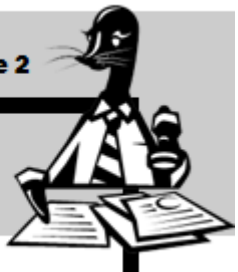
NHS England

DEVON, CORNWALL & ISLES OF SCILLY AREA TEAM

Primary Care Newsletter

March 2014 Issue 2



Significant Event Audits Learning & Sharing

Welcome to our 2nd Newsletter featuring learning from SEAs/SIRIs that you have shared with us.

In this edition we have also included Area Team activity that may be of interest.

Inside this issue:

1. Practice Management Systems & Process

Confidentiality/ Information Governance

Whenever you send an email, check and re-check the address is correct. Does your practice send sensitive information to Patients via email? As the use of email to contact patients increases, practices are reminded to use the blind copy 'bcc' for cascade distribution. **Learning: Are all staff up to date with their IG training? Reinforce the importance of maintaining patient confidentiality and awareness of Information Governance to all staff with a reminder to maintain vigilance at all times when handling patient data.**

Difficult Patients

How do you manage difficult patients within your practice? Do you add flags to the patient notes? **Learning: Full Conflict Resolution training should be given to all staff on how to deal with difficult patients. Could you book your violent patients in to be seen in the morning when the practice is fully staffed, to allow back up and reassurance for your reception staff? Could you adjust your rotas so staff do not work alone?**

Locum Staff

We understand that there is a severe shortage of GP partners and a recruitment crisis facing General Practice with many practices having long term locum doctors in place. Are your locum staff aware of practice policies and procedures? Are you assured no urgent issues will be missed? **Learning: Could your reception staff every evening send an instant message to all clinicians in the building to ask if they have any urgent prescriptions, referrals, results, forms etc. that need urgent actioning, that way information about processing the urgent item can be relayed directly to reception staff? If something urgent needs to be completed after 6pm when the reception staff have left, is there a pigeon hole which all staff are aware of, where all relevant paperwork can be left securely and picked up by reception staff first thing in the morning?**

Booking Immunisations

One contributory factor identified within 1 SEA, was a delay in booking a baby's 8 week Imms. **Learning: To remind all reception staff about the importance of booking immunisations as soon as the 6 week check has been done. Any cancelled 6 week checks to be booked in as soon as possible or within normal surgery sessions if the designated slots are fully booked.**

MEET THE TEAM

- **Susan Bracefield** Assistant Director of Nursing
- **Hazel Crook** Quality & Safety Manager
- **Rachel Newport** Patient Safety Lead

With Specialist Advice from:

- **Dr Shelagh McCormick** Assistant Medical Director

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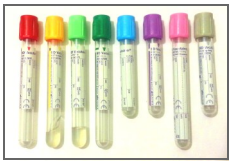
Housekeeping

Fire Alarms - Learning: Do all staff know how to reset the fire alarm?

Home Visits - Learning: Do not defer home visits. Are home visits safety netted by reception teams? Can receptionists check early PM whether all visits have been carried out?

Clinical Equipment



Did you know that blood bottles go out of date too? **Learning: When carrying out equipment checks and stock control, do you check that blood bottles are still in date? All Clinicians must check containers to ensure blood bottles are not out of date at time of use.**

Clinical Waste

Are all sharp bins in the practice out of reach from children? **Learning: Undertake a full risk assessment of the practice. Reiterate the necessity to keep sharp bins out of reach of children. Ensure that all sharp bins are relocated in all clinical rooms.** Where would your Practice Nurses put blunt metal instruments? Blunt instruments could puncture rubbish bags. **Learning: All single use metal instruments even when not sharp should be disposed of in Sharp bins rather than clinical waste bags as there is a danger they may puncture the bag where contaminated materials could fall out of the bag.**

Warfarin Management

Do all staff understand the importance of actioning INR results? What do you do if you cant reach the patient before the surgery closes?

Learning: Stress the importance of informing the appropriate parties of INR results last thing in the evening. Could all staff benefit from refresher training?

New Patient Notes

Have you received your new patient's records from their previous surgery before their 1st consultation? **Learning: To enable your practice to provide on-going care for new patients, ensure that reception staff obtain correct information regarding all patients treatment prior to first appointment with clinician.**

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2. Learning from SEAs

Items for your Clinical Governance/ SEA meetings

Patient History/ Records.

One contributory factor identified in an SEA we received recently, included out of date patient history. Are clinical records up to date and summarised correctly? Is 'Patient History' up to date? Do you have current screening data/ smoking status for all of your patients? **Learning: An emphasis to all clinicians: Clinical records should always reflect content of clinical consultation.** Where a persistent cough doesn't respond to antibiotics and nothing shows up in a chest x-ray then the possibility of CA should be considered.

Non-Compliant Patients.

Recognising patients at risk of Pressure Ulcers, are they at risk of self-neglect? In one particular case, the patient chose to remain relatively immobile due to an injury which increased the risk of the patient developing Pressure Ulcers. **Learning : When seeing or visiting patients with little or no mobility, think are they at risk of a Pressure Ulcer? Are patients clearly aware of the risks? Comprehensive record keeping is essential, document what you have done. Could you consider appending a message to a repeat prescription? Flagging the records with a reminder for opportunistic discussion? Considered a Safeguarding alert?** Patients listen to their doctor, this is an opportunity to remind them of the risk of low mobility.

Misuse of Medication?

Would you know what to do if you felt a patient was selling their medication? What if a Pharmacist approached your surgery concerned that they overheard your patient on the phone, arranging to sell their medication they are waiting to collect? One practice sought advice from the Medical Protection Society around this issue, their advice; **Learning: If you assured that the pt. is taking reasonable medication and is collecting appropriate quantities at appropriate intervals, then there is no evidence apart from hearsay, so advise the Pharmacy to call the Police.**
Further Actions: Practice to watch out for pts. future use of medication and ensure they are not collecting inappropriately, possibly consider reduction in medication or weekly scripts.

Carers

One contributory factor shared with us within an SEA regarding medication, was where the patients medication had been changed by the Doctor but the Carer did not fully understand, consequently the patient took the wrong drug & dose.
Do Carers really understand what your telling them? Are you assured that they have heard you correctly? **Learning: All Clinicians to take particular care when issuing new medications for patients with blister packs and how you communicate this information to Carers.**

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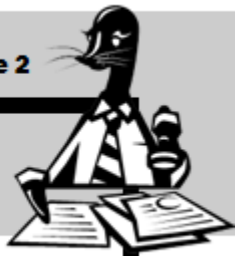

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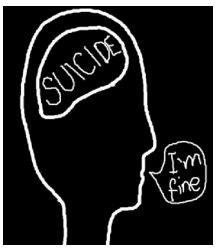
Area Team News

NHS
Treatment Escalation Plan (TEP) and Resuscitation Decision Record

Many Primary Care contractors have shared with the Quality & Safety team concerns they have with Treatment Escalation Plans (TEP) forms.

The Area Team has noted this and the process is being reviewed collectively between NEW Devon CCG and the Strategic Clinical Networks (SCNs).



Regional Learning Clinics

Suicide Prevention & Intervention; Suicide is in the top 20 leading causes of death in the UK, approx. 1 million people per year will take their life. 96% of these take place in the community, only 16% of whom are in touch with mental health services. A regional learning Suicide Serious Incidents workshop led by NHS England (South) took place in Reading. Area Teams across the South region were invited to bring people together from providers, public health, commissioners and other stakeholders to explore how we could improve our understanding of the problems locally and work together to help prevent suicide. To help inform this work we need to improve reporting rates and the quality of information that we have, we need better information and data. One GP at the workshop commented that is hard to know what to do for the patients who "don't quite meet the referral criteria". What is your experience? We would like you to share your experiences with us through the Significant Event reporting process. A local group is being set up to explore this work and develop a plan of action. If you would be interested in either joining the group as GP representative or getting involved in some way we would be very pleased to hear from you.

Please contact our Quality & Safety Manager, Hazel Crook at h.crook@nhs.net or on 07900 715212.

Upcoming Events

Getting a Head Start on QOF, Book your FREE places now!

Primary Care Master-classes on Frailty for GPs and Practice Nurses.

The Area Team is pleased to invite practices to participate in a series of Master-classes to be held in locations across the Peninsula on Frailty recognition and management. These events are aimed to support practices to prepare for the new QOF requirements e.g. the named GP for people over the age of 75, identifying vulnerable members of the practice population and managing people with complex co-morbidities. The sessions will be facilitated Helen Lynden, Clinical Lead and Nurse Consultant for Older People and Long Term conditions, and will focus on the new National Guidance on Safe compassionate care for frail older people that has been led by clinicians from across the Peninsula. Supper will be provided on arrival with registration at 6.30, and 7.00pm start. The sessions will attract 2 CPD Credits. Venues to follow, but will be in the following areas;

Thursday 3rd April in Exeter	**Wed 7th May in Torquay**
Wed 23rd April in N. Devon	**Tues 13th May in Truro**
Wed 30th April in Liskeard	**Tuesday 20th May Plymouth**

Please email the name of your practice representative/s and the date and preferred location to joanne.gage@nhs.net

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Process Update...

NHS England's national guidance, 'Standard Operating Model for Managing Serious Incidents within Services Directly Commissioned by NHS England' was distributed to Area Team's as a working draft in December 2013. Area Teams were asked to test the guidance and feedback any comments before final publication in April this year. The national guidance has been based on the local process our Quality and Safety team created in Devon and Cornwall, as our Quality & Safety Manager was a member of the steering group. We are currently updating our process to reflect the national guidance whilst retaining localized content. Once the national guidance is published and final amendments are made to our 'How To' guide, it will be redistributed to all Primary Care contractors. You can expect this by the end of May at the latest.

The Quality & Safety team are looking to host participation and engagement events once the updated guidance has been distributed. These events will be a chance for you to have your say, share with us your concerns or any problems you have with the process.

Sepsis Working Group

Across Devon, Cornwall and Isles of Scilly the Area Team has been asked to take forward work to develop better recognition, treatment and care of children and young people who develop severe sepsis or septic shock. There is a working group made up of primary, secondary (and tertiary care) clinicians working on the development of an integrated care pathway with the aim of reducing mortality and morbidity rates of this complex condition. We are aiming to run education sessions about 'the deteriorating child' with relevance to severe sepsis. These sessions are being planned to take place in the very near future for both primary and secondary care clinicians. We will of course keep you informed of dates and venues. A webpage is currently under development and will be hosted on the NHS England website, the page will hold minutes of the working group as well as the overall project plan and will be a resource to professionals interested in severe sepsis.

If you are interest in this work and would like more information then please contact our Assistant Director of Nursing, Susan Bracefield - susan.bracefield@nhs.net

Pressure Ulcer Working Group

The majority of our Pressure Ulcer incidents reported to the STEIS system across Devon and Cornwall since the 1st April, have occurred within our Community Providers, with very low reporting numbers for PU incidents occurring within our Acute Providers and Primary Care. Our Quality and Safety team are developing a work stream to explore a system wide approach to 'Win the War on Pressure Ulcers', collaborating with our 3 CCGs, Dr Bob Brown, Director of Professional Practice for Torbay, Andrew Kingsley, Tissue Viability Lead Nurse for NEW Devon and Nicci Kimpton, Tissue Viability Lead Nurse for Peninsula Community Healthcare representing Cornwall and various other provider leads. We hope to replicate workshops hosted by the BNSSSG Team locally across Devon and Cornwall.

If you have any PU Incidents you would like to share to help contribute to this working group or you have any further questions then please email our generic mailbox.

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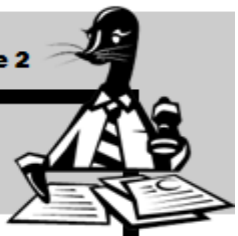

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What does an 'Excellent' SEA/SIRI Incident Form look like?

When completing an Incident Form it is important that the following points are followed;

- Incident forms should be completed by the staff member involved in the incident.
- All fields should be populated.
- Undertake a review of previous medical history and whether previous episodes of care might have indicated the patient was at risk.
- Incident forms should be completed in a timely manner, typically if the practice considers the incident to be an SIRI. All SIRI incident forms should be completed within 48 hours of the incident being identified.
- If the Incident involves any Secondary Care providers it is vitally important that the Patient Detail fields are populated; this will enable the Quality & Safety team to refer the incident to the relevant CCG in a timely manner.
- Notify other organisations when necessary. Eg. NRLS, IG Toolkit, HSE etc.
- **LEARN**—The Learning Outcomes section is the most important. Best Practice involves Learning from incidents to prevent reoccurrence. **Send us your incident forms and we will ensure learning is shared with practices across Devon & Cornwall.**

SPECIAL MENTION

The Quality & Safety Team would like to take this opportunity to thank those practices that have shared their SEA Incidents to date.

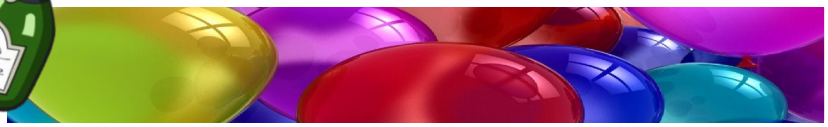
thank you!

***Crownhill Surgery *Mannamead Surgery**

***Elm Surgery *Newcombes Surgery**

***Hyde Park Surgery *Whipton Surgery**

***Knowle House Surgery *Wallingbrook Health Centre**



For more information

If you have any Serious Incidents Requiring Investigation (SIRIs) or Significant Event Audits (SEAs) you would like to share, then please complete the Primary Care Serious Incident 48 Hour Notification Form and send to; england.devcorn-incidents@nhs.net

Any thoughts/feedback or improvement suggestions you have regarding our process would be greatly received.

Quality & Safety Team

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