PATIENT SAFETY AWARDS 2020

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PROJECT SHOWCASE

IMPROVING SAFETY IN MEDICINES MANAGEMENT INITIATIVE

WINNER

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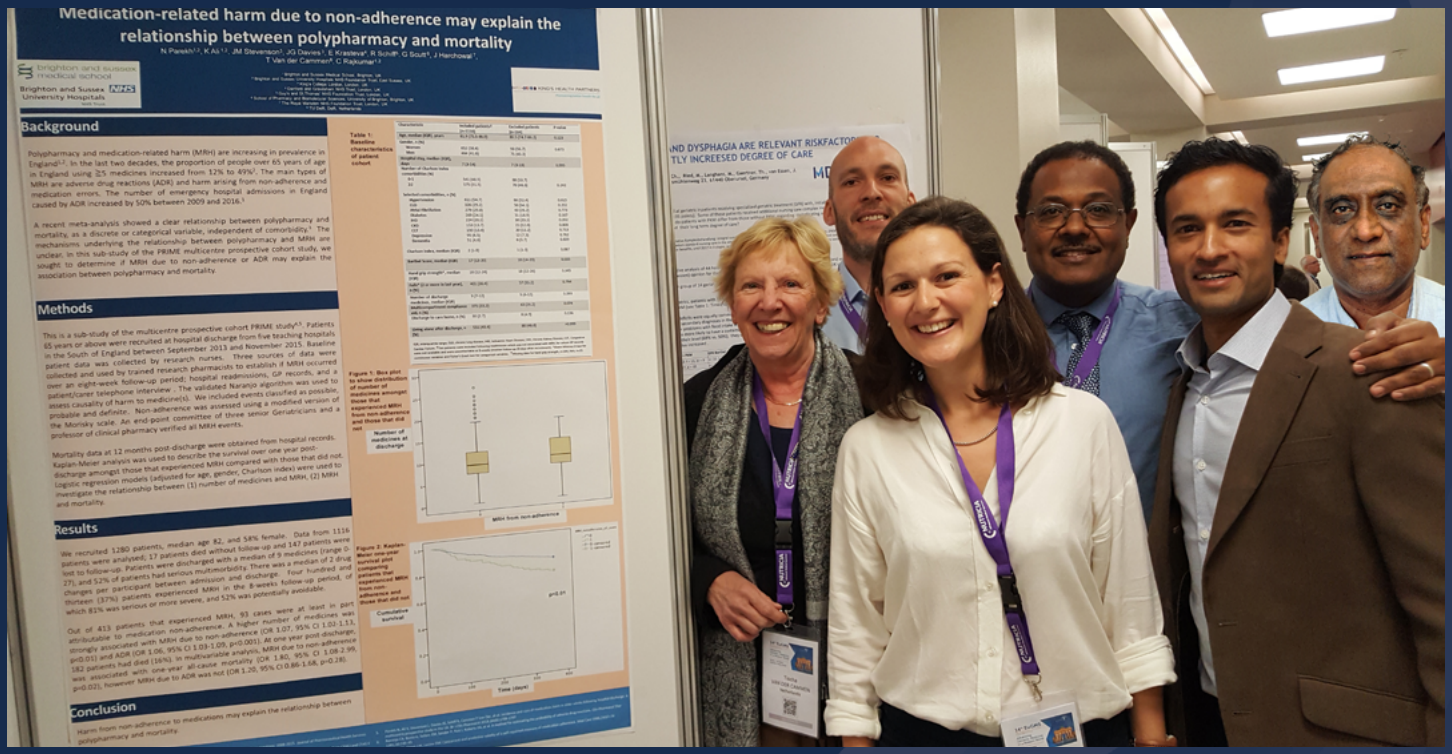

BRIGHTON AND SUSSEX MEDICAL SCHOOL, BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS TRUST, GUY'S AND ST THOMAS' FT, WESTERN SUSSEX HOSPITALS TRUST AND PORTSMOUTH HOSPITALS TRUST

REDUCING MEDICATION-RELATED HARM (MRH) IN OLDER PEOPLE DISCHARGED FROM HOSPITAL

Reducing the burden of serious and avoidable medication-related harm by 50% by 2022 is WHO's third global patient safety challenge.

Older adults are especially vulnerable to medication-related harm due to multimorbidity, polypharmacy, age-related changes in pharmacokinetics and pharmacodynamics.
Risk stratification using prediction tools is recognised as one solution to enhance the cost-effectiveness of interventions targeting patients likely to derive greatest benefit. This project surrounded the development of a risk prediction tool to identify older patients at high risk of MRH requiring healthcare use within 8 weeks following hospital discharge.

JUDGES COMMENTS

Judges felt that this was an ambitious initiative that has led to an increased national awareness and work across 5 separate NHS organisations. It is an excellent example of multidisciplinary working, which took into account the value that patients and carers themselves could add and has great potential for national adoption.

IMPROVING SAFETY IN MEDICINES MANAGEMENT INITIATIVE

HIGHLY COMMENDED

Yorkshire & Humber AHSN, Airedale FT, Barnsley Hospitals FT, Bradford Teaching Hospitals FT, Calderdale and Huddersfield FT, Hull University Teaching Hospitals Trust, Leeds Teaching Hospitals Trust, York Teaching Hospitals FT and Leeds, York Partnership FT and Community Pharmacy West Yorkshire

Medicines support to improve patient safety

NHS England commissioned the AHSN Network to roll out the Transfer of Care Around Medicines (TCAM) programme in April 2018 to support patients who may need extra help taking their prescribed medicines when they are discharged from hospital. The initiative has shown that patients who see their community pharmacist after they've been in hospital, are less likely to be readmitted and, if they are, will have a shorter length of stay. TCAM has the potential to help alleviate pressure on GP services, by building public confidence and acceptance of the pivotal role community pharmacists can play in health promotion, disease prevention and the management of urgent and long-term conditions. It also helps to reduce waste in the system and maximises opportunities for those who need it, providing patients with safer care and preventing them from harm.

JUDGES COMMENTS

Judges found this to be a great initiative bringing primary and secondary care together, with wide-reaching safety benefits for patients. Originally tested in cardiology, it is fantastic to see it being rolled out in other patients and cohorts, and even better that the team have now developed an evaluation tool that can be taken 'off the shelf' for others to use.

FINALISTS

Hertfordshire Partnership University FT

Medicines Optimisation Clinic

One of the key priorities in the Trust is around Shared Decision Making (SDM) and this is highlighted in both our Medicines Optimisation and Trust Quality Strategies.

This project surrounds a six month pilot pharmacist-led medicines optimisation clinic launched in an adult community mental health team. This aimed at evaluating the impact of a pharmacist in community based services and facilitating SDM in practice, using evidence based medicine and enhancing patient safety, thus optimising the use of medicines. Healthcare professionals worked together to individualise care, monitor outcomes more carefully, review medicines more frequently and support patients when needed.

Marie Curie Hospice, Newcastle

Reducing Medication Errors through the Introduction of an Electronic Prescibing System within a Hospice Setting

In 2018 staff at Marie Curie Hospice, Newcastle reported 110 medication related incidents. 60 of these were related to prescribing or administration. Tasked with reducing this number, a review was carried out of all incidents, demonstrating that staff were more likely to make a prescribing or administration error within the first few months of employment. Unfamiliarity with the process was often cited as a contributing factor, leading the team to explore the introduction of an ePMA system to the hospice. While information gathering, it became apparent that ePMA systems outside of hospital settings were not commonplace and the team believe they are the first to look at introduction to a hospice setting. They also aim to develop a programme fit for purpose in a non hospital setting by reviewing incidents and making changes to the system.

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FINALISTS

Neighbourhood Integrated Practice Pharmacists in Salford (NIPPs)

Rationalisation and Safety Review of DOACs in Primary Care

Many patients are given DOACS for VTE with a finite treatment period intended, however some patients continue to receive these drugs beyond the indicated end date, resulting in potential morbidity, health risks as well as cost implications. The development of proformas to guide local pharmacists in Salford in best practice was undertaken, and during this time it became clear that this exercise was also required for several other patient groups. The target was for the NIPPS team to review all these patient groups across the region ensuring no patients were on a DOAC inappropriately and conversely to ensure all patients with a confirmed diagnosis of non-valvular atrial fibrillation diagnosis were informed of the risks of not being anticoagulated as well as those already anticoagulated being on the correct dose.

Salford Care Organisation, part of the Northern Care Alliance Group

Medicines Related Admissions: Identifying and preventing medicines related harm across care boundaries

The Medicines Related Admission (MRA) project was developed by Salford Integrated Medicines Optimisation Team (SIMOT) to assist with achieving it's aims of improving medicines safety and optimisation across care boundaries. Where adverse medicines events result in admission to Salford Care Organisation they are recorded quickly using an 'MRA order' which can be requested for a patient in seconds. The data gathered from the use of the MRA order is used to identify and reduce harm from medicines across care boundaries in Salford, and where adverse drug reactions are identified to improve reporting to the MHRA via the Yellow Card scheme.

Thank you to our partners

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BD

Key Partner

General Medical Council

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Contact Us

Awards Director
Zoe Gammie
T: 0207 250 4608
E: zoe.gammie@wilmingtonhealthcare.com

Media and Marketing
Honey De Gracia
T: 0207 608 9002
E: honey.degracia@wilmingtonhealthcare.com