

Barriers to participation in a self-administration of analgesia quality improvement scheme in elective caesarean patients at a south coast district general hospital

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Introduction

Self-administration of analgesia, when the patients stores and administers their own pain medication, has been successfully implemented at some trusts for obstetric patients. Benefits include increased autonomy

Methods

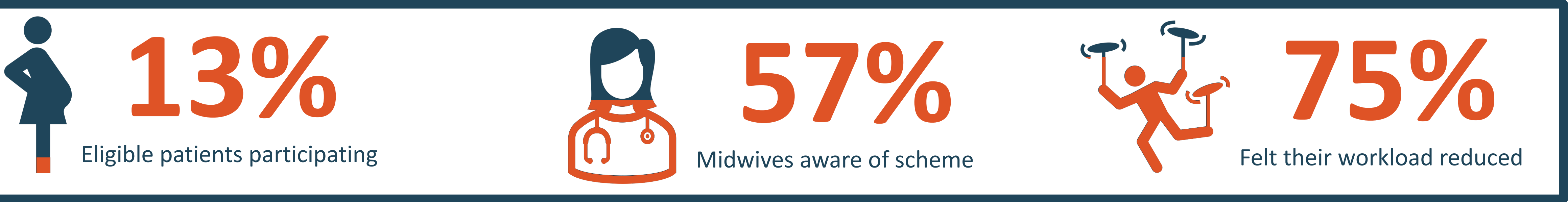
We piloted a self-administration of analgesia scheme in patients having elective Caesarean sections at Conquest Hospital, Hastings from September 2022, after an initial audit of patient pain scores and satisfaction with analgesia demonstrated a need for improvement. The audit was approved by the trust’s audit department. This was a multidisciplinary quality improvement project involving the postnatal midwifery team, and the anaesthetic and obstetric departments. An existing trust guideline on self-administration of medicines (SAM) was consulted and adhered to in developing the scheme. Bedside lockers were installed on the postnatal ward, self-administration charts and patient information leaflets were created and a teaching resource and local guideline developed and circulated to staff. Participation in the scheme was voluntary and any women lacking capacity or the physical ability to administer their own medication were excluded. As the trust pharmacy does

for patients, reduced workload for staff, better timing of analgesia and patients becoming used to a pain relief routine before going home, allowing problems to be identified earlier⁽¹⁾.

not provide TTOs of paracetamol and ibuprofen, patients were asked at pre-assessment to bring their own supplies from home to be supplemented by packs of dihydrocodeine on admission to the postnatal ward. Oral morphine remained nurse administered.

After implementation of the scheme a spot audit revealed that few women were taking part, making it difficult to audit satisfaction scores. We raised awareness of the scheme again with anaesthetic and midwifery staff, suggested appropriate ways to convey the benefits of the scheme to patients in advance of their operation and added discussion of the scheme to the pre-assessment checklist. A repeat audit of patient participation was performed and a structured questionnaire was circulated to postnatal midwifery staff to assess knowledge, concerns and satisfaction with the scheme.

Results



Despite the interventions, only 13% (2/15) eligible patients audited were actually self-administering. Only 57% (8/14) of midwifery staff surveyed were aware of the scheme although staff support for the principle of

self-administration was high. 75% (4/6) of those who had experience of the scheme said they had experienced a lower workload as a result.

Discussion

The SAM scheme was introduced at the same time as electronic prescribing in maternity which complicated matters around documentation of self-administration. The electronic prescribing had multiple implementation and safety issues (unrelated to SAM) that meant that it was subsequently withdrawn in maternity. Because of our pharmacy policy regarding analgesia TTOs, participation was effectively dependent on patients opting-in; patients had to be informed at pre-assessment, consent to participate, and remember to bring paracetamol and

Dixon-Woods et al identified ten types of challenges facing quality improvement project implementation. ⁽²⁾

The problems our SAM scheme have encountered so far could be classed under organisational cultures, capacities and contexts. These included:

-  Failure of information sharing between teams resulting in postnatal staff being unclear of responsibilities.
-  Professional demarcations and responsibilities: anaesthetists were unsure of best channels to educate and communicate with the postnatal staff responsible for enrolling women in SAM.
-  Team instability and busy clinicians leading to difficulty arranging regular meetings.
-  Regulatory context: pharmacy regulations around TTOs a barrier to a wider adoption of scheme
-  Shifting organisational agendas and priorities: electronic prescribing problems taking up a lot of staff energy making it difficult to embed other changes in medication and documentation at the same time.

ibuprofen from home. We found these presented multiple barriers to taking part. In addition, the staff questionnaire found that although support for SAM as a concept was high, midwifery awareness and understanding of the scheme was low. Staff were not clear about how women should be entered into the scheme and were unclear on where the necessary paperwork was kept.

Ten key challenges in improving quality in healthcare

- 1.Convincing people there is a problem relevant to them
- 2.Convincing them the solution chosen is the right one
- 3.Getting data collection and monitoring systems right
- 4.Excess ambitions and “projectness”
- 5.Organisational cultures, capacities and contexts
- 6.Tribalism and lack of staff engagement
- 7.Leadership
- 8.Incentivising participation and hard edges
- 9.Securing sustainability
- 10.Risk of unintended consequences

Figure 1: Ten key challenges: adapted from Dixon-Woods et al ⁽²⁾

Ways to overcome some of these problems in the future would include:

-  Increasing staff awareness: dedicated staff training time, presentations at departmental meetings, posters for staff areas and project documentation widely circulated.
-  Improving patient recruitment: creation of pharmacy packs including all analgesia TTOs included, suggested analgesia regimes, and written information for patients.
-  Professional demarcations: ensuring responsibility for documentation and TTO packs is clearly defined between anaesthetic, obstetric and midwifery teams.

1. Neetoo S, Almossawi O. Postpartum pain relief management and self-medication on postnatal ward. Archives of Disease in Childhood 2015; 100 :e1.
2. Dixon-Woods M, McNicol S, Martin G. Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature. BMJ quality & safety 2012; 21: 10: 876-884