





Learning Session 4 Orakei Health Services

Ngati Whatua Orakei Health Clinics

Results Handling Audit

PHO and Facilitator:

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Team members:

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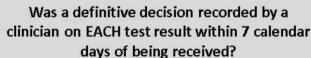


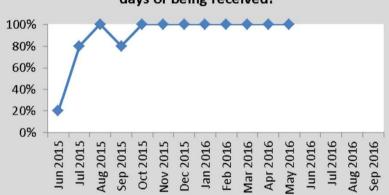


Safety in Practice

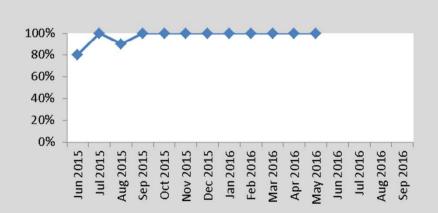


Measures Summary

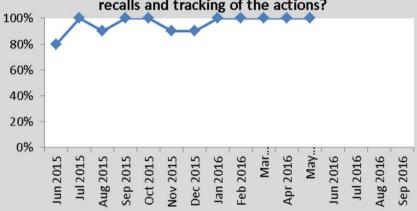




Was the patient informed as instructed?



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

























Safety in Practice



Measures Summary

What we measured:

- Was every result filed within 7 days and have an interpretation on the result along with any actions required?
- Had the decision for each result been actioned appropriately?
- Was the patient informed as instructed?

We found that within 4 months of having introduced the criteria for staff that we had consistently 100% compliance for doctors recording informative comments and actions on all results.

When nurses were short staffed however there were occasional times when non-urgent results or actions were not communicated with patient within the 7 day timeframe – resulting in 90% compliance on 2 occasions.

Added measurements:

- Actual time taken to action result and contact patient
- Method of patient contact to see if doctors texting patients directly (where this was easy) reduced nurse INBOX load and increased compliance





















Safety in Practice



Learnings & Change Package

Best Change Idea

The basic change of having a note on EVERY result which included

- Brief interpretation of result
- What actions if any are required
- Quick keys were an <u>added</u> positive that helped with process

Really improved smoother safer and more efficient processes in practice

Helpful to know

Having REGULAR practice hui were an INTEGRAL part of the success of practice team buy in to the whole concept

























Trigger Tool

1. Search Criteria

Enrolled and funded patients over age 55 yrs with diabetes

2. Harm found

INTERFACE BETWEEN GP and CHEMIST – GP stopped sulphonylurea medication re hypos but patients next blister packs not yet due so patient didn't take new script to chemist. Chemist therefor not alerted so continued on medication for longer than should have

3. Solution recommended/implemented

Recorded as significant event in our incident reporting system - discussed at practice hui - developed a recommended process when change in medication for patient receiving blister packs –new script to be written, given to patient with instructions to take remaining packs back to chemist AS WELL AS faxing or phoning to the patients chemist to alert them.

4. Incidental findings

Nil specific found

5. Experience of tool

Interesting and useful exercise – seemed quite laborious initially working out what to do but once completed actually quite straight forward and would be manageable to do on a regular basis? Once or twice a year?























Safety Climate Survey

- 1. What percentage of your practice completed the survey? 100% (from verbal discussion in practice number who completed it not in summary)
- 2. Did you have a feedback session with the team? Yes over two practice hui we met in small groups to generate feedback then met as a whole group to generate and confirm plan for practice.
- 3. Was the tool well received? Yes received positively (some chasing up to get all to complete survey initially)
- 4. What changes have you made or plan to make as a result of the tool?
 - Weekly practice panul about what happening in practice that week
 - Starting training of some of admin staff to be doing specific jobs that currently done by nurses e.g. some specific recalls, contacting patients etc
 - GM to attend some of the practice hui help facilitate better communication























Patient Experience

- 1. How do you currently determine patient experience?

 Patient satisfaction questionnaires as part of Cornerstone cycles, feedback boxes in reception, monitoring of complaints and incidents
- 2. Do you have any tips for people wanting to engage their patients and whanau?

Attitude and environment that is welcoming and comfortable for people of all backgrounds and ethnicities

Take patients on a "walk-through" of clinic for their perspective as a patient

3. What would you like do more of in regard to patient experience?

Survey that is more specific to our environment and patients

Patient "walk-throughs" including particular groups e.g. kaumatua,
adolescents























Other Thoughts

Are there highlights or anything else that the team would like to share, either with other practices this year or new practices starting soon?

- Really worth while taking part in SIP programme
- Given more confidence and experience to practice team as to how to undertake quality improvement cycles around safety
- Results management bundle a great one to do integral to stuff that can make a difference every day.















