Quality: Everybody's Business

Richard Thompson
CHC & Care Home Quality Lead Pharmacist
Sandwell & West Birmingham CCG

Introductions

- Pharmacist in Sandwell area since 2003
- Previously lead pharmacist for Sandwell community services, including two intermediate care units
- Current role with CCG since September 2013
  - includes responsibilities for NHS Continuing Health Care and care home quality
- Supported by Professional Adviser for Nursing since February 2014

Quality

In abstract terms...

"Quality [is] an optimal balance between possibilities realised and a framework of norms and values"

Harteloh, The meaning of quality in health care: A conceptual analysis. Health Care Analysis 2003.

...and Safety

- Quality is the overarching umbrella under which patient safety resides
- Institute of Medicine (IOM) - patient safety "indistinguishable from the delivery of quality healthcare"
- IOM defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"

Why everyone matters...

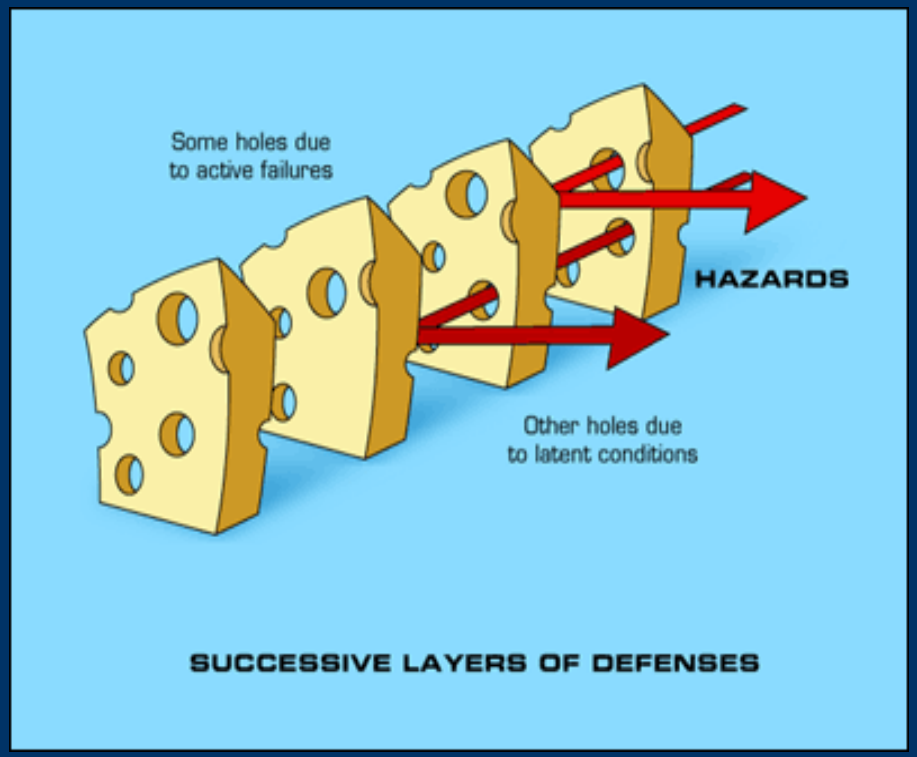
- Adverse events *can* occur following a single catastrophic error *but*
  - analysis of errors often reveals a number of failings that contribute to incidents
  - appropriately trained individuals should be supported by systems that mitigate risk and promote quality
- Failure to apply evidence judiciously may lead to poorer outcomes and quality of life

- Early warnings about problems with medicines can be identified by anyone involved in a patient's care
- Significant problems can sometimes occur in care homes without any prior concerns

Swiss Cheese Model

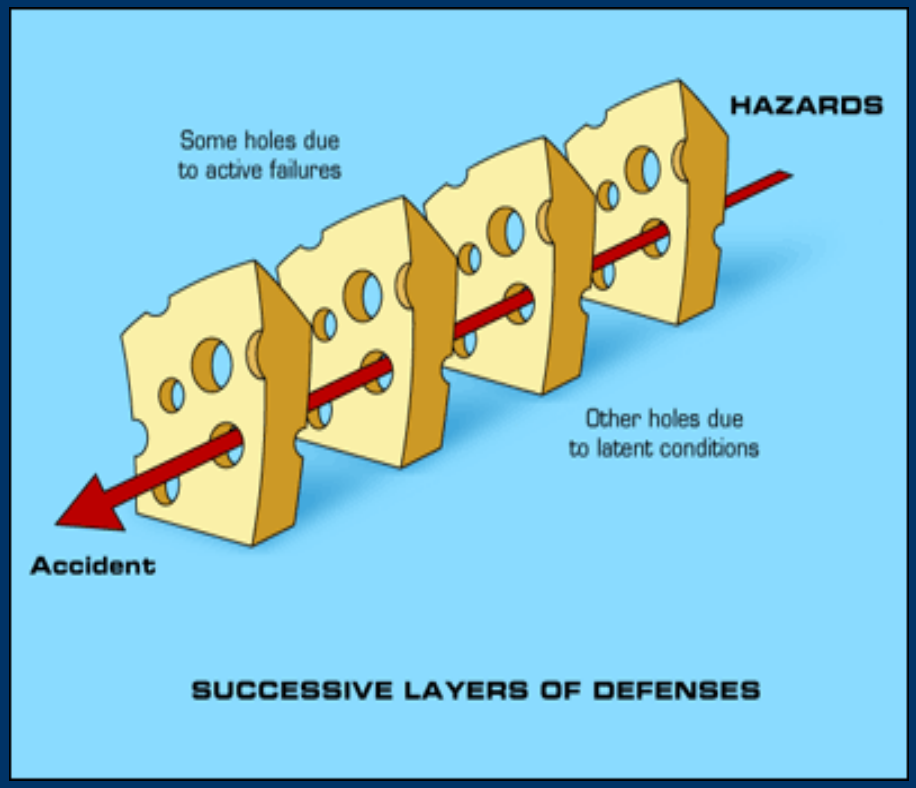
- Reason proposed what is referred to as the “Swiss Cheese Model” of system failure
- Every step in a process has the potential for failure (to varying degrees)
- The ideal system is analogous to a stack of slices of Swiss cheese

Working well...



- The holes can be viewed as opportunities for a process to fail
- Each of the slices acts as a “defensive layer” in the process
- An error may allow a problem to pass through a hole in one layer, but in the next layer the holes are in different places, and the problem should be caught
- Each layer is a defence against potential error impacting the outcome
- Outcome may be sub-optimal but not catastrophic

And not...



- For a catastrophic error to occur, the holes need to align for each step in the process
- This allows all defences to be defeated, resulting in an error
- If the layers are set up with all the holes lined up, this is an inherently flawed system that will allow a problem at the beginning to progress all the way through to adversely affect the outcome

How can we minimise risk?

- Each slice of cheese is an opportunity to stop an error
- The more defences you put up, the better
  - *But in practice...*
    - defences need to be relevant *and* practical
    - increasing tasks can impact on resources
- The fewer the holes and the smaller the holes, the more likely you are to catch/stop errors that may occur
  - think policies, procedures and practice
  - do individuals and organisations understand their risks?

Safeguarding

CQC standards define safeguarding adults as:

“Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights.”

Safeguarding and medicines…

- A safeguarding issue in relation to managing medicines could include:
  - deliberate withholding of a medicine without valid reason
  - incorrect use of medicine(s) for reasons other than the benefit of a resident
  - deliberate attempt to harm through use of medicine(s)
  - accidental harm caused by incorrect administration or a medication error

- Safeguarding concerns must be reported

Why do errors occur?

- Root causes of harm can include:
  - ORGANISATIONAL SYSTEM FAILURES
    - Management
    - Culture
    - Policies/procedures
    - Resources
    - Transfer of information
  - ACTIVE FAILURES
    - Individual errors
  - TECHNICAL FAILURES
    - Failure of facilities
    - Failure of functions provided by external parties
- Targeting work in these areas can reduce risk and increase quality

A multidisciplinary approach...

- Mr B has recently been admitted to a care home
- Who might be involved in his care?

A multidisciplinary approach...

- Mr B
- His family
- Care home management
- Staff at the care home
- His GP
- AHPs
  - OT
  - Dietician
  - Speech and Language
  - Physiotherapy
- District nurses
- Secondary care teams
- Community pharmacy
- Commissioners
- Professional advisers
- CCG/local authority
- Regulators

Mr B

- Has a right to expect things to be 'excellent'
  - or at least safe, effective, patient centred, timely and fair
- May have capacity to make decisions about aspects of his care
  - may impact on how and when medicines are used
  - may need support to make decisions
- May wish to self-medicate some/all of his medicines
  - is there a policy in place and safe storage available?
  - how will this be assessed?
- Should expect care (and care plans) to be specific to his needs, not generic

Mr B's family

- May need to make decisions relating to healthcare (with appropriate Power of Attorney)
- May be required to contribute to best interests decisions if patient lacks capacity
  - for example, covert medication
- May be able to provide useful information to complete holistic assessment of patient
  - was patient compliant with drug treatment at home?

- Families know loved ones well so may be first to express concern when things are going wrong

Care home management (1)

- Responsible for ensuring policies and procedures exist that minimise and manage risk (and promote quality)
  - tailored to setting and adhered to in practice
- Responsible for monitoring compliance with policy/quality assurance measures
  - do internal audits highlight emerging issues?
  - do managers understand the key issues in their home?

Care home management (2)

- Responsible for ensuring staffing resource and capability matches dependency level
  - are staff training/skills up to date?
  - what measures are in place to ensure staff competency?
- How are incidents/concerns responded to (culture)?
- Required to engage with commissioners, professional advisers and regulators
- Leadership failures have been identified as a key contributory factor to errors

Medicines Policy

- Providers should have a policy in place that is reviewed and based on current legislation and evidence
  - Policy should include:
    - sharing information about medicines
    - record keeping
    - identifying, reporting and reviewing problems with medicines
    - safeguarding
    - medicines reconciliation
    - medication review
    - ordering
    - receipt, storage and disposal
    - self-administration
    - staff administering medication (including competency and training)
    - covert administration
    - homely remedies (if appropriate)

Staff at care home

- Nurses and carers can influence quality in many ways:
  - Complying with local policy/procedures
  - Safe, timely and accurate medicines administration
  - Being aware of (and highlighting) risk in practice
  - Ensuring recommendations and treatment changes are actioned
  - Completing documentation unambiguously and with adequate detail
  - Adhering to policy and professional standards
  - Attending required training and undertaking CPD

Staff at care home (continued)

- Minimising disruption during drug rounds
- Actively completing tasks rather than passively collecting data
- Ensuring care plans and other documents are patient specific and updated when the patient's treatment or condition changes
- Communicate effectively with colleagues
- Proactively engaging with other professionals
- Being prepared to challenge inappropriate practice (own team and visiting professionals)
- Reporting exceptions and adverse events when they occur

Medicines administration

- Remember the 6 R's
  - **R**ight resident
  - **R**ight medicine
  - **R**ight route
  - **R**ight dose
  - **R**ight time
  - **R**esident's right to refuse

GP

- Responsible for majority of prescribing
  - avoid/minimise use of drugs more hazardous in the elderly and those of limited value
  - consider cumulative burden of adverse effects (e.g. anticholinergics)
  - medicines reconciliation particularly important as patients move between care settings
- Consider mental capacity when making prescribing decisions
- Regular medication review important (at least yearly – NICE)
  - stopping medicines just as important as starting them
  - ensures changing evidence applied in practice
- Avoid ambiguous instructions (e.g. 'as directed')
- Challenge inappropriate requests for treatment
- Have governance arrangements in place to manage prescribing
  - confirm prescription changes in writing (fax or email)
- Provide clear guidance to manage 'as required' drugs safely

Effective communication is vital

When required protocols

- Protocols should be in place to guide use of PRN drugs
- Protocols should include:
  - reason for giving when required drug
  - how much to give if variable dose prescribed
  - expected outcome
  - minimum time between doses
  - offering when needed, not prescribed times
  - when to refer to prescriber

- There should be a consistent recording method in care home to avoid confusion

Community Nurses

- From a wider quality perspective, tend to cover a number of homes so can provide useful comparative information, intelligence and early warnings
- District nurses likely to be attending residential homes to administer injectables and dressings
  - responsible for monitoring and management of diabetic patients on insulin
  - may have role to play in appropriate stock management in these patients
- Role to play in sharing best practice
  - e.g. tissue viability and promotion of formulary adherence

Secondary care (1)

- Transfer of information on discharge key to safe care
- Important for home to know drugs stopped as well as started during admission
  - home will generally be required to prepare MAR sheet and administer drugs based on discharge information until GP review (could be Friday or Bank Holiday)
- Be clear what is needed and supply adequate amounts
  - remember supplements, directives, consumables and other items administered from ward stock

Medicines reconciliation

- From NICE guideline, medicines reconciliation should involve:
  - The resident and/or their family or carers
  - A pharmacist
  - Other health and social care practitioners involved in managing medicines for the resident

Medicines reconciliation (continued)

- The following information should be available on day of transfer
  - resident details
    - name, DOB, NHS number, address and weight (if clinically appropriate)
  - GP details
  - other relevant contacts
  - known allergies (and reaction experienced)
  - current medicines
  - drug changes
    - stopped, started, dose changed and reasons
  - date and time of last when required drugs
  - arrangements for review or monitoring
  - any information given to resident/family/carers

Secondary care (2)

- Care home patients may be under on-going care of out-patient teams (such as anticoagulation) where remote dose adjustment may occur
- Processes should exist in the home to ensure
  - information is accurately updated to reflect changing doses
  - technology is used to verify doses (not just verbal changes)
  - processes exist to ensure any anomalies (missed appointments, delayed results) are managed effectively
  - where doubt exists, clarification should be sought **before** administration
- Where possible, information should be sent to homes **once** to avoid confusion
  - if amendments are necessary, safeguards should be in place to ensure the correct information has been received and actioned

Community pharmacy

- Standard operating procedures should cover dispensing and accuracy checking
- Provide MAR sheets
  - ensure home understands paperwork provided
  - keep number of MAR sheets to minimum
- Many pharmacies will provide medicines training and audit
  - if not robust, audit may provide a false sense of assurance
- Work with home and professional advisers to address concerns but also be proactive
- Comply with home requests where practical
- Work as part of MDT to address prescribing issues (quantities, discrepancies etc)

Professional advisers

- May have specific backgrounds or advise more generally on quality issues
  - employed by CCG or local authority
  - issues can be referred between specialisms (think eyes and ears)
- Important to deliver consistent messages between organisations
  - may require compromise to minimise confusion
  - important to be pragmatic and work together
- Capacity issues frequently mean work limited to more challenging homes
- Information sharing important (CQC or other partners)
- Key role in risk/quality agenda for commissioners
  - report to CCG and LA boards

Commissioners

- Responsible for placing individuals in beds (if not self-funding) via CHC (NHS) or social care funds
- Need to have processes in place to be assured of quality
- Can use contracting arrangements to specify quality requirements
- Important that effective mechanisms exist for local authority and CCG to share concerns and information about emerging risk
  - should be responsive to urgent concerns and consider risks to **all** residents
- Serious concerns managed through Senior Strategy process with LA and CCG representation
  - may impose financial sanctions or operating restrictions until required improvements seen

Regulators

- Care homes providing nursing or personal care regulated by Care Quality Commission since 2009
  - NICE guidance published March 2014
- Medicines management governed by Outcome 9
  - specifies arrangements for recording, handling, safekeeping, administration and disposal of medicines
- Effective communication and engagement valuable
  - ensures unified response
  - regular local professionals meetings held with CQC attendance
  - serious concerns discussed with inspectors as they emerge as part of an organisational response

When things go wrong...

- Aside from immediate patient concerns, when serious incidents occur there are a number of other factors to consider:
  - Who else is investigating?
    - Police or coroner involvement will change nature of investigation
  - Who else is at risk?
    - Is the incident an isolated error or indicative of whole systems failure?
    - What are the implications for other residents?
    - Is there organisational/reputation risk?
  - Who needs to be included in communication?
    - Are there residents/relatives to consider?
    - Is there a potential for press interest?
    - Are local partners aware (if appropriate)?

Learning (so far...)

- Work *with* the home where possible
  - there may be a number of other residents to protect and you will need the home's cooperation to be effective
  - be supportive when you can
- Be proportionate
  - determine what can be done to address the risk
  - can this be done safely within the home?
  - larger interventions may carry larger risks
- Try and be sensitive toward the individuals involved, where possible
  - staff involved are usually distressed themselves when errors occur
  - investigate objectively and professionally
- Work with the right people to influence change

Next steps...

- Improved intelligence
  - development of CCG database
  - increased collaboration with CCG quality team
    - improved notification, incident data
  - development of self-assessment tool to provide baseline information and target visits
- Improve local networks
  - provide feedback and clinical alerts via care home groups
- Increased emphasis on joint working with LA
  - joint visits to train members of LA quality team
  - improved referrals and consistent messages
- Move from reactive to more proactive model

Conclusions

- Quality *is* everybody's business
  - errors can occur from multiple small failings as well as single catastrophic incidents
- Systems should support individuals and not rely on them where possible
- Communication is key
- Systems should
  - prevent errors
  - learn from errors when they occur
  - promote a culture of safety that involves professionals, carers, organisations and patients

Thank you for listening