Learning Session 3

Highland Park Medical

Results Handling Bundle

Team members:

Orna McGinn – GP/ Project Lead

Jocelyn Meynell - Nurse Leader

Phillipa Taylor - Nurse

Bronwyn Mansfield - Practice Manager

PHO and Facilitator:

EastHealth - David Harrison

Measures Summary

Aim:

"HPMC will develop practice systems and processes to ensure results are handled in a safe, reliable and consistent manner, within 7 days of receipt“

What are we doing?

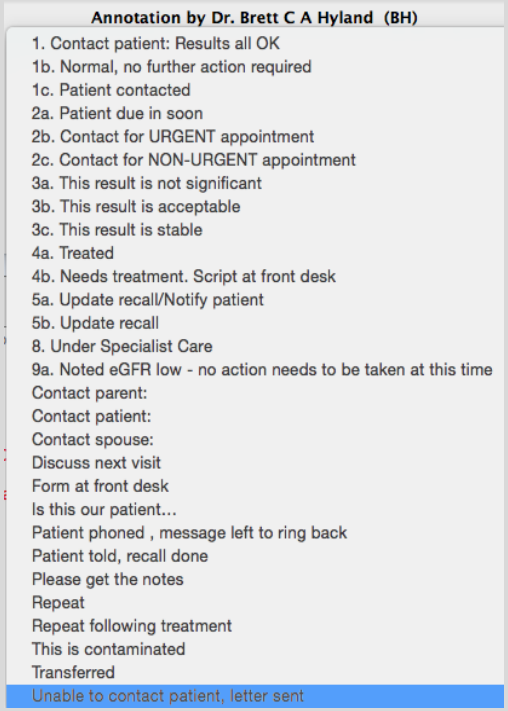
* Increase patient knowledge of process for results handling within the practice
* Consistency across the team
* Reduction of the nurse guesswork through clearer communication and standardised instructions from each GP to the nursing team

Why are we doing this?

* We have whole team involvement in a continuous quality improvement project
* The results handling process has been made simpler with less multiple handling within the process
* We now have a clear plan for slightly abnormal results which require no further action

Change Package

	Change Tested	Outcome / Evidence of Improvement
1	We had inconsistencies across the team. The GP's did not understand how the lack of annotations on the results made extra work for the nursing team	This was discussed at GP meetings and ideas were brainstormed on how we could develop a centre wide system
2	We developed a set of 'drop down' annotations in the results to standardise procedure of results processing	This was trialed and reviewed and updates made to refine these several times. These are now used by all GP's in the team. Reducing nurses need for guess work on slightly abnormal results that require no action.
3	We updated the PMS to ensure the patients 'preferred' contact is loaded	This has reduced missed calls and call backs as we are able to email and text many of our patients directly from the results box.



Trigger Tool / Climate Survey

Trigger Tool

We have undertaken the trigger tool with one GP and one nurse doing the notes reviews.

We identified several triggers, including one significant event.

The findings have been reviewed with the practice management team and will be discussed at the upcoming full team meeting.

Safety Climate Survey

We had FULL practice participation in this survey.

We still have issues with the ‘double negative’ questions and understanding the scoring in the results summary.

The outcomes of this survey will be discussed with the team at the upcoming full team meeting.

Highlights and Lowlights

HIGHLIGHTS

 Nurse Driven Change
The nurses have been able to openly discuss their concerns that ABNORMAL results were being filed with no comments. The nursing team did not know if unannotated abnormal result was because
A) The GP was comfortable with the result and they were not significant or
B) The result had been filed in error and overlooked by the GP
The nursing team was concerned as it is not within the nurse scope of practice to interpret lab results and make clinical decisions for patients
- Unannotated results lead to double handling and delay in information getting to the patient
- Inconsistencies with GP intention and information to the patient

 Increased confidence in nursing team on reporting of abnormal results back to patients. As results have been seen, clearly and uniformly annotated on and signed off by the requesting GP.

 Reduction in 'doubling handling' of results and back and forth communication between GP and Nursing team

 Specific annotation options available across the team to ensure continuity of care to all patients.

 Further implementation of PMS *direct patient communication* (via email and text) has ensured that we are able to see a trail of actions and communications taken with each result within the PMS system.

LOWLIGHTS

 Still some dissent between team members to utilise standard result notes. Not all abnormal results are being annotated on by team members.