative that aims to improve the safety and reliability of health and social care and reduce harm, whenever care is delivered.

As part of Healthcare Improvement Scotland's ihub, SPSP is a coordinated campaign of activity to increase awareness of and support the provision of safe, high quality care, whatever the setting.

Published May 2018

ihub.scot/spsp

Introduction

This guide explains how to implement the NSAIDs communication care bundle in your pharmacy. All the resources in the toolkit box have been developed to help your pharmacy team consistently deliver the key safety messages and improve the safety of NSAIDs by ensuring patients have better information about how to take NSAIDs safely.

What else do you need?

In addition to the resources for implementation, the vital keys to success with the NSAIDs communication care bundle are:

- an enthusiastic team
- a willingness to improve
- a whole-team approach
- transparency in data collection, and
- engagement.

Toolkit contents

- **NSAIDs Communication Care Bundle Guide**
  (including an introduction to care bundles)

- **Resources for data collection:**
  - one data collection sheet
  - one run chart 1 sheet (measure 1)
  - one run chart 2 sheet (measure 2)
  - one run chart 3 sheet (measure 3)
  - one run chart 4 sheet (compliance with all three measures)
  - one wipe clean pen.

- **Resources to support implementation**

  The following tools may be useful but you may also wish to create your own resources locally, so these tools are not the only way you can implement the care bundle.
  - NSAIDs safety message till prompts (5)
  - NSAID stickers (240)
  - NSAIDs Safety Information cards (150)
  - Medicine Sick Day Rules cards (50)
  - Medicine Sick Day Rules patient leaflet (10)
  - Medicine Sick Day Rules professional leaflet (5)
  - A Reorder Form for additional resources – completed form to be submitted to Healthcare Improvement Scotland by 15 June 2018.

NSAIDs care bundle

- The NSAIDs care bundle is made up of two parts:
  NSAIDs Communication Care Bundle – the toolkit box contains a range of resources designed to help you implement this bundle and help you build your safety culture.
- NSAIDs Safer Care Bundle – this bundle aims to improve the clinical care of patients who take NSAIDs in **addition to other medication**. Resources relating to this bundle are **not** included in the toolkit box but may be found here:
  ihub.scot/pharmacy-pack/

Teams who require further support should approach their local Quality Improvement contact or contact the Primary Care Portfolio team:
hcis.PCPTeam@nhs.net

What is a care bundle?

A care bundle is a structured way of improving processes of care to deliver enhanced patient safety and clinical outcomes. In relation to care bundles, this means ensuring that patients receive optimum care at every contact.

The process for achieving reliability is to test individual measures to ensure they are the correct measures, and then implementing this set of measures (a care bundle). Therefore, the key measure in a care bundle is the score which measures the level of compliance with all measures for all patients.

The care bundle data collection tool is a way of sampling whether optimum care is being delivered. This approach is therefore very different from traditional auditing approaches that are designed to identify whether individual measures are being implemented.

What makes up a care bundle?

- three to five measures
- all or nothing compliance
- measurement done by all members of pharmacy team if possible
- designed for 95% reliability
- backed by scientific evidence, and
- teamwork and communication.

Training information

It is recommended that the pharmacist goes through this training information with every member of the pharmacy team who provides or sells medicines. It may also be helpful to identify an NSAIDs leader in your pharmacy.

Why NSAIDs?

NSAIDs were chosen because they are associated with more emergency hospital admissions due to adverse drug reactions than any other class of medicine.

The aim of this quality improvement work is to improve the safety of NSAIDs by ensuring patients have better information about how to take NSAIDs safely.

Anticipated outcomes are:

- reduced number of gastrointestinal events associated with NSAIDs, and
- reduced number of acute kidney injuries associated with NSAIDs.

Why is this needed?

Research tells us that patients are not always informed how to take medicines when they collect them from pharmacies. This intervention is about ensuring key safety information is given to every patient, every time an NSAID is sold or dispensed.

We also know from research the importance of reinforcement: even if patients are given information when they are prescribed a medicine, many patients find it difficult to recall everything that is said within a consultation, so reinforcement at the point of dispensing is really important.

What does the intervention involve?

The intervention is simple: it is about improving the information patients receive when they get an NSAID from a pharmacy. The aim is for every patient who buys an NSAID over the counter or who receives a prescription for an NSAID to receive three key NSAID safety messages:

Three key safety messages

Three key safety messages
1. Always take this medicine with or after food.
2. Tell us if you get any side effects (explain what these might be).
3. Be aware of the medicine sick day rules (explain the rules).

These messages should be clearly explained to every patient who receives an NSAID for the first time (either on prescription or purchased).

For patients who are receiving repeat prescriptions, after the initial dispensing, the information could be shortened. For example, you might say: 'Do you still have the information card I gave you last time?' or 'Are you getting on OK with these, would you like me to go through the safety information again?'

It might be sensible to have a campaign once a year to repeat the full messages to every person on repeat NSAIDs.

Why give these safety messages?

Message	Why?	Any other information?
Always take this medicine **with** or **after** food.	Helps to reduce or avoid gastrointestinal side effects.	
Tell us if you get any side effects.	Earlier recognition of side effects allows action to be taken before they develop into something more serious.	Side effects to look out for: • nausea, vomiting, stomach pain or acid, black stools. What if the patient reports side effects? • If a patient reports vomiting blood or black stools, this should be referred to a GP urgently as it indicates bleeding in the gastrointestinal tract. • If a patient reports nausea, stomach pain or acid, it would be appropriate to stop the NSAID temporarily to see if this improves the symptoms.

Message	Why?	Any other information?
Be aware of the medicine sick day rules.	Some medicines, including NSAIDs, should be stopped temporarily during dehydrating illness. This is because continuing to take them when dehydrated increases the risk of serious adverse events, in particular acute kidney injury.	Explain that dehydration can occur with vomiting and diarrhoea, therefore the NSAID should be stopped until the patient is fully recovered. It can then be restarted. Explain that these rules are to cover situations like sickness bugs and food poisoning: it is separate from the advice above on gastrointestinal side effects. For patients who are buying a single pack of NSAIDs for a single episode of pain like a headache, there is no need to explain the medicine sick day rules. The rules are for people who take NSAIDs every day.

What can we use to help give the messages?

To ensure every patient is given the key safety messages, the reminder tools in the box have been developed by NHS Highland and endorsed for use across NHS Scotland. We would suggest that you agree in your teams how to use either these resources or your own locally developed resources, but the following ideas may be helpful:

Use the NSAID stickers on:

- dispensary shelves
- counter shelves
- dispensary bags
- points of sale, and
- as a prompt to give the safety advice to patients.

NSAIDs Safety Information card:

- give to patients to take away as a reminder of the safety messages, and
- also useful as a prompt for staff who could read through the card with patients.

How do we check it is working?

The only way to find out if a pharmacy is giving the safety messages to patients is to collect some data. The best way to do this is by small frequent samples: it would be impossible to audit every patient in a busy pharmacy but checking a small sample is manageable.

The evaluation involves:

- every member of the pharmacy team making anonymous observations of each other
- whenever you see a colleague giving out an NSAID and listen to see if they give all three safety messages, and
- record this in the data collection sheet, as shown below.

Date: 07.05.2018

Comments	Patient	Was the patient informed to take the NSAID with or after food?		Was the patient informed to report any side effects?		Were the Medicine Sick Day Rules explained to the patient?		Have all three messages been given?	
	1	(Y)	N	(Y)	N	(Y)	N	(Y)	N
	2	(Y)	N	(Y)	N	Y	(N)	Y	(N)
Staff member in new post	3	Y	(N)	Y	(N)	Y	(N)	Y	(N)
NSAID for occasional use	4	(Y)	N	(Y)	N	Y	(N)	Y	(N)
	5	(Y)	N	(Y)	N	(Y)	N	(Y)	N
12.30pm – busy	6	(Y)	N	(Y)	N	Y	(N)	Y	(N)
	7	(Y)	N	(Y)	N	(Y)	N	(Y)	N
Clear message given	8	(Y)	N	(Y)	N	(Y)	N	(Y)	N
	9	Y	(N)	Y	(N)	Y	(N)	Y	(N)
	10	(Y)	N	(Y)	N	(Y)	N	(Y)	N
Total Number of Ys		8		8		5		5	
		Plot the **total** number of Ys on **Chart 1** along with the date		Plot the **total** number of Ys on **Chart 2** along with the date		Plot the **total** number of Ys on **Chart 3** along with the date		Plot the **total** number of Ys on **Chart 4** along with the date	

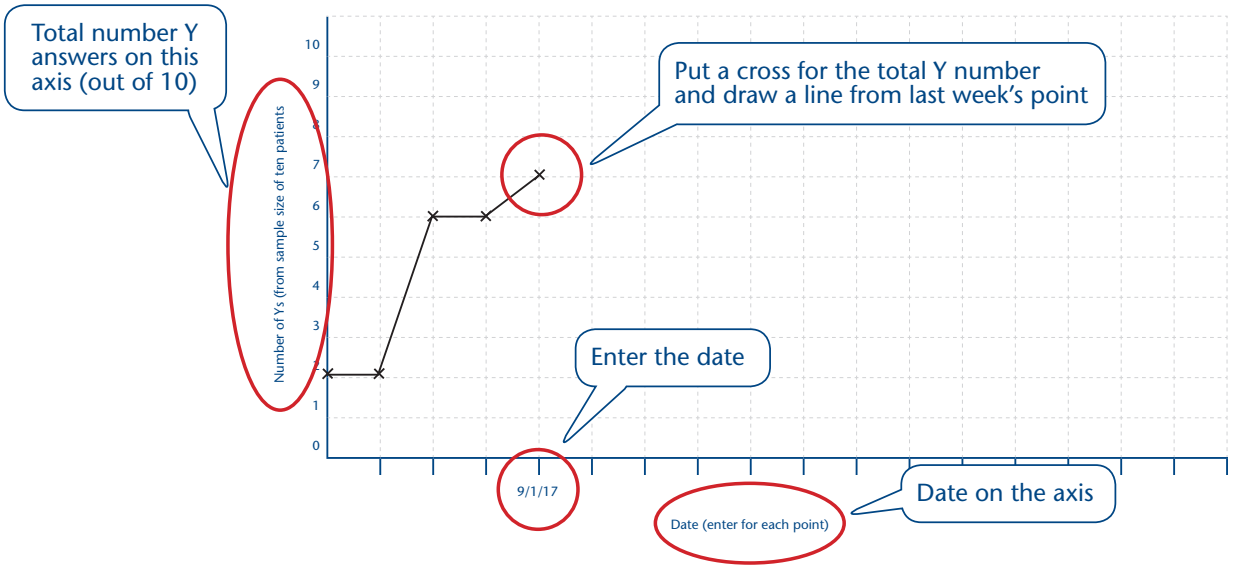
At the end of each week, you should have four numbers on the data collection tool:

- the number of patients out of 10 who received the three safety messages, and
- the number of patients out of 10 for whom all three messages have been given (compliance with the bundle).

The next step is to transfer the numbers to the charts, so that you can see how you are improving over time. These are called run charts.

Put your weekly figure on the chart template each week, as shown below:

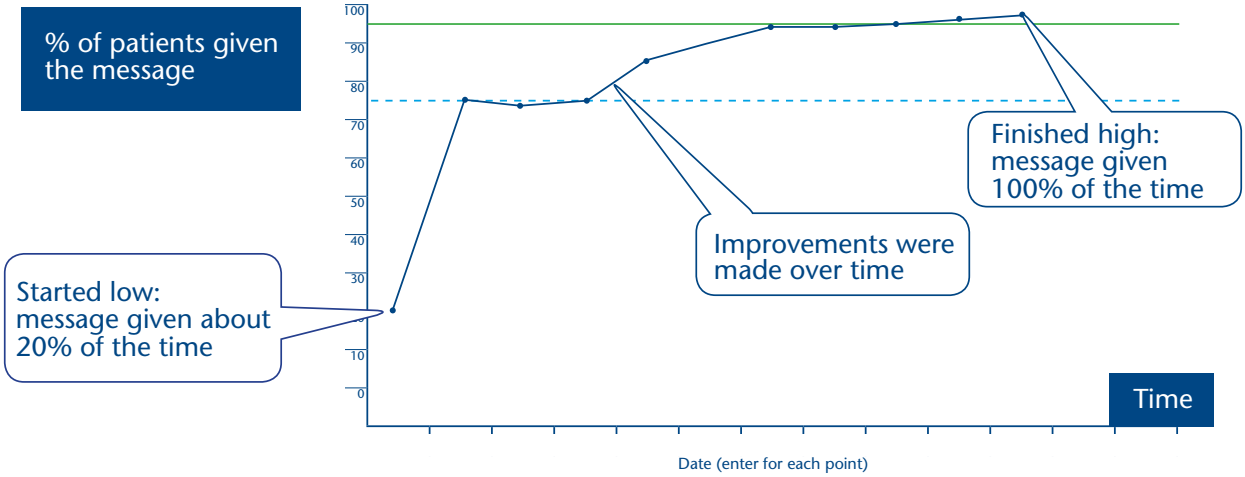
Question: **Was the patient informed to take the NSAID with or after food?**



There is one chart for each of the three questions and a fourth chart to measure whether all three messages were given to each patient (compliance with the bundle).

This chart shows how a pharmacy improved from not giving the messages often to consistently giving it all the time. The chart shows the percentage of patients given the message 'Has the patient been informed to take the NSAID with or after food?' over time.

Question: **Was the patient informed to take it with or after food?**



Pharmacies who piloted this work identified staff training and some reminder tools as the most important interventions to achieve this.

What do you do then?
If you are consistently giving the messages out, that's great, keep going.

If not, then think about how you could improve.

For example:

- Are you using all the tools from the toolkit?
- Have all staff been trained?
- What barriers are stopping staff give the safety messages?
- What could you change to make it easier to give the messages?

Then make your improvement and see if you can demonstrate a change on your chart.

Keep collecting data until you can demonstrate that you are consistently giving the safety messages to patients (12 weeks of data at above nine out of 10 [90%]).

Make sure everyone in the pharmacy team can see the run charts and understands them – they could perhaps be discussed at team meetings or huddles. Consider displaying it to the public too.

REMEMBER: The run charts will help your pharmacy team to identify which areas you need to improve and then demonstrate improvements made. Our guide on how to use run charts for improvement is available to download here:

www.healthcareimprovementscotland.org/improvement.aspx

Has this toolkit been tested?
Yes, this toolkit has been adapted from the materials that were initially developed and tested in NHS Highland as part of the Scottish Patient Safety Programme – Pharmacy in Primary Care Collaborative. Pharmacies who tested the NSAIDs communication care bundle demonstrated that it is straightforward to achieve and quickly becomes a normal part of every day practice.

Are there any other supporting materials?

For more information about quality improvement and this toolkit visit our Pharmacy in Primary Care webpage:

ihub.scot/pharmacy-pack/

The information includes the following:

- A **2-minute Guide:** this short guide to using the NSAIDs communication care bundle has been produced by Healthcare Improvement Scotland for use within pharmacy teams. It provides the basic information and should be used in addition to this full guidance booklet.
- A recording of the **NSAIDs Communication Care Bundle** webinar presented by Mark Easton, National Clinical Lead Pharmacist, Primary Care Portfolio, Healthcare Improvement Scotland on 8 March 2018 and hosted by NHS Education for Scotland.
- The toolkit resources, such as print-ready versions of cards.
- Resources to help you to implement the safer care elements of the NSAIDs care bundle which aims to improve the clinical care of patients who take NSAIDs in addition to other medication.
- Links to support continuous quality improvement in the community pharmacy setting are also available, including a link to complete the Pharmacy Safety Climate Survey which will provide a snapshot of your team's safety culture.

If you have any queries about the toolkit, please email the Primary Care Portfolio team: hcis.PCPTeam@nhs.net

May 2018

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on **0141 225 6999**
or email contactpublicinvolvement.his@nhs.net

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