



PRIMARY
CARE

Case Studies

case study 1

Using the safety climate survey to improve patient safety and communication.

Setting: a large rural practice based in purpose-built premises.

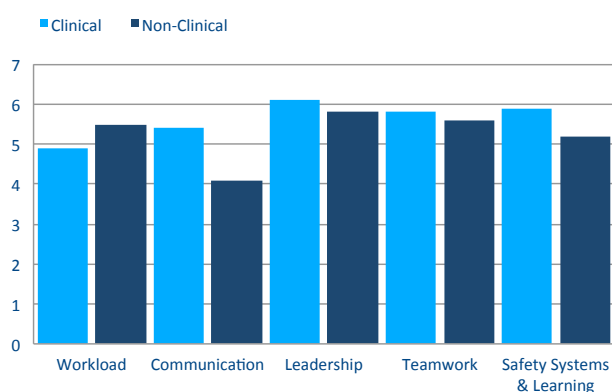
Methods

In 2013, almost all members of the practice team completed the safety climate survey for the first time as part of the Quality and Outcomes Framework (QOF). All members of the practice team attended a discussion facilitated by two members of the NHS board primary care patient safety team. Initial reactions to the survey were very positive. Discussing the results provided an opportunity for the whole practice team to meet (something which everyone agreed seldom, if ever, happened) and discuss matters in an open manner.

Findings

The overall results of the survey were reassuring with particularly good comparative results for teamwork and leadership. However, there was a discrepancy in the results for communication between different staff groups, with those who were not clinicians or managers rating communication less positively.

Clinical vs Non-Clinical



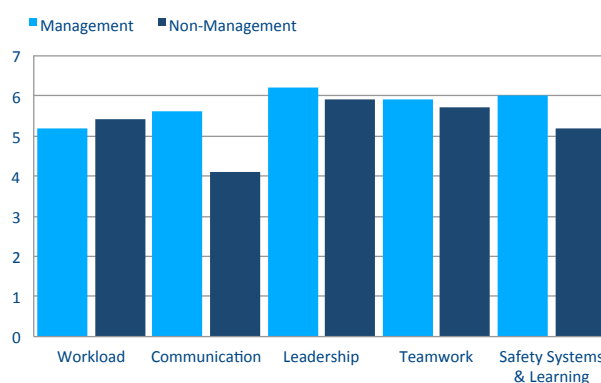
Clinical

Includes all practice employed medical and nursing staff and phlebotomists

Non-Clinical

Includes all other practice employed staff

Management vs Non-Management



Management

Includes GP Partners and practice managers

Non-Management

Includes all other practice employed staff



Learning and improvements

After exploring this in more detail, it became apparent that the biggest single issue related to the communication of results. Administrative staff described particular problems in informing patients of laboratory test results because, at times there:

- was insufficient information available to them
- were delays in clinicians commenting on the results, or
- delays in processing results.

This made it challenging for staff to reassure patients or to determine the appropriate course of action to be taken. It was also felt to increase the number of phone calls to and from patients, generating extra work for all staff groups. This, in turn, led to some patients being dissatisfied, at times complaining, and often requiring a further phone call with a clinician.

At the end of the meeting, the practice team agreed to make this a priority and agreed to meet again to discuss how to produce clearer, more reliable guidelines for all the team.

Further areas identified for improvement included the following.

- Networking with other practices, and learning from their experience.
- Improving communication to patients to better meet their expectations.
- Using electronic systems to record blood tests to be taken would allow nursing staff to work more efficiently, as they would know which bloods to take.
- Using the 'Docman system' to record GPs' comments on test results would allow staff to communicate patients' results more confidently and efficiently, reducing delays, frustration and complaints.

Completing the safety climate survey and taking part in the facilitated discussion made it possible for these issues to be raised, openly discussed and prioritised for action.



case study 2

Using the trigger tool to identify and reduce patient safety incidents for patients in a care home.

Setting: a large city centre practice.

Methods

As part of the Quality and Outcomes Framework (QOF), two trigger tool reviews of 25 nursing home patients were carried out in the practice in September 2013 and January 2014. Both reviews were undertaken by General Practice Specialty Trainees (GPSTs).

Findings

The first review highlighted five patient safety incidents, all relating to prescribing issues. This included increased risk of falls and drug intolerances. However, one patient, who had atrial fibrillation and tachycardia, was discharged from hospital without a detailed medication list. As a result, the patient had to be re-admitted to hospital where a beta blocker was restarted. The practice conducted a significant event analysis (SEA) and issues identified included discharge letters being sent to the wrong GP practice and poor communication between the practice and the nursing home.

A second trigger tool review of 25 nursing home patients again identified five potential patient safety incidents. For example, a patient on haloperidol and gabapentin was suffering from leg pain, so the prescription for gabapentin was increased. Three weeks later, the patient was felt to be sedated. As a result, haloperidol was decreased, then stopped, and the prescription for gabapentin reduced to the original dose.

Learning and improvements

The learning summary on the trigger tool return provided some very useful insights into the process, not only for the clinician undertaking the review, but also for the whole practice team and the nursing homes. For example:

- For GPs and trainees, it highlighted practical safety issues in patient care and involved GP trainees in improving processes to prevent further incidence. The trainees were then able to demonstrate learning and reflection as part of their work-based learning in their ePortfolio.
- For the practice team, there was learning from conducting an SEA about prescribing a drug which had been stopped and discussing the event, both within the practice and with the nursing home staff.
- It also raised interface issues between the GP practice and nursing homes and the need to work more closely together on patient safety.



case study 3

Improving the prescribing and monitoring of patients on methotrexate or azathioprine using a care bundle approach.

Setting: a small practice based in a medical centre in a rural village.

Methods

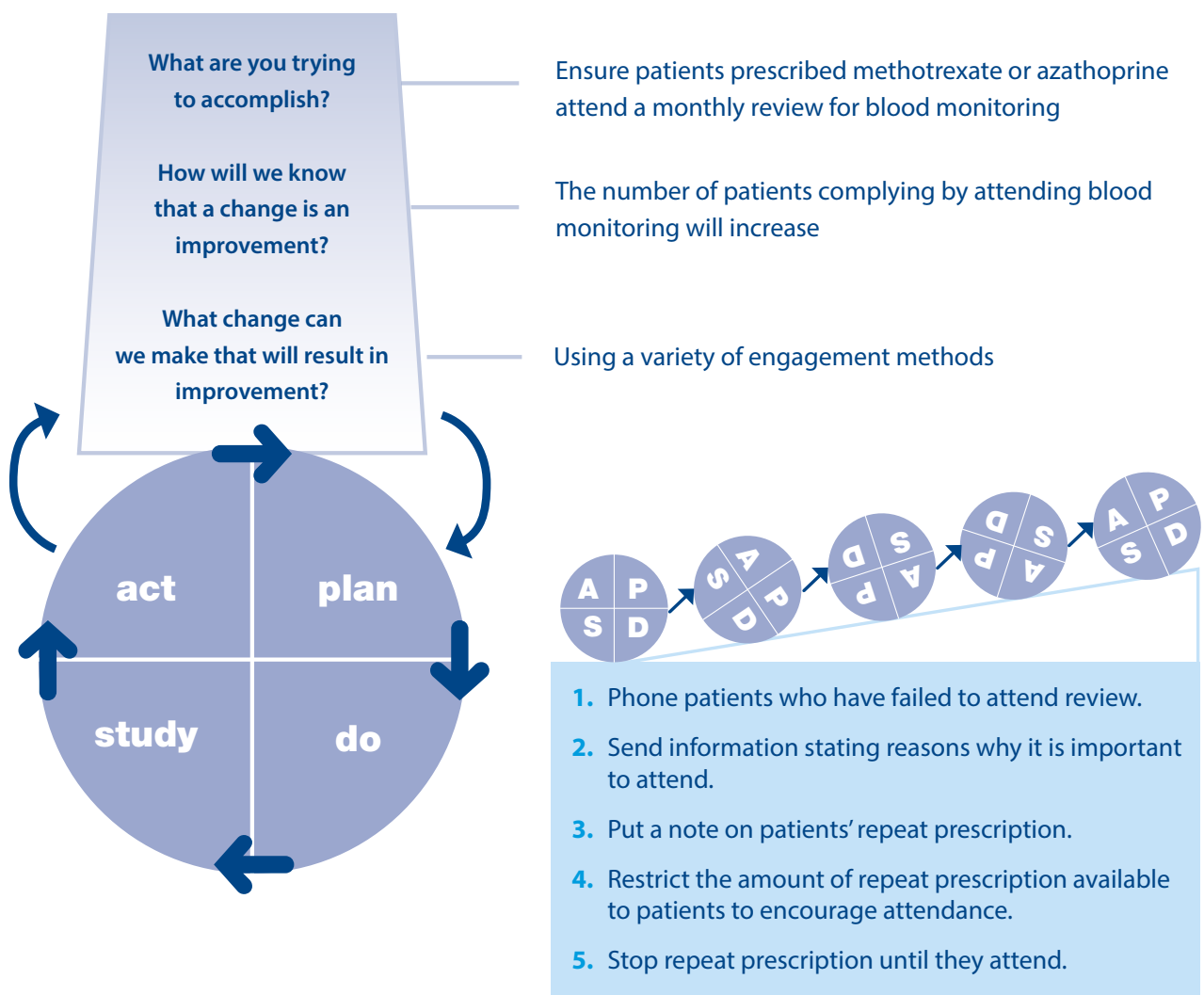
Every month, the practice collected data on 10 patients on either methotrexate or azathioprine for the following measures, using the DMARDs care bundle.

01	Appropriate tests are carried out in correct timescale? <i>Has there been a full blood count in the past 12 weeks (AZA) 8 weeks (MTX) as per local guidance?</i>
02	Appropriate action taken and documented for any abnormal results in previous 12 weeks? <i>If any abnormal results in previous 12 weeks [WBC < 4, neutrophils <2, platelets <150, ALT >x2 normal upper limit (>60)], has action been recorded in the consultation record?</i>
03	Blood tests reviewed prior to prescription? <i>Is there a documented review of blood tests prior to issue of last prescription?</i>
04	Appropriate immunisation? <i>Has the patient ever had pneumococcal vaccine?</i>
05	Patient asked about any side effects following last time blood was taken?
06	Have all the above measures been met?

On the first review of these patients, the practice found there was a problem with reliability, as patients were not attending as planned for their regular review. Using quality improvement methodology the practice team completed a rapid cycle of five PDSAs illustrated in the diagram on page 7.

Learning and improvements

PDSA - Improve compliance of patients attending monthly blood monitoring



Findings

By using the PDSA methodology, the practice was able to demonstrate increased compliance with all the measures. For example, compliance with:

- measures 1–4 rose from 0 to 80%
- measure 5 rose from 0 to 100%, and
- the composite measure rose from 0 to 80%.



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