

Medicines

# 2021/22 Care Homes Programme

## North East and North Cumbria (NENC)

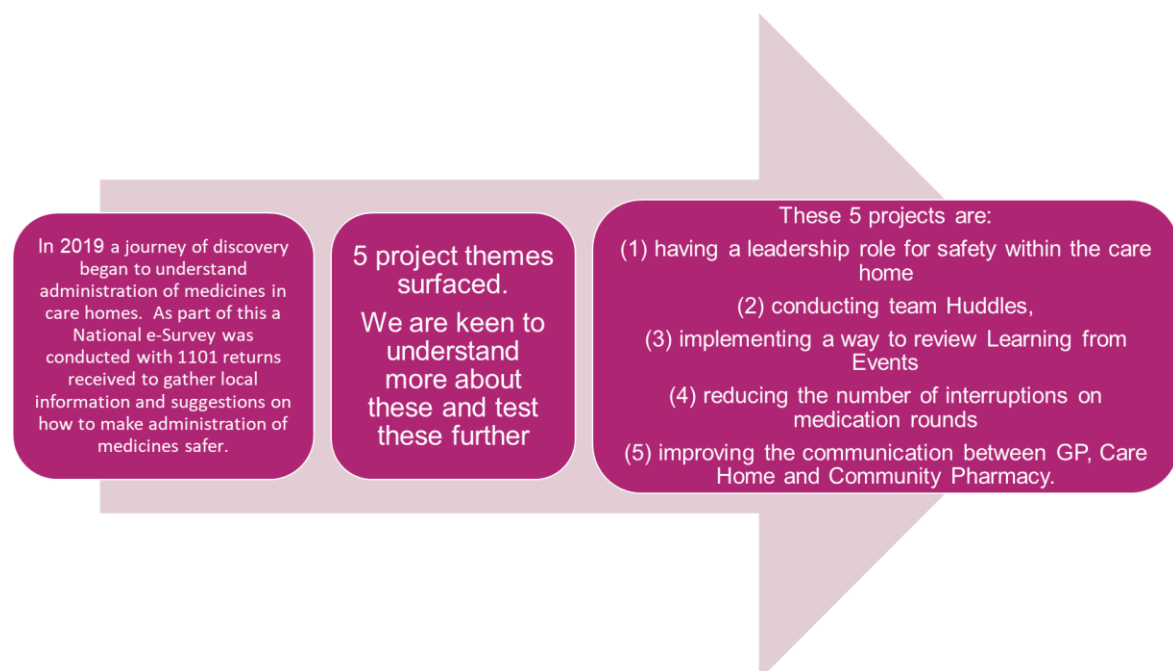
Helen Seymour, Medicines Optimisation Workstream Lead

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### 1. Overview of the programme aims and ambitions:

**To reduce medicine administration errors in care homes by 50% by March 2024,**  
through medicines optimisation and quality improvement.



By March 2022, Patient Safety Collaboratives (PSC) across England to have defined interventions (see the secondary drivers in the Medicines Safety Improvement Programme

Delivered by:

North East and North Cumbria  
**Patient Safety Collaborative**

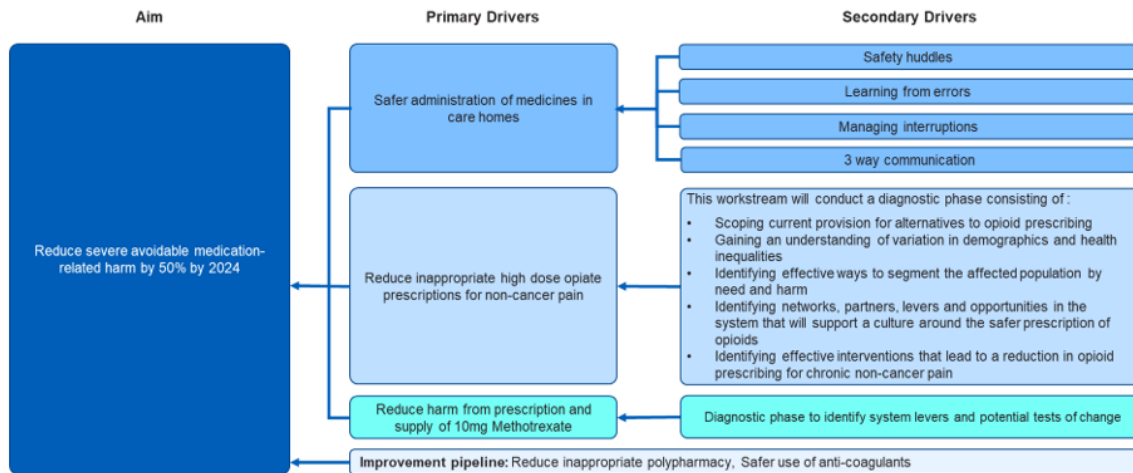
*The***AHSN***Network*

Led by:

**NHS England**  
**NHS Improvement**

Driver Diagram below) that will demonstrably improve patient safety in care homes and show the potential to be implemented at a national scale in order to improve the safety of medicines administration.

### Medicines Safety Improvement Programme Driver Diagram



### Summary of North East and North Cumbria PSC contribution to this national ambition:

Below is a summary of how the North East and North Cumbria (NENC) has contributed to the programme

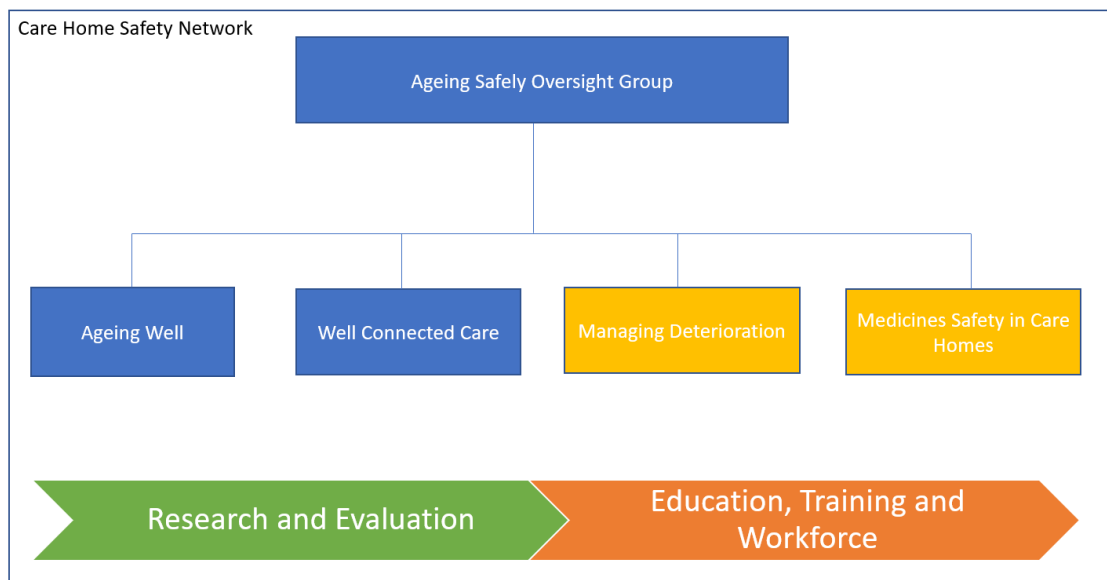
- The following secondary drivers were chosen for testing within the region although all are at different stages of the testing process:
  - Managing Interruptions (two care homes)
  - 3-way Communication (three care homes)
  - Learning from Error (two care homes)
  - Safety Huddles (one care home)
- Ten care homes initially expressed an interest in taking part in the programme, however only eight have undertaken initial safety culture surveys (SAQs). Seven remain in the programme and one left during the testing phase.
- Care homes were split into two cohorts: cohort 1 and cohort 2. Initial testing of interventions in cohort 1 care homes was undertaken, and testing of refined interventions, following national review meetings, in cohort 2 care homes.
- Three care homes have completed testing of their chosen intervention and two are in the process of/beginning the process of testing. Two care homes have undertaken safety culture questionnaires but have not had results debrief sessions yet.
- Each of the care homes was asked to appoint a Safety Champion. Three Safety Champions completed quality improvement training.
- Five debrief sessions were held with care home staff using a report of collated of Safety Attitude Questionnaire (SAQ) results. Staff sessions were held separately to manager sessions and an action plan of suggestions was drawn up to encompass discussions at all sessions. These sessions proved an invaluable intervention in engaging with staff and building trusting relationships and a solid foundation to begin testing of their chosen intervention.

## 2. Care Home Safety Network

A Well Connected Care Home Group was already in place across the NENC region and so it was agreed that this would be transitioned to become the PSC Care Home Safety Network and held its first meeting on 15<sup>th</sup> April 2021. A chair was appointed and various stakeholders from across the region were invited to join as members.

Meeting structure:

- Ageing Safely Oversight Group
  - Ageing Well Group (frailty and pre-frailty in all settings)
  - Well Connect Care Group (digital enablement in Care Homes)
  - Managing Deterioration PSN (PSC Managing Deterioration workstream)
  - Medicines Safety in Care Homes
- Research and Evaluation spans the whole network
- Education, Training and Workforce spans the whole network



### Ageing Safely Oversight Group Membership

Representation requested from the following areas:

- NHS England
- Enhanced Health in Care Homes (EHCH)
- Care Quality Commission (CQC)
- GP Practices
- Pharmacists
- Local Authorities
- Ageing Well Network
- Care Home Managers
- Health Call
- Applied Research Collaborative (ARC) research and academic representatives

- Digital
- North East Care Support (NECS) Unit

The purpose of the group is to bring key regional stakeholders and colleagues together to collaborate regarding competing agendas in respect of care homes across the system. It was agreed the role of the Ageing Safely Oversight Group members is to support, promote and enhance the coming together of likeminded people; to generate activity and to let people know what we are doing to ensure things are more joined up.

A Care Home Focus Group (Medicines Safety in Care Homes) was developed and held its first meeting on 23<sup>rd</sup> June 2021. The meetings are held every month.

The purpose of the Care Home Focus Group is to provide a forum for discussion, networking and sharing of ideas. It's role is to provide direction and leadership for the seamless delivery of the Care Home Medicines Safety Improvement Programme objectives. It also supports and develops quality improvement interventions in care homes, with the aim of reducing medication administration errors. Project updates are reported to the Ageing Safely Oversight Group.

Membership at the care home focus group include:

- Care Home Managers taking part in the Medicines Safety Improvement Programme
- Care Home Safety Champions
- Project Managers for Medicines Safety, NENC PSC

Care Home Focus Group Successes

- Co-designed intervention testing and data collection materials.
- Sharing of ideas and areas of good practice about the interventions across all care homes regardless of which intervention they have chosen to test.
- Support, coaching and networking for Safety Champions and staff leading the medicines safety interventions.
- Sharing of data from testing of interventions and celebrating successes.
- Attendance as required from individuals from other workstreams in the National Patient Safety Improvement Programme (NatPatSIP) where their work impacts on care homes i.e. Managing Deterioration.

### 3. Safety Attitude Questionnaire (SAQ)

An SAQ containing 31 questions was designed to disseminate to all care home staff at the beginning and end of the programme to complete anonymously. For each of the questions in the questionnaire respondents were asked to reply with one of the following answers: Disagree Strongly, Disagree Slightly, Neutral, Agree Slightly and Agree Strongly.

#### Example SAQ



Academic Health  
Science Network - NE

The responses are a scaled measure; agree strongly being perceived as a positive measure of the scale and disagree strongly at the negative end.

The overview of SAQ results from each care home in section 4 have been colour rated according to their overall responses to SAQ questions:

Green – A positive response to questions - Agree Strongly and Agree Slightly

Amber – A Neutral response to questions - Neutral

Red – A negative response to questions - Disagree Strongly and Disagree Slightly

Debrief sessions were held with care home staff using a report of collated of SAQ results. Staff sessions were held separately to manager sessions and an action plan of suggestions was drawn up to encompass discussions at all sessions.

## 4.1. Managing Interruptions

### Care Homes

Two care homes in NENC chose to test the managing interruptions intervention (Care Home 5 (cohort 1) and Care Home 7 (cohort 2)).

#### Care Home 5 (Cohort 1)

<b>Type of Care Home</b>	Residential care with plan for further nursing beds
<b>Residents</b>	42 residents with a 14 further nurse led beds planned for residents with challenging behaviour. Admissions to age 55+
<b>CQC Rating</b>	Good

SAQ overview and insights:

		Initial SAQ (May 2021)	Post SAQ (Feb 2022)
	<b>Response Rate</b>	43%	66%
	<b>Overall Results</b>	Overall results were very positive with the exception of stress recognition. Discussion with staff indicated that they felt that acknowledging their stress was not perceived to be a negative, but awareness that they may require some additional support.	Overall results were again very positive with the exception of stress recognition.
<b>SAQ Domains</b>	Teamwork Climate	Green	Green
	Safety Climate	Green	Green
	Perceptions of Management	Green	Green and Amber
	Job Satisfaction	Green	Green
	Stress Recognition	Red and Amber	Red
	Working Conditions	Green	Green

See Section 3 for overview of ratings key

Initial SAQ feedback

Feedback received from staff:

- *“I am very content at (name of home) and I'm looking forward to new challenges in my future career”*
- *“I enjoy working here”*
- *“I have worked at this care home for many years and have always found staff management helpful and supportive when occasions arise. Well done (name of home)”*

- *“I love working at (name of home). Every day is different and staff and management are like a big family”*

### Change Idea

An audit tool was developed to collect baseline interruptions data for each of the four medication administration rounds undertaken at the care home each day - morning, lunchtime, evening and night.

### Audit tool example



FINAL NENC  
Medication Interruptic

The baseline data was collated and the first PDSA (Plan, Do, Study, Act) sessions were held with care home staff to discuss results and ideas to change practice and reduce interruptions. Various change ideas were suggested and these included:

- Include managing interruptions work in the family and resident newsletter to highlight the importance of not interrupting the medicine round where possible.
- Display a poster in the main front door advising visitors that staff may be undertaking 'safety critical task' and will be with them as soon as possible.
- Introduce a communications book to note down communications for the administrator to review after the round.
- Discuss recreation plan for residents and their timing to coincide with medication rounds to occupy residents and reduce interruptions.
- Senior carers to take turns in leaving morning meeting after handover when non urgent information is discussed so that medication round can be started. Any information of note to be cascaded to the absent senior.
- Blank audit forms to be submitted so that 'no interruptions' could also be recorded.

The main change idea taken forward in this care home was for two senior carers to undertake the medicines round. One senior carer to administer medicines and the second person to manage the interruptions.

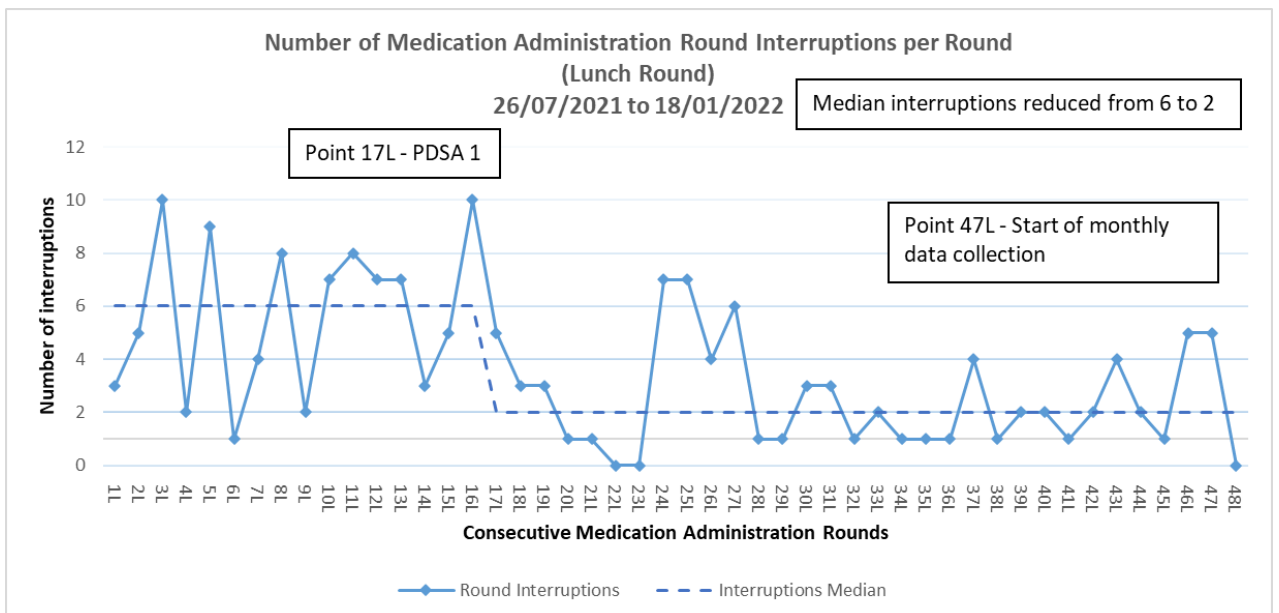
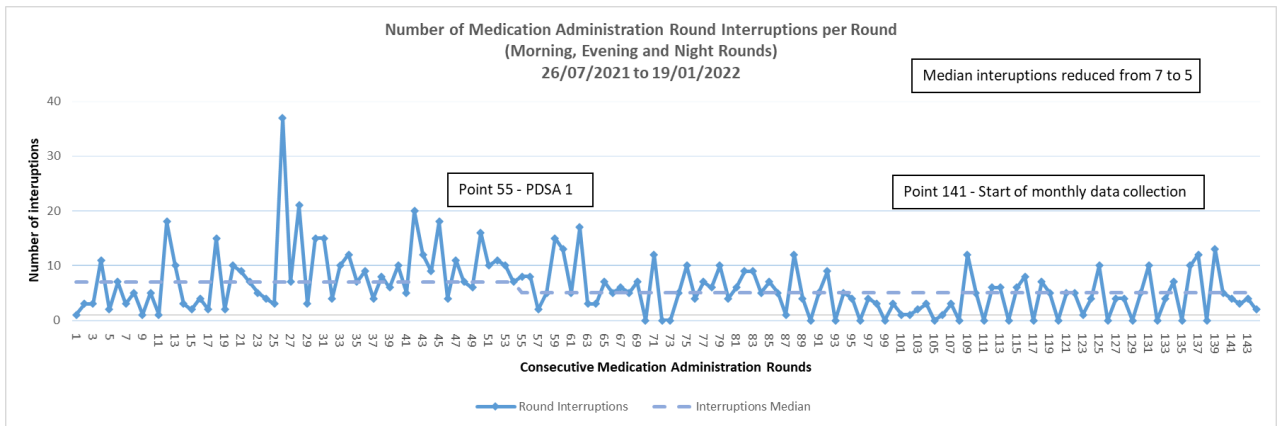
The care home staff collectively agreed the following Specific, Measurable, Achievable, Realistic, Timely (SMART) objective:

***Reduce the overall number of interruptions to the medication administration rounds by 25% over 4 weeks.***

## Results/data

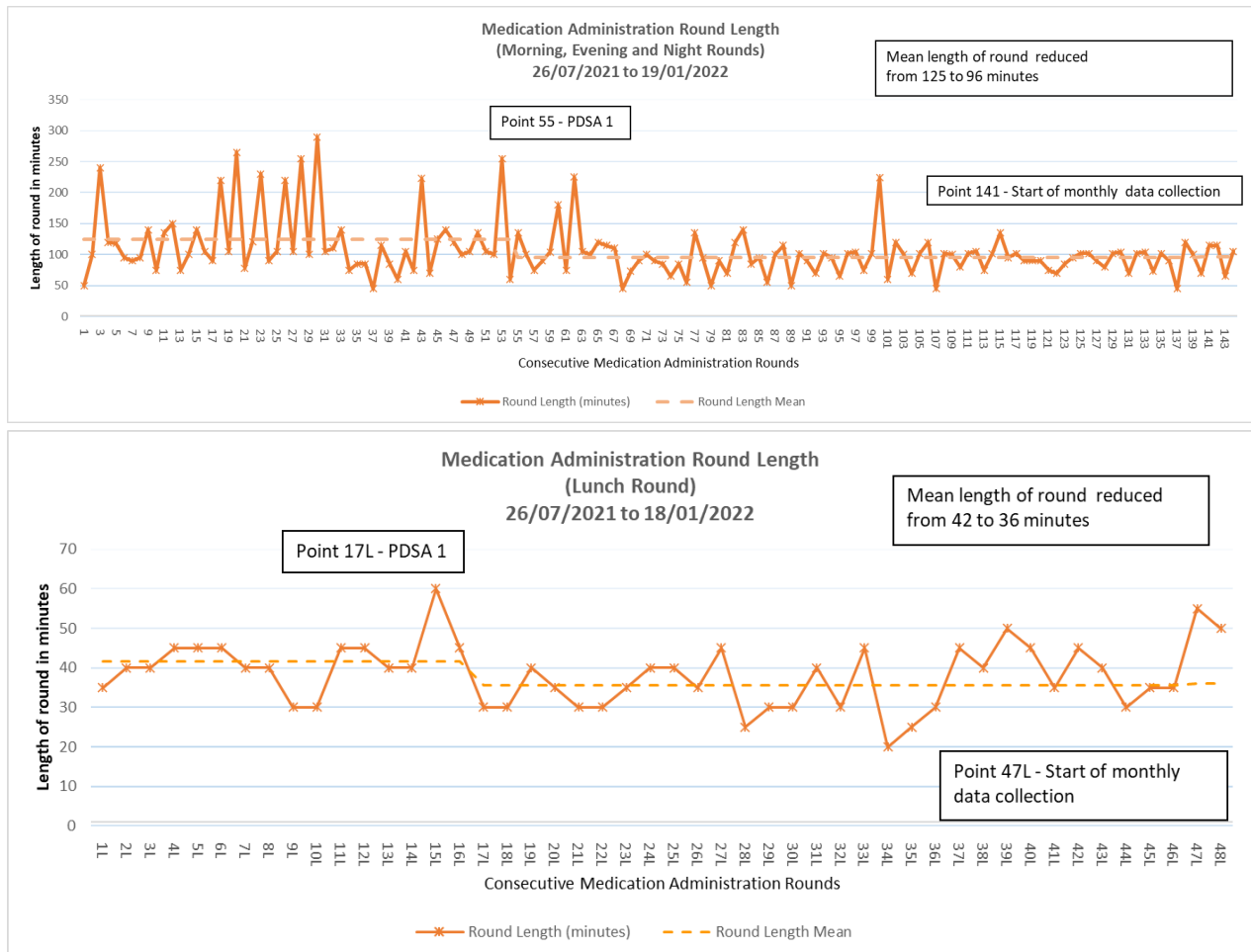
### Outcome Measures

#### Number of interruptions to medication administration rounds





## Medication administration round length



There was an overall reduction of 43% in the median interruptions to the medication administration round. The care home achieved their SMART objective target to reduce the overall number of interruptions to the medication administration rounds by 25%. Posters and case studies with results and programme successes have been developed to celebrate highlights to display within the care home.

### Balancing Measures

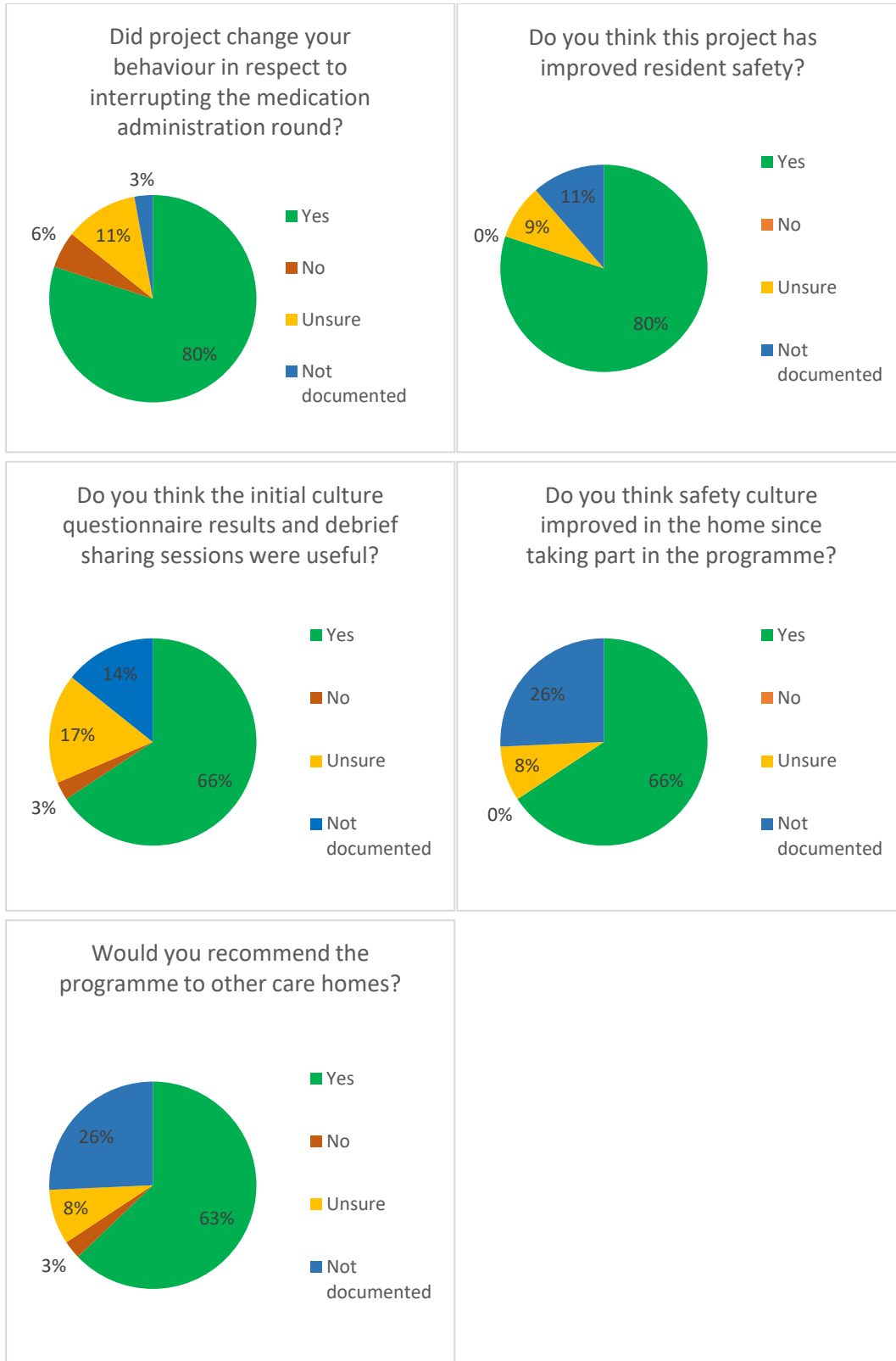
We considered balancing measures and asked staff responsible for medicines administration whether they swapped role (being the medicines administrator and being the person to manage interruptions) so that they didn't become deskilled in any one area. They alternated roles so that this did not become a problem.

We also considered the review of medication incident data to compare incidents with interruptions experienced. When asked about incident data, the care home explained that they had not had a medication incident in some time and did not have any data relating to the programme timescales.

### General Feedback from the Care Home

A series of additional questions were included on the post SAQ distributed to staff following completion of the intervention testing to gain some general feedback about the programme. The respondents were asked to answer each question with 'yes', 'no' or 'unsure'.

35 responses were received from staff at the care home:



The Manager of the Care Home gave the following feedback when they had identified a significant improvement in the number of interruptions to their medication round:

*“The staff and I are overjoyed with this result. As a team this has greatly improved our working system, medication rounds have been reduced giving more time for the residents. I cannot thank the PSC Medicines Safety Team enough for helping us change to a better way and a more efficient and safer way of giving medication”*

Staff quotes also gave some insights and feedback about the programme:

- *“It’s a good thing for our home”*
- *“It gave me an insight to what can go wrong with interruptions on medication rounds”*
- *“I found the meetings were useful and informative”*
- *“I enjoyed all the programme”*
- *“It highlighted the failures within the home”*
- *“Good to hear each other’s views and opinions”*
- *“Every change made a difference”*
- *“I enjoyed how we all discussed how we could change things to make it better”*
- *“It made me realise that interruptions during medication can lead to mistakes”*
- *“I enjoyed the meetings”*
- *“Very informative”*
- *“I like that the whole care home was involved”*
- *“I enjoy my job role; the survey help me to understand the importance of errors that can be made on medication rounds”*

### Approach to Sustainability

Once a significant improvement to reduce interruptions in Care Home 5 had been identified, consideration was given to how the project could be sustained. It was collectively decided with the care home that interruptions data would be collected at least once a month to plot within the run chart and monitor any changes. Reasons for interruptions was also reviewed and there is a plan to use an interruptions dashboard to maintain the intervention within the home; to record and monitor number and cause of interruptions which can be managed by the care home staff. An online IT training support module has been identified to support care home staff in using Microsoft Excel if required.

### Approach to Spread/Scale up

#### Care Home 7 (Cohort 2)

<b>Type of Care Home</b>	Residential care including dementia
<b>Residents</b>	40 residents. Admissions to age 65+
<b>CQC Rating</b>	Good

### SAQ overview and insights:

		Initial SAQ (November 2021)
	<b>Response Rate</b>	47%
	<b>Overall Results</b>	Overall results were very positive with the exception of stress recognition. Discussion with staff indicated that they felt that COVID pandemic had influenced stress levels. Senior carers and management try to identify staff who are stressed and encourage them to take a break and offer support.
<b>SAQ Domains</b>	Teamwork Climate	Green
	Safety Climate	Green and Red
	Perceptions of Management	Green
	Job Satisfaction	Green
	Stress Recognition	Red and Amber
	Working Conditions	Green

See Section 3 for overview of ratings key

#### Initial SAQ feedback

Feedback received from staff:

*"I love my job!"*

#### Change Idea

The audit tool from the initial testing of the managing interruptions intervention in Care Home 5 was amended, so that the information to complete by staff reflected the data required to populate the managing interruptions dashboard. Baseline interruptions data is being collected for each of the four medication administration rounds undertaken at the care home each day - morning, lunchtime, evening and night.

#### Audit tool example



FINAL NENC  
Medication Interruptic

The care home programme is no longer being commissioned from 1<sup>st</sup> April 2022 and so the care home has been provided with resources and support to undertake the intervention independently.

## 4.2. 3-Way Communication (GP Practice, Community Pharmacy and Care Home)

### Care Homes

Three care homes in NENC chose to test the 3-way communications intervention (Care Home 1, Care Home 3 and Care Home 4 (all cohort 1))

#### Care Home 1 (Cohort 1)

<b>Type of Care Home</b>	General residential – Includes EMI (Elderly Mentally Infirm), General Nursing, Intermediate Care
<b>Residents</b>	54 residents. Admissions to age 65+
<b>CQC Rating</b>	Good

#### SAQ overview and insights:

		Initial SAQ (June 2021)	Post SAQ (Mar 2022)
	<b>Response Rate</b>	58%	42%
	<b>Overall Results</b>	Overall results were mixed	Overall, post SAQ results appear to be less positive. There were less responses due to staffing issues. Debrief sessions to undertake with staff to discuss further.
<b>SAQ Domains</b>	Teamwork Climate	Green and Amber	Amber and Red
	Safety Climate	Green, Amber and Red	Amber and Red
	Perceptions of Management	Red and Amber	Red
	Job Satisfaction	Green, Amber and Red	Green, Amber and Red
	Stress Recognition	Red and Amber	Green, Amber and Red
	Working Conditions	Green and Red	Red

See Section 3 for overview of ratings key

#### Initial SAQ feedback

Staff feedback about the Deputy Manager:

- *Effective regarding management and resolution*
- *Excellent at appropriately managing errors*
- *Offers support and deals with problems constructively*

#### Improvement suggestions:

- *Staff are helpful and approachable, but for the occasions where staff may act abruptly, there is an appropriate reporting mechanism*

- *Manager is supportive, however sometimes a satisfactory resolution to issues raised, was not identified.*
- *Staff felt that enhanced support from the manager would be beneficial*
- *Staff felt that they would benefit from additional staff members, especially during the nightshifts.*
- What staff said:
- *"I enjoy coming to work at the home. It is a lovely place to work and I love all of my residents"*
- *"I have always felt if I need support I can go to a particular member of staff for any issues or even if I have personal issues - always there for me and others"*

### Change Idea

Meetings were held with care home staff responsible for ordering medication and the PSC Medicines Safety Team on 28<sup>th</sup> July and 17<sup>th</sup> August 2021. A data collection tool was co-designed and agreed and it was decided that baseline data would be collected over a four week period to encompass a full 28 day medication ordering cycle.

Responses to questions included in the attached data collection tool were collected for each day where communication was made with either the GP practice or the community pharmacy.

### 3-Way Communication Data Collection Tool



3 Way  
Communication Micro

The PSC Medicines Safety Team met with the care home deputy manager to undertake the first PDSA cycle on 7<sup>th</sup> October 2021 to discuss the baseline data and agree next steps. An action plan was drawn up of activities to undertake, with an aim of conducting a 3-way communication meeting with representatives from the GP practice, community pharmacy and care home, with facilitation by the PSC Medicines Safety Team. The care home deputy manager acted as lead for the programme intervention.

The care home agreed the following SMART objective:

***A 50% improvement in the number of issues resulting from medication ordering process being resolved in 24 hours***

### Results/data

Baseline Data 01/09/2021 to 01/10/2021

	Number of Times Contacted	% Resolved in 24 hours	% Issues resolved satisfactorily after 24 hours
GP Practice	72	4%	29%
Community Pharmacy	61	0%	3%

On review of baseline data, 4% of GP practice issues and 0% of community pharmacy issues were resolved satisfactorily within 24 hours. 29% of issues were resolved satisfactorily with the GP practice and 3% with the community pharmacy after 24 hours. This highlighted the need to improve communication processes with the GP practice and community pharmacy.

Many of the activities on the first PDSA action plan involved meetings and information gathering visits by the PSC Medicines Safety Team and included:

- PSC Medicines Safety Team to gain an insight into the GP practice processes for ordering and issue of medicines.
- PSC Medicines Safety Team to gain a better understanding of community pharmacy processes
- 3-Way meeting to be arranged with care home, GP practice and community pharmacy to resolve and clarify problematic communication processes.

The main change idea taken forward in this care home was to undertake a 3-way communication meeting. The meetings and information gathering visits by the PSC Medicines Safety Team allowed the team to collect and collate feedback from all key parties for an effective facilitated discussion at the 3-way communication meeting planned with the three stakeholder groups.

An online 3-way communication meeting was held via Microsoft Teams on 19<sup>th</sup> January 2022 to discuss the agenda and resolve any communication issues. In attendance at the meeting was:

Care Home Deputy Manager  
 Practice Pharmacist  
 Community Pharmacy Care Home Services Pharmacist  
 Two Project Managers for Medicines Safety, PSC

Following the meeting, notes and an action log were developed of issues to resolve and information to cascade by attendees within their respective areas of work.

A second wave of data was collected from the care home over a 28 day period covering the same questions collected during the baseline collection phase.

Second Wave Data 31/01/2022 to 27/02/2022

	Number of times Contacted	% Resolved in 24 hours	% Issues resolved satisfactorily after 24 hours
GP Practice	16	56%	6%
Community Pharmacy	16	81%	19%

Comparison of baseline data to second wave data following implementation of change idea

	Number of Times Contacted		% Resolved in 24 hours		% Issues resolved satisfactorily after 24 hours	
	Baseline	2 <sup>nd</sup> Wave	Baseline	2nd Wave	Baseline	2nd Wave
GP Practice	72	16	4%	56%	29%	6%
Community Pharmacy	61	16	0%	81%	3%	19%

#### GP Practice

- Number of times the care home contacted the GP practice reduced from 72 to 16
- % of issues resolved within 24 hours increased from 4% to 56%
- % of issues resolved satisfactorily after 24 hours from 29% to 6%

#### Community Pharmacy

- Number of times the care home contacted the community pharmacy reduced from 61 to 16
- % of issues resolved increased from 0% to 81%
- % of issues resolved satisfactorily after 24 hours from 3% to 19%

The care home achieved their initial SMART objective which was a 50% improvement in the number of issues resulting from medication ordering process being resolved in 24 hours. The number of contacts with both the GP practice and the community pharmacy significantly decreased with issues being resolved within 24 hours in the GP practice increasing from 4% to 56% and those with the community pharmacy increasing from 0% to 81%.

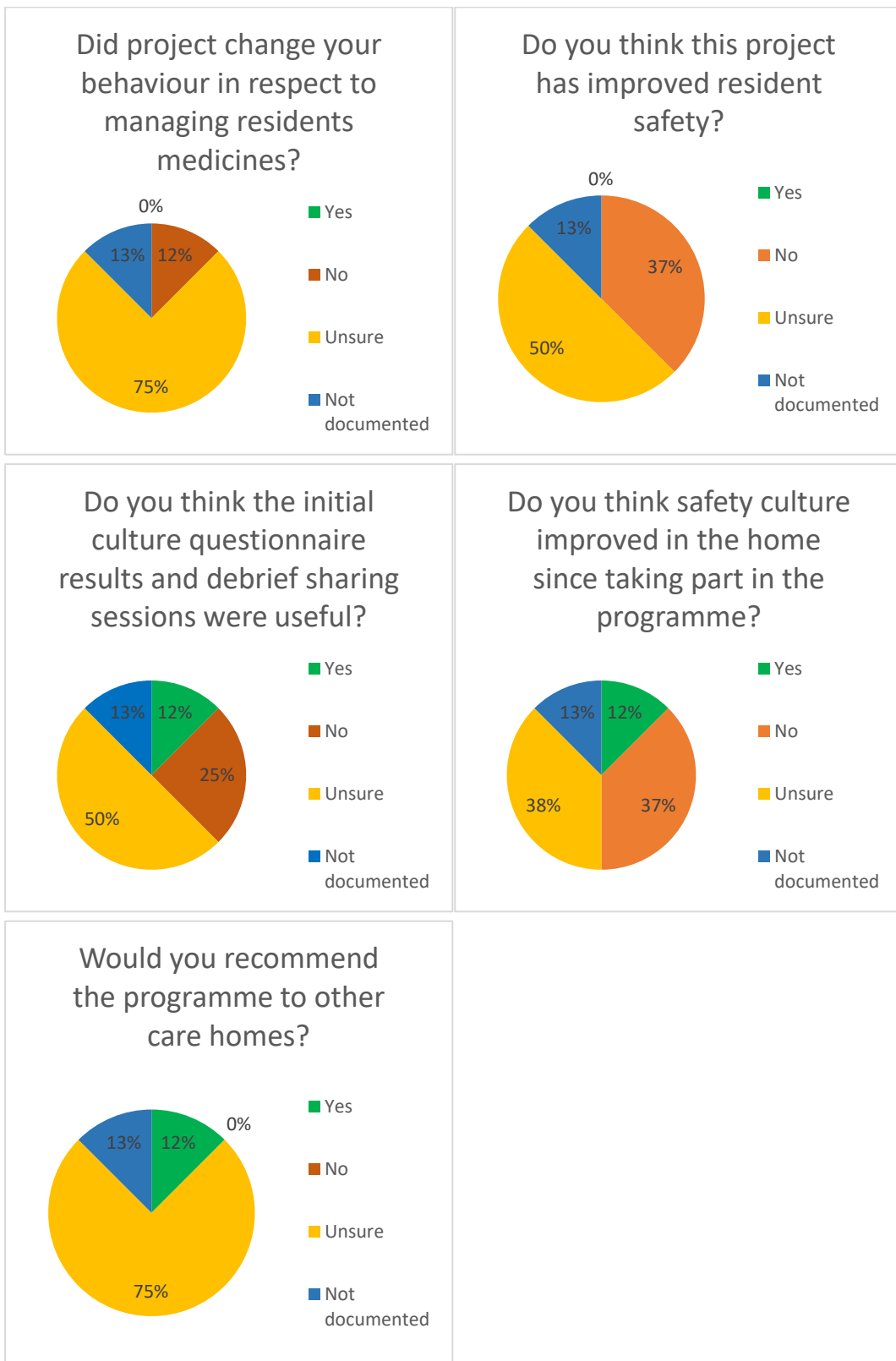
Posters and case studies with results and programme successes have been developed to celebrate highlights to display within the care home.

#### General Feedback from the Care Home

A series of additional questions were included on the post SAQ distributed to staff following completion of the intervention testing to gain some general feedback about the programme. The respondents were asked to answer each question with 'yes', 'no' or 'unsure'.



8 responses were received from staff at the care home:



### Approach to Sustainability

All stakeholders agreed that the 3-way meeting held between the GP practice, Care home and community pharmacy was very beneficial and have planned to continue these regularly.

The data collection tool has also been shared with the care home so that ad-hoc audit can be undertaken as required.

### Care Home 4 (Cohort 1)

<b>Type of Care Home</b>	Residential and Nursing
<b>Residents</b>	30 residents – Old age
<b>CQC Rating</b>	Outstanding

### *SAQ overview and insights:*

		<b>Initial SAQ (May 2021)</b>	<b>Post SAQ (Feb 2022)</b>
	<b>Response Rate</b>	59%	57%
	<b>Overall Results</b>	Overall results were positive. It was noted that they could do with more staff, but 'always got the job done'. The environment can be stressful but management team at the care home is supportive	Overall results remain positive. Stress Recognition responses appear to have improved.
<b>SAQ Domains</b>	Teamwork Climate	Green	Green and Amber
	Safety Climate	Green	Green
	Perceptions of Management	Green and Amber	Green and Amber
	Job Satisfaction	Green	Green
	Stress Recognition	Green, Amber and Red	Green and Amber
	Working Conditions	Green	Green

See Section 3 for overview of ratings key

### Initial SAQ feedback

Feedback received from staff:

- *"All of management team are easy to talk to and always take our concerns seriously and deal with them straight away. It's a really nice place to work"*
- *"We don't always know the outcome when an issue has been raised"*

### Change Idea

Meetings were held with care home staff responsible for ordering medication and the PSC Medicines Safety Team on 12<sup>th</sup> August 2021. A data collection form was co-designed and agreed and it was decided that baseline data would be collected over a four week period to encompass a full 28 day medication ordering cycle.

Responses to questions included in the attached data collection tool were collected for each day where communication was made with either the GP practice or the community pharmacy.

### 3-Way Communication Data Collection Tool



3 Way  
Communication Micrc

The PSC Medicines Safety Team met with the care home manager to undertake the first PDSA cycle on 21<sup>st</sup> September 2021 to discuss the baseline data and agree next steps. An action plan was drawn up of activities to undertake with an aim of conducting a 3-way communication meeting with representatives from the GP practice, community pharmacy, care home with facilitation by the PSC Medicines Safety Team. The intervention was led by the care home manager and clinical lead.

The care home agreed the following SMART objective:

***A 50% improvement in the number of issues resulting from medication ordering process being resolved in 24 hours***

#### Results

Baseline Data 16/08/2021 to 12/09/2021

	Number of Times Contacted	% Issues Resolved in 24 hours
GP Practice	8	100%
Community Pharmacy	13	31%

On review of baseline data, 100% of GP practice issues and 31% of community pharmacy issues were resolved satisfactorily within 24 hours. 69% of issues were not resolved or documented as ongoing with the community pharmacy after 24 hours. This highlighted the need to improve communication processes with the community pharmacy.

Many of the activities on the PDSA 1 action plan involved meetings and information gathering visits by the PSC Medicines Safety Team and included:

- PSC Medicines Safety Team to gain an insight into the processes and procedures for prescription supply.
- PSC Medicines Safety Team to gain a better understanding of community pharmacy processes.
- PSC Medicines Safety Team to investigate if the 'token number' or 'prescription barcode' could be access by the care home to use in communications regarding medication queries.
- Investigate why all repeat medicines are dispensed when 3 or more medications are ordered from the community pharmacy.
- Follow up training for care home staff by community pharmacy.
- Find out what the communication process is between the GP practice and the community pharmacy

- Can notice be provided by the community pharmacy to the care home when medicines are not in stock.
- 3-Way meeting to be arranged with care home, GP practice and community pharmacy to resolve and clarify problematic communication processes.

The main change idea taken forward in this care home was to undertake a 3-way communication meeting. The meetings and information gathering visits by the PSC Medicines Safety Team allowed the team to collect and collate feedback from all key parties for effective facilitation of discussion at the 3-way communication meeting planned with the three stakeholder groups.

An online 3-way communication meeting was held via Microsoft Teams on 2nd February 2022 to discuss the agenda and resolve any communication issues. In attendance at the meeting was:

Care Home Manager  
 Clinical Lead/Deputy Care Home Manager  
 Practice Pharmacist  
 Pharmacist, Community Pharmacy  
 Two Project Managers for Medicines Safety, PSC

Following the meeting, notes and an action log were developed of issues to resolve and information to cascade by attendees within their respective areas of work.

A second wave of data was collected from the care home over a 28 day period covering the same questions collected during the baseline collection phase.

Second Wave Data 03/02/2022 to 03/03/2022

	Number of Times Contacted	% Issues Resolved in 24 hours
GP Practice	6	100%
Community Pharmacy	4	100%

Comparison of baseline data to second wave data following implementation of change idea

	Number of Times Contacted		% Resolved in 24 hours	
	Baseline	2 <sup>nd</sup> Wave	Baseline	2 <sup>nd</sup> Wave
GP Practice	8	6	100%	100%
Community Pharmacy	13	4	31%	100%

#### GP Practice

- Number of times contacted the care home contacted the GP practice reduced from 8 to 6
- % of issues resolved remained the same, 100% and 100%

#### Community Pharmacy

- Number of times the care home contacted the community pharmacy contacted reduced from 13 to 4
- % of issues resolved increased from 31% to 100%

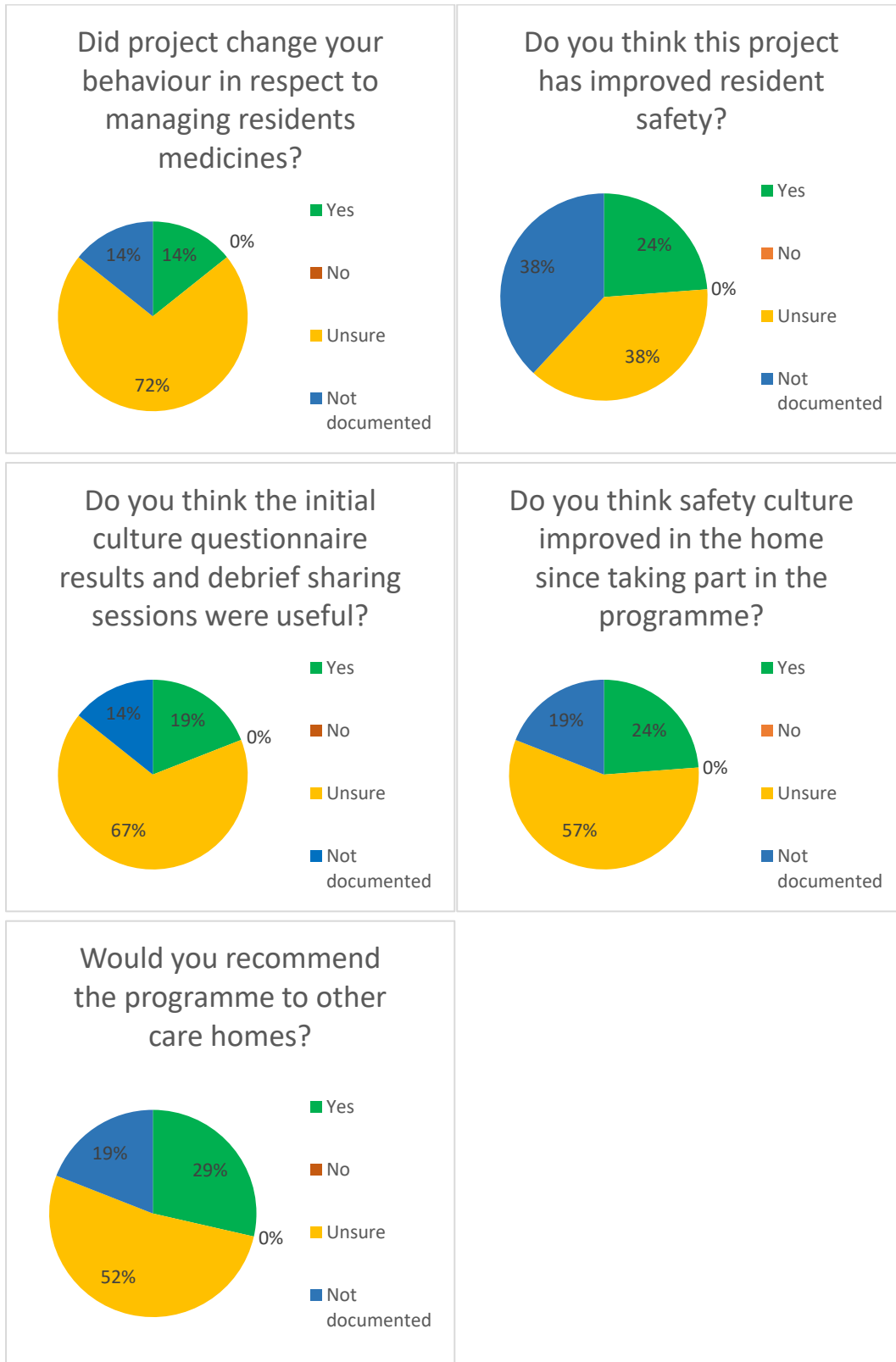
The care home achieved their initial SMART objective which was a 50% improvement in the number of issues resulting from medication ordering process being resolved in 24 hours. The number of contacts with both the GP practice and the community pharmacy decreased with issues being resolved within 24 hours in the GP practice staying at 100% and the community pharmacy increasing from 31% to 100%.

Posters and case studies with results and programme successes have been developed to celebrate highlights to display within the care home.

#### General Feedback from the Care Home

A series of additional questions were included on the post SAQ distributed to staff following completion of the intervention testing to gain some general feedback about the programme. The respondents were asked to answer each question with 'yes', 'no' or 'unsure'.

21 responses were received from staff at the care home:



The Clinical Lead/Deputy Manager of the Care Home gave the following feedback after they had seen an improvement in communication pathways with the GP practice and Community Pharmacy:

*“This experience has been very positive and worthwhile project; I would encourage any care home to participate in this. From our visit meeting with the PSC Medicines Safety Team, we have felt supported, encouraged and empowered. The PSC Medicines Safety Team are very approachable, knowledgeable and professional, whilst also providing a warm, relaxed atmosphere to be able to freely discuss concerns, barriers and issues that we have, without judgement or finger pointing.*

*Having the forms to write down our communication to either the community pharmacy or GP helped us to record and manage our communication, as often conversations and details can be forgotten.*

*Knowing the PSC Medicines Safety Team were able to meet and speak with the community pharmacy and the GP to open communication and discuss issues and barriers we had to also listen to their issues and concerns and feed them back to us was of vital importance to us.*

*The 3-way communication Teams meeting was a very positive outcome, with all participants working together and moving forward to reach the same goal.*

*Our home has greatly benefitted from the PSC Medicine Safety Team’s input, support and knowledge. Medication orders, requests and dispensing are all running much smoother and without previous delays or barriers that we felt we had prior to this project. We now have new ways of discussing medication requests at the GP surgery, when the GPs are understandably too busy, we can speak directly to the practice pharmacist and he will work to resolve issues very quickly and efficiently, the pharmacist will even communicate directly with the community pharmacy to resolve any issues, which has helped us immensely. We no longer spend our valuable time sitting on the end of a phone for up to an hour trying to resolve issues. This time can now be spent with our residents which can only mean this has been a huge success all round”*

Staff quotes also gave some insights and feedback about the programme:

- *“Staff were able to speak freely and without judgement. Comfortable environment and lovely to hear feedback”*
- *“Helped to discuss issues”*
- *“No finger pointing, only ways to improve all services. Positive outcomes opened up communication to provide amazing teamwork for the benefit of our residents”*

### Approach to Sustainability

All stakeholders agreed that the 3-way meeting held between the GP practice, Care home and community pharmacy was very beneficial and have planned to continue these regularly.

The data collection tool has also been shared with the care home so that ad-hoc audit can be undertaken as required.

### Care Home 3 (Cohort 1)

<b>Type of Care Home</b>	Residential - Specialist Short-Term Rehabilitation
<b>Residents</b>	Capacity for 22 residents. Admissions to Old Age, Physical Disability, Younger Adults
<b>CQC Rating</b>	Good

### *SAQ overview and insights:*

Care home 3 undertook completion of SAQs but have not engaged further in the programme.

## 4.3. Learning From Error

### Care Homes

Two care homes in NENC chose to test the Learning from Error intervention (Care Home 2 (cohort 1) and Care Home 8 (cohort 2))

### Care Home 2 (Cohort 1)

<b>Type of Care Home</b>	General residential and Dementia
<b>Residents</b>	58 residents. Admissions to age 40+
<b>CQC Rating</b>	Inadequate

### *SAQ overview and insights:*

		<b>Initial SAQ (June 2021)</b>
	<b>Response Rate</b>	13%
	<b>Overall Results</b>	Overall results were mixed and a poor return of questionnaires meant that overall results may not be a true representation of responses for all of the care home staff
<b>SAQ Domains</b>	Teamwork Climate	Green and Amber
	Safety Climate	Green and Red
	Perceptions of Management	Green
	Job Satisfaction	Green
	Stress Recognition	Red and Amber
	Working Conditions	Green and Amber

See Section 3 for overview of ratings key

There were no additional comments from staff.



## Change Idea

Meetings were held with care home managers and staff and the PSC Medicines Safety Team on 10th August 2021. An error reporting tool and grading of error impact categories document was produced by the PSC Medicines Safety team to discuss with staff and understand their current systems for reporting incidents, near misses and excellence. Encouragement was given to increase reporting of 'near miss' and 'no harm' incidents. It was decided that the incident collection tool and supporting incident categories document would be used alongside their current incident reporting processes to collect their baseline data over a four week period. The medicines lead at the care home would submit the incident data using an online version of the tool.

### Example incident data collection and grading of incident impact tools



Medication Error  
Reporting Form.pdf



Grading Incident  
Impact NENC V3.pdf

The PSC Medicines Safety Team monitored online submissions and contacted the medicines lead at the care home each week to discuss progress and offer any support required. Unfortunately, no data was submitted by the care home.

Following discussion with the medicines lead a further meeting with care home staff was arranged for 6<sup>th</sup> October 2021 to undertake more supportive coaching with staff to understand the identification and categorising of incidents with particular emphasis on 'near miss' and 'no harm' graded incidents. A 'workshop' format was developed where example incidents would be used to discuss and categorise during the sessions. Unfortunately, due to unforeseen circumstances the care home withdrew from the programme at this point.

## Approach to Spread/Scale up

### Care Home 8 (Cohort 2)

<b>Type of Care Home</b>	Residential
<b>Residents</b>	19 residents. Admissions to age 55+
<b>CQC Rating</b>	Good

SAQ overview and insights:

		Initial SAQ (November 2021)
	<b>Response Rate</b>	50%
	<b>Overall Results</b>	Overall results were mixed. Discussion at staff debrief sessions provided some positive suggestions to resolve issues raised.
<b>SAQ Domains</b>	Teamwork Climate	Green
	Safety Climate	Green and Amber
	Perceptions of Management	Green and Amber
	Job Satisfaction	Green
	Stress Recognition	Green and Amber
	Working Conditions	Green

See Section 3 for overview of ratings key

Initial SAQ feedback

Feedback from staff:

- *“Last year has been very difficult and everybody has worked incredibly hard”*
- *“Staffing could be better at times, lots of pressure due to staff sickness”*
- *“Due to staff sickness, lots of shifts to cover which results in having too little staff on shift, making shifts too difficult to provide the level of care expected”*
- *“Workload varies day by, on a good day when residents are settled (name of home) is a pleasant, safe and rewarding place to work and live. On a more challenging day it can be difficult to deliver the care to the quality I would like”*

Change Idea

Having identified learning points from discussions and experiences with this intervention in Care Home 2 and review of interventions with PSC MedSIP colleagues in other areas, the approach to delivery of this intervention in Care Home 8 has been adapted.

The care home already has a system to report medicine incidents and so baseline data has been gained from review of the previous months incident data. The care home wants to build on their existing practice. Sessions regarding incidents categorised as ‘near miss’ and ‘no harm’ to residents are have been undertaken in a workshop format with care home staff with discussion around care home specific incident examples.

The care home programme is no longer being commissioned from 1<sup>st</sup> April 2022 and so the care home has been provided with resources and support to continue the intervention independently.

## 4.4. Safety Huddles

### Care Homes

One care home in NENC chose to test the Safety Huddle intervention (Care Home 10 (cohort 2))

### Care Home 10 (Cohort 2)

<b>Type of Care Home</b>	Residential
<b>Residents</b>	39 residents (can accommodate up to 55). Admissions to age 60+
<b>CQC Rating</b>	Good

		<b>Initial SAQ (February 2022)</b>
	<b>Response Rate</b>	30%
	<b>Overall Results</b>	Overall results were mixed and will be discussed with staff when a debrief session is planned with the care home.
<b>SAQ Domains</b>	Teamwork Climate	Green and Amber
	Safety Climate	Green and Amber
	Perceptions of Management	Green, Amber and Red
	Job Satisfaction	Green, Amber and Red
	Stress Recognition	Red
	Working Conditions	Green and Amber

Collection of SAQs was started in the care home on 8<sup>th</sup> December 2021. An extension to complete the SAQs was made and therefore completed SAQs were collected on 27<sup>th</sup> January 2022 and on 28<sup>th</sup> February 2022.

The care home programme is no longer being commissioned from 1<sup>st</sup> April 2022 and so the care home has been provided with resources and support to undertake the intervention independently.

## 5. Safety Champions

### About the participants

We began the programme with the intention to enrol at least one Safety Champion in each care home testing one of the MedSIP interventions.

#### Care Home Safety Champions

Care Home	Safety Champion	Quality Improvement (QI) Online Training Undertaken?	MedSIP Care Home Intervention Lead
Care Home 1	Nurse identified to take Safety Champion role	Online QI training not completed	Deputy Manager led the MedSIP intervention
Care Home 2	Safety Champion identified	Online QI training not completed	Medicines Lead identified to lead the MedSIP intervention
Care Home 3	No Safety Champion identified	N/A	N/A
Care Home 4	Nurse identified to take Safety Champion role	Nurse left post and new Safety Champion to be identified	Care Home Manager and Clinical Lead led the MedSIP intervention
Care Home 5	Nurse and two senior carers identified to undertake Safety Champion role. Nurse has now left her role at the home.	Online QI training completed. Care Home Manager also completed training.	Two Senior Carers/Safety Champions led the MedSIP intervention
Care Home 7	Senior Carer identified to take Safety Champion role	Online QI training ongoing	Senior Carer and Care Home Manager leading the MedSIP intervention
Care Home 8	Senior Carer identified to take Safety Champion role	Online QI training ongoing	In progress
Care Home 10	Senior Carer identified to take Safety Champion role	Online QI training ongoing	In progress

### Approach to building Safety Champions

We identified a Quality Improvement (QI) online module developed by Social Care Institute for Excellence (SCIE, June 2018) for care home staff to undertake if they wanted to become Safety Champions. The offer to complete training was given to all care home staff. The module takes around 45 minutes to complete and describes the process of using and implementing quality improvement methodology with examples cited in social care settings. The PSC Medicines Safety Team completed the online training too to ensure the content was fit for purpose for the care home staff.

The learning outcomes described by SCIE for the module are:

- To be able to consider making improvements in service area using the model for improvement.
- Recognise what is required to motivate and involve other people in the improvement process.
- Recognise the importance and need for the service user to be directly or indirectly involved.
- To identify some qualities to help individual become a quality improvement leader.

There are two main sections within the resource:

- A core learning pathway which describes the steps to implement quality improvement using the model for improvement
- A number of case studies – both individual and organisational – which illustrate how quality improvement has been implemented and measured

The PSC Medicines Safety Team discussed the concept of Safety Champions in all introductory meetings with care home staff along with quality improvement and associated training. All staff were advised of the QI online module offered by the SCIE at these sessions. The link for the QI training was sent to all care home managers and deputy managers taking part in the programme and shared at the Care Home Focus Group for dissemination to staff within care homes. The PSC Medicines Safety Team offered to do on site sessional time with staff to complete the QI training for those that preferred 1:1 support while completing the module. This offer was taken up by two members of staff in one care home.

Other areas of support given to Safety Champions in care homes:

- An Illustrated Guide to QI from East London Foundation Trust (May, 2019) shared with Safety Champions to act as a reference source and support quality improvement within their care homes.
- Identified Safety Champions at programme care homes were invited to the monthly Care Homes Focus Group. Safety Champions were given the opportunity to highlight any areas of support that they required.
- A coaching approach was taken by the PSC Medicines Safety Team with Safety Champions and care home staff leading the interventions in each care home to support

and offer guidance throughout the programme. This was undertaken when visiting the care home for face-to-face visits or during online meetings.

A Safety Champions data collection tool was co-designed with members of the care home focus group and was intended to feedback how confident the individual felt in their role as Safety Champion in their care home.

#### Safety Champion Data Collection Tool



Safety Champions  
Microsoft Forms.pdf

#### Results

At the beginning of the programme, we intended on collecting the confidence feedback tool from all Safety Champions on a weekly basis. However, it was soon realised that this was too time intensive and very few returns were submitted and so the approach was changed and data was collected from Safety Champions at the start, mid-point and end of the MedSIP intervention testing. Two Safety Champions completed all requested feedback forms.

- Three Safety Champions started the Safety Champions development programme.
- Two Safety Champions completed the Safety Champions development programme.

## Safety Champion Confidence Measures

Safety Champion	Initial Confidence Measure	Mid-Point Confidence Measure	End Confidence Measure
SC03	Mostly Confident	Mostly Confident	Mostly Confident
Additional Comments from Safety Champion in response to confidence rating		Staff will come to me about any safety concerns I feel more confident than I used to	I feel confident in the safety champion role
SC02	Very Confident	Very Confident	Very Confident
Additional Comments from Safety Champion in response to confidence rating	As a Senior I am aware of things that can become hazards within my job role. I feel confident in doing all medication and filling in the correct paperwork relevant to meds round.	To make other senior staff aware of dealing with medication in the correct manner and complete all paperwork relevant to the meds round.	I feel very confident doing medication in the correct manner and I feel confident to guide new senior member that has come into the home in medicines and all relevant paperwork to do with medication.

- The two Safety Champions that completed the SCIE online QI training were instrumental in leading the managing interruptions intervention within their care home (Care Home 5). The Care Home Manager in Care Home 5 also completed the training.
- Confidence scores for both Safety Champions did not change throughout the programme. SC03 remained 'mostly confident' and SC02 'very confident'.
- At the initial stages of the programme, we identified Safety Champions as those individuals that had completed the online SCIE QI training and had expressed an interest in taking up the Safety Champion role. As the programme has progressed, we have acknowledged that those individuals that have led the interventions within their care homes have promoted a Safety Champion role without identifying themselves as the 'Safety Champion'.

## 6. Capability and Capacity Building

In addition to testing the MedSIP interventions in care homes, below is a summary of the additional capability and capacity building work to develop safety culture, QI and patient safety in care homes detailed throughout this report.

- SCIE online QI training and QI resources.
- Model for Improvement discussion at training sessions.
- Safety culture debrief sessions and culture overview discussions with all care home staff.
- Information gathering visits to GP practice and community pharmacy to discuss and find resolutions to issues raised in 3-way communication intervention.
- Highlighted community pharmacy medicines related online training available to care home staff.
- Linked care home staff with Clinical Commissioning Group's Digital Lead to access training on clinical IT systems in applicable nursing homes.
- Incident reporting training; how to report
- Categorising a medication incident – near miss, no harm, minor harm, moderate harm, severe harm, death.
- Face-to-face/online coaching and mentoring with Safety Champions and care home MedSIP intervention leads.

## 7. Challenges and Key Learning Points

- Covid and care home staffing issues has made it difficult with care home staff capacity and to access the care homes. A flexible approach was taken accessing care homes and face-to-face visits with the PSC Medicines Safety Team were used efficiently to cover as much information as reasonably possible. Remote sessions for some meetings have been held where possible to ease pressure where large staff numbers are not required.
- Face-to-face meetings were found to be much more beneficial in terms of engagement and building trust and relationships with staff in the care homes. During the selection phase of care homes to engage, we deliberately engaged with care homes that were geographically nearer to the location of PSC Medicine Team staff's location so that face-to-face visits could be conducted more easily.
- Regular contact with care homes via telephone conversations, online Microsoft Teams meetings, focus group meetings, face-to-face visits and drop off/collection of data and resources facilitated engagement and fostered good relationships.
- Care home staff are not often office based and emails cannot always be answered in a timely way. Using telephone communication was much more efficient and useful.
- Culture debrief sessions following collection of SAQ data were found to be an invaluable intervention in engaging with staff and building trusting relationships and a solid foundation to begin testing of their chosen intervention. Developing an environment of psychological safety has been important to promote honest discussions and have been



indicative in identifying if the care home is 'change ready' to begin testing of their chosen QI intervention.

- Engagement of cohort 2 care homes was made easier by asking for suggestions for care homes that may be interested in participating in the programme at Care Home Focus Group. Local authority contacts were also engaged to make suggestions.
- A meeting was arranged with the NENC regional Care Quality Commission (CQC) representative and the PSC Medicines Safety Team to highlight and discuss the MedSIP programme and the PSC Medicines Safety Team were particularly interested in understanding their perspective on the 'learning from error' intervention and the potential impact on increased error reporting would have from a CQC perspective.
- The PSC Medicines Team provided the care home that left the programme with all of the intervention training materials and care home developed reports to use as CQC evidence. Files containing this information will be provided to all care homes that have taken part in the programme.
- The PSC Medicines Safety Team have taken a holistic approach to the delivery of the MedSIP in care homes and have engaged with peers in other areas of the National Patient Safety Programme such as the managing deterioration programme (ManDetSIP). We have found this approach very beneficial and have linked managing deterioration into our visits to care homes and in discussion at the Care Home Focus Group to maximise resident safety.

## References

East London NHS Foundation Trust, (May 2019), *An Illustrated Guide to Quality Improvement*

Social Care Institute for Excellence, (June 2018), *Quality improvement in health and social care*. Available at: <https://www.scie.org.uk/e-learning/quality-improvement>