Southdown

Making Life Work

Final Report

HEEKSS funded epilepsy awareness and Buccal Midazolam administration 'train the trainer' project

Contents

1. Introduction and summary of key findings

This project set out to develop in-house training expertise in epilepsy awareness/Buccal Midazolam administration. (Buccal Midazolam is an emergency medication for epilepsy.) Developing sustainable, in-house provision means that we can guarantee and manage the availability, quality, tailoring and cost of the input – all of which have been issues historically. We also hoped that we might find an approach that could work more widely across the sector.

Whilst this project focused on epilepsy and administration of Buccal Midazolam training, the challenges are similar to those faced in a range of areas where social care and health overlap and social care staff require some health related training. As a consequence our findings might have wider application.

Summary of Key findings:

- This project has enabled us to identify a successful and sustainable model for delivery of in-house medication administration and epilepsy awareness plus administration of Buccal Midazolam at Southdown – ensuring that the trainers have regular CPD input so that their knowledge is current.

Practicing administration of Buccal Midazolam during a course

- There may be limits to the extent to which this model could work across the sector, because of the amount of work required to achieve the accreditation. This approach may only be suitable for larger organisations and/or services with dedicated training staff. For those organisations, however, this could prove a useful model. There may also be value in exploring a similar model for other areas where social care staff need some health training.
- Commissioning good quality training can be challenging. We are informed commissioners of training – but found courses we previously commissioned, also used by other providers in the sector (including local authorities), to be of poor quality or giving incorrect information. This highlights a real issue for the sector as a whole.
- Feedback from staff and managers re the new courses has been very positive – although staff initially said that seeing reference to ‘pass/fail’ on the sign in sheet for medication administration was anxiety provoking (we have, as a consequence, removed this). The focus on the practical aspects of medication administration – including Buccal Midazolam - has been appreciated.
- Feedback from clients about their experience of having medication administered by specific individuals has been predominantly positive.

- The issues we identified re confusion about what constitutes competence to administer Buccal Midazolam and what is required to be able to deliver the training, together with issues re capacity and quality of training remains the same as it was nearly 2 years ago. Whilst the solution we have identified works for us, it won't necessarily work for the rest of the sector. The continuing lack of national guidance is of concern. Attempts to develop a local protocol have not yet succeeded – although there is still interest in this. We hope that the HEEKSS clinical hub may enable this work to be taken forward.
- The project has driven some additional activity and subsequent outcomes which has been welcome (e.g. new medication policy; review of recording of medication errors).
- Using medication errors as an evaluation tool proved much more complex than we had anticipated. Does an increase in recorded errors indicate an increase in errors, or an increase in the ***reporting*** of errors? The chemist/trainer who licenses our medication administration training suggested we that what we wanted to see from better training was an increase in the ***reporting*** of errors (from increased reporting, rather than occurrence) and a decrease in the ***severity*** of errors.

2. Context and history

2.1 Brief synopsis of project:

The project aimed to train 2-3 managers or trainers as epilepsy trainers (and medication administration trainers as part of this) so that they are able to deliver epilepsy awareness and administration of Buccal Midazolam training to Southdown staff.

The intention was that this will enable Southdown staff to

- have the knowledge/awareness and skills to administer medication safely
- identify and meet the specific needs of clients who have epilepsy (appropriate to their role) – including having the competence and confidence to administer Buccal Midazolam when required and prescribed
- refer on to health services when the client's (epilepsy related) needs exceed their role/expertise.

In turn this would mean that:

- the person with a learning disability receives personalised, caring and effective support from people with whom s/he has a relationship - and experiences fewer (or no) severe health situations/crises that require more invasive procedures or hospital treatment (from strangers)
- The people we support make less call on emergency or expensive (particularly inpatient) health services
- We reduce medication errors
- We make less demand on local health service training – freeing up places for other providers locally who are less able to organise training themselves (e.g. smaller organisations).

2.2 Southdown

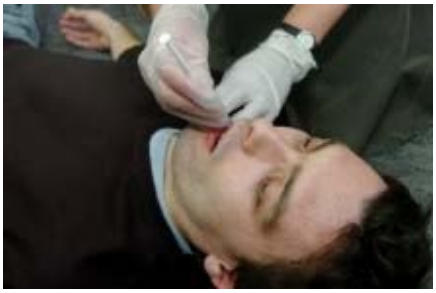
Southdown is a housing and support provider based in Sussex. In our learning disability division 574 staff (including 100 bank staff) support 212 people with a learning disability in supported living, community outreach and residential services across Sussex. We have particular expertise in supporting people with complex needs, including autism, multiple/complex physical and learning disabilities and/or behaviour that can challenge. Most of the clients we support need staff to

administer their medication and just under 1/3 of those living in our supported living and residential care services have epilepsy. 18 clients (in 15 services) at the start of the project were prescribed Buccal Midazolam. New referrals tend to have more complex needs and so are more likely to have epilepsy.

We have a strong focus on staff learning and development with an in-house Training Department (599 courses provided in 2017 – from induction to management development) and Positive Behaviour Support team. See our website for more details: https://www.southdown.org

2.3 Buccal Midazolam

Buccal Midazolam is an emergency medication prescribed to treat prolonged (five minutes or more) seizures. It is designed to stop 'status' (seizures lasting 30 minutes or more). 'Status' is a medical emergency as it can cause permanent neurological damage or be fatal. Buccal Midazolam is administered via syringe into the buccal cavity (cheek). For most of our clients, the alternative to Buccal Midazolam is rectal Diazepam. This is far more invasive to administer, raising issues of dignity and respect. It also has an impact for much longer than Buccal Midazolam, making it harder for the recipient to return to normal functioning quickly after administration.



There is some nervousness about the administration of Buccal Midazolam (BM) and, particularly, training to administer. This is probably because:

- BM is prescribed, but not licensed, for adults. It is licensed for children
- It belongs to a group of drugs called Benzodiazepines and is a Schedule 3 drug – exempt from safe storage regulations (barbiturates are also Schedule 3). Some Health Trusts treat it as Schedule 2 (so requiring safe storage) on wards
- It has a street value
- It's an emergency medication – so administered in potentially life threatening situations
- There is no national guidance re training

For providers who administer a significant amount/range of medication every day (including other Benzodiazepines/Schedule 3 drugs), with potentially fatal consequences if some of this is administered incorrectly, the nervousness about BM is a bit baffling (even given the points above).

2.4 Epilepsy/Buccal Midazolam training: guidance and competence to administer

The nervousness about BM has led to some confusion about the requirements for training to administer it – in particular what constitutes competency to do so. The Joint Epilepsy Council (JEC) provided national guidance on training requirements in 2012. At the start of the project these guidelines were being reviewed. The JEC, however, appears to have ceased functioning, with organisations pulling out of it and the website disappearing. This means that the previous guidance is no longer available. Some training providers appeared unaware of the guidance even when it was available, so stated requirements that were not part of/over and above the JEC guidance. Some

organisations (notably Health Trusts) publish their own local protocols, but some of these are less workable in community settings or if a person only has BM rarely. For example, some training providers and protocols state that for someone to be deemed competent to administer BM they have to first be observed administering it, live, on three occasions – by someone qualified to deem them competent. Many of the people we support who are prescribed BM will require it infrequently (e.g. once a year – at an unpredictable time) and many are supported 1:1 in their own flat and in the community. This makes it almost impossible to meet these stated competency requirements – yet whoever is supporting that individual at the time they need BM has to be able to administer it.
As an illustration, in a team of 16 staff, with once a year administration and assuming (unrealistically) no turnover, it would take 48 years for the whole team to be deemed competent to administer BM following these protocols. And this assumes that the manager happens to be on duty to observe staff each time BM is administered (and would themselves be deemed competent to observe). In reality, it is likely that no one would ever be deemed competent.
Whilst there has been talk about taking the JEC training requirements work forward for a couple of years, this hasn't come to fruition to date.

This lack of clarity/confusion leaves service providers in a potentially vulnerable position and can create real problems. For example, the parent of a woman with epilepsy attending the first HEEKSS Community of Practice said that if his daughter had a seizure requiring Buccal Midazolam whilst at the day centre, he or his wife were called by the centre staff to go and administer it, as day centre staff were unable to do so.

2.5 Accessing Buccal Midazolam administration training

Prior to this project we had significant difficulty accessing or commissioning good quality epilepsy/Buccal Midazolam administration training to meet needs. Whilst we did make use of local authority commissioned/health delivered training, we could only access places for a small percentage of our staff (and would not expect to meet all our needs to be met this way).
We encountered wide variation in quality, high costs and confusing messages re competency and other requirements (see section 2.4 above and 6.a below in 'Findings').

a. Concerns voiced

The issues above, and issues with capacity re epilepsy/Buccal Midazolam training, had been identified as of concern:

- by Sussex local authorities and service providers (e.g. East Sussex Learning Disability Workforce Development Group)
- across Sussex workforce groups (Sussex Skills For Care Group and Health Education forums)
- at the Learning Disability meeting arranged by HEEKSS (Health Education England Kent, Surrey and Sussex) in December 2015
- at the HEEKSS Learning Disability Community of Practice in summer 2016. A parent attending (from another area) said that if his daughter required Buccal Midazolam he or his wife were called (from whatever they were doing) to go and administer the drug as day centre staff were not able/allowed to do so.

Within East Sussex, the Learning Disability Workforce Development Group (comprising of health and local authority staff plus independent providers and a carer) has been considering development of a local protocol signed off by health professionals and local authority commissioners, providing guidance on the level of training acceptable locally. This work is not progressing currently, but there is still interest in it.

3. Approach adopted

We sought the advice of

- the then Sapphire nurse at the Epilepsy Society
- colleagues in East Sussex Training Department (who work with their health counterparts)
- the chemist/trainer delivering our medication train the trainer course who also delivers Buccal Midazolam training

We used this, with the JEC guidance, to develop our own approach, in line with that of East Sussex County Council. This meant that trainers have to have:

- Train the trainer accreditation in medication administration
- Train the trainer accreditation in epilepsy awareness and Buccal Midazolam administration
- Education and Training (EAT) Award Level 3 (or other training qualification)
- Ongoing CPD

This approach enabled us to feel more confident in developing a course that tested competence of participants to administer a syringe of water to a peer on the course. We combined this with a clear message about the need to follow individual client's epilepsy plans. We could then treat BM similarly to other drugs administered in the service – with the manager having responsibility for ensuring competence in the workplace, recognising that this might be much more challenging where the drug is administered infrequently.

We intended to work with the Sapphire nurse at the Epilepsy Society (contributor to the review of the Joint Epilepsy Council training guidance) to pilot a new 'train the trainer' epilepsy/BM course. She then left the Epilepsy Society and the work has not continued. As a backup we also approached a local training provider about whom we had some concerns – but with a contingency plan re working with the local authority to ensure we met the same standards as their trainer.
In the event, we found an alternative accredited epilepsy/Buccal Midazolam course delivered by Guardian Angel that included the Education and Training Award Level 3. This was accredited with Industry Qualifications at the time (they are now accredited with Open Awards). As this cost more than the funding from HEEKSS we opened the course to two other local organisations and shared the additional cost with them. This enabled them to access the training at a much reduced rate.

We used The Medication Training Company (run by a pharmacist) for the medication administration train the trainer course – and set up a licensing system with them. Their course is accredited with the Pharmaceutical Society. For a small fee per participant we have access to their materials and virtual medication round and they 'mark' the assessment and issue certificates. They also provide CPD (at a cost). The inclusion of the virtual 'medication round' with a pass/fail assessment makes the training far more robust.

We hoped that delivering a much clearer medication administration course in-house, focusing on the practicalities/good practice of medication administration with a robust assessment process, would help to improve medication administration and reduce medication errors.

See appendix One for a detailed breakdown of the methodology/inputs.

4. Outputs/Outcomes

Small group training in epilepsy awareness and Buccal Midazolam administration

- We have two staff (one manager and one Practice Development Trainer) who are accredited medication administration and epilepsy awareness/BM administration trainers
- We delivered:
    - 29 medication administration courses to 171 participants (27 more courses and 157 more participants than stated in the project plan) up until 31st Aug 2017. This rose to 36 courses and 216 participants by March 31st 2018
    - 14 epilepsy/Buccal Midazolam induction courses to 94 participants up until 31st Aug (32 courses and 214 participants by March 31st 2018)
    - 3 refresher epilepsy/Buccal Midazolam courses to 11 participants up until 31st Aug 2016 (14 courses and 50 participants by March 31st 2018).

  This amounts to 15 more courses and 91 more participants than stated in the project plan up to Aug 2016 (42 more courses and 250 more participants by March 31st 2018).

Additional outcomes/activity (not part of initial project plan) as a consequence of this project:

- We have reviewed, re-written and relaunched our medication policy
- We have reviewed and amended (internal) client epilepsy plans/documentation – and asked for some profiles to be reviewed
- We have reviewed the collection of medication error data and are working with managers on ways to improve this
- We provided managers with an overview/'taste' of the new medication administration course (including undertaking the virtual medication round)
- We were able to offer two other organisations places on the epilepsy/BM administration/EAT train the trainer course. One of these organisations now provides epilepsy/Buccal Midazolam administration training to their staff

5. Evaluation methodology:

This project has been evaluated in the following ways:

- Baseline feedback from trainer attending previous medication administration train the trainer course and her observation of medication administration in practice in some services
- Baseline feedback from staff and managers attending previous epilepsy/Buccal Midazolam courses
- Feedback from managers/Practice Development Trainers attending the project 'train the trainer' courses for Medication Administration and Epilepsy/Buccal Midazolam
- Feedback from the medication 'train the trainer' course trainer (a pharmacist) after he observed the two Southdown trainers delivering medication administration training
- Feedback from staff attending the new courses and their managers – phone interviews with 22 staff re the medication administration course and 37 re epilepsy/Buccal Midazolam
- Feedback from a small sample of clients on the medication administration they have received from staff completing the course
- We were unable to obtain feedback from clients re the administration of Buccal Midazolam – partly because this is administered at a time when they are less likely to be aware but mainly because most of our clients who are prescribed Buccal Midazolam are profoundly and multiply disabled
- Analysis of medication errors

6. Findings:

6.a Baseline feedback/observations

Medication administration:
A Practice Development Trainer observed the previous in-house medication administration course and noted that it was too theory based, lacked sufficient structure and was not sufficiently relevant to front line staff. She observed medication administration in some services prior to undertaking the train the trainer course. Alongside some excellent practice, she noted some custom and practice that had developed slightly at odds with our policy and could be susceptible to errors. This, together with participants' frequent requests for more practical training, highlighted the need for the training to have a greater practical focus – as well as the need to discuss the medication policy with managers. Managers fed back that the course did not prepare staff for the medication administration assessment in the service.

Previous medication 'train the trainer' course:
The same Practice Development Trainer attended the previously used medication 'train the trainer' course (also used by local authorities) and said that it was of poor quality and chaotic – with crucial information incorrect (acknowledged by trainer when challenged). The trainer did not use the teaching methods she was teaching. Given this, it was not surprising that our managers (who had attended previously) developed an in-house course that was too theoretical and not sufficiently structured/relevant.

Epilepsy awareness Buccal Midazolam administration:
Feedback about previous Buccal Midazolam administration training has generally been poor, despite trainers being recommended. One or two services used a local chemist who would train staff from services using them and this was well received, but not available to other services. One of

the only positively received external courses commissioned by us (and a local authority) conveyed the message that Buccal Midazolam is a control drug requiring control drug storage and recording. Other trainers told participants that they would not be competent to administer Buccal Midazolam at the end of the course, increasing staff anxiety. On one occasion a trainer refused to deliver the Buccal Midazolam Administration part of the course because she thought staff might say they were competent afterwards. We commissioned one course as part of the project so that the trainee trainers could see a course being delivered, but this was of such poor quality (with a poor value base) that instead our trainee trainer had to repeatedly intervene to prevent staff going away with the wrong messages.

6.b Competence to administer

Confusion about what is required to be deemed competent to administer Buccal Midazolam remains nationally – see 1.4 above. Health colleagues attending Sussex Skills for Care meetings kindly shared their competency procedures/training with the group, but this involved quite lengthy workbooks and/or observation of administration that were too onerous or impractical in a community setting. This lack of clarity re training requirements/competency to administer urgently needs resolving.

Practicing administration of Buccal Midazolam during a course

6.c Feedback on the project 'train the trainer' courses

Epilepsy and Buccal Midazolam administration train the trainer

All 10 participants (4 from Southdown and 3 each from 2 other local organisations) who attended this 3 day course rated it highly and found it useful. The trainer was deemed 'excellent' and 'very good' – the course seen as well-structured and interesting; materials of a good quality. Two of the participants were particularly impressed by the way the trainer wove the Education and Training Award through the whole course – demonstrating different techniques to enable people to learn and practicing what he preached in a seamless 'wheels within wheels' manner. Participants learnt, experienced and practiced training techniques as they learnt about epilepsy and the administration

of Buccal Midazolam. Because of this, the Southdown managers/trainers said that the content stayed with them.

Of the 10 people who attended the training, only 4 completed the accreditation assignments (3 of the 4 from Southdown and 1 from another organisation). We understand that at the time this was a not untypical level of completion (for this course). The assignments involved much more work than any of us had expected and this was not clear from the information given to us (despite attempts to clarify). In addition, the instructions for some of the assignments were not clear – and it took time to establish what was required. Despite this, one of the Southdown trainees submitted a portfolio that was one of the best the training provider had ever seen and did enough work to achieve an additional epilepsy qualification at no additional cost.

The training provider says that they have made a number of changes since 2016 after 3 qualification/course reviews. This includes reducing the amount of post course work slightly, introducing other ways to obtain evidence (e.g. recorded skype calls), rewriting assignments and including a support pack outlining terminology and requirements. They say that they are also much clearer about the requirements up front (including approx. 60 hours post course self-directed study) and as a consequence their completion rate has risen to 80%.

Of the 10 original trainees, only 4 (including 3 out of the 4 Southdown staff) have delivered any training to staff in their organisation. One organisation sent 3 staff on the course but as none of their staff achieved the accreditation they have not delivered any in-house training, nor have they given other staff any information/briefings from the course. The other partner organisation has run in-house courses and is very pleased with how they have gone. They told us that it has been really helpful to be able to provide face-to-face training for staff with a focus on supporting clients with complex needs and epilepsy.

Medication administration train the trainer:
The 4 Southdown staff who attended this course rated it as good. Some of their comments are: “training materials extremely high quality”, “trainer consulted with us regarding the content of the materials” “clear course plan provided” “good use of practical exercises” and “continuous opportunities for discussions”. One of the Practice Development Trainers did note that the epilepsy course had a better focus on training skills, but still said that this course was of a high standard.

The chemist/trainer who delivers this course then observed the two current trainers delivering it. He assessed them using the same criteria he uses for his own trainers and passed them both – with some additional useful comments about style, pace and content.

6.d flexibility

Having in-house trainers enables us to respond to need and deliver input to small groups close to their service if required. This would be far too expensive if we were commissioning external trainers – where we need to commission a course for a large group run centrally to make it cost-effective/affordable.

6e Sustainability

Two of the three original trainees for this project left Southdown before the end of the 1st year. This was due to unanticipated events and despite careful selection of trainees we thought would be likely to stay with us for a while. One trainee received a bequest that allowed her to fulfil a lifetime ambition and go travelling. The other had personal circumstances that meant she needed a break from being a residential care manager. This highlights one of the challenges/risks in running a project that involves intensely training a few key personnel and then being reliant on them. However the model that we have identified enabled us to send another Practice Development Trainer on open train the trainer courses run by the same trainers/training providers (at our cost) – demonstrating that this model is reasonably robust and sustainable with potentially only short gaps.

6.f feedback from staff and managers

We (phone) interviewed a sample of staff who had attended either course. See appendix 4 for the basic, broad questions asked.

Epilepsy and Buccal Midazolam Administration (37 staff interviewed)
The feedback has been overwhelmingly positive.

> "I have done this training before with the local authority, both for Adult and Children's services, and this [Southdown's] training was the most comprehensive and gave me confidence that I could deal with an emergency situation"
> Support worker

The only issue has been that a few staff who do not currently support anyone prescribed Buccal Midazolam have asked why they need to attend (we made the decision to train everyone because staff sometimes move service or need to work in other services, clients' needs change and new clients may be prescribed Buccal Midazolam).

92% of those interviewed found the course useful.
2 of the three staff who were less effusive have had previous training, frequently witness seizures/administer Buccal Midazolam and still felt that the course was a helpful refresher.
32% commented positively on the information they gained re epilepsy.
The majority of respondents focused on the administration of Buccal Midazolam as this is the potentially anxiety provoking part of the course.
Just under 30% said that they really valued the practical aspect of the course (with some contrasting this with previous training that had just been theoretical or involved watching a film of administration).
Just under 30% highlighted the value of going through the process for administering Buccal Midazolam.

> "It was good to practice the skills and run through the checks and process you would follow if you had to give Buccal. I enjoyed that exercise. The course was about the right length to give you the information and practice time."
> Support worker attending epilepsy training for the first time

"I had to administer Buccal 5 days after the course. Because of the course I had the confidence to deal with the situation and to give the Buccal. I felt prepared. "
Support worker

19% talked about feeling more confident, reassured or less anxious about administering Buccal Midazolam (and others made comments that suggested this).

1 participant (who had not yet witnessed a seizure) suggested that it would be useful to have film clips of seizures. We found some excellent Epilepsy Society film clips and are now showing these on the course.

Managers who attended the training unanimously gave positive feedback – with 'useful' and 'good' being amongst the most frequent comments.

"I think the training was good and the [Epilepsy Society] Buccal leaflet will be a good reference for the rest of the team. I think going through a mock incident and following a protocol will help staff feel more confident to know what to do and that they will have clear guidance as to what to do and when."
Service Manager participant

For some managers, this had triggered other actions. This could be providing more information to staff and in one case ""I have also gone back and looked at the criteria for our client and referred them back to the CLDT as I would like these [criteria] reviewed and fine-tuned"

I thought the content was good with just the right amount of information which was not complicated or difficult to digest"
Service Manager participant

Medication administration (22 staff interviewed; feedback obtained from managers at managers meeting):
Feedback (sought at the time) from managers who attended the managers meeting which took them through the new course was positive. They reported that the course appeared "really thorough", "in depth" and said that it was "good that practical skills are being taught on course" (Some added that the previous course was too theory based and did not prepare people for the assessment back in the service). Some said that they liked the 7 point check and have seen staff using this in the service.

81% of staff participants interviewed talked positively about the course and rated it as useful.
32% noted the anxiety caused by having to pass an assessment (unusual for our training), although most recognised the importance of this. 2 participants, however, felt that this got in the way of their learning.

"We were given plenty of time, it didn't feel rushed and it was done well. Of course knowing you could fail makes you feel anxious but it's good to be put under that pressure as it is important you get it right." Support Worker
Support Worker

6 participants (27%) noted that the course highlighted/successfully imparted the need to be vigilant and the importance of getting this right.

The main negative comment arose from staff seeing pass/fail written on the sign in sheet – this was particularly difficult for those staff who had had negative experiences at school. As a consequence we have changed this, so that this is not visible to participants but held by the trainer.

The anxiety about the test was passed onto some staff before the course. One stated "there is nothing wrong with the course but I found the build up to it made me feel anxious – comments from colleagues 'oh, you are doing the meds course..oooh'". We will consider how to address the anxiety, although it won't be possible to remove it altogether and, as some participants noted, this was one of the drivers to their focus/concentration and appreciation of the importance of getting things right.

> "It was daunting to see pass/fail against your name on the sign in sheet; made me feel like a failure right away. The training isn't an issue as everything was explained well but it's the thought of taking a 'test' that made me feel anxious as I have never been good at exams" Support Worker

6.g Feedback from clients

We obtained feedback from 9 clients who had had their medication administered by a member of staff who had attended the medication administration training. Unfortunately I shredded some of the feedback forms before inputting the data from them. Although we were able to go back to 2 clients the subsequent feedback was less rich than the initial feedback. All bar 2 clients were positive about the way the trained member of staff had administered their medication – although one added that she wanted to take her medication with a cup of tea rather than water (giving the manager the opportunity to explain why this wasn't possible). Two clients had more specific feedback about the way in which their medication was administered by the trained member of staff and the approach taken by the staff member. Unfortunately as these were amongst the shredded forms we don't have the detail – and the two clients concerned didn't repeat the detailed feedback when we went back to them. We will be asking for feedback from more clients in future.

See appendix 3 for feedback form/questions used.

6.h Medication assessment 'failures' and staff with additional learning needs

11 staff failed the medication assessment (simulated medication round – undertaken 3 times on the course). Of these, 10 passed on their second attempt (either re taking the whole course or having 1:1 input from a trainer in service) and one failed on three occasions, despite a Practice Development Trainer going to the service to take her through the learning and assess her 1:1. This staff member's role was restricted so that she did not administer medication (and she has now left Southdown). We have had no further failures since Dec 2016 – suggesting that the message about the need to pay attention may have become more embedded in services.

We had some concerns that the course methodology/assessment might disadvantage those staff with additional learning needs (e.g. dyslexia) or those for whom English was not their first language. Having in-house trainers, however, enables us to provide 1:1 follow up input and a second assessment (in the case of anyone who fails) in-service if required – in the environment in which someone would be administering medication. The assessment mirrors what a staff member would be expected to do when administering medication – and ultimately staff have to be able to undertake this task as part of their role. The lack of further failures since December 2016 suggests that this is not as big an issue as we feared.

6.i The role of managers

We had planned to take managers through the new course early on in the project, but as the project work highlighted the need to review/amend our medication policy we delayed the input to managers until this had been done. As a consequence managers were not fully aware of the training their staff were receiving, making it harder for them to prepare staff for it. This might have contributed to the cluster of simulated medication round assessment failures early on in the project (see 5.i above). This perhaps reinforces the findings from other workplace learning research that the role of the manager is critical in staff learning.

6.j Medication errors

Using medication errors as an evaluation tool proved much more complex than we had anticipated. Problems with/gaps in data entry meant that it was often difficult to tell who was responsible for the error (to establish whether they had received the new training). This has led to a concerted effort to improve data entry and it has improved – from an average of 48% of errors where we know who was responsible) up until the end of 2017 to an average of 70% in the first quarter of 2018. In addition, there are more fundamental issues re using medication error data as an evaluative tool. Does an increase in recorded errors indicate an increase in errors, or an increase in the ***reporting*** of errors? Could an increase or decrease indicate an increase or decrease in the amount or complexity of the medication prescribed to clients? The chemist/trainer who licenses our training suggested we needed a different approach – considering errors as 'our friend'- something to learn from (to avoid a blame culture). He suggested that what we wanted to see from better training was an increase in the ***reporting*** of errors (from increased reporting, rather than occurrence) and a decrease in the ***severity*** of errors. Southdown has a dedicated group that is examining the medication errors data in more detail and information from them may be useful to us.

In reporting from the medication error data there are two important caveats.

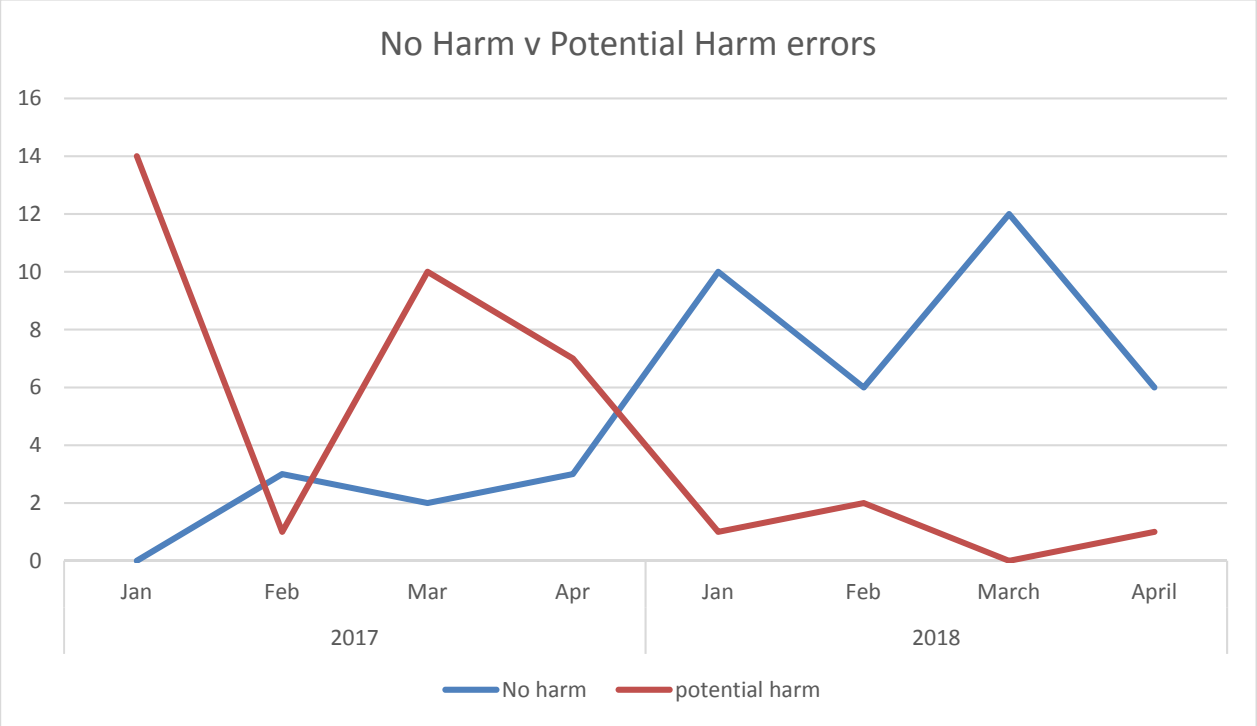
1) We changed the way medication errors are reported part way through the project
2) There are gaps in the data re who was responsible for the error making it hard to know in some instances if the person responsible has received the new training or not

Bearing these caveats in mind, the following two charts may show some correlation between positive outcomes and the new course.

Chart 1: Errors with the potential to cause harm committed by staff who have undergone the new training (where the person responsible is known)

This chart shows that the percentage of errors (with the potential to cause harm) committed by staff who have received the new training is consistently and (since Oct 2017) increasingly ***lower*** than the percentage of staff who have been trained. Staff receiving the new training are committing fewer potential harm errors than would be the case if they committed the level of errors proportionate to their number.

Chart 2: Numbers of errors with potential to cause harm and those causing no harm



This chart indicates a significant decrease in the numbers of errors committed that have the potential to cause harm during the project and beyond. There were 2 serious incidents in the final quarter of this chart – but they were both committed by staff who had not received the new training.

By the end of the project 14 staff (34 to 31st March) had been booked onto the new medication course by their manager even though they had already attended the previous course and were not yet due a refresher. This typically followed medication errors in the service or other concerns about the individual's medication administration practice. This suggests a level of confidence amongst managers in the new course, as this was a rare occurrence with the previous course.

7. Recommendations

1. The lack of clarity re training requirements/competency to administer Buccal Midazolam urgently needs resolving nationally and regionally. Any guidance that is produced must be fit for purpose in community settings and where Buccal is administered infrequently. We hope to be able to work with the HEEKSS clinical hub to develop something workable for our region.
2. Local authorities could consider commissioning the medication train the trainer and epilepsy/Buccal administration train the trainer courses (or developing something similar themselves/with health colleagues) for those services/organisations that have the resources to support trainers to achieve the accreditation and maintain their skills. They could also commission CPD input. Providers could then pay a pro-rata rate to attend – making it possible for services to train/accredit one or two people.
3. Managers need to be involved early on when new training is introduced, so that they can provide the most effective support to staff attending.
4. Support for providers in commissioning training is still an area of concern and probably warrants more work. We are, however, informed, experienced and diligent commissioners of training and we still struggled to find good quality epilepsy/Buccal Midazolam training prior to this project. National/regional guidance on the competency and training requirements for the administration of Buccal Midazolam will help.
5. Don't shred surveys until you know you have inputted results!
6. This project focuses on one example where health and social care overlap, but there are many others. If we want people with a learning disability and specific health needs to live ordinary lives in the community (rather than in hospitals or specialist units) social care staff have to be able to undertake some 'health' care tasks (appropriate to their role). This is beneficial to the individual receiving support; s/he can receive some health care support from people familiar to him/her as part of his/her everyday life. In addition, this avoids unnecessary call on more expensive, stretched and specialist health services. To be able to carry out these tasks we need clear guidance about what tasks care staff can perform under what circumstances. At the moment the guidance is lacking and access to required training can be problematic. This requires a whole system and regional/national approach. Other areas which can give rise to similar issues include enteral feeding, diabetes, oxygen and dysphagia.

   It would be helpful to have national/regional guidance covering:
   - the health tasks social care staff can undertake under what circumstances
   - the limits of this (which tasks/parts of tasks can only be carried out by trained health personnel)

- the training/competency required and
- how this training will/could be delivered and competency achieved.

Any guidance needs to be fit for purpose/workable in a community/non-health setting and realistic about the availability of health resources. This is something the HEEKSS clinical hub could usefully consider.

8. Conclusions:

This project has enabled us to identify a successful and sustainable model for delivery of in-house medication administration and epilepsy awareness plus administration of Buccal Midazolam at Southdown – ensuring that the trainers have regular CPD input so that their knowledge is current.

The model we have developed could also be suitable for other services/organisations that have the resources (e.g. dedicated training personnel) to support trainees to achieve the 'train the trainer' accreditation.

The approach taken in this project could have wider application for the training social care staff require in the health care tasks they may need to undertake (appropriate to their role).

Small group training in epilepsy awareness and Buccal Midazolam administration

We would like to thank HEEKSS for the funding that enabled us to do this work.

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9. Appendices

Appendix One: The project methodology/inputs

The project had the following broad elements/inputs:

- 2 managers and 1 Practice Development Trainer attended a train the trainer medication administration course (accredited with the Pharmaceutical Society) May 2016 – with simulated medication round
- The same three managers/trainer attended a 3 day train the trainer epilepsy awareness and Buccal Midazolam course in Sept 2016 – which included the Level 3 Education and Training (EAT) Award assessment and qualification for the two managers who did not have this. Because we commissioned this we were able to open it up to two other local providers at cost. This included observation of the trainee trainers delivering part of the course
- 2 of the three Southdown participants completed the accreditation for epilepsy/Buccal Midazolam train the trainer and 1 completed the EAT (one trainer already had this)
- External epilepsy/Buccal Midazolam training commissioned which new trainer attended
- A fourth Practice Development trainer undertook both the medication and epilepsy/Buccal Midazolam train the trainer courses (at our cost) when two of the other trainers left Southdown (she already had a teaching qualification)
- The trained trainers worked together to adapt both the epilepsy/Buccal Midazolam and medication administration course to meet our needs (e.g. including more about the need to be person-centred in the medication course)
- One trained trainer attended the training run by a local authority to ensure we were working to at least the same standards
- The chemist/trainer who delivered the medication administration train the trainer course reviewed the amended course, observed the two remaining trainers delivering the medication course, approved the course and their delivery of it and gave feedback
- We set up a 'licensing' arrangement with the company run by the chemist (at our cost) which for a relatively low cost gives us access to their virtual medication rounds and assessment of this, other equipment, a workbook for each participant and ongoing/regular CPD/updates (at our cost) for the trainers. Participants who successfully complete the course and medication round then get a certificate from the chemists company
- We set up an arrangement with East Sussex County Council (and local health professionals) for our epilepsy/Buccal Midazolam trainers to join their lead trainer for epilepsy/Buccal Midazolam in her regular meetings with an epilepsy nurse as CPD.
- We produced a plan for medication administration and epilepsy/Buccal Midazolam training from induction through to regular refreshers plus input where there is a concern (about individuals or a service)
- When two of the newly trained/qualified trainers left Southdown we agreed with HEKSS that we could extend the project timeframe to end of August 2016 to give the final trainee time to train and deliver courses

Appendix Two: Training providers used:

Epilepsy awareness and Buccal Midazolam administration Train the Trainer course and Education and Training Award Level 3 accredited with Open Awards:
Guardian Angel https://www.guardianangelstraining.co.uk/
National company that can deliver in-house. Open courses available - their main training venue is in Wigan.

Medication Administration Train the Trainer course and licensing: The Medication Training Company – accredited with the Pharmaceutical Society:
www.medicationtraining.co.uk – based in West Sussex

Appendix 3: 2 Examples of client feedback

Do you like the way (*Karen*) *helps/gives you* your *medication/tablets/meds*?

"Yes I do".

"In the morning in a quiet way to give me time to act on it all".

"Gives it to my Mum to explain to her I need it at two O'clock".

"She gives the cold water to myself which I enjoy so much in my life"

"Karen counts it all up for myself, it makes her day"

"In the evening she never forgets there so important for me at Nine O'clock on the dot"

Sent by email by service manager to Practice Development Trainer:

Hi Sharon, I had a chat with Jack this morning and asked him these questions:

Q- Do you like the way that Peter helps you with your medication?
A- " Yes" and he pointed to the green smiley face.

Q- Does he ask if you are ready to take your medication?
A- Yes.

Q- Would you be able to say to Peter that you didn't want your meds?
A- Yes, sometimes I'm busy and ask him if I can have it later.

Q- Is Peter ok with this?
A- Yes, he's very polite, he's a nice man.

Q- How does Peter give you your meds?
A- He puts my tablets in a pot one at a time and gives me the pot.

Q- Do you feel that Peter is patient with you when he is waiting for you to take your meds or is he in a hurry?
A- He is very patient.

These are good /accurate answers from Jack as he would say if he wasn't happy with the support from Peter.

Appendix 4: Phone interview with staff:

Training - Evaluation Questions (phone)

Thinking about the recent Medication/Epilepsy & Buccal Course you attended – what was your impression of it?	Comments:
What worked well?	Comments:
Anything that didn't work or that we could do differently? E.g. add, omit, change	Comments: