UKMI Annual Conference 2023

Wednesday 29th November 10am-5pm

UKMI's 49th annual conference encouraging networking, practice sharing and development within Medicines Information.

UKMi
UK Medicines Information

Dear Delegate,

Welcome to 49th UKMi Conference.

We have put together a professional programme that reflects current pharmacy-wide and MI specific topics of interest to inform and inspire you.

As usual we are very appreciative of the work the organising committee has undertaken and to the UKMi members and external speakers who are contributing to make this event a success.

We will be tweeting throughout the event today. Please follow us @ukmedicinesinfo. If you tweet, include our hashtag for the conference #ukmiconference2023 and we can retweet and follow you.

All the organisers hope you have an enjoyable and professionally rewarding Conference.

UKMi

UK Medicines Information

Proceedings

10:00am

Welcome to UKMI conference

Dianne Burnett

10:30am

Plenary Session 1: Into the future

Shaping the future of digital technology in healthcare

Dr Sarah Slight, Professor of Patient Safety & Digital Health, Newcastle University

Opportunities and risks of artificial intelligence within MI

Dr Goran Nenadic, Pankhurst Institute, Manchester University

11:50am

Coffee break and poster viewing

12:15pm

Plenary 2: Clinical Update – Renal impairment

Clare Morlidge, Consultant Renal Pharmacist President UK Kidney Association

Katherine Parker, Specialist Renal Pharmacist, Manchester

1:10pm

Lunch break

Posters, New version MIDatabank demonstrations & exhibition

2:15pm

Workshop 1: Delegates will be able to choose from the following sessions:

IV compatibilities – Rob Dugdale, MI Pharmacist, Manchester

Pharmacogenetics in Clinical Practice – Jessica Keen, Emma Groves Genomics Pharmacists

Critical appraisal – Dave Abbott, Lead MA Pharmacist, Leeds Teaching Hospital

Research/ QI projects – Lisa Jamieson, Effectiveness and Quality & Patient Safety Manager, Bradford Teaching

Using new UKMi KPIs in practice – Charlotte Hay, MI Pharmacists Cardiff

Kandarp Thakkar, Associate Lecturer, Peninsula Medical School, Plymouth

Liver disease – Penny North-Lewis, Liver Specialist Pharmacist, Leeds Teaching Hospital

3:15pm

Comfort break

3:30pm

Workshops

4:35pm

Poster winner presentations and delegates choice winner

5:00pm

Conference closing comments

Speaker Information

Dianne Burnett

Interim Chair of the UKMi Executive & National Lead Pharmacist for Medicines Advice Wales

Dianne is the National Lead Pharmacist for Medicines Advice in Wales and the Director of the Welsh Medicines Advice Service in Cardiff and Vale University Health Board. She previously worked as the Pharmacy Site Manager in Glangwilli General Hospital during the pandemic and prior to that she was the Lead Medicines Advice Pharmacist for Hywel Dda University Health Board for 15 years.

Dianne's current role as National Lead is focused on transforming the Welsh Medicines Advice Service. There are 5 individual medicines advice services in Wales who provide bespoke services within their organisation. Her vision has a strong emphasis on connecting individual medicines advice services together using innovative technology, with a view to reducing duplication of work, collaborating together to provide advice once for Wales.

The medicines advice service based in Cardiff delivers the specialist porphyria service, it hosts the Yellow Card Centre Wales and provides an enquiry answering service to patient and healthcare professionals from all sectors within Cardiff and Vale UHB. It provides enquiry answering support to the individual medicine's advice services across Wales. It hosts the National Vaccine Allergy Advice Service in partnership with clinicians from AWTTC (All Wales Therapeutics and Toxicology Centre). It has a growing publications portfolio delivering targeted advice to healthcare professionals which is shared across Wales.

Dianne is currently the Interim Chair of the UKMI Executive Committee and Chair of the Mi Databank Online Steering Committee. She also chairs the All-Wales Drug Library and Smart Pump Group. Dianne works closely with Welsh Government to deliver key priorities set out in the vision document Pharmacy: Delivering a Healthier Wales, in particular the Clinical Community Pharmacy Service for example: seasonal influenza vaccination, emergency contraception, sore throat test and treat and the Common Ailment Service.

Speaker Information

Dave Abbott

Highly advanced Pharmacist, Leeds Medicines Advice Service

After approaching 20 years in pharmacy, working for the majority of that time in Medicines Information, Formulary and Pharmacy IT roles, Dave is the lead pharmacist for Medicines Advice at the Leeds Medicines Information Service. He is passionate about supporting and promoting evidence-based decision making about medicines, and the role Medicines Advice services can have in improving how medicines are used for patients.

Dave provides training on critical appraisal on the UKMi National Training Course, is the current chair of the UKMi Quality and Risk Management Group (QRMG) and runs a podcast ("Pharmacy Microteaches" on Spotify, Apple and more) covering the fundamentals of answering questions on medicines, evidence-based medicine, critical appraisal and secondary care pharmacy in bite-sized 8 minute micro-teach sessions. And quizzes.

X: @DaveA_Pharm
Spotify: Pharmacy Microteaches
www.linktr.ee/pharmacymicroteaches

Speaker Information

Dr Sarah Slight

Professor of Patient Safety and Digital Health, Newcastle University

Sarah Slight is Professor of Patient Safety and Digital Health at Newcastle University. Her research is aimed at developing and evaluating novel digital health technologies to improve patient safety, inform clinical decision-making, and support patient care.

She has been awarded substantial peer-reviewed research funding totaling over £12 million from national and international funders, including UK NIHR, and European Commission. This included a €2.4 million EU Horizon 2020 grant to assess the performance of an innovative technology to prevent medication administration errors that was ranked one of the top 5% projects in Europe.
She has a substantial volume of high-quality research publications (>161 articles), most of which have been published in top ranking journals, such as Lancet Digital Health. She is currently Associate Editor for the Journal for Patient Safety and Associate Editor for BMC Medical Informatics and Decision Making. She has co-authored several national reports and book chapters on the topic of medication errors and health information technology, including a chapter for the World Health Organisation (WHO) Safer Primary Care Technical Series.

She was awarded Fellowship of the Royal Pharmaceutical Society (Nov 2022) for her distinction in Profession of Pharmacy, the Royal Pharmaceutical Society Practice Research Award (Sept 2017) for her contribution to pharmacy practice research in the UK, the Partners in Excellence Award for Leadership and Innovation twice (2015 and 2017) for her contribution to international research with Harvard University. She holds a number of honorary positions, including Visiting Professor at Kings College London.

Speaker Information

Abstract of presentation

Prof Sarah Slight will share her experiences on developing and implementing digital health technologies in the NHS, and she will inspire delegates to think about the role predictive analytics can play in informing shared decision making between healthcare professionals and patients.

Speaker Information

Dr Goran Nenadic

Professor in Computer Science, Pankhurst Institute, Manchester University

Goran Nenadic is a Professor in the Department of Computer Science, University of Manchester and a fellow of The Christabel Pankhurst Institute for Health Technology Research and Innovation. Until recently, he was a Fellow of The Alan Turing Institute, the UK national institute for data science and AI.

His research focuses on methods that can help make sense of free-text data, in particular in the health and social care settings. He currently leads an EPSRC Healthcare Impact Partnership that works with the NHS and industry to provide standards-based and governance-led healthcare text processing algorithms. He is specifically interested how large language models can be adopted in the NHS to support direct clinical care, epidemiological research, and administrative activities, including audit. He has extensive experience in working with both government and public sectors (NHS Digital, several NHS trusts, The National Archives) and industrial partners.

Abstract of presentation

The recent advent of Generative AI and specifically Large Language Models (LLMs) has brought both optimistic and pessimistic anticipations of their use within the healthcare sector. In this talk, we will first illustrate the opportunities that such technology is bringing to healthcare, and then outline the risks and potential safeguards that would need to be in place for such technology to be more widely used to support direct clinical care, epidemiological research, or knowledge synthesis. We will also discuss the potential roles for different stakeholders in that process.

Speaker Information

Tiffany Barrett

Lead Pharmacist for Medicines Information and Advice, University Hospitals Plymouth NHS Trust

I have been a medicines information pharmacist for more than 20 years as well as working in other sectors including academia, general practice, and primary care. In this time, I've worked at local, regional, and national level dealing with queries about medicines and developing the role of the medicines information team. I have been an active member of the UKMI Executive for a number of years, leading particularly on developing the role of pharmacy technicians in MI. Having worked at and latterly led a regional MI Centre for a number of years, I am now developing a local MI service in a large teaching hospital in the Southwest. My professional enthusiasm is to develop the skills of the pharmacy team to deal with questions about medicines competently and to develop a well-supported, well-resourced, valued, and well-staffed MI service.

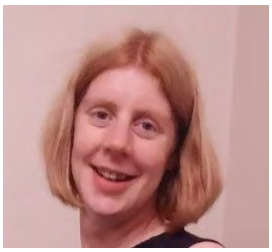
Speaker Information

Clare Morlidge

Consultant Renal Pharmacist, Kings College Hospital NHS Foundation Trust

Clare Morlidge is a Consultant Renal Pharmacist at East and North Hertfordshire NHS Trust. She is President of the UKKA and the immediate past Chair of the UK Renal Pharmacy Group (RPG) and was co-editor of their *Introduction to Renal Therapeutics reference text*.

She is a member of the NHS England Clinical Reference Group and currently is co-chair of UKKA AKI Specialist Interest Group.



Kathrine Parker

Highly Specialist Renal Pharmacist, Manchester University NHS Foundation Trust

Kathrine has worked as a specialist renal pharmacist at Manchester University NHS Foundation trust since 2010. In 2015 she was awarded a small grant from Kidneys for Life to explore drug pharmacokinetics in newer dialysis methods. Then in 2016 she completed her Masters in clinical pharmacy exploring the effects of immunosuppression in older transplant recipients. In 2019 she received a personal funding award from the NIHR to investigate anticoagulant use in chronic kidney disease as part of a clinical academic doctoral fellowship. The outputs of this work include influence on national policy and ongoing development of a national guideline.

Kathrine was recently appointed as the UK Kidney Association Academic Vice President representing the multi-professional team and sits on the board of trustees. She is also part of the UK renal pharmacy group executive committee where she leads the research group, is a member of the UK Kidney Association clinical guideline committee, a member of the scientific advisory committee for the cardiorenal forum and has been an invited speaker at numerous regional and national kidney, hematology, and cardiology educational sessions.

Speaker Information

Abstract of presentation

The RPG is providing an update on AKI and CKD for the non-renal specialist. We will cover the basics around the kidney, how to measure kidney function, how to look after AKI patients, how to prevent progression of CKD and how to dose a dialysis patient and of course top tips on drug dosing in renal impairment. Cases will cover aspects commonly asked questions and top tips on how to answer these.

Workshop Information

Rob Dugdale,

Highly Specialist Pharmacist – Inherited Metabolic Disorders, Manchester

Rob was as a hospital-based Medicines Information pharmacist in Manchester from January 2018 to October 2023, and now works as part of the Inherited Metabolic Disorders team at Royal Manchester Children's Hospital.

Rob is also a passionate rally fan and marshal. When not at his desk, he will usually be found at the side of a forest road (regardless of weather).

IV compatibilities – what are all the different lines?

Abstract of presentation

This workshop is aimed towards pharmacists looking to refresh their knowledge and application of the key principles of vascular access and solution compatibility.

The workshop will provide a brief review of types of vascular access devices, resources for injection compatibility information, and "first principles" of decision making when answering queries on IV injection compatibility.

This review will be followed by case studies to integrate these principles to practical scenarios.

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Workshop Information

Jessica Keen

Pharmacy Lead Genomic Medicine, NHS North West Genomic Medicine Service Alliance

Jessica Keen is the Pharmacy Lead at the NHS North West Genomic Medicines Service Alliance in the UK, working to embed genomic medicine into routine clinical pathways and ensure equity of access to genomic testing and treatments for patients. She is the pharmacy lead for the PROGRESS programme (Delivering Pharmacogenetics for the NHS).

She has recently completed an MSc in Genomic Medicine at the University of Manchester, with particular interest in the role of pharmacy teams and the wider workforce in the implementation of pharmacogenomics in the NHS.

Her background is as an oncology pharmacist prescriber, specialising in Upper GI cancers and electronic prescribing. As a prescriber she has seen the benefit of genomics to inform treatment from diagnosis through to stratification and medicines optimisation. She is a member of the BOPA Genomics Special Interest Group.

Emma Groves

Pharmacy Lead Genomic Medicine, NHS North East and Yorkshire Genomic Medicine Service Alliance

Emma is the NHS North East & Yorkshire Genomic Medicine Service Alliance Pharmacy Lead and her role involves providing leadership to embed genomic medicine into clinical pathways, enabling implementation of pharmacogenomics and supporting pharmacy workforce development and transformation.

Emma’s area of clinical practice is Oncology and I she has worked in cancer services at the Newcastle Upon Tyne Hospitals since 2017. Emma supports a range of transformation clinical projects that require pharmacy input. The work of our NHS

Workshop Information

GMS Alliance will build a foundation for pharmacy workforce transformation, enabling staff to combine existing expertise with genomic testing to improve treatment plans, optimise regimes and enable more effective and safe use of medicines for patients. Emma also provides pharmacy subject matter expertise to the National Genomics Education programme.

Pharmacogenetics in Clinical Practice – a hands-on workshop

Abstract of workshop

Pharmacogenetics is the study of how genetic variation can impact on an individual's response to medicines. Research has shown that pharmacists have broadly positive views on pharmacogenetics but feel unprepared to deliver it in practice. This workshop offers an opportunity to experience the practical application of pharmacogenetics through case studies.

Learning Objectives

- Describe the delivery of Pharmacogenetics services in the NHS Genomic Medicines Service in England.
- List appropriate pharmacogenetics information resources and guidelines
- Understand and interpret pharmacogenetic results including star allele format and phenotypes.
- Apply clinical guidance in the context of a case study with pharmacogenomic results.
- Develop and present a care plan for a case study patient with PGx results.

Workshop Information

Dave Abbott

Highly advanced Pharmacist, Leeds Medicines Advice Service

After approaching 20 years in pharmacy, working for the majority of that time in Medicines Information, Formulary and Pharmacy IT roles, Dave is the lead pharmacist for Medicines Advice at the Leeds Medicines Information Service. He is passionate about supporting and promoting evidence-based decision making about medicines, and the role Medicines Advice services can have in improving how medicines are used for patients.

Dave provides training on critical appraisal on the UKMi National Training Course, is the current chair of the UKMi Quality and Risk Management Group (QRMG) and runs a podcast ("Pharmacy Microteaches" on Spotify, Apple and more) covering the fundamentals of answering questions on medicines, evidence based medicine, critical appraisal and secondary care pharmacy in bite-sized 8 minute micro-teach sessions. And quizzes.

X: @DaveA_Pharm

Spotify: Pharmacy Microteaches

www.linktr.ee/pharmacymicroteaches

Critical appraisal – what do you need to know to train your trainees?

Abstract of workshop

What's the point of teaching critical appraisal to trainees? What should we be teaching them (what should we not be teaching them?), and how can they use what we teach them in their current and future roles? And importantly, what do you need to know to be able to train them effectively? In this workshop we hope to pick through many of these aspects to give attendees an opportunity to think about why we teach critical appraisal and how and what we teach, so that they can reflect on and develop their own training programmes in their services.

Workshop Information

Lisa Jamieson

Quality & Patient Safety Manager

Lisa is a Quality & Patient Safety Manager at Bradford Teaching Hospital Foundation Trust and a Pharmacy Technician by profession. Lisa's career in the NHS spans over 30 years where she has worked across primary, community, mental health, & acute sectors. Her passion for medication safety led her into a quality and patient safety role in 2016, and since then she has been empowering and supporting staff at all levels to make improvements to patient care. Lisa joined Bradford in January 2021 after 18 years in primary care, where along with developing Quality Improvement skills, Lisa completed an MSc in Strategic Project Management. More recently Lisa completed an ILM Level 5 in Effective Coaching and Mentoring, and she is passionate about using coaching along with improvement skills to make the working lives of staff, and the experience of care for patients, better.

Demystifying QI – A beginner's guide to Quality Improvement

Abstract of presentation

If you google QI you will see it stands for Quite Interesting, the award-winning BBC comedy panel show! In the world of healthcare, it's also short for Quality Improvement, perhaps not quite as amusing, but with the right team it can be equally as fun.

But what is quality improvement and how could it be different from improving quality? Is quality improvement some wishy-washy mumbo jumbo or an evidence based scientific method? And could it be the answer to all of life's frustrations?!

Interested to learn more? Come along to this fast paced, fun, QI masterclass, which if I stay true to the principles of QI, will be just a little bit better than the last time I delivered it.

Workshop Information

Charlotte Hay

Pharmacist Team leader – Medicines Advice,
Betsi Cadwaladr University Health Board

Charlotte started working as a Medicines Information pharmacist at Royal Manchester Children's Hospital in 2010. Having relocated back home to north Wales she now leads a team of Medicines Advice pharmacists and pharmacy technicians across three acute sites in Betsi Cadwaladr University Health Board. She is an active member of the Welsh Medicines Advice Service network and represents Wales on the UKMI Quality and Risk Management group and the programme board for the PDWS Medicines Information Training Programme for Pharmacy Technicians.

Using new UKMi Key Performance Indicators in practice

Abstract of presentation

The UKMi Quality and Risk Management Group (QRMG) have developed a number of Key Performance Indicators (KPIs) that can be used in individual centres to support measuring, recording, and presenting performance over time. This workshop will give an overview of Core KPIs and expanded KPIs that may be selected depending on an individual centres services and needs.

It will include a viewpoint of KPIs from a chief pharmacist and consideration of how to make KPIs work for you.

Workshop Information

Kandarp Thakkar

Clinical Director of Pharmacy and Medicines Optimisation and Associate Lecturer – Peninsula Medical School, University of Plymouth

Video with Chief Pharmacist

Workshop Information

Penny North-Lewis

Paediatric Liver Pharmacist, Leeds Teaching Hospital

Penny North-Lewis obtained her Pharmacy degree from Nottingham University and completed her training at King's College Hospital where she started out her career as a Paediatric Liver Pharmacist. She has continued in the field of hepatology, moving to Leeds in 2000. Penny has presented nationally and internationally and is a member of the British Liver Transplant Group and the British Society of Paediatric Gastroenterology, Hepatology and Nutrition. She is the editor of 'Drugs and the Liver - A guide to drug handling in liver dysfunction'. Penny was honored to be made a Fellow of the RPS in 2017.

Liver dysfunction and medicines

Abstract

This session will start with some hepatology revision to set the scene - interpreting liver function tests, signs, and symptoms. We will then look at how deranged liver function affects drug handling and what we need to look out for to make rational decisions about drug choice and dosing. We will finish with an overview of hepatotoxicity - how to identify it and what to do about it.

2023 Posters

Poster 1 – Dave Abbott - Making links across the care interface: Reciprocal Shadowing between Medicines Advice and Primary Care

Poster 2 – Sally Badin - Medicines advice out-of-hours – supporting the on-call workforce to make safe decisions

Poster 3 – Anna Burgess - The Good the Bad and the Ugly – Transforming the National Enquiry Management System

Poster 4 – Katy Davies - Contributing to Medicines Safety at University Hospitals of Birmingham

Poster 5 - Lindsay Davies - The Group A Strep Demand in Wales 2022-23 – How the Welsh Medicines Advice Service responded

Poster 6 – Kirsty Habibi-Parker - MI QI: Collaboration and Alignment of MI across an Integrated Care Settings (ICS) – first steps

Poster 7 – Marianna Howes - Howes, Marianna - Reliable cancer drug interactions checker

Poster 8 – Louise Park - Innovation in Medicines Information & Governance training for Newly Qualified Pharmacists

Poster 9 – Lisa Pazik - The benefits of using a cloud-based telephony system in a Medicines Resource Centre

Poster 10 – Marina Ribeiro - How can Medicines Information (MI) help streamline workflow

Poster 11 – Thaaranii Rajkumar - A 5-year retrospective review of enquiries received from primary care healthcare professionals

Poster 12 – Michele Skipp - The Future of Specialist Medicines Information Pharmacy Technician Training

Poster 13 – Louise C Smith - Barriers and Enablers affecting Yellow Card reporting in submissions in Medicines Information

Poster 14 – Gwenllian Thomas - Integrating the COVID-19 Antiviral Treatment Service into our local Medicines Advice

Poster 15 – Wen Xuan Pua - Impact of the UHS Nurse Discharge Checklist

Poster 1

Making links across the care interface: Reciprocal Shadowing between Medicines Advice and Primary Care

Dave Abbott, Phillippa Lofts, Hadeel Mohamed, SEL GP Group.

Introduction

Like many Medicines Advice teams, we have noticed an increase in "post discharge" contacts from primary care colleagues as the pharmacy workforce in the area has expanded. Whilst the number of contacts between Medicines Advice and primary care teams has increased, and the opportunities for senior staff to collaborate and network across different sectors are well established, we did not see the same opportunities for those "doing the work" to see what the other side looks like. We propose this may be creating barriers to understanding and appreciation of roles, potentially hindering working practices and relationships. We therefore piloted facilitation of exchange opportunities between pharmacy colleagues working in Medicines Advice and those in general practice, with the aim of providing these opportunities.

Method

We organised opportunities for pharmacists and pharmacy technicians working in Leeds Medicines Advice or the South and East Leeds (SEL) GP Group to complete reciprocal shadowing - one shadowing another in their place of work, then the arrangement switched round for a return visit. We provided a programme book and suggested objectives, leaving scope for individuals to plan their own objectives too. We asked for pre- and post- questionnaires to be completed to give an idea of the impact of the programme. 13 pharmacists, 5 pharmacy technicians and one pre-registration pharmacy technician participated.

Results

In total 19 individuals completed at least 1 questionnaire. Prior to and after the exchange, all participants were asked "How confident are you […] that you understand the role of Pharmacists and Pharmacy Technicians working in the sector you will visit?" Results are tabulated below:

	Extremely confident	Somewhat confident	Neutral	Somewhat not confident	Extremely not confident
Pre-	0%	26%	53%	11%	11%
Post-	36%	64%	0%	0%	0%

In addition, participants were asked for comments on their experience. These were largely positive.

Discussion

Although challenging to set up and run as well as being difficult to quantify benefits, providing people involved in managing information around medicines at discharge with opportunities to "see the other side" has been beneficial. An increase in understanding of roles on both sides was observed, and feedback on the experience has been optimistic. Taking this forward, we aim to provide similar opportunities to individuals who request it in the future and suggest it may be a model that other centres could use to improve links and understanding across the care interface for those actively "doing the work" on the ground.

Poster 2

Medicines advice out-of-hours – supporting the on-call workforce to make safe decisions

Sally Badin, Angela Badiani, Lauren Williams - University Hospital Southampton NHS Trust

Focal Points

- The key objective was to look at medicines advice enquiries answered out-of-hours and ensure that our pharmacists are trained to undertake this role effectively and safely.
- Over the 3-month study period, 24.4% of all calls required medicines advice. Many of these calls related to administration of medicines. The most asked about group of medicines were antibiotics.
- The medicines advice on-call teaching programme will be reviewed to ensure that the content remains comprehensive and relevant.

Background

Medicines advice is an integral part of the NHS pharmacy on-call service which is typically delivered by newly qualified staff.[1] Thorough training for this role is crucial prior to starting, to ensure that pharmacists are equipped with the knowledge and skills to solve clinical problems that may arise out-of-hours. At UHS, pharmacists undergo a structured face-to-face teaching programme and complete a module on the Medicines Learning Portal before starting an on-call role. This service evaluation study aimed to understand the type of medicines advice enquiries received out-of-hours, the information resources used, and answers given to ensure that the teaching remains relevant and that our pharmacists are trained to undertake this role effectively and safely.

Method

Clinical enquires entered out-of-hours into the "On Call Manager'' database at UHS for the period of July - September 2022 were reviewed retrospectively. The data were sorted using Microsoft Excel into enquiry category, name of medicine in question, and drug therapeutic class. The answers were peer reviewed by an experienced Medicines Advice pharmacist to ensure accurate advice was given. This study did not require ethics approval.

Results

A total of 709 calls were received during the data collection period, with 173 (24.4%) of these calls requiring medicines advice. Most of the calls related to administration advice in adults (n=46, 26.6%), followed by choice of therapy (n=39, 22.5%), managing delays in patients receiving treatment (n=30, 17.3%), adult dosing (n=30, 17.3%), and pharmaceutical issues (n=14, 8.1%).

Antibiotics were the most asked about group of medicines (n=24, 13.9%) with gentamicin, vancomycin and metronidazole being mentioned in 4 calls each. Other drug classes in order were TPN (n=19, 11.0 %), COVID medications (n=13, 7.5%), opioids (n=10, 5.8%) with morphine being mentioned in 7 of these calls, insulins (n=10, 5.8%), and antiepileptics (n=9, 5.2%).

Unfortunately, 36.4% (n= 63) of calls received were unable to be peer reviewed due to a lack of documentation or unclear advice. Of the calls that were peer reviewed, only one (0.6%) was considered inappropriate advice.

Conclusion

Over the 3-month study period, one quarter of calls received by the UHS on-call pharmacy team required the provision of medicines advice. This reinforces the importance of teaching the core aspects of clinical problem solving to pharmacists before undertaking an on-call role. Most calls related to administering medicines in adults, choosing medicines, with antibiotics, TPN and COVID treatments being the most common therapeutic classes. The advice given was judged appropriate in most cases. The medicines advice on-call teaching programme will be reviewed to ensure that the content remains comprehensive and relevant.

Reference

Cheeseman MP, Rutter, P. On-call hospital pharmacy services in NHS England: service provision and documentation of medicines advice calls. Eur J Hosp Pharm 2016;23:11-15.

Poster 3

The Good the Bad and the Ugly – Transforming the National Enquiry Management System

Anna Burgess,[a] Dianne Burnett,[a] and Hannah Leggett [b]

[a] WMAS, University Hospital of Wales, Cardiff and Vale University Health Board; [b] WMAS, Withybush General Hospital, Hywel Dda University Health Board

[b] Welsh Medicines Advice Service, Withybush General Hospital, Hywel Dda University Health Board

Focal Points

- What are we are trying to achieve?
    - improve user interface, reporting, dashboard, and search functionalities.
    - improve collaboration.
    - enable more agile working practice.
- This presentation is a progress update of the Welsh Medicines Advice Service (WMAS)-led transformation of the MiDatabank enquiry answering management system (EMS).

Introduction

In recent years, there has been a shift in the way Medicines Information (MI) services are being delivered. The current EMS has been in use for many years with only minor improvements. It is clear, that if MI services are to be more efficient, agile, and responsive with a greater ability to share and collaborate, the EMS needs to be fit for purpose. With Welsh Government Pharmacy Improvement funding, WMAS is leading the transformation of the current EMS, maximising benefit by involving members of the UK Medicines Information (UKMi) network. In the summer of 2022, the UKMi executive committee supported the transformation of the EMS with the establishment of the UKMi Steering Group and an MiDBOnline user group.

The Good

- The project is led by the National Lead for Medicines Advice, Wales and the project managers who work in two different Health Boards.
- Forty-two enthusiastic individuals from across the UKMi network have volunteered to be part of the user group.
- The user group represents the diverse nature of the UKMi workforce.
- Participation in the project is active, positive, and supportive from all members of the user group both in meetings and email discussions.
- Supportive input from the steering group and UKMi executive committee.
- Positive and collaborative relationship with the developers, CoAcS.
- Regular updates and good communication from all involved.
- A wide range of benefits to both patients and service providers, locally and nationally, for example:
    - reduced waiting time for advice.
    - efficiencies gained from sharing enquiries across the nation.
    - reducing duplication of work

The Bad

- Additional workload for staff on top of workforce and operational pressures which may cause delays in progress.
- Managing expectations is challenging along with financial limitations and technology capabilities.

The Ugly

- Information governance for cloud-based systems is complex. A wide range of support has been required from different IT specialists and Digital Health and Care Wales (DHCW).
- Identifying potential outputs for “Do Once” groups from the reporting function of the EMS is challenging.
- Cost. The need for the new EMS to have greater functionality that is fit for purpose compared to the current system will come at an increased recurrent cost to the subscriber.

Summary

Improvements to the EMS will be introduced in a phased way so the developers can respond to user feedback. The initial priorities are the enquiry answering interface, dashboard and reporting functions.

Poster 4

Contributing to Medicines Safety at University Hospitals of Birmingham

Katy Davies, Rishvana Mohamed – University Hospitals Birmingham NHS Foundation Trust

Focal Points

- In October 2020 the Medicines Information (MI) team implemented processes to enable reporting of errors identified via the Medicines Helpline.
- Regular reporting at the Trust Safe Medicines Practice Group (SMPG) has identified improvements to facilitate safer discharges.
- Joint working between Medicines Information and the pharmacy governance team has resulted in several actions to improve patient experience and medicines safety.

Introduction

The Medicines Helpline provides a service to patients discharged from University Hospitals Birmingham NHS Foundation Trust to answer enquiries relating to their discharge medicines. In October 2020, the Medicines Information team implemented processes to enable regular reporting of errors identified via this service. Since February 2021 quarterly reporting of these errors to the Trust Safe Medicines Practice Group has influenced discussions at Trust level. The Medicines Information team has worked collaboratively with the pharmacy governance team, and wider Trust Patient Safety team resulting in demonstrable outcomes to improve medication safety.

Results & Discussion:

Improved documentation on discharge letters.

A key issue highlighted through error reporting was poor discharge documentation regarding medication changes. This led to a change to the electronic prescribing system which resulted in a trust-wide improvement in the quality of medications reconciliation at discharge with associated documentation.

Improved discharge with respect to medicines.

Reporting identified several general themes resulting in patient safety issues with respect to medications. We worked with the MSO and Trust Patient Safety Team to issue a 'Lesson of the Month' focussing on discharging patients safely with medicines. Nurses received additional communication with education around discharge processes. Table 1 shows improvement observed in medication issues originating from wards.

Table 1 Ward discharge errors reported through the helpline.

	% of total incidents		
	Feb-Apr 21	Feb–Apr 22	Feb–Apr 23
Ward discharge errors	20%	6%	7%

Learning from the Medicines Helpline

Key learning is communicated to the pharmacy team via newsletters using case studies to demonstrate issues. Content is included at induction and as part of trainee pharmacist, and foundation level training. This has resulted in a greater awareness of issues resulting from poor practice and has facilitated an overall improvement in the quality of the discharge information regarding medicines.

Future actions

Recent reports highlighted issues with analgesia prescribing at discharge. This has been mirrored with incidents resulting from opioid prescribing errors. We have worked with the MSO and pharmacy governance team to produce a Patient Safety Notice focussing on prescribing analgesia on discharge and implemented an additional error keyword on MiDatabank for ongoing monitoring. A need for improved discharge medication counselling has been identified and we are working with the pharmacy governance team to develop resources.

Poster 5

The Group A Strep Demand in Wales 2022-23 – How the Welsh Medicines Advice Service responded

Alex Bailey, Dianne Burnett, Lindsay Davies, Christina Fowler; WMAS Cardiff and Vale University Health Board.

Charlotte Hay, Charlotte Storer; WMAS Betsi Cadwaladr University Health Board.

Background

WMAS is a Wales wide team of medicines information (MI) experts working together, to provide medicines advice and information for NHS Wales. One of the objectives of WMAS is to provide advice about the safe and effective use of medicines to health care professionals and their patients "Once for Wales". The Group A streptococcal disease outbreak in Wales provided WMAS with an opportunity to demonstrate this cohesive team approach.

Problem

- Media reports of increases in Scarlet fever and invasive Group A streptococcal (iGAS) disease.
- High demand for assessment and treatment.
- Increased pressure to supply antibiotics.
- Demand for antibiotics exceeded usual levels.
- Supply-chain mechanism insufficient to cope.
- Patients presenting in multiple pharmacies.
- Prescription changes needed or multiple prescriptions issued.

Solution

1. Develop new guidance.
2. Write patient information leaflets.
3. Update existing documentation.
4. Create new PGDs.

The responsive and effective outputs from WMAS has raised their profile in NHS Wales, while delivering key UKMi objectives:

- Advising health care professionals
- Optimising treatments
- Implementing national guidance
- Supporting patients
- Delivering a proactive responsive service

Poster 6

MI QI: Collaboration and Alignment of MI across an Integrated Care Settings (ICS) – first steps

Kirsty Habibi-Parker, Medicines Resource Centre, Buckinghamshire Healthcare NHS Trust, with the BOB ICS MI Alignment Workstream

Background and Introduction

Within the BOB ICS (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System) we have **3 acute trusts** (Buckinghamshire Healthcare NHS Trust, Oxford University Hospitals Foundation NHS Trust and Royal Berkshire NHS Foundation Trust) and **2 mental health trusts** (Oxford Health Foundation Trust and Berkshire NHS Foundation Trust) providing medicines information services, to a population of 1.8 million.

Method and Timeline

- Workstream group established in order to scope what we need to do differently.
- Develop best practices into a single unified process.
- Initial ideas brainstormed.
- Potential quick wins identified to build momentum with progress.
- Action plan formulated to assign next steps and priorities.
- 1 year timeline to seek joint up approach to licences and implement initial changes
- Longer term to align services, potential 5-year plan

Standardisation

- Enquiries via email, not all Trusts have standard response.
- Variation in format of user satisfaction surveys and collation of feedback.
- Training – core and specialist.
- Licensing: better pricing transparency from resource providers.
- Learn from others: Welsh MI resources and access and NEWT role out, SPS, previous Trust's experiences of approaching collaboration.

Future

- Address key stakeholders
- Aim to demonstrate efficiency and productivity benefits

Poster 7

Howes, Marianna; - Reliable cancer drug interactions checker

Marianna Howes, Senior Pharmacy Technician Medicines Advice, Betsi Cadwaladr University Health Board

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Focal Points

- Huge reliance on the Liverpool Cancer Drug Interactions Website as a resource for checking the safety of medication in cancer patients.
- Large variation in advice from alternative resources available.
- Clear need for available, consistent, and reliable resources to healthcare professionals to avoid unnecessary increase in work pressures within the Medicine Advice department.

Introduction

Betsi Cadwaladr University Health Board is the largest health board in Wales. The Medicines advice service provide an evidence-based enquiry answering service to 3 acute general hospitals in North Wales, which include 3 cancer service facilities, 152 GP surgeries and other community hospitals.

Currently, the pharmacy staff working in these cancer centres rely on the Liverpool Cancer Centre Drug Interactions Website. They use it as their main source of information during medicine management tasks for inpatients and outpatients. However, as of September 30th 2023, the website will be offline indefinitely due to lack of funding raising concerns about other consistent and reliable resources widely available.

Method

A review of five recent drug interaction reports took place, using resources commonly available to the Medicine Advice Pharmacy Team, to identify which one was the most consistent and comparable with the Liverpool Website. The resources included:

- DrugReax interaction checker on Micromedex, accessed via a national subscription
- Stockley's Drug Interactions, accessed using a Medicines Information subscription
- British National Formulary (BNF) interactions checker, freely accessible
- Lexicomp Drug Interactions, available through a Health Board subscription of UpToDate.

Results

Micromedex and BNF seem to be the two least reliable resources for interactions. On average, they found no interaction 92.3% of the time; major interactions 4.8% of the time. BNF found 5.76% of the time moderate interaction whereas Micromedex found none.

In comparison, the Liverpool Cancer Drug Interaction website found no interaction 78.84% of the time, major interactions 11.53% of the time and moderate to severe interaction 9.6% of the time.

Stockley's seems to be the one resource with similar findings, with no interaction at 80.76%, major interaction 11.53% and moderate interaction 7.7% of the time.

Lexicomp found no interaction 78.84% of the time, major interaction 1.92% of the time and moderate interaction 19.22% of the time.

Discussion

There is concerns that all resources commonly used vary hugely in their advice regarding drug interaction. Some seem very cautious, recommending further monitoring or stopping treatment altogether, where others do not seem to have any issues at all.

The reliance on that one trusted website for a number of years has meant that healthcare professionals do not know now where to look for quick and reliable information. This means that until such resource is available again, healthcare professionals will be relying on the Medicine Advice department for their complex drug interactions enquiries putting further unnecessary pressure on the service.

Poster 8

Innovation in Medicines Information & Governance training for Newly Qualified Pharmacists

Louise Park* [1], Cristina Coelho[1], Elaine McIvor[1]

1. NHS Greater Glasgow & Clyde Medicines Information service, Glasgow Royal Infirmary, 84 Castle St, Glasgow, G4 0SF

Focal Points

- Launch of NHS Education for Scotland (NES) Post-Registration Foundation programme for Newly Qualified Pharmacists (NQPs) without a specific MI element required changes to training provided by MI&G for NQPs
- A placement was designed which 100% of NQPs providing feedback would recommend or maybe recommend where they complete work such as answering complex enquiries, guideline reviews, Formulary updates
- The positively received placement allows the NQPs to deliver specific pieces of work that support safe and effective use of medicines and demonstrate their learning outcomes.

Introduction

The NHSGGC Medicines Information & Governance Team delivers a range of pharmacy-led services aligned to priorities from local prescribing and therapeutics committees. As well as the core element of enquiry answering (EA), MI&G proactively supports safe and clinical effective use of medicines via development and maintenance of resources such as the Formulary, Therapeutics Handbook (TH) and Medicines Update (MU) blogs.

The new NES Post-Registration Foundation programme for NQPs is designed to develop pharmacist independent prescribers with the knowledge, skills, and behaviour to deliver safe and effective holistic person-centred pharmaceutical care. The previous NES framework included an MI element with specific tasks to be completed to meet EA outcomes e.g., answer 3 complex MI enquiries. Launch of the new programme without the MI element prompted a review of our EA focused approach to training.

A new MI&G placement was designed to support NQPs in acute hospitals to: demonstrate learning outcomes across the domains of the new programme; develop knowledge and skills in areas such communication, answering questions about medicines, workload prioritisation, literature searching; contribute to the different strands of work in the wider MI&G team.

Method

Teams across MI&G collaborated to design the new placement. This included identifying strands of MI&G work that could be undertaken by NQPs during a 4-week placement and mapping these activities to the outcomes of the programme. A placement template was produced to help coordinate the activities and an online survey was used to obtain feedback from NQPs. Microsoft Teams was used for communication.

Results

The new MI&G placement includes: EA tasks such as receiving MI enquiries, triaging workload, answering complex enquiries; Proactive work: guideline review, writing MU blogs, TH and Formulary updates, small audits and presenting at committee meetings.

10 out of 14 NQPs who completed a placement so far provided feedback with 80% stating they would recommend the placement to colleagues and 20% would maybe recommend.

90% felt more confident to carry out literature searches, more confident to provide evidence-based information on medicines and more aware of what resources to use to find evidence-based information on medicines.

On a scale of 1 to 5 (1 = not very useful/ easy; 5 = very useful/ easy):

- When asked 'How useful the placement was in meeting learning outcomes from the programme' the average rating was 4.
- When asked 'How easy it was to complete supervised learning events as evidence for the programme' the average rating was 4

Discussion

An innovative approach to MI&G training has been successfully delivered in NHSGGC Acute. The NQPs deliver specific pieces of work that support safe and effective use of medicines. This placement supports NQPs achieving the NES programme outcomes and develops their knowledge and skills. It has been positively received by NQPs to date and awareness of the role and wider work of MI&G in NHSGGC has increased. Our collaborative approach to workforce development continues to evolve and next steps are the inclusion of medication safety and medicines planning.

Poster 9

The benefits of using a cloud-based telephony system in a Medicines Resource Centre

Lisa Pazik Lead Pharmacist Medicines Resource Centre (MRC), Kirsty Habibi-Parker Associate Director of Pharmacy MRC, Dean Hoadley Digital Transformation Officer MRC – Buckinghamshire Healthcare NHS Trust

Focal Points

- We aim to describe the benefits that have been observed since the introduction of a cloud-based telephony system to replace a traditional fixed line telephone system.
- The cloud system enables multiple team members in various locations to answer calls to our service, improving resilience in service provision, facilitating hybrid working and improved training and supervision opportunities.
- The use of a cloud-based telephony service (8x8) has brought multiple benefits for staff, enquirers, and the operation and management of our service.

Introduction

A cloud-based telephony system (8x8) was implemented with a view to providing benefits to our service delivery over that provided by a historical fixed telephone line system. We aim to describe the benefits that have been observed since this system was implemented.

Method

Observation and commentary of how our service has been developing since the new telephony system was introduced approximately 12 months ago.

Benefits

We can now include staff working on other hospital sites and those participating in hybrid working from home to provide call answering services. This has enabled more resilience in service provision and has enabled a better work life balance for our staff.

We constructed a ring group where the unanswered call is moved between MRC staff in a set order to give each the opportunity to answer the call. Callers hear instructions to remain on the call until it is answered. Only when all the staff available on the ring group have been called does the system default to an answerphone. This means multiple calls can be answered at the same time rather than an enquirer hearing an engaged tone or the call immediately defaulting to an answerphone.

We enabled functions such as “barge” to facilitate supervisors listening in on the telephone calls of staff in training and this provides enhanced support to staff when participating in calls with enquirers. If necessary, the supervisor can interrupt the call and take over the conversation.

The system is enabled to show and record the date, time, call duration, and the external caller’s telephone number which is particularly helpful for patient helpline calls. The accurate records of calls and the recordings from the answerphone messages have been found to be useful when responding to service issues.

Future Plans

We are still working through the many options built into the system and hope to enable further options in the future such as “whisper”. We hope to record standardised telephone role plays to benefit new or junior staff providing more consistent training. We expect to interrogate caller metrics to map calls including those abandoned prior to connection to better match staffing to demand patterns.

Poster 10

How can Medicines Information (MI) help streamline workflow

Marina Ribeiro, Mosopefoluwa (Sophie) Oduyale Medicines Information and Advice service, Northampton General Hospital, Northampton

Focal Points

- The aim of this project is to develop an appropriate guidance for Nuclear Medicine department to reduce the number of 99mTc-Tektrotyd scan and drug interaction enquiries received by the MI team.
- There was significant reduction in the number of 99mTc-Tektrotyd scan and drug interaction enquiries being received by MI.
- By providing clear guidance, MI can empower clinical teams to manage simple medicines enquiries whilst streamlining workflow.

Introduction

The Nuclear Medicine (NM) department at NGH performs several diagnostic scans. Some of which may be affected by patients' regular medication(s). The NM team seeks advice from Medicines Information (MI) services for support with drug interaction enquiries and specific scans by emailing the patient details, the list of their regular medication, and the diagnostic scan they have booked. One of the scans is the radiopharmaceutical preparation 99mTc-EDDA/HYNIC-TOC also commonly known as 99mTc-Tektrotyd scan. [1] On average, the MI team received 2 enquiries a month from NM team which over time were found to be quite repetitive. National and local drivers (Carter report, NHS Long-term plan, Integrated Care Systems) encourage increased collaboration to improve the efficiency of service provision and to empower and upskill clinical staff.[2] The NM team was also informed that if there were any challenges or if the patient had a complex medical history MI service would still be available to support. The aim of this project was to develop an appropriate guidance on 99mTc-Tektrotyd scan and drug interactions for NM department to reduce the number of these enquiries received by the MI team.

Method

All 99mTc-Tektrotyd scan and drug interaction enquiries are recorded on MiDatabank v3.2. The final approved guidance produced by the MI team using evidence-based resources was sent out to the NM team to use on the 8th of January of 2019. Two reports were conducted on MiDatabank v3.2 to collate the number of these enquiries received 2 years prior implementation (1st of February 2017 to 31st of January 2019), and 2 years post implementation (1st February 2019 to 31st of January 2021) of the guidance. The keyword used to collect relevant data was Tektrotyd.

From the data collected, the average number of enquiries received, and time taken to complete per month were calculated.

Results

Using reports generated on MIDatabank v3.2 with the criteria pre-defined, the following results were obtained:

- Period pre-guidance - total of 42 enquiries received;
- Period post-guidance - total of 2 enquiries received.

In both reports, the calculated average time spent on each enquiry was 30minutes.

Discussion

With the guidance there was a reduction of 96% of 99mTc-Tektrotyd scan and drug interaction enquiries. This comes to show that if and where appropriate to do so, guidance and support tools provided by MI using evidence-based resources can positively impact the safe and efficient service provision to patients, whilst streamlining the workflow for both clinical and MI teams. The time saved allowed the MI team to focus on more complex enquiries whilst still supporting the NM team and the Trust in line with the NHS long-term plan of incorporating integration between departments, better engagement of different teams and supporting workforce and patients in providing better care.2 The guidance will be updated every 2 years to ensure that the information provided is still relevant and up to date.

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Poster 11

A 5-year retrospective review of enquiries received from primary care healthcare professionals

Thaaranii Rajkumar, Esther Wong, Joanna White, Chelsea and Westminster NHS Foundation Trust

Focal Points

- The aim of this audit was to retrospectively review the number of enquiries received from primary care professionals (PCPs) and to determine the type of enquiries commonly answered.
- Between 2018 and 2022, 34% (n = 5982) of all calls received were from primary care healthcare providers.
- Calls from primary care pharmacists have increased over the last five years, with a majority of enquiries referring to questions regarding medication reconciliation on discharge.
- Changes to current practice should be made to improve the quality of discharge documentation within the inpatient pharmacy; hence reducing this workload.

Introduction

The aim of this audit was to retrospectively review the number of enquiries received from primary care professionals, to determine the type of enquiries commonly answered. From this data, common trends can be analysed in order for recommendations to be made, subsequently improving patient care.

Method

Data was extracted from MIDatabank retrospectively using the Reporter function. Data was collected from 01/01/2018 to 31/12/2022. The data was entered on an excel spreadsheet and analysed. The enquiries received from PCPs were subcategorized into enquirer type (GP, primary care pharmacist and community pharmacist) and into enquiry types.

Results

- Between 2018 and 2022, the Chelsea and Westminster MI service received a total of 5982 enquiries. Of these enquiries, 2032 (34%) were received from PCPs.
- When analysed by year, there is a 17% increase in enquiries from primary care during the five-year period.
- The biggest increase was seen within the enquiries received from practice pharmacists. In 2018, only 3% of all enquiries received by the MI centre were from practice pharmacists, compared to 11% in 2022. Queries relating to medicines reconciliation on discharge made up the majority of queries from practice pharmacists; this has increased from only 28 queries in 2018 to 54 in 2022.
- Enquiries received directly from GP's decreased from 8% of total enquiries in 2018 to 1% in 2022.

Discussion

During the five-year period captured within the audit data collection, one third of all enquiries received were from PCPs. PCPs therefore make a significant contribution to the total number of enquiries received. Furthermore, a substantial increase was noted in the percentage of enquiries received from PCPs from 2018 to 2022, with a total increase of 17%. A significant increase has also been identified in the number of queries received from clinical pharmacists working in primary care. This coincides with the introduction of the five-year GP Contract Framework in 2019, which guaranteed funding for up to 20,000 additional staff, including clinical pharmacists1. The results indicated that the most prevalent type of enquiry related to medicines reconciliation at discharge; making up 24% of all primary care pharmacist enquiries between 2018 and 2022. This accounts for a significant portion of the work completed by MI. Changes to current practice should be made to improve the quality of discharge documentation within the inpatient pharmacy, improving communication between secondary and primary care, hence reducing this workload.

References

[1]NHS England» Five-year deal to expand GP services and kick start NHS Long Term Plan implementation [Internet]. www.england.nhs.uk. 2019. Available from: https://www.england.nhs.uk/2019/01/five-year-deal-to-expand-gp-services-and-kick-start-nhs-long-term-plan-implementation/

Poster 12

The Future of Specialist Medicines Information Pharmacy Technician Training

Michele Skipp and Kate Postle, Pharmacy Workforce Development South, www.pwds.nhs.uk

Focal Points

- This service development project aimed to review, develop, and redesign the Accredited Medicine Information Technician Training Scheme (AMITTS). This was conducted by Pharmacy Workforce Development South (PWDS) in collaboration with UKMI, in line with national and educational practice standards.
- The new training programme will reflect the current and future workforce needs through new enquiry-type categories and novel competencies.
- The new programme will be a robust, accessible, relevant, quality assured programme, endorsed by UKMI and delivered by PWDS.

Introduction

Pharmacy Workforce Development South (PWDS) are a leading NHS Pharmacy Education & Training Provider and have been responsible for the delivery of the AMITTS programme since December 2022. AMITTS was developed in 1999 to provide UKMI accreditation to pharmacy technicians (PTs) wishing to specialise in MI. Since its development, many educational reforms and changes to practice have occurred, including professional registration of PTs1-3. Specialist MI PTs are contributing to increasingly varied and complex functions in MI units. The project's objective was the development of a new training programme to support MI PTs for their current and future roles.

Method

A programme board consisting of 9 UKMI and non-UKMI pharmacy team members, providing expertise in MI, training and service provision was created. The board reviewed the portfolio-based programme requirements and agreed changes to encompass the broader enquiry workload experienced by current MI PTs. These changes included: new enquiry categories and novel assessment pathways to align with current educational practice and UKMI standards. Existing enquiry types were reviewed to ensure relevance and reflection of the full range of enquiries included in the category. Online delivery of training was redesigned to provide deeper underpinning knowledge. The quality and suitability of the new programme is assured through endorsement of programme decisions by the UKMI executive.

Outcome of Programme Review

The new UKMI endorsed Medicines Information and Advice Training Programme for PTs is nearing its final development phase and will be available early 2024. Learners will be able to select the enquiry types to develop and demonstrate competency in from the following list: access to medicines on the NHS, adverse drug reactions, availability of medicines, complementary medicines, formulation of medicines, identification of pharmaceuticals, interactions, IV administration, IV compatibility, member of public enquiries, palliative care syringe drivers, renal impairment, stability of medicines, transfer of care, vaccinations.

Assessment will include direct observations, portfolio of evidence, holistic review, reflective writing, and summative interview. Learners will continue to require an experienced MI specialist practitioner to act as Educational Supervisor, providing regular feedback and assessment throughout the 12-month programme. Programme Support Officers will offer external validation of assessment decisions and a quality assurance sampling process adds robustness.

Discussion

The AMITTS scheme has provided accreditation to PTs working in MI for over two decades. Major changes to the programme were needed to reflect the extended roles undertaken by professionally registered specialist MI PTs. The new training programme will reflect the current and future workforce needs through new enquiry-type categories and novel competencies. The Medicines Information and Advice Training Programme will be a robust, accessible, relevant, quality assured programme, endorsed by UKMI and delivered by PWDS, launching early 2024. In order to support the MI service further, PWDS will be providing opportunities for existing MI PTs to extend their roles by undertaking supplementary training and assessment in any of the enquiry categories offered by the new programme. This will allow the UKMI service to fully utilise the skills and potential of their specialist PT workforce, whilst also aiding workforce recruitment and retention through facilitating career progression opportunities.

The programme will be kept under regular review to ensure it remains aligned to educational reforms and the needs of the UKMI workforce. Further expansion of the programme to primary care pharmacy professionals and non-UKMI workforce are future aims.

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Poster 13

Barriers and Enablers affecting Yellow Card reporting in submissions in Medicines Information

Louise C Smith; Sarah C Jones and Matthew D Jones – Yellow Card Centre Scotland, University of Bath and NHS Lothian

Focal Points

- To investigate the barriers and enablers affecting Medicines Information (MI) staff reporting adverse drug reactions (ADRs) via the integrated electronic Yellow Card (e-YC) reporting function on MiDatabank in line with the UK Medicines Information (UKMi) standard to improve patient safety.
- Barriers and enablers were identified related to MI staff capability, opportunity, and motivation to report ADRs.
- Both technological development and person-centred barriers need to be addressed with a suite of interventions to increase reporting via the integrated e-YC ADR reporting function on MiDatabank.

Introduction

Only a fraction of adverse drug reactions (ADRs) are reported internationally, with between 3 to 7% of hospital admissions in the UK relating to ADRs, this underreporting is a patient safety concern1. To embed Yellow Card (YC) reporting into the healthcare system, the Medicines and Healthcare products Regulatory Agency (MHRA) integrated reporting forms into clinical IT systems (e-YCs), including the pharmacy medicines information system, MIDatabank. Despite this technology, the MHRA received 49% fewer reports in 2021/22 compared with the previous year from MIDatabank in Scotland2. There is a need to understand the barriers and enablers to MI staff reporting ADRs on e-YCs via MIDatabank, and behavioural theory will inform appropriate interventions to increase reporting rates via this route.

Methods

MI centres in Scotland were asked to provide reports of the numbers of e-YCs submitted via MIDatabank, the total number of enquiries and the number of enquires categorised as relating to adverse events, between 2017 and 2022. MI staff in Scotland of all roles and experience, who use MIDatabank for MI enquiries with permission to complete e-YCs were invited to participate in this study. Semi-structured interviews were conducted between March and May 2023, using a Theoretical Domains Framework (TDF)-informed interview schedule to identify barriers and enablers of MI staff reporting ADRs on MIDatabank. Interviews were transcribed verbatim and thematically analysed inductively and deductively using NVivo software. Qualitative findings were mapped to the behaviour change wheel to identify appropriate interventions to address capability, opportunity, and motivation.

Results

The highest reporting centre had an average of 20 e-YCs per annum over five years, which equates to a reporting rate average based on number of adverse events enquires of 22%. The lowest centre submitted no reports. Seven interviews were conducted with staff of differing roles and experience from five MI centres in Scotland. Professional role and identity, knowledge, belief about capabilities, memory attention and decision processes, and social influences were the most significant TDF domains influencing behaviour of MI staff in ADR reporting. Uncertainty about enquirer consent to report, knowledge and confidence about reporting based on suspicion, identifying ADRs within a clinical enquiry, and the belief that it's the role of the patient-facing practitioner to submit e-YCs were barriers. There were mixed views on the functionality of e-YC reporting on MiDatabank. All participants who have used the e-YC integrated function (n=6) describe it as being easy, however some common themes for improvement emerged and hope for "better functionality for reporting" on MiDatabank

Discussion

Reporting data confirmed variation existed in the number of e-YCs submitted annually across the six centres that provided data, suggesting there is scope for improvement. Interventions including education, persuasion, training, modelling and enablement may help address some of the barriers. A suite of interventions has been suggesting including peer discussion and support, adding YC reporting to MI team agendas, and increasing awareness of the national SOP for ADRs.

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Poster 14

Integrating the COVID-19 Antiviral Treatment Service into our local Medicines Advice

Gwenllian Thomas, Betsi Cadwaladr University Health Board

Introduction

The National Antiviral Service (NAVS) is commissioned by the Welsh Government, and it aims to identify high risk COVID-19 positive patients within Wales. NAVS collates daily patients lists, these patients require follow up, triage and treatment delivery.

From May 2023 the task of follow up, triage and treatment supply of COVID-19 positive patients who were deemed high risk was transferred from NAVS to the local health boards to manage. Within Betsi Cadwaladr University Health Board (BCUHB) this work was assigned to the Pharmacy Governance team.

The Medicines Advice team works within the Governance team and were well placed to support the service delivery. They are experienced in working closely and communicating well within the team whilst working geographically apart across the health board. The team has excellent telephone consultation skills with members of the public as well as healthcare professionals. Medicines advice is adept at performing interaction checks and reviewing tests results, counselling patients on side effects, and encouraging adverse reaction yellow card reports.

To support the service delivery across the Health Board, a senior pharmacy technician was funded to support service delivery. This role was shared between existing and new Medicines Advice Pharmacy Technicians. This poster discusses how the patients are identified for COVID-19 treatment eligibility, how they are triaged by the pharmacy team, and how treatment is delivered in a timely manner across BCUHB.

Methodology – Service Delivery

Pharmacy staff recruited into the Antiviral Service received a training from BCUHB Pharmacists who had been involved with the service and treatment delivery co-ordination alongside NAVS since 2022.

Additional pharmacists were added to the service delivery plans in BCUHB – pharmacists are expected to co-ordinate the treatment delivery and ensure communication is clear between patient and treatment providers. Pharmacists were signed up to the Patient Group Directive (PGD), to enable treatment supply in a timely manner.

In BCUHB this service was provided Monday to Friday 9am to 5pm (excluding bank holidays). The service had a rota of one pharmacy technician to triage and one pharmacist to co-ordinate daily. The pharmacy technician would discuss regular medications, allergies and health conditions with the patient and complete an approved checklist. Once eligibility was confirmed and medications checked for any potential interactions, then COVID-19 treatment could be offered as per Welsh Government guidance. The pharmacist would co-ordinate the supply of treatment from nearest acute hospital to the patient, or alternatively refer the patient to their nearest intravenous drug delivery suite within the Health Board

Result

Between May and September 2023, 296 patients identified as high risk of becoming seriously unwell with COVID-19 had tested positive.

Discussion

The NAVS service is essential to identify and highlight high risk patients who have tested positive with COVID-19 in the health board. The Antiviral Treatment service within BCUHB Governance/Medicines Advice team act quickly to triage patients and ensure antiviral treatment is supplied in a timely manner. Efficient delivery of this service is essential to avoid potential hospital admissions of patients with COVID-19 complications which could have been avoided with appropriate antiviral treatment.

Poster 15

Impact of the UHS Nurse Discharge Checklist

Wen Xuan Pua, University Hospital Southampton NHS Foundation Trust, Southampton
Project supervisors: Angela Badiani, Jonathan Hall

Focal Points

- UHS NHS FT developed a nurse checklist in 2019 to try to prevent errors or omissions relating to medicines occurring at the point of discharge.
- Errors or omissions continued to be reported to the Trust's Medicines Helpline and this study aimed to evaluate the effectiveness of the Checklist.
- The study found that the Checklist was not being used to discharge patients, but that if it had been used it would have prevented nearly 40% of the errors/omissions reported to the UHS Medicines Helpline over a 5-month period.

Background

The UHS Medicines Helpline service has assisted over 12 000 patients and their careers with a range of medication-related concerns since its launch in 2011. However, some calls to the helpline relate to errors or omissions. In order to try to prevent some of these problems, the UHS Nurse Discharge Checklist was developed in 2019. However, the helpline service continues to receive calls where errors or omissions have occurred. Therefore, this study was undertaken to evaluate the effectiveness of the Checklist.

Method

All helpline calls received between February and June 2022 were screened by 2 independent assessors (AB and WP) to identify if they involved an error/omission. For all calls identified as involving an error/omission, the individual patient's medical notes were reviewed to identify if the Checklist was used correctly. If it was not used, the 2 assessors judged whether the Checklist would have been expected to prevent the error/omission. If the Checklist would have been expected to prevent the error/omission, then the assessors judged whether the content needed amendment. If the Checklist would not have been expected to prevent the error/omission, the assessors judged whether new content was required. Ethics approval was not required.

Results

Of the 612 helpline calls received during the study period, 114 were identified as involving an inpatient discharge with an error/omission (18.6%). The Checklist would have been expected to prevent 39.5% (n=45) of these errors/omissions. The Checklist was used correctly in 12.3% (n=14) of cases, completed only partially in 15.8% (n=18) of cases and not completed at all in 71.9% (n=82) of cases. For the calls where the Checklist was completed correctly (n=14), 21.4% (n=3) errors/omissions would have been expected to have been avoided. The assessors judged that amendment of the Checklist was not required. For the 100 calls when the Checklist was not used at all or used incorrectly, 42.0% (n=42) of errors/omissions would have been expected to be avoided.

Discussion

The UHS Nurse Discharge Checklist was developed to try to prevent errors/omissions relating to medicines at the point of hospital discharge. This study has shown that if used correctly, it could have prevented nearly 40% of the errors/omissions reported to the UHS Medicines Helpline over a 5-month period.

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