Learning Session 4

Mount Smart Medical Centre

Team members:

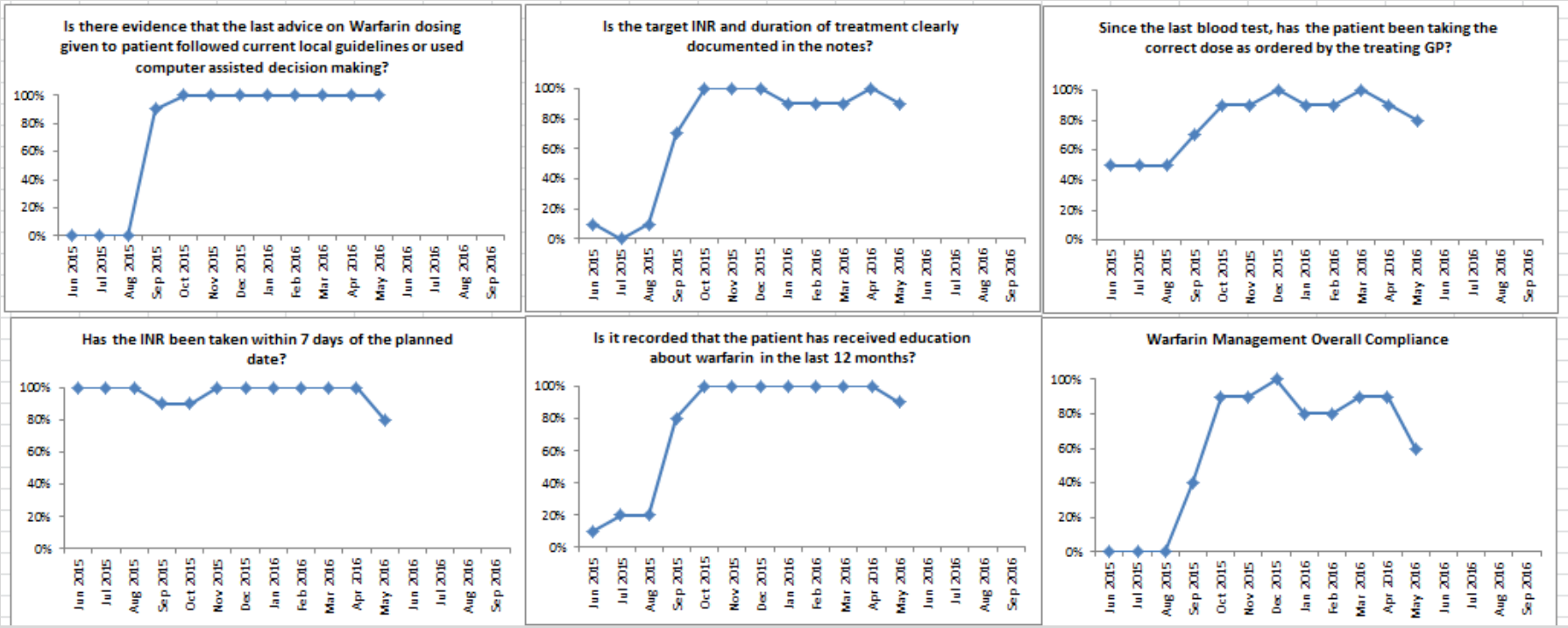
Dr Guy Naden (Clinical Lead)

Hine kura Ngataki (Practice Nurse)

PHO Facilitator:

Philippa Little (Alliance Health Plus)

Measures Summary



Learnings & Change Package

- ***Best Change Idea***
- Transition from paper to electronic records
- Introducing INR Screening Term
- Patient Education Leaflet added to Screening term and sent to patients

Trigger Tool

1. Search Criteria

Maori Diabetic Patients

2. Review Findings

5 patient safety trigger/ incidents detected, nil harm found.

Patient 1 & 3 - 2 visits in less then 7 days, ***Patient 2*** - Cessation of medications,

Patient 9 - eGFR<35, ***Patient 21 –*** Hospital Discharge

3. Incidental findings

Patient 9 - eGFR<35 – The patient safety incident for patient 9, had the potential for a significant event to occur but nil harm was identified.

Background Information: Renal function test 32ML/Min, diagnosed chronic renal failure and chronic heart failure. Patient DNA renal out patient appointment.

4. Reflection, Action & Improvement

- **Reflection:** Currently there is no monitoring of patients you have DNA outpatient appointments
- **Action:** Doctor & Nurse to contact high risk patients who have DNA outpatient appointments
- **Improvement:** Discussion and implementation and process for DNA appointments

5. Experience of tool

Great learning experience. Identified some good opportunities for improvement especially with missed appointments.

Safety in Practice

Safety Climate Survey

1. What percentage of your practice completed the survey? 100%

2. Did you have a feedback session with the team?

Yes, we held a lunch time discussion

3. Was the tool well received?

Yes it was, the tool allowed an opportunity to have an honest discussion between team members.

4. What changes have you made or plan to make as a result of the tool?

- We will continue to have quarterly team meetings to discuss any issues, big or small that might come up.

-Make plans to promote and enhance team work – lunches, open discussions, professional development

Other Thoughts

- Complete regular trigger tools to identify unintentional harm and provide if need be opportunities for improvement.
- Meet with other practices who have similar populations and similar issues