

MANGERE BRIDGE SURGERY

PHO and Facilitator

Procure: Suz Heslop, Nicky Bricknell.

Team members: Dr Chand,

Nurse: Marianita D Gamayon.

Receptionist: Tania

Practice Manager: R Chand.

Organisational “Buy - In”

Aim: To be able to manage lab result efficiently.

Buy-in: Discussed that doing this project will:

1. enable us to spend minimum time imparting results to clients;
2. find ways of having efficient communication within the staff, and with the clients .
3. ensure that results are looked into on arrival in timely manner.
4. generate a clear decision agreed by everyone, that needs to be in place for all results and method of communication to client.

Held staff meeting, explained the value of this project, gave time estimates needed, & commitment with flexibility. Everybody agreed into it.

Change Ideas

Driver Diagram

:audited lab test results for 10 random patients each month, taking FBC as result obtained in that month. Found all were seen within 7 days and were normal. Therefore no action required to be taken. Discussed in team meeting that what can be improved.

What Changes have you tested?

	Change Tested	Outcome
1	Communication with clients at each visit ,how result should be communicated	Dr & nurse & reception asked methods of communication and documented in notes in to-do task – 100% co-operation achieved from staff and clients .
2	Since looking at results & advising client was already on time as seen from our Audit data (in our study)	Improvement was made to have a procedure to look at result twice a day in the inbox and add in comments for nurse to act on in given time frame.
3	Comments written in lab results, (as follows): Abnormal - stated action needed such as recall, repeat test etc. Abnormal - no action required; Normal - Result communicated to clients as their method of choice within 2 days	Very effective- saved nurses time to ask for action plan, Result reached clients in timely manner.

Most Successful PDSA Cycles?

Lab results FBC audited randomly of 10 patients; found were seen within 7 days and acted on. Up till this Audit, Comments were not in lab results & method of communication was not documented in all client record.

Made Poster in waiting-room advising clients to check for results if it has not been communicated to them within 7 days of doing tests.

Also verbally communicated to them when tests are requested for them to give us valid contact details of their choice of communication and follow it up with us if they have not received results in 7 days.

All staff took responsibility in keeping updated contact details.

Key words used for abbreviation, used in comments section of lab results.

Action plan was communicated to nurse via red bulb in MedTech32 (PMS).

Measures Summary

Briefly describe what you are measuring and how and why? Include Dashboard

- 1) Were measuring efficiency of **Lab results' handling** within the practice.
- 2) Found that this was efficient but could make some improvements, which was done and successful.
- 3) This was possible by involving all practice team and clients, plus some enhanced communications.
- 4) Method of results given to clients, was given more attention to get it documented on dashboard.

Highlights and Lowlights

What has been the experience of the team (General Practitioners, nursing and administrative staff and patients) in terms of their involvement in the improvements that have been made?

1. Responsibility of admin staff to keep updated contact details at each visit, got more attention.
 2. Doctor to look at INBOX results twice a day (morning & afternoon), and comment on action to be taken.
 3. Nurse carries out action plan twice daily.
- Efficiency improved and this lab results procedure applied to discharge summaries, radiology results as well.

Achievements to date

Do you have an

- agreed aim? “All lab results be looked into daily by Doctor; and Dr & Nurse be ready for action/release/communication of same with client in timely manner. Teamwork (including Reception), be promoted.”
- a change package: “Check Lab Results’ INBOX twice daily; Dr continue to prioritize actions with Red bulbs in PMS; document in Clinical notes on actions taken with client.”
- measurement plan: “Monthly review random sample, using Query”.

Do people on your team know what their responsibilities are and what is expected of them? :Yes.

What has changed and what difference have the changes made?

:Certain areas been identified that needed greater attention, and will get higher priority going forward.

Any other achievements?

Add any thing else you'd like to share here:

- Experiences with trigger tool
 - How the work has impacted your team
 - Anything else you think might be useful to share
- * *Keep tract of results ordered & follow up results; responsibility of person ordering tests, using red bulb as “to-do” list in patients notes.***
- ** *Clients given responsibility to chase up their own results within a week of having tests by ring up practice & speaking to nurse or leaving a message for the practice team to return call on same day & detailed Documentation of communication made with clients .***
- *** *This avoids delay in looking up results and missing urgent action if required or delay in diagnosis & management.***