Safety in Practice

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Nurses: Katie, Coleen, Beryl
Admin team: Jenny Jenkin (Practice Manager)Julie, Jo and Jackie.

Change Ideas

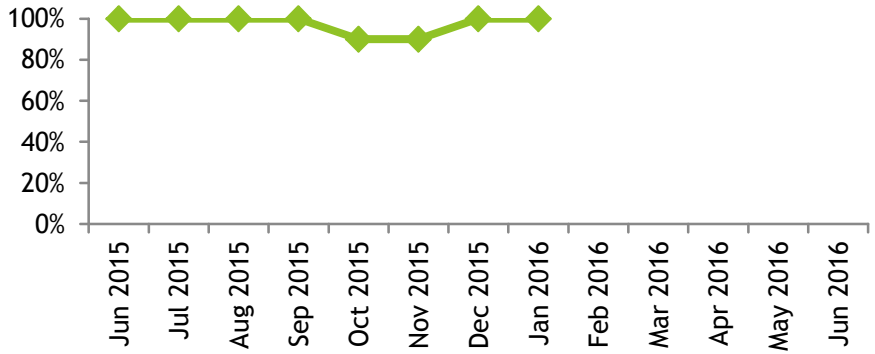
- Standardise the process of lab result handling-time frames and annotations to results.
- Focus on the outcome to the patient in how the results are communicated-is this a significant result?-texting, letters, phone calls. Use reminders-for important results, tasking if contact with the patient is not guaranteed.
- Patient Portal –Manage My Health MMH introduced
- Tasks-auto generation of a task from blood test letter if letter sent as a result of an abnormal result.
- Tasks not closed off until confirmation that message has been received.
- Education of locums-expected result turn around times, using of quick keys, tasking nurses.
- Ongoing audit of results handling
- Trigger tool audit-started-we have selected a sample of patients from the over 75yr olds looking for harms. Each of the GPs will do a group each.
- Climate survey completed and results awaited.

What Changes have you tested?

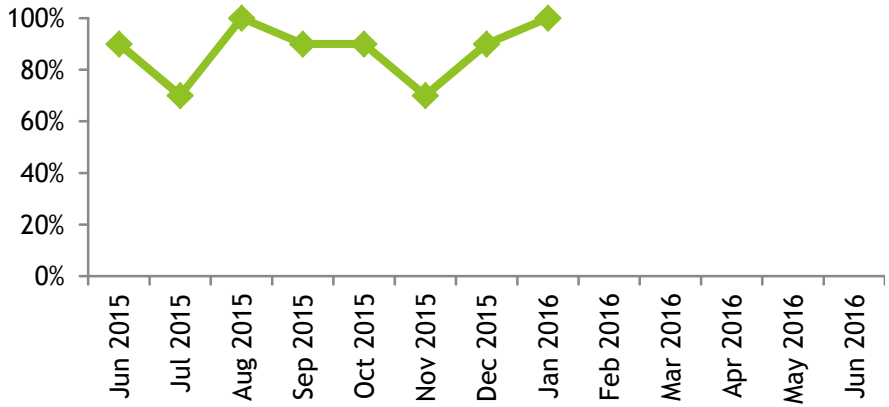
	Change Tested	Outcome
1	Some standardized comments	Quick keys developed –a small number are being used. Normal, Abnormal but not clinically significant, mammogram-normal, recall in 2yrs. This has become more important since the implementation of ManageMy Health
2	Standardised process to ensure appropriate communication	Process clarified- better use of tasks and rolling over of tasks and understanding of responsibility to ensuring the patient has received the result. Tasks not closed until message received especially if high priority message
3	Education of Drs in barriers to dealing with results in a timely manner	The Drs are now dealing (tasking nurses, contacting patient, MMH, txting etc) with almost 100% of lab results within 3 days of receiving it.

Results summary

Was a definitive decision recorded by a clinician on EACH test result within 7 calendar days of being received?



Was the patient informed as instructed?



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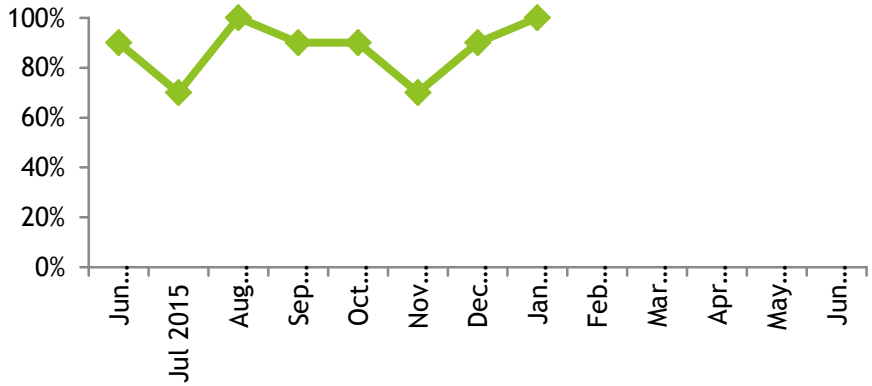
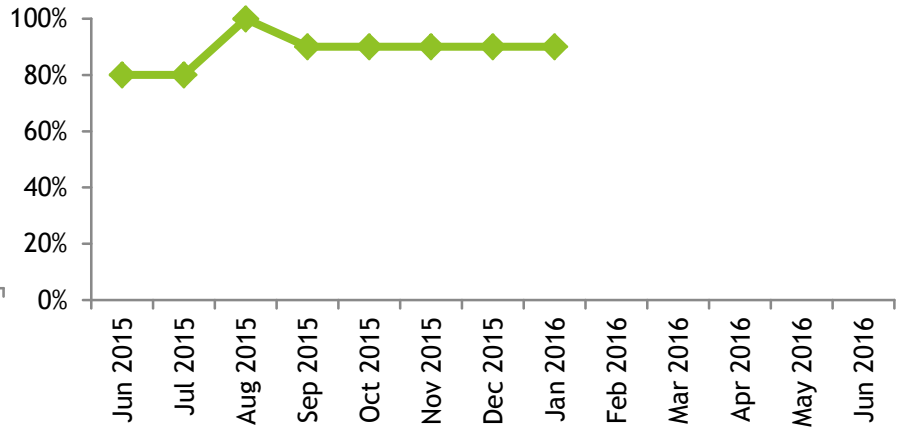


Have the decisions for EACH test result been 'actioned' by the practice including appropriate recalls and tracking of the actions?



Trigger Tool and Safety Climate survey

- We have completed the Safety Climate survey but have not looked at the results as yet.
- We have started the trigger tool. We have decided to look at our over 75s-we have 271 patients and will cross match these patients to those on 6 or more medications. We have randomly selected 25 patients and 5 clinicians within the practice will complete the trigger tool analysis for 5 patients each.

Highlights and Lowlights

Highlights

- Getting together regularly and having some robust discussions about how we work
- Hearing how other colleagues deal with things
- Getting an understanding of how we can make our nurses lives easier!
- Trying out some new ways of doing things, realising we aren't that bad and working together to improve things.
- Implementing MMH

Low Lights

- Quick keys are not that quick-we have agreed to a small number of set quick keys and we free type anything else
- Having to discuss with colleagues if things have been missed
- Actually making change happen-we are great at coming up with ideas but not great at measuring the changes we make.