EPMA Challenges: Patient Self Administration & CQC

By Carly Reeves

Lead Pharmacist Electronic Prescribing and Medicines Administration
Brief Background

- Royal Brompton & Harefield NHS Foundation Trust is the largest specialist heart and lung centre in the UK and among the largest in Europe.
- We are a tertiary referral centre and treat patients with a range of long term and acute conditions
- We work across two sites, Royal Brompton Hospital in Chelsea, London, and Harefield Hospital near Uxbridge.
Brief Background

• The Trust was awarded funding through the ‘Safer Hospitals Safer Wards’ Technology Fund to implement electronic prescribing in December 2013

• CSC’s MedChart was chosen after a full tender process in August 2014 and implementation began in February 2015
Brief Background

• Since then we have fully rolled out across both hospital sites, and all inpatient prescribing is now electronic
• ICCA electronic prescribing is used in Level 3 areas and theatres
• Outpatients electronic prescribing is due in Spring 2017
RBHT Challenges

Particular challenges we faced at RBHT were:

- **Infection Control** – single bedded rooms for Cystic Fibrosis patients
  - Required a flexible strategy for ward devices and a review of our wireless coverage!

- **Transfer of patients between different care settings**
  - No integration between electronic systems means manual re-prescribing occurs when moving patients between ICCA and MedChart wards

- **Trust Wide Digital transformation project**
  - Our PAS system was replaced shortly after roll out completed – change fatigue
RBHT Challenges

• Fast patient turnover including emergency admissions straight into the Catheter Labs
  • Required ‘real-time’ PAS processes and a culture change for the whole Trust
  • Day case and pre-admission patients still present a challenge

• Patient/Carer self administration on our Respiratory, Transplant and Paediatric wards
  • Some staff and patients felt that going electronic was a ‘back wards step’!

• A CQC visit during the middle of our implementation
• Culture change within IT and managing expectations once roll-out completed
Patient/Carer Self Administration

- The Trust has a proud culture of promoting self-administration of medicines:
  “The Self Administration of Medicines (SAM) scheme is a means of preparing patients and their parents/carers for continuing care and discharge by ensuring that they have sufficient knowledge about their medicines and the practical skills to comply with their therapy.’

The scheme was recently recognised as an “excellent benefit for [CF] patients”
Patient/Carer Self Administration

• The SAM’s scheme is mainly used for patients with long terms conditions who have a high ‘tablet burden’ and are often experts at managing their own medication (such as Cystic Fibrosis)

• Also used for patients who have newly started medication to check compliance and understanding of medication, such as Transplant patients
Patient/Carer Self Administration

- Patients undergo an assessment to check their understanding of their medications, and are assigned a SAM’s level according to their competency
- Responsibility for who administers, stores and records administration varies according to the level assigned
Patient/Carer Self Administration

- SAM’s Levels prior to EPMA implementation:

<table>
<thead>
<tr>
<th>Level</th>
<th>Responsibility for Administration</th>
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<th>Responsibility for Signing Drug chart</th>
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<tbody>
<tr>
<td>0</td>
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Patient/Carer Self Administration

- This presented a challenge when rolling out electronic prescribing because patients would not be able to independently review or sign on the electronic drug chart.
- Some staff and patients saw it as taking away the ability to self administer medications.
  - A ‘backwards step’
- Nursing staff were not keen on having to sign on behalf of patients when they didn’t actually administer the drug.
  - Felt it would add to their workload and that it meant they were accountable for the administration.
Patient/Carer Self Administration

- We were unable to give patients access to MedChart as they would have the ability to view other patient’s details
  - We have requested that CSC design a restricted access view so that patients can only see their own drug chart, however this is not yet available
- Although we could print copies of the drug chart, these become out of date the moment they are printed and staff did not want to take responsibility for making sure these were correct
Patient/Carer Self Administration

- The answer? There isn’t one!
- We put together a working group to discuss the issues and ensured there was patient representation
- Ultimately we worked on the principle that patients who self administer do not have access to a drug chart at home, and so should not be self administering in hospital unless they are competent in the use of their medications
- Any changes to the patients existing regimen should be communicated with them and the patient re-assessed to check that self administration is still appropriate
Principles of Self Administration on MedChart:

- All staff involved in the patients care need to be aware they are self administering and to inform the patient of any changes to their drug regimen.
- Communication about any changes are the responsibility of all staff who look after the patient – doctors, nurses and pharmacists (this was a key feature of the existing policy but was often overlooked).
Principles of Self Administration on MedChart:

- Even if the patient self administers staff still have a responsibility to ensure the patient is correctly taking the medications whilst in their care.
- Patients who still want a list of their medications are provided with a print out – but they are responsible for keeping this up to date and ensuring they document any changes they are informed about.
Benefits of Self Administration on EPMA

• Staff now record the patient’s SAM’s level on MedChart as an ‘alert warning’, so that everyone who views the drug chart is aware that the patient self administers

• Nursing staff document ‘patient self administered’ when recording the administration to ensure there is clear documentation of who administered the drug

• Nurses are also now going through the patients medications with them rather than just “have you taken all your medicines”, and therefore are picking up on discrepancies between the prescribed medication and what the patient actually takes
Example SAM’s Alert

Patient Alert - Prescribing Medications

Patient SAM's Level 3

E7ns on: discharge

Created by: Carly Reeves (EPMA Admin) on 08-Nov-2016

09:33

Please discuss all changes to medication directly with patient/carer
Example of Self Administration Recording
Benefits of Self Administration on EPMA

• Instead of having to use a hospital drug chart (which was often illegible and confusing to them) patients are now encouraged to keep to the method they use at home to keep track of their medications

• This helps patients to continue to take responsibility for their medications whilst in hospital
Patient/Carer Self Administration

- SAM’s Levels post EPMA implementation:

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CQC Visit

• The CQC visited RBHT in June 2016, just as we were about to go-live in Paediatrics
• Results of the visit are not yet available
• However in preparation for the visit we looked into the reports of other Trusts who have electronic prescribing to see if there were any common themes or if we could anticipate any questions they might have
Feedback from other CQC reports

• “The trust’s electronic recording system did not support the prescribing of medical oxygen”
• “Staff told us there were not enough computers to undertake this task [of prescribing]”
• “There were not enough portable computers on the ward”
• “This resulted in medications appearing as if they had been given late”
Feedback from other CQC reports

- “Nursing and medical staff told us they couldn’t rely on agency nurses because they were not familiar with the trust’s electronic recording system”
- “Agency nurses could not access the electronic patient record, and the regular nurses had to complete this task for them”
- “The electronic medicines records for patients being cared for by an agency nurse had not been updated to confirm medication had been given from the 8am medicine round”
Feedback from other CQC reports

• “Staff told us the support for the rollout of the electronic recording system had been withdrawn too soon”
• “Medical staff were prescribing medicines electronically without consulting patients’ monitoring charts at the bedside”
• “[Some] medications were prescribed on paper charts separate from the patient’s electronic medicines record.”
CQC Preparation

• In order to pre-empt some of these questions we made sure that we had standard operating procedures in place for key processes such as prescribing, administration, agency staff and downtime

• We also gave presentations to Trust staff and ran ‘EPMA Q&A’ drop in sessions

• During the visit we had a pharmacy ‘Whatsapp’ group which kept everyone up to date with the questions asked and possible concerns so that they could be addressed swiftly
Questions asked by the CQC

- ‘What is the process for agency staff getting access to electronic prescribing?’
- ‘What is the back up (contingency process) for the electronic prescribing?’
- ‘The electronic prescribing system prompts to record batch number and expiry of IV’s – why is this not being done?’
- ‘Why are there lots of overdue doses for these patients?’
Any questions?