Name of project: Medicines Optimisation in Special Schools

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What was our aim?

The primary aim of this project is to promote:

1. Increased patient safety in schools through the development of a bespoke medicines optimisation service which allows for the:

1.1 Improvements to upskill unregistered teaching workforce in medicines administration

1.2 Reduction in errors – for example, omitted doses through medicines reconciliation provision.

2. Standardisation, consistency and equality of health provision across more special schools in Kent through recruitment of an additional pharmacy technician to complement the new service

3. Development and transformational leadership opportunities for pharmacy technicians expanding on their traditional roles, through working in a relatively untapped sector, for instance, special schools, promoting medicines optimisation.

Why is it important to service users and carers?

Special schools are those which provide an education for children and young people (CYP) with a special educational need or disability (SEND). On 1 September 2014, a new duty came into force for governing bodies. Section 100 of the Children and Families Act 2014 places a duty on governing bodies of maintained schools, proprietors of academies and management committees of pupil referral units (PRUs) to have in place arrangements to support pupils with medical conditions at their school.
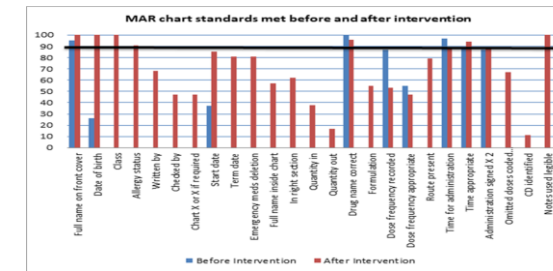
Within the collaborative commissioning structure between the NHS and local authorities for special schools, there has never been a formal pathway to promote or support the need for a pharmacy led medicines optimisation service in schools. With there being no standardised approach to how this is achieved, great variations exist nationally on how this model is being delivered; including vast differences even in localised areas where some schools have full collaborative working between local authorities and health partners (primarily specialist community nursing services) and other schools having little or no support at all with the need to fund their own health provisions.

Reducing health inequalities and improving health and wellbeing are major priorities for pharmacy. Pharmacist and pharmacy technicians skills of listening, explaining, advising and questioning are all highly relevant to help identify and support the medicines optimisation needs of CYP with complex health needs in special schools.

As part of supporting transformation and innovation in pharmacy, we were successful in bidding for NHS Health Education England transformation funding in 2020-21 to support with an additional pharmacy technician on a fixed term contract.
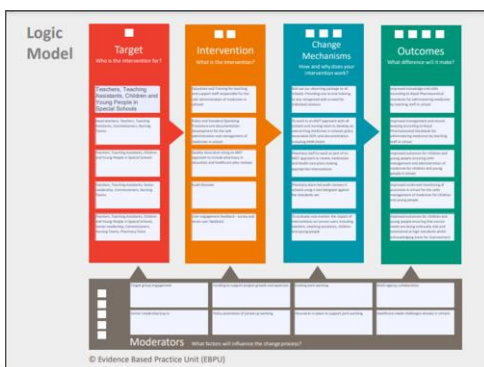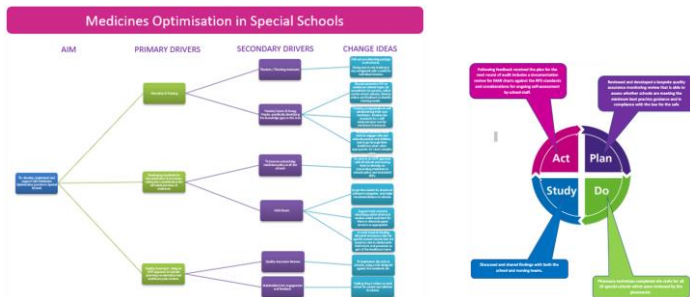
Ideas and tests of change

A pilot study in 2018 by the KCHFT CYP Pharmacy Team, in a special school, highlighted that with the appropriate level of specialist pharmacy support, the school was largely successful at supporting the safe and effective management of medicines to CYP, minimising the risk of errors. Evidence illustrated in the figure below shows that standards on Medicine Administration Record (MAR) charts increased from nine out of 25 before the intervention to 25 out of 25 after the intervention. However, the number being met at 90 per cent or above only increased from three to seven, which emphasised the importance and need for ongoing collaboration between specialist pharmacy services and special schools.

The KCHFT CYP pharmacy team made appropriate interventions including deprescribing recommendations to the special school which directly supported the school to achieve a 60 per cent reduction of when required (PRN) salbutamol inhalers at school, improving patient outcomes and indirectly minimised the medicines waste burden on the wider health economy.

The tools we used

- Driver diagram to produce a strategy for implementation of the new service over a phased period of time during the academic year.
- Plan do study act (PDSA) cycle to complete pre and post evaluation of medicines management practices as part of quality assurance monitoring.
- Logic models to support clarity in thinking, which enabled the development of appropriate evaluation strategies throughout the project.

Results/How did we do/Anticipated outcome

Medicines management quality assurance monitoring involved a baseline pre-audit of the sites at the outset, then followed up with a post project commencement audit to assess their compliance with the recommended guidance. The pre and post audit results below provides a graphic representation showing level of improvement following appropriate specialist pharmacy service support in areas including medicines management training, expert pharmaceutical advice, medicines related clinical interventions, guidance and support in policy and Standard Operating Procedure (SOP) development, to improve standards across the schools. Four of the schools have demonstrated meeting above the 90 per cent threshold for medicines management standards and two schools achieved 87 per cent post implementation ,in comparison to pre-project review that identified a number of the schools were significantly below this threshold, as outlined in Figure 1 below.
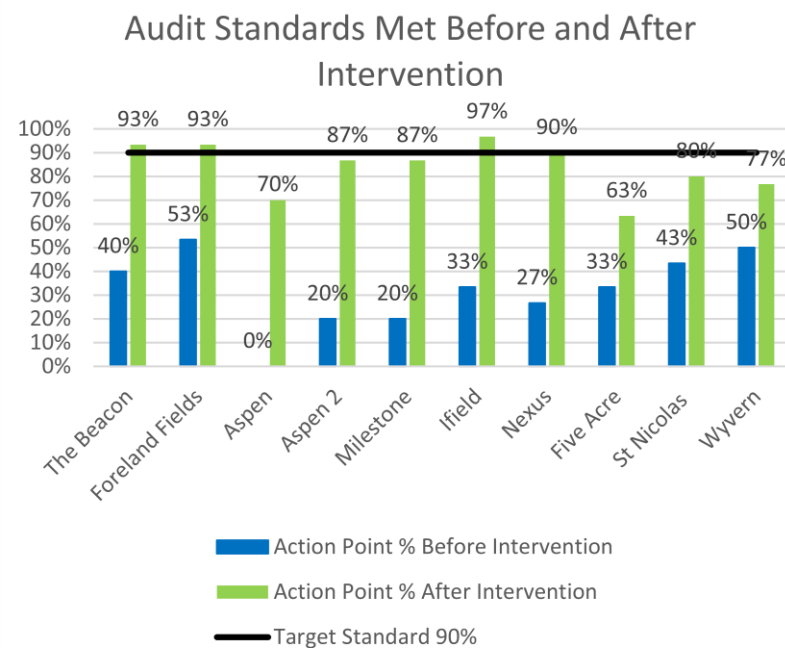

FIGURE 1: QUALITY ASSURANCE REVIEW FOR MEDICINES STANDARDS

FIGURE 2: CLINICAL PHARMACY INTERVENTIONS

Clinical Interventions undertaken by the team across all the schools over a 6-month period has been broken down in Figure 2 above. A total of 232 interventions were made. Key areas where significant interventions were highlighted included emergency medication plan reviews for asthma (35%), epilepsy (32%) and specialist medical emergencies (23%).
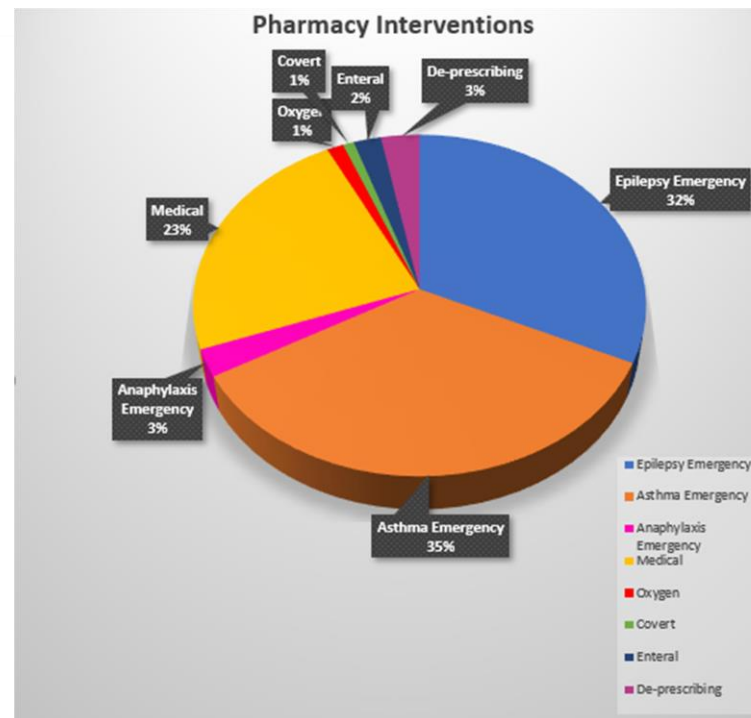
What we learned and what's next

Medicines optimisation is about helping people to get the best outcomes from their medicines. It describes systems and processes used by colleagues working in health and social care, which ensure people receive the best possible care with medicines.

Smith et al identified medication related issues such as the adverse effects of medication being highlighted as a cause of both non-adherence and poorer school performance by CYP and parents/carers. This growing evidence base further reinforces the need and importance of medicines optimisation in special schools through structured commissioning and collaboration with community pharmacies to provide:

- A repeat prescription service
- Effective medication reviews which includes considerations for deprescribing
- MAR chart provision
- Medicines information and counselling
- Provision of suitable emergency medicine kits for salbutamol and adrenaline auto-injectors in schools.

These small but significant steps will support schools not only to effectively manage medicines that are essential during school hours but also support CYP to get the best outcomes from their medicines thereby promoting medicines safety in schools.

Our next steps include continuing to build on this work locally and also support other special schools/pharmacy teams nationally through collaboration and sharing innovative practice as well as lessons learned. Closer integrated working with pupils, parents and carer involvement in focus groups are planned for the next academic year.

To support this work on a national and strategic level, the project lead presented to MPs at the Westminster Forum in September 2021, when the SEND policy review was being discussed. Following this, invitations to speak at several schools and forums across the UK are planned throughout 2022.

A FutureNHS Workspace was recently approved for medicines optimisation in special schools to enable the collaboration to reach a wider audience through active engagement/ networking which will include working with national organisations such as National Association for Special Education Needs (NASEN).

References to articles/research quoted within this project can be made available on request.