QUALITY IMPROVEMENT IN COMMUNITY PHARMACY: NSAIDs

This pack is about improving the safety of non-steroidal anti-inflammatory drugs (NSAIDs).

It is an improvement package designed to support the “building a safety culture” activity in the NHS circular PCP(P) 2016(15). It is linked with the Scottish Patient Safety Programme (SPSP) in Pharmacy.

This pack comprises:

- Training information
- Resources
  - NSAID stickers
  - Patient information cards
  - Template patient information letter
- Data collection sheet
- Data chart
- Wipe off pen

For further information or for further supplies of the resources, contact:
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January 2017
TRAINING INFORMATION

It is recommended that the pharmacist goes through this training information with every member of the pharmacy team who gives out or sells medicines.

Why NSAIDs?

Non-steroidal anti-inflammatory drugs (NSAIDs) were picked because they are associated with more emergency hospital admissions due to adverse drug reactions than any other class of medicine.

The aim of this project is to improve the safety of NSAIDs by ensuring patients have better information about how to take NSAIDs safely.

The outcomes this project is trying to achieve are:
- Reduce the number of gastrointestinal events associated with NSAIDs
- Reduce the number of acute kidney injuries associated with NSAIDs

Why is this needed?

Research tells us that patients are not always told how to take medicines when they collect them from pharmacies. This project is about ensuring key safety information is given to every patient, every time an NSAID is sold or dispensed.

We also know from research the importance of reinforcement: even if patients are given information when they are prescribed a medicine, many patients find it difficult to recall everything that is said within a consultation, so reinforcement at the point of dispensing is really important.

What does the project involve?

The project is simple: it is about improving the information patients receive when they get an NSAID from a pharmacy. The aim is for every patient who buys an NSAID over the counter or who receives a prescription for an NSAID to receive three key NSAID safety messages:

<table>
<thead>
<tr>
<th>Three key safety messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Always take this medicine with or after food</td>
</tr>
<tr>
<td>✓ Tell us if you get any side effects (<em>explain what these might be</em>)</td>
</tr>
<tr>
<td>✓ Be aware of the medicine sick day rules (<em>explain the rules</em>)</td>
</tr>
</tbody>
</table>

These messages should be clearly explained to every patient who receives an NSAID for the first time (either on prescription or purchased).

For patients who are receiving repeat prescriptions, after the initial dispensing, the information could be shortened. For example, you might say: “Do you still have the information card I gave you last time?” or “Are you getting on OK with these, would you like me to go through the safety information again?”

It might be sensible to have a campaign once a year to repeat the full messages to every person on repeat NSAIDs.
## What’s the rationale for these safety messages?

<table>
<thead>
<tr>
<th>Message</th>
<th>Why?</th>
<th>Any other information?</th>
</tr>
</thead>
</table>
| Always take this medicine with or after food | Helps to reduce or avoid gastrointestinal side effects | Side effects to look out for:  
- Nausea, vomiting, stomach pain, acid black stools.  
What if the patient reports side effects?  
- If a patient reports vomiting blood or black stools, this should be referred to a GP urgently as it indicates bleeding in the GI tract.  
- If a patient reports nausea, stomach pain or acid, it would be appropriate to stop the NSAID temporarily to see if this improves the symptoms. |
| Tell us if you get any side effects | Earlier recognition of side effects allows action to be taken before it develops into something more serious | |
| Be aware of the medicine sick day rules | Some medicines including NSAIDs should be stopped temporarily during dehydrating illness. This is because continuing to take them when dehydrated increases the risk of serious adverse events, in particular acute kidney injury. | Explain that dehydration can occur with vomiting and diarrhoea, therefore the NSAID should be stopped until the patient is fully recovered. It can then be restarted. Explain that these rules are to cover situations like sickness bugs and food poisoning: it is separate from the advice above on gastrointestinal side effects.  
For patients who are buying a single pack of NSAID for a single episode of pain like a headache, there is no need to explain the medicine sick day rules. The rules are for people who take NSAIDs every day. |

## Has this been tested?

Yes, 20 community pharmacies and dispensing practices in NHS Highland have tested giving these three safety messages to patients. They have demonstrated that it is straightforward to achieve and quickly becomes a normal part of everyday practice.

This chart shows how they improved from not giving the messages often to consistently giving it all the time. The chart shows the % of patients given the message "Has the patient been informed to take the NSAID with or after food?" over time:

These pharmacies and dispensing practices identified staff training and some reminder tools (below) as the most important interventions to achieve this.
What can we use to help give the messages?

To ensure every patient is given the key safety messages, the following reminder tools have been developed by the 20 pharmacies and practices that started this work:

<table>
<thead>
<tr>
<th>Tool</th>
<th>What is it?</th>
<th>How do we use it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reminder stickers</td>
<td>Use the stickers on:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dispensary shelves</td>
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<tr>
<td></td>
<td>• Counter shelves</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dispensary bags</td>
<td></td>
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<td></td>
<td>• Points of sale</td>
<td></td>
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<tr>
<td></td>
<td>As a prompt to give the safety advice to patients</td>
<td></td>
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<tr>
<td>Patient card</td>
<td>Give to patients as a reminder of the safety messages to take away.</td>
<td>Also useful as a prompt for staff: could read through the card with patients.</td>
</tr>
<tr>
<td>Patient letter</td>
<td>For patients who do not come into the pharmacy to collect medicines: place in the dispensed medicine bag along with a patient card. This letter explains why the patient has been given a patient card.</td>
<td></td>
</tr>
</tbody>
</table>

How do we check it is working?

The only way to find out if a pharmacy is giving the safety messages to patients is to collect some data. The best way to do this is by small frequent samples: it would be impossible to audit every patient in a busy pharmacy but checking a small sample is manageable.

The evaluation involves:
- Every member of the pharmacy team making anonymous observations of each other
- Whenever you see a colleague giving out an NSAID, listen to see if they gave all three safety messages
- Record in this data collection sheet:

<table>
<thead>
<tr>
<th>Patient 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
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<td>2.</td>
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<td>3.</td>
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</table>

Then add up the total Yes (Y) for each question
At the end of each week, you should have 3 numbers: for each of the 3 safety messages, the number of patients out of 10 who received the message.

The next step is to transfer your weekly figure onto a chart so you can see how you are improving over time.

Put your weekly figure on the chart template each week, as shown below:

There is one chart for each of the questions, so three charts in total.

**What do you do then?**

If you are consistently giving the messages out, that’s great, keep going.

If not, then think about how you could improve. For example:

- Are you using the tools highlighted above?
- Have all staff been trained?
- What barriers are stopping staff give the safety messages?
- What could you change to make it easier to give the messages?

Then make your improvement and see if you demonstrate a change on your chart.

Keep collecting data until you can demonstrate that you are consistently giving the safety messages to patients (12 weeks of data at above 90%).

Make sure everyone in the pharmacy team can see the charts and understands them. Consider displaying them to the public too.

**REMEMBER:** These charts are for your pharmacy team to help you identify what areas you need to improve and then demonstrate improvements.

If you want to share your charts with us, we would be delighted to see them. We would anonymise any charts received and then share them with the wider NHS Highland team to describe the improvements being made in community pharmacies in NHS Highland. If you are happy to share your charts, please fax them to Tracy Beauchamp

tracy.beauchamp@nhs.net

NHS Highland, January 2017