primecare

patientsafety news

Patient Safety Newsletter January 2011

Dear Colleagues

A Happy New Year to you all and welcome to the first 2011 edition of Primecare's Patient Safety News.

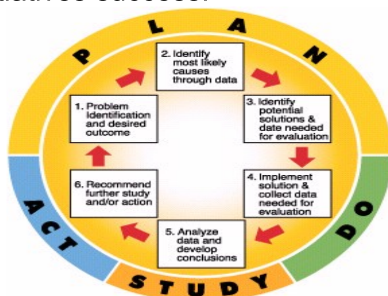
In this edition we will be updating you on some of the initiatives we started in 2010 plus outlining some case studies which we hope will reduce complaints and adverse clinical incidents and increase patient safety.

Finally we will be once again coming around to your region to ask you all to participate in the coming year's safety campaign.

The Next Steps Card

Primecare introduced a Next Steps initiative in our out of hours services in 2010. A card is completed and handed to patients who have had an out of hours consultation and require follow-up with their own GP, improving communication and empowering and acting as a reminder to the patient and their GP of recommended next steps.

The tear off forms and packs were all sent out to the branches plus an informational outcome was added to the Adastra software to track usage of the Next Steps Card and to enable us to follow up on the initiatives success.



Using the PDSA model, our objectives were -to fully implement the scheme across all our services as evidenced by at least 100 forms being given to patients per month plus to reduce the numbers of incidents and complaints related to poor communication.

The project was audited in late October after three months of full implementation. 1042 next steps forms had been issued to patients in England and 94 in Wales as evidenced by the Adastra patient record. This is significantly higher than our target of 100 forms per month, demonstrating the success of the initiative.

Communication-related incidents and complaints have reduced. For the 3 months prior to implementation we had 3 incidents relating to poor communication between the out of hours service and other providers. Since implementation, we have had no such incidents or complaints, demonstrating that the initiative is improving patient safety. We also had positive feedback from GP practices and we have now begun asking patients how they feel about the form in our patient satisfaction surveys.

A full audit is planned this spring to include:

- Review of usage of forms
- Patient satisfaction survey
- GP survey
- Monitoring of complaints and incidents

Thank you to all those of you who have used the initiative- please let us know how it is going and any problems you may have. Thank you

Urgent Care- Case Study.

A 27 year old previously healthy man was seen in a GP-led walk in centre during a week-day morning by Dr A. He was complaining of several days' vomiting, intermittent numbness to the right side of the face and right arm and an intermittent headache for which he had recently been given amitriptyline by his own GP. He was pain-free at the time of the examination, though had vomited twice that day and was concerned that his symptoms were persisting

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Dr A saw and examined the patient recording a thorough general and neurological examination, but was unable to find any abnormality. Dr A checked an FBC and asked the patient to return the following day

When the patient returned the following day, he remained pain-free, but was still vomiting. The FBC proved to be normal and Dr A was no nearer a diagnosis. Dr A checked an ECG to exclude a pericarditis but this was normal too. Dr A felt that the patient was probably suffering from gastroenteritis and prescribed prochlorperazine to resolve the vomiting, asking the patient to contact the surgery later that day to ensure his symptoms were settling. This he did and reported that his vomiting had now settled.

Three days later, after the weekend, the patient returned to the walk-in centre, this time consulting Dr B. The patient reported having attended the local A+E department over the weekend and that they had diagnosed a migraine. He had required IV fluids and felt much better after this. However, by now his nausea and vomiting had returned and he was again suffering from a headache.

Dr B carried out a full examination, prescribed an analgesic for the headache and increased the dose of prochlorperazine. Dr B Advised the patient to increase his fluid intake.

Later that week the patient was admitted to hospital. His condition deteriorated and he was transferred to the QEH in Birmingham, where he was diagnosed with tuberculosis meningitis. Sadly, in spite of intensive treatment, he died approximately two weeks after transfer.

The patient's family issued a multi-agency complaint involving Primecare, the patient's own surgery and the local hospital. They were primarily concerned about the failure to diagnose the fatal illness, but also raised queries about the appropriateness of the prescribing and his investigations at the walk-in centre, particularly the ECG.

Learning points:

1. TB meningitis is an uncommon condition; in the UK there are approximately 100 new cases per annum. These mostly occur in either patients with pre-existing TB or the immunocompromised. However, as this case illustrates, they can occur in previously healthy individuals.

2. When a doctor is uncertain about a diagnosis, it is important to exclude the relatively common, serious illnesses that can present with these symptoms (such as SAH, meningococcal meningitis). However, exclusion of these should not induce a false sense of security. Dr A felt that the cause of the vomiting here was probably gastroenteritis, however the absence of diarrhoea and the chronicity of the symptoms perhaps should have cast doubt on this.

   Often, if an experienced clinician feels uncomfortable about a diagnosis, it is because the diagnosis given does not fit into a recognised pattern. It is foolish to ignore such feelings and one should never be afraid to discuss such cases with a specialist.

3. Be wary of the "scattergun" approach to investigations and explain carefully to the patient why each test is being carried out; otherwise what you perceive as being thorough can be interpreted by the patient as indecisiveness.

4. The patient had been seen by approximately seven primary care physicians before admission to hospital. Although this does reduce the chances of mis-diagnosis, there is a danger of "groupthink" developing, where each new doctor agrees with the consensus of opinion without allowing themselves to consider the possibility of an alternative diagnosis. It is important to remember that each doctor is responsible for his or her own conclusion and must be able to justify their management. When a large number of clinicians are involved in a case it is *vitally* important that notes are clear, comprehensive and unambiguous and that all parties maintain good communication.

If you have any case studies which you would like to share nationally for learning purposes, please forward them to me.

PRIZES EACH MONTHFOR EACH ONE PUBLISHED!!!

Other Safety Initiatives – following up YOUR ideas…….

Infection Control
Following last years training for 20 link workers across the company, further updates and audits are planned to demonstrate the success of this work.

Equipment
We have now defined the essential and recommended equipment for urgent care and added this to the induction manuals plus have contingency bags available in all centres.

Communication card to Health Visitor- This idea from Hereford is now nationally available on the L.I.S system.

Privacy statement - these are now available for patients to ensure they have information on how their data is used and shared.

No Antibiotic required card- these are currently being produced for use in urgent care and we will update you shortly

Zero Tolerance posters- these are currently in production and we will forward them to you early in the New Year.

Seasonal 'Flu'

In order to ensure that patient safety is optimised during the peak seasonal 'flu' time, Primecare have taken several actions.

Firstly, we have strengthened our telephony systems and changed our message to callers giving them several options to assist self care and signpost to appropriate services.

Secondly we have been able to offer patients calling with 'flu' a divert into our dedicated advice line, where usually well patients with flu like symptoms can receive advice from a clinician. This ensures that patients calling with other urgent care requests do not have to wait unduly due to the high volumes of flu calls we have received.

We continue in each contract to work with commissioners to maximise patient safety in line with locally agreed pathways.

Clinical Supervision

Clinical Supervision is an integral component of the clinical governance arrangements which supports the promotion of quality and safety as well as the management of demand and therefore risk across our very busy diverse and exciting healthcare divisions. Indeed the principles of Clinical Supervision and the support which it provides to health professionals are an ongoing essential activity and a commitment for all our clinical staff.

In the past we have had rather semi-formal ad-hoc arrangements in place for Clinical Supervision and the process has been implemented as follows;

Nurses and HC clinicians have dedicated time for Clinical Supervision built into their contract of employment of an hour per month or more dependent upon need. They should attend group supervision/guided reflection sessions and can also request one to one supervision and have a choice of supervisor.

Clinical audit and written feedback links into Clinical Supervision and Primecare request clinicians to place audit, feedback and reflection from ACIs or complaints into their portfolio for their annual Primecare and/or PCT led appraisal.

We also support the GP Registrar training in OOHs scheme. Each GP Registrar has a named clinical supervisor and for GP's the LMA provides professional leadership and facilitates clinical supervision and development.

Whilst these arrangements are undoubtedly fit for purpose on a needs led basis for individual clinical areas, we now plan to formalise the process across the whole organisation as per our policy.

The aspirations of any clinical supervision arrangements for a healthcare provider are;

- To enable clinicians to reflect on their practice and to be able to openly recognise and acknowledge their strengths and weaknesses
- To support the development of practice in order to develop the clinicians knowledge base and their acquisition of new skills thus ensuring that as providers the organisation is working to, achieving and maintaining local and national 'best practice' standards
- To provide opportunities for clinicians to reflect on and in action and in order to help them to develop measured considered responses, in particular those developed following difficult practice situations.
- Finally to enable clinicians to constantly evaluate and improve their contribution to patient/client care.

In context; The NMC and the HPC strongly advocate and promote clinical supervision as being an essential component of sound professional practice. It is recommended that clinical supervision is regarded as essential to all clinical roles, and as such that a requirement to engage in clinical supervision is included in all clinical job descriptions.

2011

In January 2011 we will be working in partnership with Birmingham City University to deliver a formal programme on Non Managerial Clinical Supervision. The course lasts three days the aims of which are:

To develop, through non-managerial clinical supervision, an appreciation and full understanding of a clinician's responsibilities laid out by the clinical governance agenda; to develop the necessary skills and to feel empowered to implement and lead appropriate change to professional practice

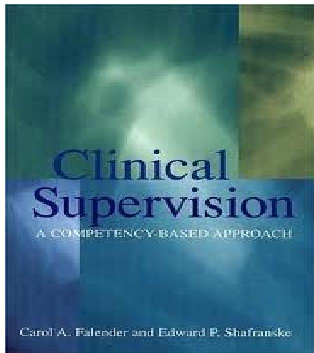
The Learning Outcomes are:

- For practitioners to understand the strengths and weaknesses of 1:1 and group supervision so that selection of the appropriate method of supervision is informed.
- To learn the necessary skills to be a supervisee and a supervisor
- To learn how to reflect both in theory and practice
- To learn non-judgemental problem-solving and decision making strategies
- To appreciate different learning styles, identify their own style and understand what issues this is likely to raise for themselves and others
- To learn clinical leadership and negotiation skills

This course is aimed at clinicians who are leading and negotiating changes in practice and hopefully it will help our clinical staff to anticipate and deal with conflict resolution and assist them to manage changes in the clinical area appropriately.

We have representatives from across the organisation, Primary Care, WIC, Police and Secure. The course commences on the 18th January and I look forward to seeing the delegates in the CRC

Watch this space next time for feedback on the outcomes of the course. .



Best wishes Ursula Holt
Educational and Service Development Lead

Top Three avoidable complaints and adverse clinical incidents for 2011

In order to determine the 'top ten' list of avoidable incidents we looked at the complaints and ACI database and looked at trends.

The following are taken from each service line as the top 3. In each edition of this newsletter this year, we will examine some of the top ten avoidable incidents.

Primecare Primary Care

1. Complaint Type: Unsatisfactory Attitude

Quite a significant proportion of complaints that we receive are precipitated by the patient's or their representative's perception of the clinician's attitude toward them. If one or two aspects did not meet their expectations or perhaps diverged from their understanding of expected practice, they may complain and the clinician will need to address those issues in their response. It is often the carers of the patient that are the most anguished, particularly if the patient has died.

Clinicians are usually very considerate to patients however in the out of hours urgent care setting, the clinician is not known by the patient and so a therapeutic relationship has not had time to build up.

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This may require additional attention, here are some tips:

i. Relationships based on openness, trust and good communication will enable clinicians to work in partnership with patients to address their individual needs.
   a. be polite, considerate and honest
   b. treat patients with dignity
   c. treat each patient as an individual

ii. Clinicians must be considerate to relatives, carers, partners and others close to the patient, and be sensitive and responsive in providing information and support, including after a patient has died. In doing this you must follow the guidance in *Confidentiality: Protecting and providing information (GMC).*

Other actions you should take to avoid complaints:

- Effective Communication included in **all** training
- Refresher training for non clinical staff
- Individual clinician reflection and clinical supervision
- Audits undertaken and individual feedback given
- Management of patient expectations

2. Complaint type: Poor clinical care

It is difficult to define the types of complaints under this category and therefore how we avoid this type of complaint but generally this usually relates to patients complaining that they have not had enough time with the clinician, that they have not been examined thoroughly or that the diagnosis was incorrect.

A few of the actions the clinician can take to avoid these situations include:

- Take time with each patient and take a full history
- Explain each step in the examination
- Give advice and always give ' next steps' advice and safety netting
- Explain your outcome and gain agreement from the patient on the next steps

And finally, and **most importantly**, fully document your consultation as in the majority of cases this will support you as a clinician in refuting any case of poor clinical care. This should include negative findings as well as positive.

3. Complaint Type: Delay in provision of care

Delay in the provision of care is usually outside of the control of the consulting clinician or reception staff and this can present a difficult scenario.

However everyone can make a real difference in whether the patient issues a complaint or not just by offering an apology for the delay upon arrival at the patient's home, in the PCC or walk in centre or by phone. A simple apology and explanation of why the delay has occurred without blame to others is usually easy and diffuses the situation.

Other actions we can take to avoid delays are:

- Explain Primecare processes to patients i.e. walk-in patients
- Ensure patients receive comfort calls and are advised of all delays
- Ensure patients are advised to recall if symptoms are worsening and re prioritise.
- Audit and telephone triage training to ensure correct priorities are assigned
- Resource levels reviewed and all clinicians working productively and to time
- Standby rotas and contingency measures.

And remember, that whilst we strive to have no delay in the system, we are not perfect but the majority of patients will accept some delay as long as they receive a timely explanation and apology.

Another Case Study

Following a complaint by a patient who complained that the doctor did not visit her, (even though the notes support that he did), the Wales office have introduced a calling card system for the doctor.

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OOH Doctor Advice

You were visited/seen by the Out of Hours Doctor

Dr ____________________ on ________________

You were advised to:

____

____

Please recall Primecare if you are worried or your symptoms worsen

This is not the same as a card advising the patient that the doctor called but could not gain entry, this is a card to leave for patients who may have short term memory problems and whose family may need to know when the doctor called and what was recommended should the patient forget.

And Finally…….

2010 has been great year for patient safety across Primecare

- help us to make it even safer by sending us your experiences and recommendations so that we can share learning across the organisation.

Make 2011 a safe one and thank you all for your continued efforts especially the patient safety representatives in each area.

The BEACON Awards for the person or team, who has raised patient safety awareness or delivered a key improvement, are coming soon!

Keep up the good work

Judy Prescott
Head of Safety and Quality