Clinical risk management in out-of-hours services

Developing systems that reduce the likelihood of patient harm and introducing standards for staff to follow are vital to ensure high quality care, write Julie Wilson and Kate Taylor

Summary
The role of primary care nurses has expanded in recent years, and many now work for urgent care service providers. With role expansion comes increased professional autonomy, but this, in turn, carries a greater risk of error and, consequently, a greater need for medicolegal protection. This article considers some of the risks associated with out-of-hours care delivery, particularly in relation to telephone triage.

Keywords
Out-of-hours care, triage, risk assessment, primary care, patient harm, safety, clinical governance

MORE THAN one million people are treated safely in the NHS each year, although evidence suggests that in complex healthcare systems things will and do go wrong, no matter how dedicated the staff (National Patient Safety Agency (NPSA) 2004). Mistakes include prescribing errors, missed diagnoses or wrong-site surgery.

The term ‘out of hours’ usually refers to care delivered between 6.30pm and 8am on weekdays, at weekends and public holidays. These times amount to 70 per cent of the 168 hours in a week.

Many dedicated clinicians and managers strive to offer high quality and responsive services to the seven million patients who contact general practice out-of-hours services in England each year (Thomé and Field 2010).

However, the quality of these services has come under scrutiny in recent years after several high profile and tragic cases of patient harm, including that of David Gray (Care Quality Commission (CQC) 2010a), who in 2008 received a fatal overdose of painkillers prescribed by an out-of-hours doctor, and Penny Campbell (Thompsons Solicitors 2008), who died from multiple organ failure in 2005 after consulting eight out-of-hours doctors over four days.

Patients and their families often feel vulnerable out of hours because of the limited access to health care. During these often anxious times, people want access to reliable, authoritative and reassuring medical and nursing advice, and to be managed in ways most appropriate to their circumstances, whether this be via telephone advice, face-to-face consultations or home visits.

Campbell and Clay (2010) note that patients are not merely ‘casual’ users of out-of-hours services; for many, the decision to seek such care is made with forethought, perhaps after discussion with others.

From the first point of contact with patients, it is imperative for out-of-hours care providers to ensure they deliver high quality, safe care.

Providers have increasingly used nurses and other healthcare professionals to work with GPs in out-of-hours services. This is often a way of making services more cost effective (National Audit Office 2006) and nurses can now handle many aspects of out-of-hours care, although doctors remain an essential element of provision (House of Commons 2007).

Nursing roles and responsibilities in out-of-hours clinical care have expanded over recent years, with implications for training and development and the risks associated with this type of care delivery. Treatment options that nurses are usually involved in include providing advice over the telephone and face-to-face clinical assessments at clinics and in patients’ homes.
Risk management

The theory of clinical risk management is simple: it acknowledges that all healthcare activity, by its nature, carries a risk. To understand the risks associated with out-of-hours care provision, it is important to look at the data relating to complaints and claims.

The data cited here, which are the findings of an internal study undertaken by the Medical Protection Society (MPS), are, however, limited because they do not implicate nursing roles specifically as part of the risk-management process.

The MPS study analysed 526 complaints it had received over a six-month period in 2006. Each case was analysed and prevalent themes in the sample were identified. The aim of the study was to determine common themes in primary-care complaints, to understand what motivates patients, or their representatives, to complain, and to feed this back to the healthcare professions concerned.

The study found that of the total number of complaints, 86 (16 per cent) involved out-of-hours care, 15 (17 per cent) of which were made after bereavement. Figure 1 shows the reasons for the complaints, as expressed by complainants.

Failure or delay in diagnosis or wrong diagnosis is the most common reason for complaint and the conditions involved in these diagnostic errors included pneumonia, meningitis, cerebrovascular accident and duodenal ulcer. Some case studies from the MPS study are outlined in Box 1.

Risk assessment

The skills and experience of staff working for NHS Direct and other out-of-hours services can differ greatly, which is a major concern, because some patients could be put at greater risk of misdiagnosis. It is, therefore, imperative that organisations providing out-of-hours services undertake risk assessments of their systems and procedures.

Risk assessment is a review of systems to identify risk to patients or staff. It is increasingly recognised that safety in organisations depends on their ‘safety culture’ (NPSA 2004) and whether:
- Individuals and teams have constant and active awareness of the potential for things to go wrong.
- Cultures are open and fair, and encourage staff and patients to speak up about mistakes.
- Staff can learn about what has gone wrong and be part of the process of putting it right.
- An organisation’s safety culture influences overall vision and goals of the teams or organisations, as well as the day-to-day activities.

A core function of MPS educational services is to undertake clinical risk assessments of out-of-hours service providers. Common areas of risk in such services, as shown by an analysis of MPS clinical risk assessment reports, are listed in Box 2 (page 28).

The MPS identifies a number of issues that healthcare services must focus on to enable nurses to provide good out-of-hours care:
Box 2 Common areas of risk

- Call handlers giving clinical advice and prioritising calls inappropriately.
- Inadequate recruitment of staff.
- Poor communication with callers and between healthcare professionals.
- Failure to document home-visit consultations.
- Lack of knowledge about the procedures for both the handling and interpretation of test results.
- Lack of individual responsibility for checking equipment.
- Failure to provide effective risk management strategies to help nurse clinicians take steps to reduce risk in their care delivery.
- Inadequate audit of clinical performance.

Box 3 Essential points of telephone triage

- Consultations should be documented contemporaneously.
- Documentation of patient history needs to be thorough, because telephone consultations give no opportunity to assess clinical signs.
- Visual body-language cues are lost.
- Patients should be informed if consultations are recorded (General Medical Council 2002) and there should be robust procedures in place for storage, retrieval and transcription.
- Training in the use of algorithms must be provided.
- A clinical audit of performance, including call monitoring, must be undertaken for each handler.

Nursing roles and responsibilities can include telephone triage and consultation, and referral to doctors on duty or emergency services. These assessments are often helped by decision-support software that enables nurses to follow pathways to determine the most appropriate course of action.

Telephone triage is difficult and good communication and listening skills are essential to enable nurses to pick up non-visual clues, such as pain, anxiety, fear and level of comprehension.

Triage nurses must assess patients’ symptoms fully and, importantly, include a full assessment of their medical histories. This can be frustrating for patients, some of whom may fail to appreciate that out-of-hours providers do not have access to their clinical records. However, eliciting these details reduces the risk of overlooking any important information.

Nurses sometimes fail to understand the risks associated with telephone triage and may take on the role without additional training (Pygall 2010). This should be an integral part of professional development and should cover, for example, use of software employed by the provider. The essential points of telephone triage are summarised in Box 3.

Communication

Effective communication skills Price et al (2007) agree that effective communication is one of the most powerful risk-management tools. It is well recognised that poor communication can be the reason for many complaints and claims of negligence against healthcare professionals (Price et al 2007).

Communication can be verbal and non-verbal. Listening is just as important as talking, and having effective conversations with patients can lead to more accurate diagnoses, helping reduce risk of clinical error. Out-of-hours clinicians should therefore review, improve and adapt their communications skills to enable them to deal with some of the barriers they may encounter.

Team communication Communication between all team members and between healthcare staff and patients is fundamental to good care. However, problems often arise in out-of-hours services because organisational communication systems break down. This can be avoided if the following measures are in place:

- An effective and efficient system for passing information to other healthcare professionals and for prioritising calls.
- A system to inform patients’ GPs about any calls.
- Good communication between staff.

Regular meetings are essential to support communication between staff, for example to discuss problems, and should have agreed agendas and minute taking to ensure that problems or ideas are discussed and followed up formally.

Risk management should be integral to team meeting agendas, allowing team members the opportunity to review patient-safety incidents and
services’ risk registers. Concerns about care must be reported to other healthcare professionals to ensure continuity of care.

Medication
Medicines’ governance focuses on safety and risk-management issues concerned with medicines, that is the systems and risks that can lead to errors and result in adverse incidents. It includes how medicines are selected, procured, delivered, prescribed, administered and reviewed (Audit Commission 2001). This has implications for out-of-hours nurses who may be working within patient group directions (PGDs), undertaking non-medical prescribing or administering medicines.

Good medicines’ governance demands the following:
- Accurate medication histories must be obtained and documented along with known allergies.
- PGDs must be up to date; nurses working with PGDs must be aware of the legal framework and accountability implications as set out by the National Prescribing Centre (2010), in compliance with the Medicines Act 1968 and other relevant medicines legislation.
- Nurses who are qualified in non-medical prescribing, and can prescribe medications within their clinical competence, must maintain their knowledge and be aware of the limitations to their ability to prescribe for certain patient groups (National Prescribing Centre 2010).
- Nurses must ensure that, with regard to the issuing of controlled drugs, the out-of-hours services in which they work have, and adhere to, local systems and standard operating procedures.

Protocols
Good risk management involves developing systems that reduce the likelihood of patient harm by introducing and maintaining standards and processes to which services aim to adhere. Organisations are required to have protocols summarising these standards and processes. Staff must follow them, to ensure they all practise in the same way and contribute towards good clinical governance.

Protocols define areas of responsibility and document the standards of care to be provided. However, it is considered poor practice for individuals to develop them in isolation, because this can result in a lack of ownership by other team members. Unless they are agreed by the teams implementing them, the protocols will rarely be referred to or followed, and only occasionally updated, which can result in team members working to different standards, to the detriment of patient care (Box 4).

Particular attention should be paid to ensuring that there are specific policies and guidelines for managing children and other particularly vulnerable patient groups. There should also be a policy to flag up patients who have accessed the out-of-hours service on several occasions as part of the same episodes of care (Thompsons Solicitors 2008).

Training and development
Patient care needs out of hours are diverse, so it is important for all clinicians to maintain their professional development and clinical competencies. Induction processes for working in out-of-hours services should be comprehensive and robust, and tailored to meet the needs of individual nurses, particularly those new to such settings. Induction should include shadowing and mentoring.

Auditing
It is essential to audit and provide regular feedback to nurses on their performance to improve quality assurance across out-of-hours services and a consistent approach to patient care.

The out-of-hours audit toolkit from the Royal College of General Practitioners (2007) is accredited and can be used by all staff groups, including doctors, nurses and non-clinical call handlers. It is designed to capture the main components of patient contact with out-of-hours services and provide a framework by which staff can examine and improve the quality of calls and consultations.

Risk assessment and incident reporting
Nurses working in out-of-hours care services must be aware of the purpose of patient safety incident reporting. Reporting when things go wrong is essential, as is looking at the underlying causes and learning how to prevent incidents recurring.

Box 4 Protocols

They should:
- Be discussed and agreed by teams.
- Involve representatives from different parts of the service in their development, because they rarely involve just clinical processes.
- Be revised regularly and amended if necessary.
- State the date they came into effect.
- Be easily accessible to all.

Out-of-date protocols should:
- Record the date they are withdrawn.
- Be stored for at least eight years in case of litigation.
It is easy to blame individuals when things go wrong, but close analysis can reveal many possible underlying causes. An incident may occur, for example, because staff have had insufficient training or because policies or procedures are not stringent enough are outdated or fail to reflect best practice.

Associated risks must be identified and measures put in place to minimise the risk of harm to patients or staff (CQC 2010b). This process involves identifying and analysing the risks, identifying the required actions and associated costs, and ensuring that systems are in place to allow regular review of the risks.

Risk can be identified through incidents, complaints, audits, team meetings, or legislation and policy. But to support this, an open and fair safety culture that encourages information sharing and learning with all members of out-of-hours care teams must be promoted.

Emergency procedures
Policies and procedures that identify individual roles and responsibilities in times of clinical emergency must be in place. All nurses working in out-of-hours services must be competent in basic life support and in the use of emergency equipment. All emergency care must be documented and shared at the point of transfer to other healthcare professionals.

Security
Out-of-hours care can involve working alone or in isolated premises, so it is essential that nurses take appropriate precautions and follow local lone-worker policies and guidance.

Safety features, such as risk assessments, must be in place to deal with high-risk situations such as responding to patients with histories of violent behaviour. Practical steps should be taken to reduce the risk of violence to staff, and all team members must have training in conflict resolution and dealing with aggressive patients.

Professional indemnity
All nurses working in out-of-hours services must have adequate professional indemnity, which is an expectation of the Nursing and Midwifery Council (2008).

Conclusion
Nurses working in out-of-hours settings have a responsibility to provide high quality services and prevent avoidable harm to patients. It is vital to provide them with appropriate training and ensure that local policies and protocols are in place, and to involve staff in developing them.

Implementing simple risk-management strategies and good practice mitigate against patient or staff incidents, and reduce complaints and legal claims. Where incidents do occur, it is important to keep staff informed and to involve them in the processes necessary to rectify the situation.

Teamwork and good communication ensure that all staff are working to the same standards and are kept up to date about any changes and developments in local and national policies. It is also important to stress the need for good communication with patients in order to have all the necessary information to provide an assessment or diagnosis, especially with regard to telephone triage.

Managers must have risk-management strategies in place and ensure that all staff are aware of them, if their organisations are to provide and maintain high quality, safe services.

References
Care Quality Commission (2010a) Investigation into the Out-Of-Hours Services Provided By Take Care Now. CQC, London.

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Julie Wilson is clinical risk programme manager
Kate Taylor is clinical manager
Both at the Medical Protection Society