

NSAIDs Communication Care Toolkit Development in NHS Highland



Context

NHS Highland services a population of 320,000 spread over 32,500 square kilometres and so has specific challenges and opportunities in delivering healthcare in rural settings. There are over 1200 Community Pharmacies across Scotland and 99 Dispensing GP Practices (40 of which are in NHS Highland).



Why a change was needed?

Research tells us that patients are not always adequately informed about how to take over the counter medicines when they collect them from pharmacies or dispensing practices. Non-steroidal anti-inflammatory drugs (NSAIDs), such as Aspirin and Ibuprofen, Diclofenac and Naproxen are associated with more emergency hospital admissions than any other class of medicine. The most common harms associated with NSAIDs include gastrointestinal ulceration and bleeding but they can also include heart and kidney complications.



Impact

An improvement in the consistency of information given to patients about NSAIDs.

Participating dispensing practice staff reported feeling empowered for the first time to provide key medicines safety advice.

Engagement of all dispensing practice staff involved in the supply of medicines by increasing confidence to provide safety messages to patients.



Top tips

Giving staff an easy way to capture and record their data increases engagement and ownership of quality improvement.

Front-line staff and patients are a great source of ideas about what works and how to make things happen in practice.

Involve practices/pharmacies in rural and urban settings as early as possible to maximise learning.

Using plan do study act (PDSA) cycles can help give staff the confidence to test various strategies.

¹ Morrison C, Beauchamp T, MacDonald H, Beattie, M. Implementing a non-steroidal anti-inflammatory drugs communication bundle in remote and rural pharmacies and dispensing practices. *BMJ Open Quality* 2018;**7**:e000303



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Where can I learn more?

Visit our dedicated NSAIDs webpages where you can access all the tools and supporting materials:

Community Pharmacy: https://ihub.scot/pharmacy-pack/

Dispensing GP Practices: https://ihub.scot/nsaidsgp

Read the BMJ Quality Improvement report article "<u>Implementing a non-steroidal anti-inflammatory drugs communication bundle in remote and rural pharmacies and dispensing practices</u>" by Clare Morrison, Tracy Beauchamp, Helen MacDonald and Michelle Beattie.

Tell us your thoughts

Did you find this case study useful? Do you want to find out more? Contact us by completing our online form.

Primary Care Improvement Support Team



Context

NHS Board: NHS Highland

Population: The population of NHS Highland is 320,000 people and is spread over 32,500 square kilometres, making it one of the largest and most sparsely populated Health Boards in the UK.

Community Pharmacies: There are approximately 80

Community Pharmacies



Clare Morrison, NHS Highland

Dispensing GP Practices: There are 40 Dispensing GP

Practices in NHS Highland. Not everyone has access to a community pharmacy, and this is more common in NHS Highland due to the number of remote/rural locations.

About Clare: Clare Morrison is Senior Clinical Quality Lead at NHS Highland. She has a special interest in remote and rural health care, and is currently leading the development the video consulting service 'NHS Near Me'. She was previously Lead Pharmacist (quality improvement) at NHS Highland and, as part of that role, led the Scottish Patient Safety Programme (SPSP) Pharmacy pilot in NHS Highland and the subsequent development of the NSAIDs safety work with community pharmacies and dispensing practices. Clare is a Fellow of the Royal Pharmaceutical Society, a Scottish Quality and Safety Fellow, a graduate of the Intermountain Advanced Training Program in quality improvement, and was awarded an MBE for services to healthcare in 2018.



Why a change was needed?

This project aimed to ensure that key safety information for NSAIDs is given to every patient, every time an NSAID is sold or dispensed. NSAIDs are one of the most commonly prescribed drug groups in the UK and are associated with more emergency hospital admissions that any other class of medication.

Adverse events most commonly associated with NSAIDS include gastrointestinal ulceration and bleeding but can also include cardiovascular and renal complications.



Develop an NSAIDs bundle

This project began in 2015 as part of the SPSP Pharmacy in Primary Care Collaborative.

The NHS Highland SPSP Pharmacy in Primary Care Steering Group comprised representatives from:

- Community Pharmacy
- GP practices
- NHS Highland
- a patient representative

This group produced a driver diagram and a draft bundle for consultation.

The three key safety messages in the Communication Care bundle are:

- 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).

The bundle was then tested in one pharmacy for one month, before testing across seven teams (five pharmacies and two dispensing practices). Each pharmacy identified one or two leads who were supported by the national collaborative in their understanding of the model for improvement, the NSAIDs bundle and measurement. After three months a WebEx was held to help teams learn from each other's experiences.

Having reflected it would have been great to involve some urban as well as rural community pharmacies in the testing. They have a more transient population so it would have been helpful to understand early-on if they would have different challenges in implementing the bundle.

Clare Morrison, Senior Clinical Quality Lead at NHS
Highland

Test spread

From January 2016 to September 2016 the bundle was spread to a further five community pharmacies and eight more dispensing practices, giving a total of 20 teams involved in the testing.

From this there were some great examples of using PDSA cycles. One of the cycles aimed

to develop an effective way to help remind busy staff to complete the bundle. The initial test of highlighting the bundle on dispensing labels wasn't working on a consistent basis. The next idea tested was to use Post-It notes on dispensary shelves and point of sale tills as a reminder but these tended to fall off. This idea was then developed into an NSAID sticker to act as a visual prompt (which is now the sticker used in the national pack).



NSAID sticker

Another resource developed was a laminated till prompt which gives the NSAID drug names/brand names on one side and the

key safety messages on the other – this evolved from using some pieces of cardboard and Post-its!

The idea for an information card came from the patient representative on the local SPSP Pharmacy Steering Group. Patients and customers reported the card was useful (as a tool to reinforce information that occurred as part of a clinical discussion) but the learning from testing also showed that the cards helped staff with their confidence in delivering the key safety messages. The cards have since been updated again and print-ready versions. Visit our website to download.



NSAID Safety Information Card

Toolkit sent to all NHS Highland Community Pharmacies

From the PDSA cycles, the resources and bundle were developed into a NSAIDs toolkit which was distributed to all community pharmacies in NHS Highland throughout 2017.

Everything that became part of pack such as the stickers and cards came from staff who were doing the initial piloting – that's really why it worked!

Clare Morrison, Senior Clinical Quality
Lead at NHS Highland

Toolkit launched nationally by Healthcare Improvement Scotland



NSAIDs Toolkit – Community Pharmacy

The great work in NHS Highland was taken forward by Healthcare Improvement Scotland who launched a national toolkit to all community pharmacies in Scotland in 2018.

The toolkit contains a guidance booklet and all of the developed resources to support the Communication Bundle. To access the online versions of the toolkit resources for community pharmacies visit our website.

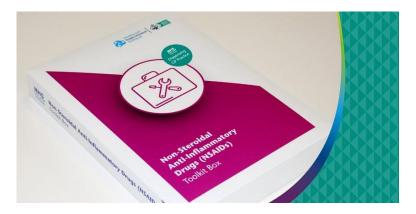
I was just delighted when the pack was taken on to see that the idea of laminated run charts carried on as it teaches people about improvement data in a way that nothing else has for our pharmacy teams.

Clare Morrison, Senior Clinical Quality Lead at NHS Highland

Toolkit launched to Dispensing GP Practices across Scotland.

Dispensing GP Practices have unique challenges and Clare provided her expertise and guidance when Healthcare Improvement Scotland introduced a bespoke toolkit for these teams in 2019.

The toolkit was fully reviewed to make sure it reflected the process dispensing GP practices would follow. Where appropriate the resources were redesigned, for example amending the community pharmacy "till prompt" to provide a "dispensing prompt" instead. Click here to access the dispensing GP toolkit resources.

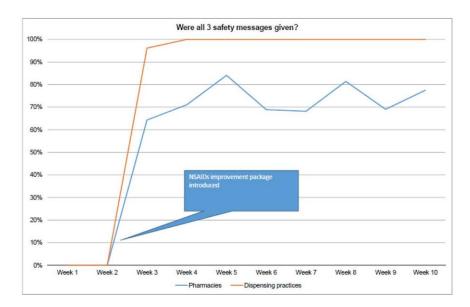


NSAIDs Toolkit – Dispensing GP Practices

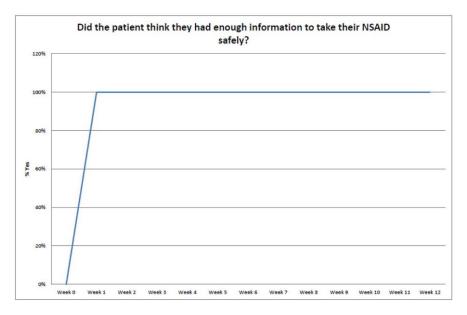


Impact

Results from testing, as reported in the BMJ Quality Improvement report article "Implementing a non-steroidal anti-inflammatory drugs communication bundle in remote and rural pharmacies and dispensing practices" showed that both community pharmacies and dispensing GP practices showed rapid improvement in the consistency of delivery of the three safety messages.



Similarly patients consistently reported feeling that they had enough information to take their NSAID safely.



Patient feedback

Most feedback from patients was positive however in some cases, patients did feel they were receiving information repeatedly. The learning from this was to change the conversation for example asking the patient if they have had the messages explained before.

Staff feedback

Staff reported that they felt more confident and empowered to give the safety messages to patients

In community pharmacies engaging the whole team and giving them easy ways to collect their own data gave them ownership – this was data for improvement not data for audit!

For community pharmacies staff did not have to spend much additional time as they would already be expected to be having conversations with patients. There is a little extra time required for data collection and action planning but feedback has been that this is not time-intensive and teams felt supported in this by the resources in the toolkit.

In Dispensing Practices this was more of a change as although GPs would give information at point of prescribing, staff involved in dispensing hadn't routinely been engaging with patients about their medicines. In testing, the bundle gave them the confidence to start this and a bespoke NSAIDs toolkit has now been provided to all dispensing GP practices in Scotland.



Top tips

- Giving staff an easy way to capture and record their data increases engagement and ownership of quality improvement
- Front-line staff and patients are a great source of ideas about what works and how to make things happen in practice
- Involve practices/pharmacies in rural and urban settings as early as possible to maximise learning



Run chart

• Using PDSA cycles can help give staff the confidence to test various strategies resulting in solutions that really work

Primary Care Improvement Support Team



Where can I learn more

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Read the BMJ quality improvement report article "Implementing a non-steroidal antiinflammatory drugs communication bundle in remote and rural pharmacies and dispensing practices" by Clare Morrison, Tracy Beauchamp, Helen MacDonald and Michelle Beattie https://bmjopenguality.bmj.com/content/7/3/e000303



Final remarks

What are the three things you would share with someone wanting to do this project?

- Empower staff to test changes using PDSA cycles
- Consider involving a mixture of urban and rural practices in early testing, and
- Give staff an easy way to record their data: help them to take ownership of the data and focus on improvement, rather than data collection.