

Learning Session 3

Health, Counselling and Wellbeing

Cervical Screening

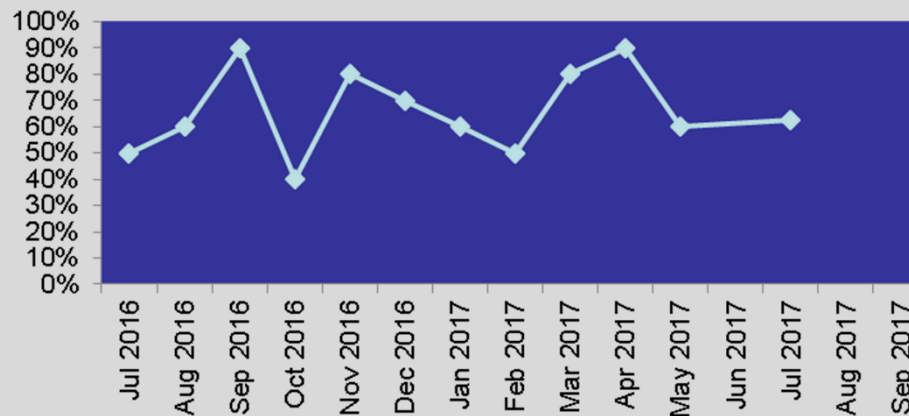
Team members: Susie Poon,
Shona McLeod, Alison Brown,
Stella McFarlane

PHO and Facilitator: Jean Lyle

Measures Summary

Share your results for the year and annotate any key change ideas

Is there documented evidence that a smear has been completed within the clinically defined timeframe?



Measures Summary

Share your results for the year and annotate any key change ideas

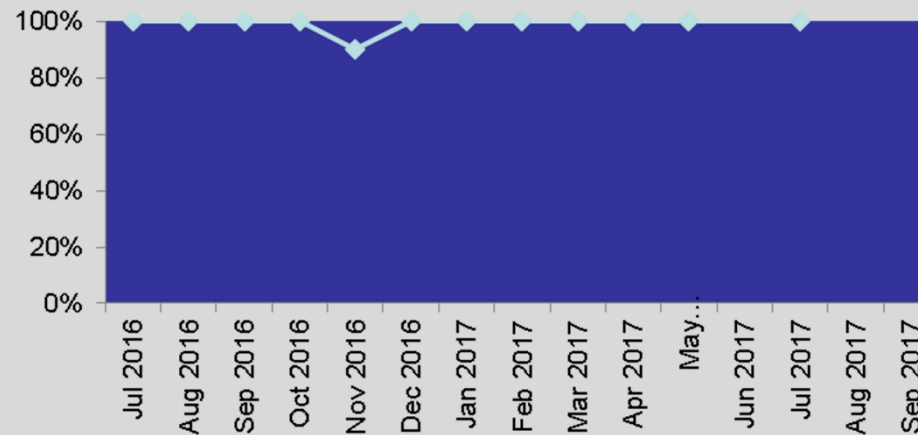
Is there an appropriate recall for their next smear within the PMS system?



Measures Summary

Share your results for the year and annotate any key change ideas

A clear clinical reason why a smear is not required documented (if applicable).



Measures Summary

Share your results for the year and annotate any key change ideas

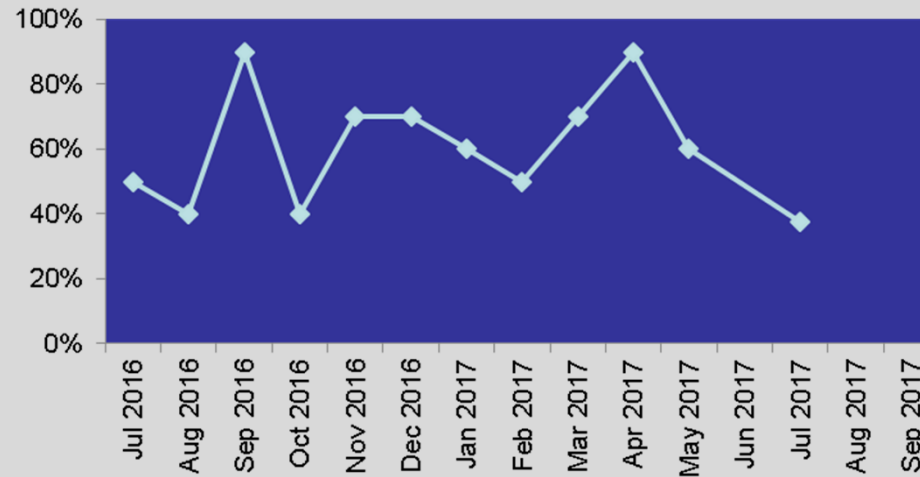
Is there documented evidence that the last smear result was conveyed to the patient with a clear follow up plan?



Measures Summary

Share your results for the year and annotate any key change ideas

Cervical Smears Overall Compliance



Non-responders have a significant impact on AUT overall compliance

Learnings & Change Package

- Performance improved – 69% screened to 74%
- Contacting of patients who are no longer at AUT
- Standardising the process for recording and advising of results
- Improving accuracy of patient contacts
- How did you achieve this improvement?
 - Use of text for results
 - Standardising the cervical screening outcomes
 - Being in Safety in Practice and working as a team, across campuses
 - Communication between staff and staff and patients has improved

Learnings & Change Package

- Best Change Idea
 - Moving from mail to texting for recalls and especially results
- Helpful to know
 - Students prefer electronic communication, we need to adapt to new ways of communicating
 - Need to book in specific safety in practice team meetings to ensure you get the best out of the process

Other Thoughts

- As an administrator, I understand more about the cervical screening process – feel more part of the team
- Clinical staff reminding patients about their smear that is due often results in the patient making an appointment
- Trigger tool – useful for raising awareness of risk of harm with patients who access after hours care but may not respond to follow up calls
- Trigger tool helped us to think about harm in others areas – potential for harm in results that are not triaged effectively
- Electronic referrals need to have the ability to set an automatic task reminder for follow up

Highlights

What are your main highlights from your year in Safety in Practice?

- Working more closely as a team on a specific topic