Can we improve the communication between secondary and primary care?

Poor quality information between secondary and primary care can increase the risk of adverse events and admission or re-admission to hospital\(^1\) so it is important for our patients that we get this right. When requesting that the GP complete further investigations or follow up, it is crucial that they have a clear understanding of what is required, why and the timescale for completion. The BMA and NHS England have published guidance stating that the doctor requesting a test retains responsibility for the results unless this has been explicitly accepted by the GP\(^2,3\). Using the SBAR\(^4\) (situation, background, assessment and recommendation) format in written communication with our GP colleagues will ensure understanding of what is expected and why.

When recommending that a medication is started; the dose should be written alongside any monitoring instructions. When a blood test is required; the patient should be given a form clearly indicating who the results should be sent to. When expecting the GP to interpret any blood results; the most recent results should be included in the correspondence.

It is very important that patients are made aware of any further management plans following an outpatient appointment or on discharge from hospital and that this communication should also be noted on any correspondence to the GP. Following a face-to-face consultation, a useful way to communicate results with a patient can be via a letter, for example;

‘Your blood test indicated that your iron stores are a little bit low and I would suggest you arrange to see your GP and discuss whether you would need to go on a short course of iron supplement’

These simple rules aim to reduce the risk of medication errors, missing investigation results and misinterpretation of these results. It also ensures we maintain good communication with our colleagues and that there is an effective and safe outcome for the patient.

**Dr Rebecca Brown, Specialist Registrar and Chair of the Junior Doctors Safety Improvement Group, [Rebecca.Brown@york.nhs.uk](mailto:Rebecca.Brown@york.nhs.uk)**

**References**


\(^3\)England N. Standards for the communication of patient diagnostic test results on discharge from hospital. London2016.

Pharmacy

Calcium & Colecalciferol (Vitamin D) Preparations

There is a wide range of calcium and colecalciferol (Vitamin D) preparations available. The following aims to summarise the current products and formulary advice.

New Patients

Adcal D3 chewable tablets are the Trust’s formulary choice and should be used when initiating calcium and colecalciferol supplements. The recommended dose of Adcal D3 chewable tablets is ONE tablet TWICE daily. Twice daily dosing improves absorption compared to once daily.

Patients admitted on other forms of calcium and colecalciferol (Vitamin D)

The Trust Drug and Therapeutics committee have agreed that Adcal D3 chewable tablets can be substituted for the calcium and vitamin D preparations shown in the table below.

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Recommended dose:</th>
<th>Calcium (mg) per tablet:</th>
<th>Colecalciferol (units) per tablet:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adcal D3 chew tablets (Trust’s formulary choice)</td>
<td>One BD</td>
<td>600</td>
<td>400</td>
</tr>
<tr>
<td>Accrete D3 tablets</td>
<td>One BD</td>
<td>600</td>
<td>400</td>
</tr>
<tr>
<td>Adcal D3 dissolve effervescent tablets</td>
<td>One BD</td>
<td>600</td>
<td>400</td>
</tr>
<tr>
<td>Cacit D3 granules</td>
<td>Two sachets per day</td>
<td>500</td>
<td>440</td>
</tr>
<tr>
<td>Calcis3 chew tablets</td>
<td>One BD</td>
<td>500</td>
<td>400</td>
</tr>
<tr>
<td>Calichew D3 forte chew tablets</td>
<td>One BD</td>
<td>500</td>
<td>400</td>
</tr>
<tr>
<td>Natical D3 chew tablets</td>
<td>One BD</td>
<td>600</td>
<td>400</td>
</tr>
</tbody>
</table>

Preparations not equivalent to Adcal D3 chewable tablets

If the patient is on a preparation which is not equivalent to Adcal D3 chewable tablets (see table above) the preparation they are on can be sourced from pharmacy. Alternatively the prescription can be changed to Adcal D3 chewable tablets and the dose altered.

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Recommended dose:</th>
<th>Calcium (mg) per tablet:</th>
<th>Colecalciferol (units) per tablet:</th>
<th>Action:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adcal D3 capsules. Note: contains half the amount of calcium and colecalciferol</td>
<td>Two BD</td>
<td>300</td>
<td>200</td>
<td>Order from pharmacy</td>
</tr>
<tr>
<td>Calffovit D3 powder</td>
<td>One sachet at night</td>
<td>1200</td>
<td>800</td>
<td>Order from pharmacy</td>
</tr>
<tr>
<td>Calichew D3 1000mg/860 units once daily chewable tablets</td>
<td>One OD</td>
<td>1000</td>
<td>800</td>
<td>Change to Adcal D3 one BD</td>
</tr>
<tr>
<td>Calichew D3 capsules. Note: contains half the amount of colecalciferol</td>
<td>One BD</td>
<td>500</td>
<td>200</td>
<td>Refer to pharmacy or prescriber for advice</td>
</tr>
</tbody>
</table>

N.B: when either calcium carbonate (e.g. Calichew) or colecalciferol (Vitamin D) are prescribed alone, Adcal D3 chewable tablets should not be used as a substitute.

Prescribe according to Trust formulary. Adcal D3 chewable tablet is first choice.

If you have any questions or comments please contact Annabel Bojkowski 771 2182 or email Annabel.Bojkowski@york.nhs.uk

Medicines Policy Group

The IGNAZ smartphone app has been developed within the Trust to provide junior doctors with access to the latest key clinical information from Staff Room in an easy and simple way.

The app is available to download on Staff Room: [http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/postgraduate-education/the-ignaz-app-for-junior-doctors](http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/postgraduate-education/the-ignaz-app-for-junior-doctors)

or if you would like to suggest any clinical content please contact Jocelyn.matthews@york.nhs.uk
Improving recognition of deteriorating in children in hospital is the key driver for the RCPCH S.A.F.E. (Situational Awareness For Everyone) project. Electronic patient records present opportunities to improve patient safety through reducing errors in recording. We developed and implemented a paediatric electronic observation system with automatic calculation of Paediatric Advanced Warning Score (PAWS). It was anticipated that this would improve outcomes, through better observation recording and PAWS calculation, prompting appropriate escalation of deteriorating patients.

Adult electronic observation and scoring systems were already in use in our trust. Our system built on that, allowing automatic selection of the correct age parameters and calculation of the PAWS using inputted observations. It also included escalation prompts. Staff training on assessment, observation standards, recognition of sick children, and the electronic system preceded the introduction.

Anticipated outcomes of reduced unplanned transfers to PICU and mortality on the paediatric ward were considered to be difficult to evidence since these events are rare. Therefore, process measures were used to demonstrate improvement.

Data was collected pre-implementation, at 2 months and 7 months' post implementation.

Recording of observations, calculation of PAWS and escalation improved following the introduction of the electronic system. The correct age chart is now used for all patients. The correct PAWS are recorded 96% of the time now compared to 70% pre-implementation. (Of those requiring transfer to PICU this was 100% vs. 31%). Frequency of observations was only prescribed in 16% pre-implementation. Frequency is now automatically updated with 99% compliance after 2 months. Escalation of ward patients improved from 56% to 82%.

Recording of PAWS and escalation has improved following the introduction of the electronic system. Documentation of medical reviews requires improvement. There is on-going development of the electronic system e.g. recent addition of neuro-observations.

The electronic system has been primarily designed to reduce error, making it easy for staff to do the right thing. Early warning scores should be not used in isolation. Used in combination with other S.A.F.E strategies, such as improved team and parent communications, we hope to demonstrate an improvement in unplanned transfers to PICU and mortality.

Dr Aesha Mohammedi, Leadership Clinical Fellow Paediatrics, Aesha.Mohammedi@YORK.NHS.UK

More information and resources are available from https://www.england.nhs.uk/signuptosafety/
Results telephoned from Laboratory Medicine

In response to previous concerns about timely and accurate notification to clinical staff of significantly abnormal results, an updated version of the results pad for results telephoned from Laboratory Medicine will shortly be distributed to the wards. It has been agreed by the Patient Safety Group that these forms, which follow the SBAR script (Situation Background Assessment Recommendation), will be the primary means of communicating this type of result. Laboratory staff will be following the read back procedures so that the risk of the wrong patient details being recorded are reduced.

Results are telephoned directly to the ward or requestor because the patient may require prompt clinical assessment or treatment. It is therefore vital that these results are passed onto an appropriate person immediately. Whilst every effort is made for results to be released onto CPD in a timely fashion, the timescale may vary between pathology disciplines. Clinical staff should be able to work from the SBARR results sheet when making management decisions, confident that they are an accurate clinical record and can be relied upon to safely guide clinical management.

The SBAR results sheet is part of the patient’s clinical record and must be filed in the patient’s notes (or scanned and included in CPD).

As per the GMC Good Medical Practice guidance, it remains the responsibility of the requesting clinician to follow-up results and arrange appropriate action.

**Kirsti Miller**, Consultant, Histopathology, Kirsti.Miller@York.nhs.uk

Further information can be found in the Laboratory Medicine Policy available at: https://www.yorkhospitals.nhs.uk/our_services/az_of_services/laboratory_medicine/laboratory_reports/

Spot Diagnosis - Answers

A. Ganglion cyst [http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-291.html](http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-291.html)
B. Reynaud's phenomenon [http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-287.html](http://facultyofmedicine1.blogspot.co.uk/2011/01/what-is-your-medical-diagnosis-287.html)
C. Peripheral Cyanosis [http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-267.html](http://facultyofmedicine1.blogspot.co.uk/2010/12/what-is-your-medical-diagnosis-267.html)

Group Representation

We are working to **empower** and **support** junior doctors to attend and **contribute** to Trust level meetings. Junior doctors and groups will benefit! The following groups are looking for junior representation:

- EPMA (Electronic Prescribing)
- HIPC (Infection Prevention)
- Point of Care Testing Committee
- Admission Proforma Group
- Deteriorating Patient Group
- Patient Experience Steering Group

Contact PatientSafetyMatters@york.nhs.uk for more information or if you would like to get involved.

Editorial Team

Michel Zar, Editor (Specialty Doctor Trauma and Orthopaedics), Laura Bamford, Deputy Editor (Dental Core Trainee), William Lea (Improvement Fellow), Diane Palmer (Patient Safety), Helen Holdsworth (Pharmacy), Donald Richardson (Quality Improvement), Liz Jackson (Patient Safety), Elaine Vinter (Media & Communications)

**Email** PatientSafetyMatters@york.nhs.uk if you have any comments or would like to contribute.

Check out [www.yorkhospitals.nhs.uk/patientsafetymatters/](http://www.yorkhospitals.nhs.uk/patientsafetymatters/) for more information.