

Improving Medicines Safety and Transfer of Care: A Quality Improvement Programme in Greater Manchester

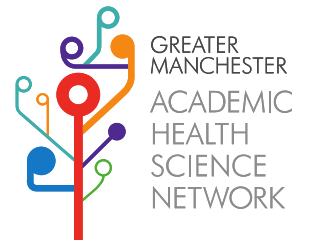
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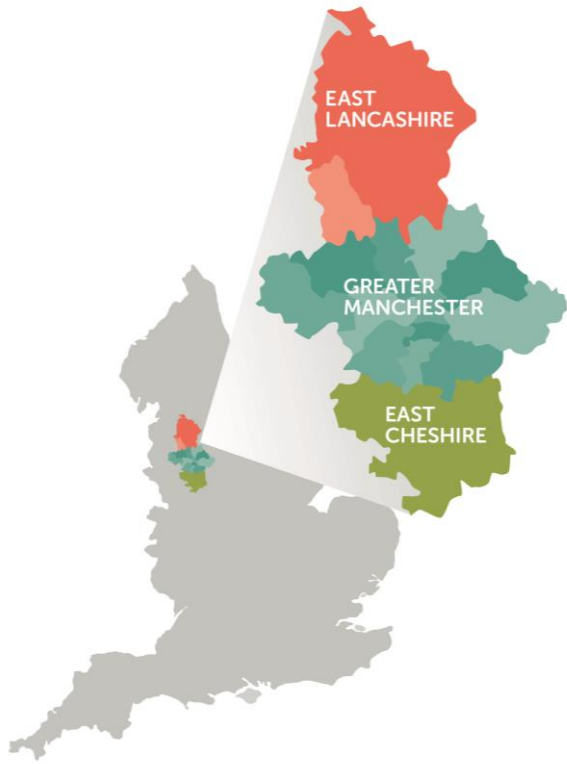
Declaration of interest

This programme has been commissioned by the Greater Manchester Academic Health Science Network (GM AHSN) and is delivered in partnership by Haelo, an innovation and improvement science centre based in Salford, Manchester



GM AHSN Membership

AHSN footprint



14
Commissioners

500
GP
Practices

4
Universities

12
Local
Authorities

16
Provider
Organisations



1
Ambulance Service



Introduction and objectives

Achieving safe medicines management during transfer of care was identified as a healthcare priority that affects many patients

Our solution: To create a collaborative quality improvement programme across multiple healthcare systems, teams and individuals in Greater Manchester

Today's presentation will:

- Share our I.H.I. Break Through Series Collaborative model and show how a using a '*plan-do-study-act*' approach helped build effective cross-organisational teams and projects
- Report the outcomes of the programme against our ambition to achieve **95%** '**defect-free**' medicines care
- Provide individual exemplars of success from project teams and share **what we learned**



Receiving safe medicines on transfer of care should be every patient's expectation...



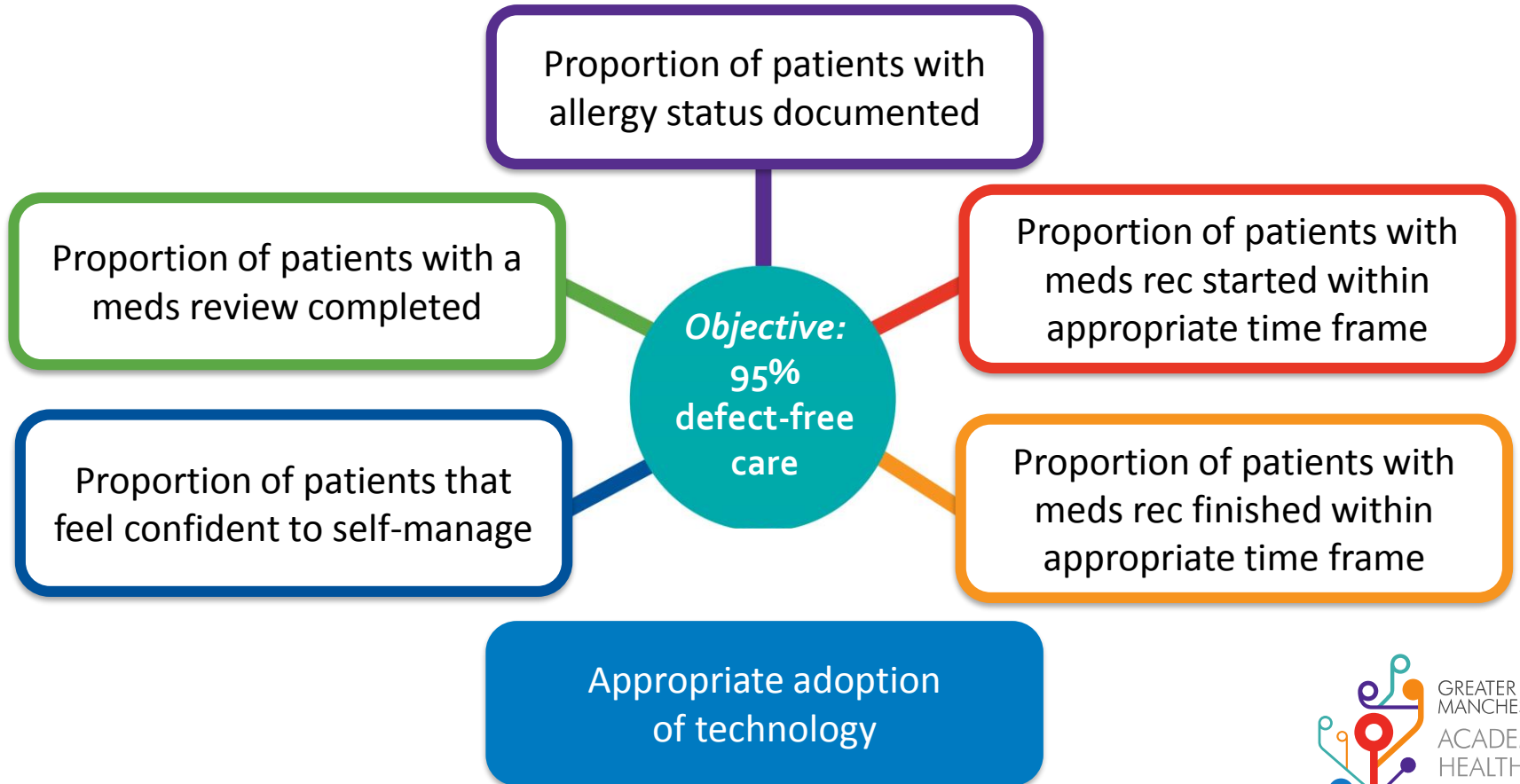
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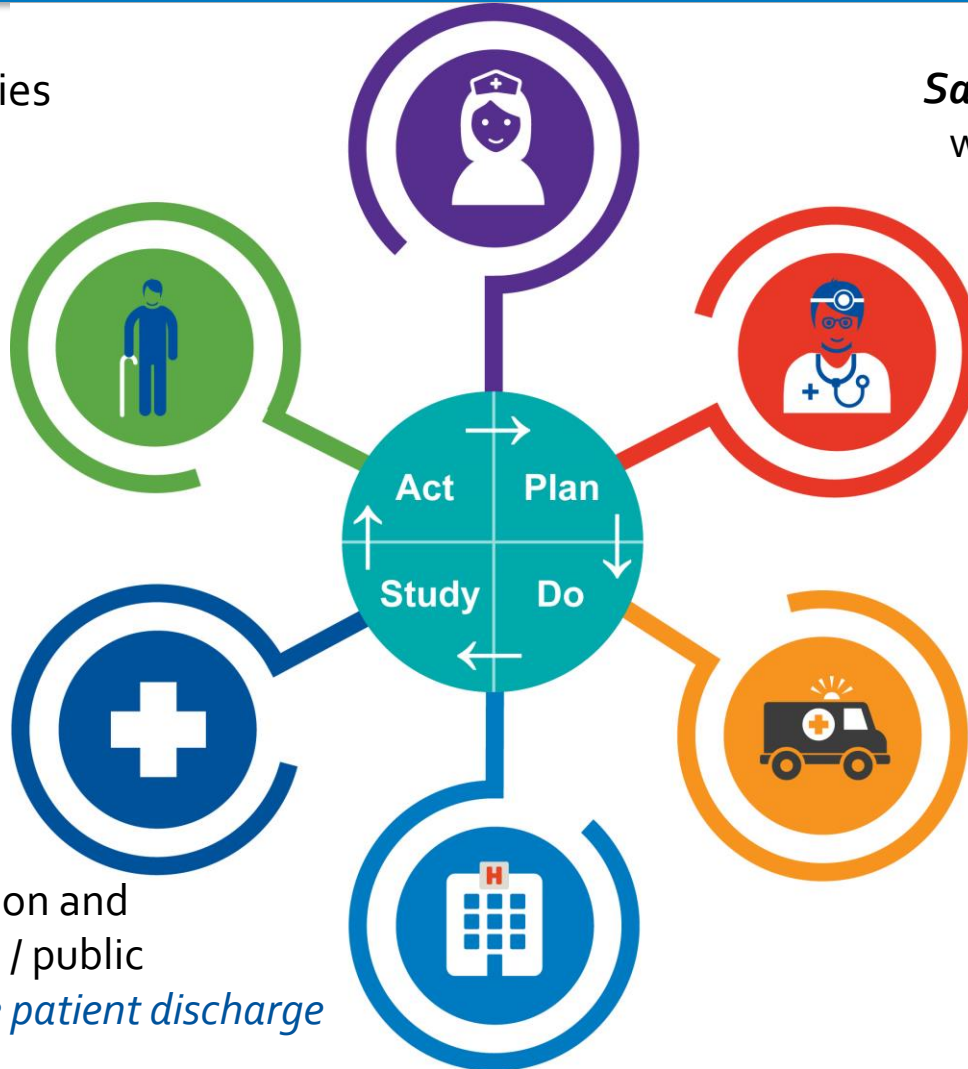


Using the Breakthrough Series (BTS) collaborative model



Using the Breakthrough Series (BTS) collaborative model

9/14 Health economies participated



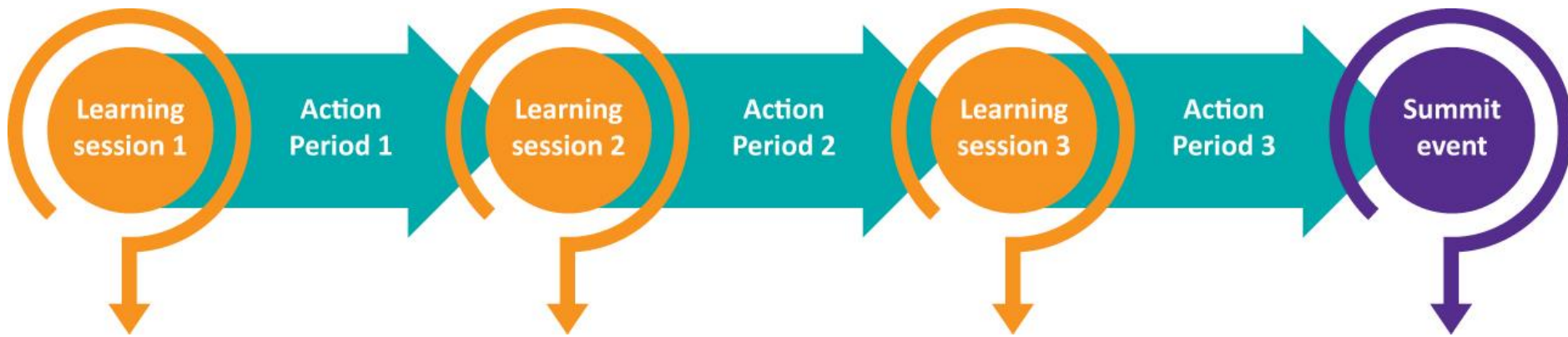
Salford Royal collaborated with **Heartly Green Care Home** to improve *transfer from acute hospital to intermediate care homes*

Wrightington, Wigan and Leigh pharmacy team

improved documentation and effectively used patient / public involvement to *improve patient discharge*

Teams from **Manchester Mental Health and Social Care** and **HMP Manchester** *reviewed medicines reconciliation for newly transferred patients*

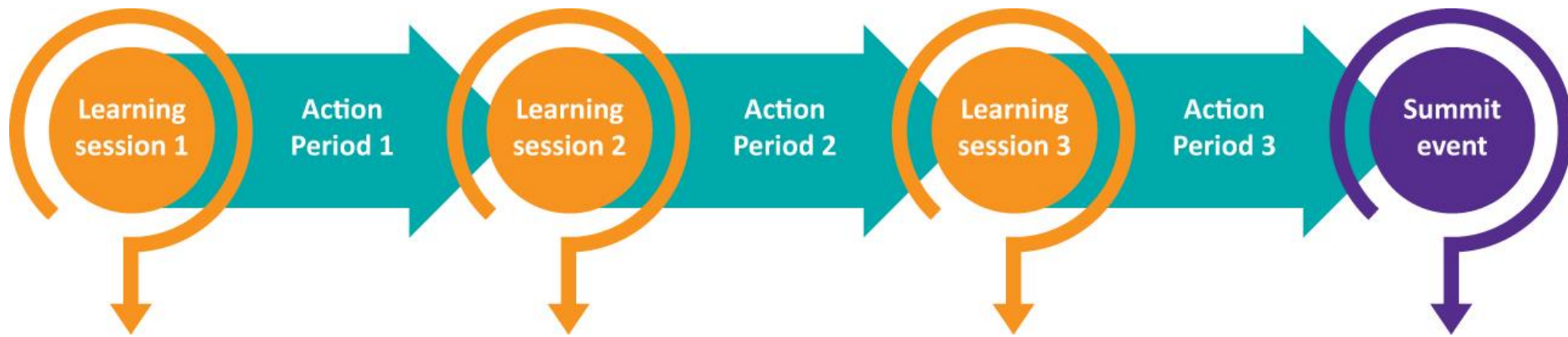
Using the Breakthrough Series (BTS) collaborative model



Haelo Retweeted
 **Jessica Wickham** @grrrrjess · 24 Jun 2015
Great Improving Medicines Safety event yesterday, now to set up our team meetings and map out our actions! #IMSTransfers #transformation

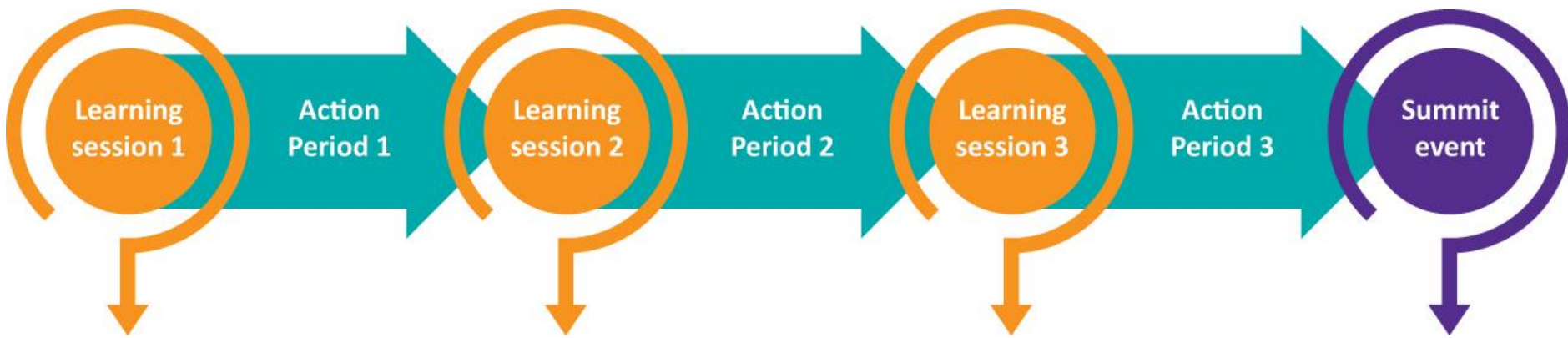
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Case Study 1: Salford team embedding medicines reconciliation in Intermediate Care

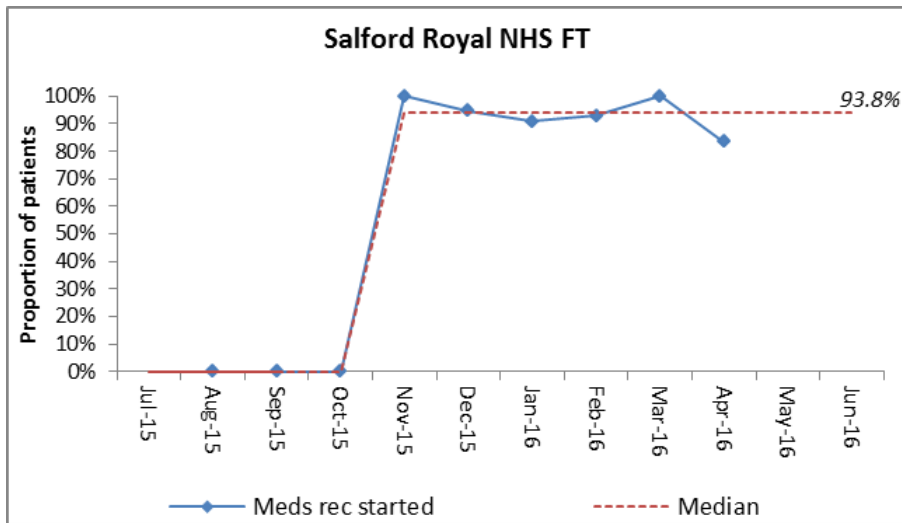


- The Salford team looked at how they could improve medicines processes for patients discharged to intermediate care
- An in-house pharmacy technician was introduced at a pilot intermediate care home
- It immediately impacted the number of patients who had medicine reconciliations within 72 hours: from 0% to 93.8%
- The introduction of an onsite medicines stock cupboard reduced omitted or delayed doses
- *A business case has now been approved to introduce pharmacy technicians to all intermediate care units in Salford*

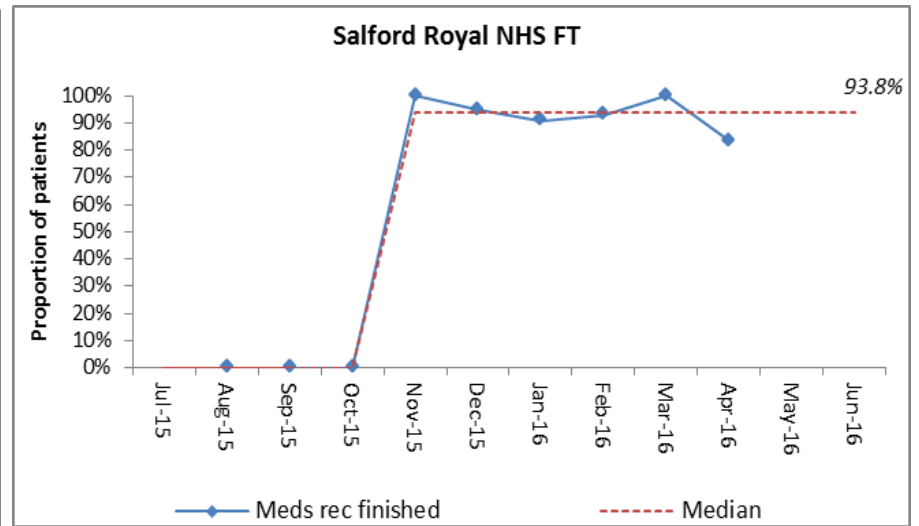
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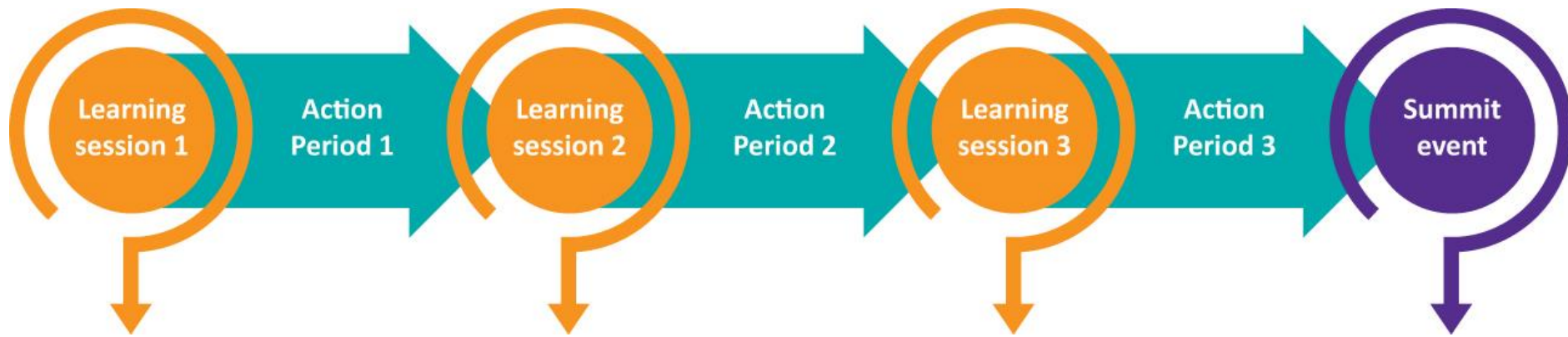
Proportion of patients with meds recs started



Proportion of patients with meds recs finished



Case Study 2: Manchester Mental Health and HMP process mapping in the prison system

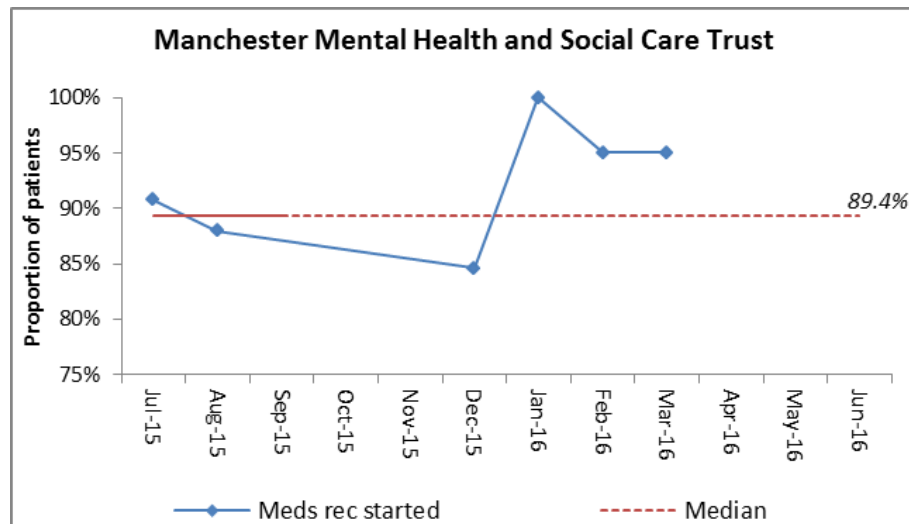


- A process mapping session was held with the prison pharmacist, GP and senior reception nurse to understand the current system of care from intake to final medicines reconciliation. The Mental Health Trust facilitated staff relations.
- This immediately identified the absence of pharmacy from the clerking process and that critical medicines were not available in the reception drugs cupboard
- The need for a guiding pathway for prison reception staff was also identified
- *Several tests of change are now ongoing based on this evidential analysis*

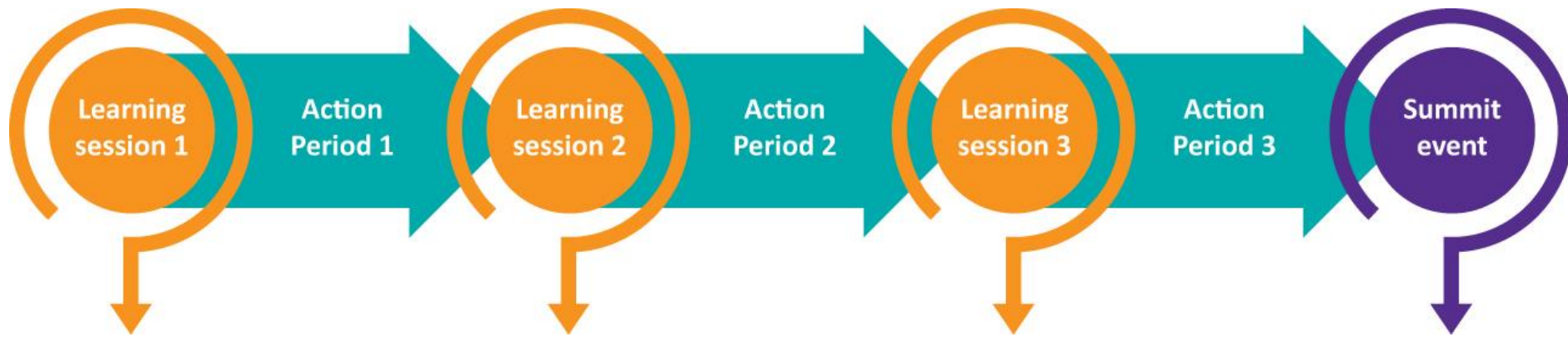
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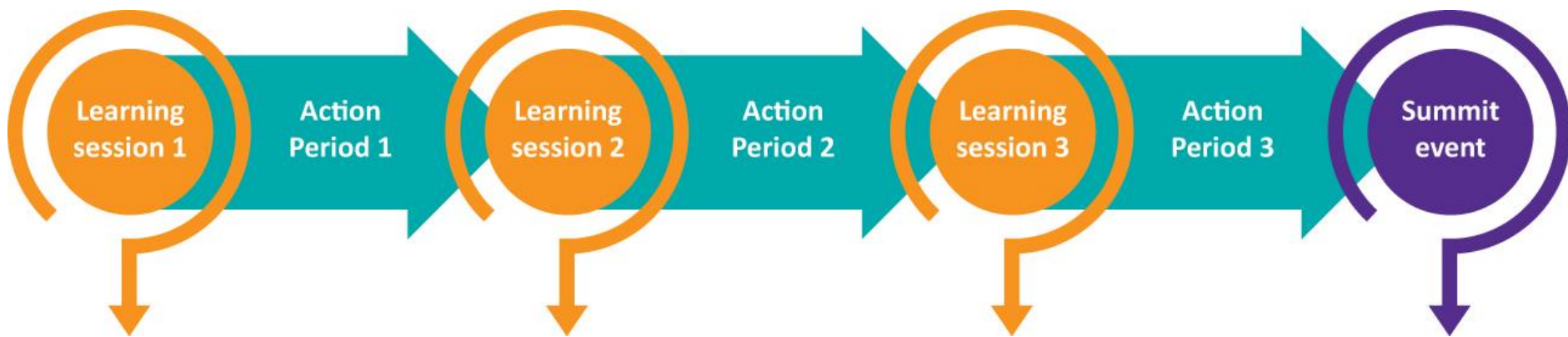


Case Study 3: Wrightington, Wigan and Leigh pharmacy team improving discharge communications

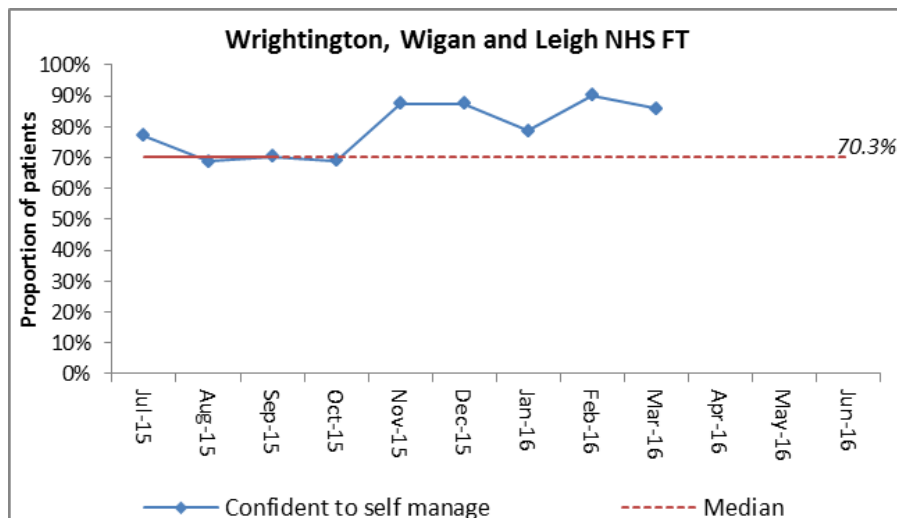


- The pharmacy team identified variations in the quality of patient communications in different healthcare settings
- The objective was to make patient medication information of equal quality at discharge as it is at admission
- A group of patient representatives, district nurses and CCG pharmacists collaborated to develop seven key tests of change
- *The most effective solution was a discharge summary sheet that is sent to the community pharmacy to support all discharge prescriptions*

Case Study 3: Wrightington, Wigan and Leigh pharmacy team improving discharge communications



Proportion of patients confident to self-manage



Outcomes, achievements and key learnings...



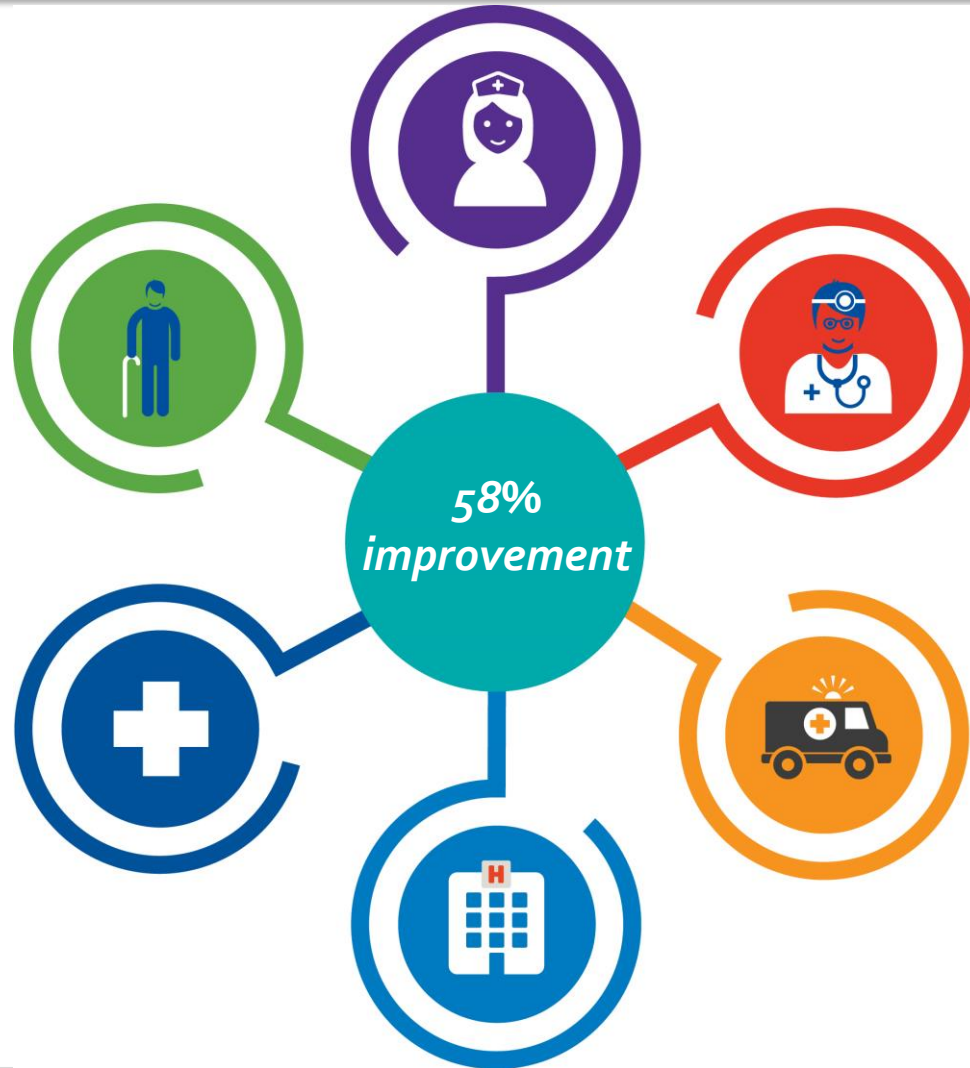
Outcomes, achievements and key learnings...



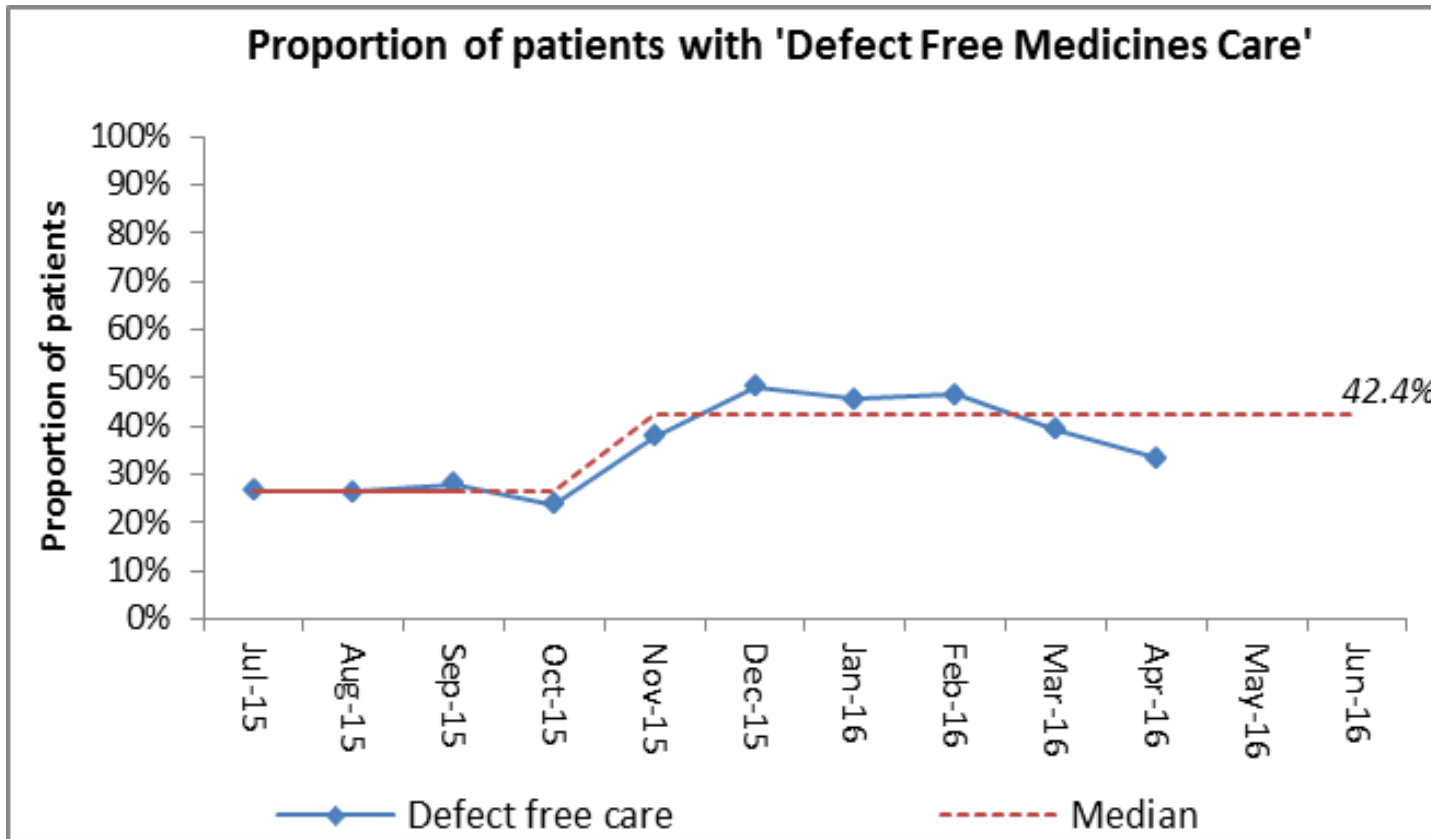
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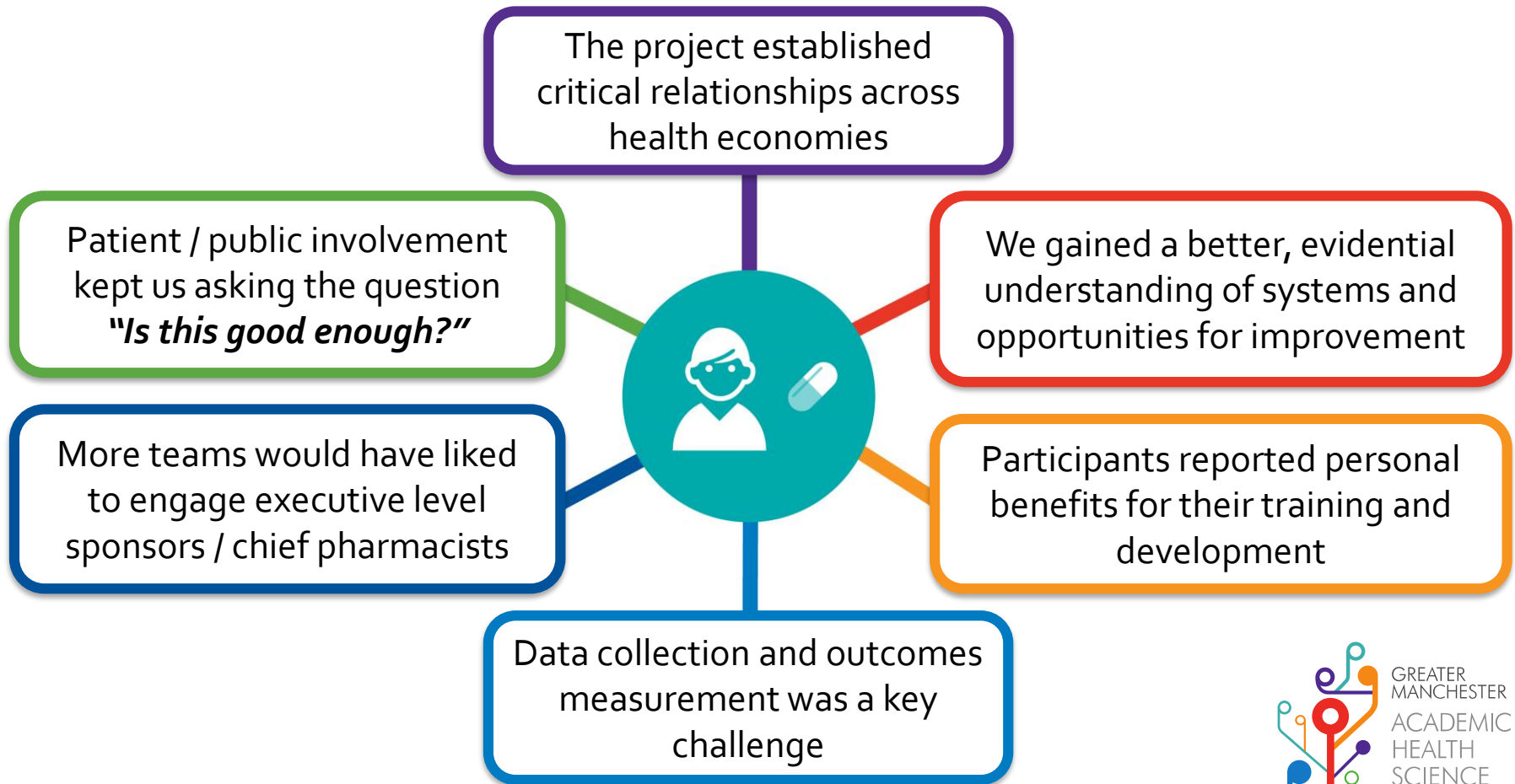
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Outcomes, achievements and key learnings...

Did we make Manchester the safest place to take medicines..?



⁵³ Improving
Medici¹⁰Ne s
Sa²⁶Fe ty

..no, but we did make it safer