Appraisal Support Pack
Out Of Hours

Appraisal support packs

This pack is one in a series of educational resources which have been designed to help doctors prepare for their appraisal. It has been developed by HEIW.

The pack is designed to give doctors ideas about how they might review their practice and learning in specific practical areas, including for example prescribing. The pack provides guidelines on the types of issues doctors might wish to consider in relation to these areas, and about how they might collect, record and structure this information. The pack includes templates which will help doctors structure this information in a format which can meaningfully be included in the appraisal process.

It is hoped that the pack will help doctors to collect information based on their day to day practice without necessitating a large amount of additional work. Some of this information may already be available to doctors, including for example through clinical governance activities managed by the Local Health Board.

It should be noted that while the information may be the same, the purposes of the activities are separate and distinct. These packs are designed to help doctors reflect on the implications of this information for their personal learning and development and do not form part of any clinical governance or performance management process.

Using the materials for appraisal

It is not compulsory that doctors use these packs, they are available as an additional resource for those who wish to make use of them. It is not suggested that an individual completes all the sections every year; rather it may be used as a guide to produce information for appraisal in a structured format. This should enable the appraisal discussion to become more focussed.

In some cases doctors may simply wish to include the completed templates in their supporting information. You can upload any completed templates to MARS. Under the 'Appraisal Information' section there is an option to 'Add Information', so any templates could be uploaded here. In other cases it may be appropriate to make reference to the activity which has been carried out and to keep the materials suggested here as additional supporting materials. Doctors should use these materials in the way they feel is most appropriate to them and meaningful to their appraiser, and avoid duplication of work or information.

Out Of Hours (OOH)

Under current arrangements some doctors have opted not to perform Out of Hours (OOH) duties at all, and some perform a mixture of in-hours duties and OOH sessions. There are a small number of Doctors who either exclusively or mainly perform OOH duties. If you are performing OOH work this will need to be discussed with your appraiser and should be added to your supporting information to help cover your whole practice.

Contents

Section 1 – Knowledge skills and performance

Prescribing habits

Collect 20 consecutive OOH consultations in which prescribing is an issue – this could be a conscious decision not to prescribe as well as issuing a prescription. Your reflections could include factors that make OOH prescribing difficult – e.g. strong analgesia or sedatives.

Sex	Age	Diagnosis	Prescribing choice	Allergies	Why did you choose this course of action

Learning points identified from these cases

Action to be taken/changes to be made

Example

Sex	Age	Diagnosis	Prescribing choice	Allergies	Why did you choose this course of action
F	*3*	*Sore throat*	*Penicillin V 125mg qid*	*y*	*Chid was unwell some pus on tonsils*
M	*37*	*Back pain*	*Co-codamol 8500*	*n*	*Acute back pain following lifting analgesia only*
M	*65*	*Diabetes with acute febrile illness and blood sugar of 23*	*Amoxycillin 250mg tid and bolus dose of Actrapid (10 units)*	*y*	*Had cold all week now coughing green phlegm – antibiotic in absence of chest signs – no ketones in urine – 10 units Actrapid only 10% of normal daily dose*
F	*44*	*Depressio n and insomnia*	*Given diazepam 5 mg one tablet to see own doctor*	*n*	*Anxious and unable to keep still. Previous episode of depression. Currently no treatment*
M	*6*	*Sore throat*	*Penicillin V 125mg qid*	*y*	*Mum pressurised for antibiotics – child feverish*
F	*60*	*Vomiting and diarrhoea for 4 days*	*Buccastem and loperamide*	*y*	*Patient distressed no evidence fever but unable to tolerate even fluids. Made descision to prescribe Buccastem and pressurised into loperamide also "had them before"*
F	*32*	*Cough*	*Advice only*	*y*	*Patient had 3 day history of non productive cough chest clear advice only*
M	*65*	*Chest pain*	*No prescription*	*y*	*Short episode of possible angina, diabetic patient on aspirin as primary prevention. No previous history well and stable now. Advised to see own doctor for further evaluation – recall prn.*

F	*4*	*Otitis media*	*Amoxycillin 125mg tid*	*y*	*Child in pain with fever mother wanted treatment*

M	*27*	*Dental abscess*	*Metronidazole 400mg tid*	*y*	*Would normally have been triaged over to dentist but was casual attender at the base*
F	*19*	*Morning after pill request (Saturday am)*	*Levonelle 2*	*y*	*Appropriate prescription – appropriate OOH as 24 hours since event- also told to take the two at once – I picked this up on my recent contraception course*
F	*17*	*PV bleeding with pain*	*Ponstan Forte*	*y*	*No evidence infective cause denies sexual activity usually has painful periods*
M	*12*	*Asthma*	*Nebulised salbutamol then addition of beclomethasone – initially 250mg bd Peak flow meter*	*y*	*Patient on salbutamol alone – never had attack before. Nebulised as very frightened and made full recovery add steroid – written instructions given to represent as required*
F	*2*	*Runny nose and cough*	*Amoxycillin 125mg tid*	*y*	*Had symptoms for 3 days with purulent nasal discharge – chest clear*
F	*56*	*Anxiety and depressio n*	*Diazepam 2mg (20 only given)*	*n*	*This lady was very anxious I therefore prescribed short term diazepam in addition to the anti depressant her own GP prescribed yesterday which should help long term*
M	*52*	*Back pain*	*Co-dydramol 2 qid prn (50 tabs)*	*n*	*Acute on chronic back pain seems arthritic in origin*
M	*63*	*Testicular pain*	*Ciproxin 250mg bd for 2 weeks*	*y*	*Appears to have epidymo-orchitis – treated and advised review by own GP in 34 days*

F	*4*	*Sore throat red eyes*	*chloramphenicol eye drops, amoxicillin 125mg tid*	*y*	*Sticky eye red and red throat*
M	*2*	*Sore throat*	*Amoxicillin 125mg tid*	*y*	*Red throat brother of the patient above*
F	*78*	*Cough*	*Amoxicillin 250mg tid*	*y*	*Chest clear but unwell*

Learning points identified from these cases

I was struck by the fact that in these 20 cases I prescribed 10 courses of antibiotics. On looking at my case notes it seems that some of these prescriptions were probably unnecessary. I know that in my own practice (in hours) that I would not have prescribed so many, it may be a case of taking the easy option. I also used benzodiazepines twice, I am far more strict in hours.

The elderly patient with D&V was inappropriately given loperamide and this was entirely down to patient pressure.

I tended to ask about allergy status when prescribing antibiotics

Action to be taken/changes to be made

I can see from these consultations that I am probably more easily pressurised into prescribing out of hours. I will make a conscious effort to stop this.

I will read the protocol for nebuliser use in children and their aftercare as I was not entirely sure what to do in that case.

I need to check allergy status for all prescribing decisions.

Emergency admissions

A GP working in OOH is likely to admit a number of patients to hospital each shift – particularly if performing a "mobile" session. There will also be a number of factors that influence the decision to admit that may not necessarily be present in an in-hours consultation. Some factors you may wish to consider are:-

- Lack of prior knowledge of patient
- Lack of support (nursing, lab results, relatives etc.) OOH
- Difficulty in examining patient (if seen in a poorly lit home with no examination facilities
- "Things seeming worse at night"
- Alcohol +/- drugs
- Your own time needs – e.g. 5 patients waiting for a call

There are probably many other circumstances that impact on this decision. The following section may help you to analyse pressures on you to admit a patient and also allow you to discuss a mix of cases seen in an emergency situation.

To be able to follow up patient progress when admitting it would be wise to get patient consent for this at the time of admission.

Record 10 consecutive cases Out Of Hours in which admission was considered. A conscious decision not to admit is as important as a decision to admit.

Clinical details	**Reason that admission considered**	**Admitted Y/N**	**Was follow up possible**	**Discussion – could the outcome have been different**

Learning points identified from these cases

Action to be taken/changes to be made

Example

Clinical details	Reason that admission considered	Admitted Y/N	Was follow up possible	Discussion – could the outcome have been different
6 Month old child with high temp not feeding and vomiting	*No obvious focus of infection 10 pm mum worried*	*Y*	*NO*	*This child had been ill for 12 hours was getting worse – no calpol had been given. No obvious focus of infection and child v hot – some social pressure on admission (mum living alone not coping)*
27 year old female with left sided pelvic pain and 5 weeks since LMP	*Possible ectopic*	*Y*	*NO*	*I believe this an appropriate admission – could not wait until morning due to risk of serious bleed*
86 year old female patient in nursing home very confused and shouting out (2 am)	*Pressure from nurse in charge as disturbing other residents*	*N*	*N/A*	*Seemed like toxic confusional state of acute onset. The patient was not previously known to this nurse but it was obvious from the records that this lady had previous episodes which responded to antibiotics – prescription given*
45 year old man with acute severe r flank pain IM diclofenac administered and advice for recall in 1 hour if no better	*Renal colic*	*N*	*N/A*	*I could have admitted this patient and probably would have a few years ago. These days however the ability to recall is much improved and indeed this chap had settled considerably – advised to see own GP the next day*
3 year old child with D+V for 3 days not keeping fluids down and lifeless (11pm)	*Child unwell and dehydrated*	*Y*	*NO*	*Had been seen earlier in day by own GP – advised to try small amounts of fluid – child unable to tolerate even sips – Needed admission*

18 month child with abdominal pain and diarrhoea	*Extreme pressure from father (? Alcohol)*	*Y*	*NO*	*Child did not require admission but social circumstances poor, father very aggressive and I had no real choice – letter to own GP highlights this*
74 year old man living with wife. Cough and high temp for 3 days on Amoxicillin no better difficulty sleeping (11.30pm)	*Chap was quite unwell*	*Y*	*NO*	*I don't think admission was appropriate here on reflection. There were no physical signs in chest and although feverish he was quite lucid and able to walk around – last patient on my shift – I wonder?*
67 year old diabetic lady symptoms of UTI and high sugars. Type 2 DM on insulin – capillary sugars 19, 21 and 17 over last 3 hours	*Loss of diabetic control with infection*	*Y*	*NO*	*I really was not sure what to advise this lady regarding her insulin and I could not check her urine for ketones so I admitted her*
52 year old man with	*Possible*	*Y*	*NO*	*Younger man with possible*
3 episodes of short lived chest pain over last 48 hours	*anginal episodes*			*new angina I felt more comfortable in admitting him despite the fact that he was fine and there were no physical signs*
14 year old boy with 12 hour history of r sided abdominal pain	*Possible appendix*	*Y*	*NO*	*Gave a story of progressive colicky abdominal pain with tenderness in RIF*

Learning points identified from these cases

The 10 cases took me 3 sessions to collect (18 hours). I feel that the vast majority of these cases demonstrate appropriate clinical care. There are however four cases that I would have perhaps treated differently had they been my own patients In-Hours.

I remember the consultation with the 18month old child and the aggressive father vividly. I felt intimidated and took the easy option to extricate myself from a sticky situation. I did highlight the issue with the aggressive father to his own GP and indeed once I had left the house I phoned the Paeds SHO and warned her. The child did not need admission from a medical point of view but I believe I had very little option. I don't often get problems with aggressive patients OOH but this case reminded me that every so often there are personal safety issues. There is an event planned for next year dealing with the aggressive patient and I will make every effort to attend.

The 74 year old man with the cough that I admitted was probably not the best choice. I was at the end of my shift and tired, it was easier to admit. I have reflected on that decision and will make an effort not to do that again.

The 67 year old diabetic lady with the UTI and loss of diabetic control raises two issues for me. Firstly I did not have the correct equipment available (ketostix) – I have since addressed this with OOH medical director and they are now part of the standard equipment (oddly enough they would have been available at base). The second issue is a personal learning point – I really did not feel confident in adjusting this lady's insulin dose (the real reason for admission). I have had similar issues InHours and have identified diabetes in general as a learning need but now with more and more Type-2 diabetic patients converting to insulin I need an update in management.

The 52 year old man with 3 episodes of short lived chest pain threw me a bit and as they sounded cardiac in nature my instinct was to admit. On reflection these episodes were all related to rushing up a certain hill near his home and lasted less than 3 minutes each – I should probably have given a GTN spray, advice to take it easy and referred him to his own GP the next day. I am a little confused with the acute investigation of possible new angina and as such probably need to read local protocols.

Action to be taken/changes to be made

From the above I would like to make the following changes:-

- *Attend an event on dealing with the aggressive patient*
- *Learn more about diabetes – specifically issues around insulin use in type-2*
  DM
- *Examine my referral pattern again to pick out patients I may admit as "an easy option"*
- *Find local or national protocols regarding management of new onset angina*
- *Explore ways to follow up admitted cases out of hours for my personal learning feedback.*

Medical Records

Medical record keeping is an important part of any doctor's professional work; it is even more vital out of hours. The patient contact made by a doctor working in OOH will often be the first and only time that patient is seen by that doctor. The medical record is therefore important to record the interaction in case of complaint and to facilitate continuity with the patients in-hour GP. There are a number of important issues that need to be recorded and it may be useful to use the template below to examine your record keeping.

Examine 20 consecutive medical records you have made, these may be face to face or telephone consultations or a mixture. Try to look at them as if your only contact with the patient is the medical record – ask "does this give me sufficient information?"

Presenting Complaint	**Duration of symptoms recorded**	**PMH Family History Social history**	**Drug History /Allergy status**	**Examination findings recorded (including –ve ones)**	**Diagnosis clear**	**Prescription or plan of action recorded**	**Safety netting**

What do the findings tell you about your medical records?

Are there any learning points or actions from this exercise?

Example

Presenting Complaint	Duration of symptoms recorded	PMH Family History Social history	Drug History /Allergy status	Examination findings recorded (including –ve ones)	Diagnosis clear	Prescription or plan of action recorded	Safety netting
Y	*N*	*N*	*Y*	*Y*	*N*	*Y*	*Y*
Y	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*
Y	*Y*	*N*	*Y*	*Y*	*Y*	*Y*	*N*
Y	*N*	*N*	*N*	*Y*	*N*	*Y*	*Y*
Y	*Y*	*Y*	*N*	*Y*	*Y*	*N*	*Y*
Y	*N*	*Y*	*N*	*Y*	*Y*	*N*	*Y*
Y	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*
Y	*N*	*N*	*Y*	*Y*	*Y*	*Y*	*Y*
Y	*N*	*N*	*Y*	*Y*	*Y*	*Y*	*Y*
Y	*N*	*N*	*Y*	*Y*	*Y*	*Y*	*N*
Y	*Y*	*Y*	*Y*	*N*	*N*	*N*	*N*
Y	*Y*	*N*	*N*	*N*	*Y*	*Y*	*Y*
Y	*Y*	*N*	*Y*	*Y*	*Y*	*Y*	*Y*
Y	*Y*	*Y*	*N*	*Y*	*Y*	*N*	*Y*
Y	*Y*	*Y*	*Y*	*Y*	*Y*	*N*	*Y*
Y	*Y*	*Y*	*Y*	*N*	*Y*	*Y*	*Y*
Y	*N*	*N*	*Y*	*Y*	*Y*	*Y*	*Y*
Y	*Y*	*N*	*Y*	*Y*	*N*	*N*	*Y*
Y	*N*	*Y*	*N*	*Y*	*Y*	*Y*	*Y*
Y	*Y*	*Y*	*Y*	*Y*	*N*	*N*	*N*

What do the findings tell you about your medical records?

This was an interesting experience for me, I tried to put myself in the position of not having seen the patient and to look to see if there was enough information for a doctor to glean sufficient information from the medical record to understand what went on in the consultation. I was surprised to notice at least 5 out of the twenty cases did not give a final outcome and that the diagnosis was not clear. The one area that I felt that I had not recorded information that I would have asked the patient was in the drug and past medical histories, I did not record negatives (ie no drugs or no PMH)

Are there any learning points or actions from this exercise?

Yes – I will try harder to record negatives and will include an outcome in each consultation even if that outcome is no diagnosis possible or no action taken. I will repeat this exercise next year to compare.

I understand the importance of safety netting and had the impression that I always documented this but it was missed on a few occasions so will have to be more vigilant.

Reflecting on your learning in OOH care

There are many clinical contacts or educational events that lead to learning and/or a change in practice. You may wish to use the template below to record that experience.

Description of learning experience

As a result do I need to change my current practice?

Do I need further study or updating?

Example

Description of learning experience
I saw an 18 month child on a home visit OOH with abdominal pain and diarrhoea Extreme pressure from father (? Alcohol) for admission – admission arranged. Child did not require admission but social circumstances poor, father very aggressive and I had no real choice. This highlighted to me that I needed further training in dealing with aggressive patients. I have previously seen a video on this issue it was however quite low level and mainly dealt with the "office situation" where there is plenty of help on hand and indeed was aimed at receptionists.

The OOH provider was running a half day session on "aggression in the consultation and how to deal with it" so I attended. This was very valuable and in a way cathartic in that I was able to listen to others and their experiences – one GP had even had a knife pulled on them!

As a result do I need to change my current practice?
The main thing I gained was a sense of not being alone in having this type of experience and indeed that others had extricated themselves from even trickier situations.

In the workshop sessions my admission of the child was seen as a good option and put myself and the child in a position of safety – the importance of letting the paeds SHO know of the background was reinforced as was communication with the patients own GP. I did however pick up that the way in which I initially dealt with the patient probably reflected his anger back on him and possibly inflamed the situation. The father had met me at the door and said "my son needs to be in hospital and you need to admit him" *I replied with something like* "give me a chance to see him first*" which probably set the tone. I learned that accepting and being seen to accept the patients concern may have diffused the situation and that using body language to "tone down" the aggression may be important. In the situation I had responded to the aggression with aggression.*

Do I need further study or updating?
I don't think so but I will examine the next consultation with an aggressive patient to see if I have managed to use these lessons learned.

Reflecting on your learning – Puns and Dens

An alternative way of recording patient experiences is through PUNS and DENS (Patient's Unmet Needs and Doctors Educational Needs, see http://www.bmjlearning.com/planrecord/assessment/punDenIntro.jsp) the example above could look like this:-

Identify PUN

PUN

Describe the PUN

Record the DEN

Fulfil the DEN

<u>Example</u> (from above)

Identify PUN
I saw an 18 month child on a home visit OOH with abdominal pain and diarrhoea Extreme pressure from father (? Alcohol) for admission – admission arranged. Child did not require admission but social circumstances poor, father very aggressive and I had no real choice.
PUN was actually the need to diffuse the situation and deal rationally with the aggressive father

PUN
Patient admitted to hospital unnecessarily and aggressive father not placated

Describe the PUN
Situation beyond my control and possibly not dealt with effectively

Record the DEN
To examine my techniques in dealing with aggressive patients

Fulfil the DEN

The OOH provider was running a half day session on "aggression in the consultation and how to deal with it" so I attended. This was very valuable and in a way cathartic in that I was able to listen to others and their experiences – one GP had even had a knife pulled on them!
The main thing I gained was a sense of not being alone in having this type of experience and indeed that others had extricated themselves from even trickier situations.

In the workshop sessions my admission of the child was seen as a good option and put myself and the child in a position of safety – the importance of letting the paeds SHO know of the background was reinforced as was communication with the patients own GP. I did however pick up that the way in which I initially dealt with the patient probably reflected his anger back on him and possibly inflamed the situation. The father had met me at the door and said "my son needs to be in hospital and you need to admit him" *I replied with something like* "give me a chance to see him first*" which probably set the tone. I learned that accepting and being seen to accept the patients concern may have diffused the situation and*

that using body language to "tone down" the aggression may be important. In the situation I had responded to the aggression with aggression.
I will try to use these techniques in future and will record them as they arise.

Section 2 – Safety and Quality

Significant event analysis

Significant event analysis if carried out correctly can be a powerful learning tool acting as a catalyst for change. A significant event may be defined as *"Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice"* (Pringle et al 1995).

Significant events can be an event where something has gone wrong, where a less correct course of action has been taken or may be an example of where the system or an individual has worked well and the event is analysed in an attempt to ensure that the system will perform equally well should the same situation arise again. The worked examples include one positive and one negative significant event.

Significant events should not be used to apportion blame, rather, to foster an environment of openness and a willingness to examine practice and systems to improve services and safety.

It is important to have a meeting to discuss the event ideally with people involved in the event or if this is not possible with other clinicians e.g Peer support group.

Description of event
Identify the reasons for the event
What are the learning points from group discussion
What changes have occurred as a result?

Example

Description of event
I was working in the base surgery when a 57 year old man attended, he had a PMH of type 2 DM and had been feeling light headed and sweaty for 4 hours. I had triaged his case myself and arranged an immediate (20 minutes from 1st encounter) base assessment. There was no history of chest pain and the patient had insisted that he felt well in himself otherwise. On arrival it was plain that he was experiencing some sort of cardiac event and I immediately asked the receptionist to call a 999 ambulance and ask the other base doctor to join me. The patient then arrested and the two of us started resuscitation. *The resuscitation pack was complete, an appropriate size airway easily found. Both my colleague and myself had attended a resuscitation update organised by the OOH provider (certificate available for inspection) and had been trained in the base defibrillator. We successfully resuscitated this patient and he was conscious when the ambulance arrived. I later discovered he left hospital 10 days later.*
Identify the reasons for the event
I was initially concerned at asking this patient to attend the base; on reflection it was probably the best thing I could have done in the circumstances. I had identified that there was a potential for a serious diagnosis but with a lack of chest pain and other symptoms it could have simply been viral or of non serious aetiology.
What are the learning points?
Everything went well, I acted promptly, used others present at the base to form a team and both doctors were trained in resuscitation and more importantly the use of the defibrillator. I took the patients symptoms seriously and even on reflection appropriately asked him to attend base.
What changes have occurred as a result?
No real changes necessary, this event has been used in a training event specifically for the OOH doctors locally to reinforce the importance of training – the OOH provider now has trained 100% of their doctors and nurses in resuscitation and use of the defibrillator.

Example

Description of event
I was performing a session of telephone triage combined with a base surgery later – all the patients I asked to attend the centre would need to be seen by me. At the end of my triage shift a call came in for a 57 year old man with back pain that had only been present for 2 hours requesting a visit. I advised analgesia as the patient had not even
taken a paracetamol. Three hours later a further request for an urgent visit was made and it transpired that the visiting doctor made a diagnosis of renal colic and had to admit the patient who was in extreme pain.
Identify the reasons for the event

I dealt with this call at the end of a telephone shift after which I was performing a base face-to-face session. I recall being a little jaded with giving telephone advice and when I looked at my clinical records I had not taken a full history. I had assumed short-lived back pain as being musculo-skeletal in origin and had probably been quite short in my advice. Fortunately (although painful) the back pain was not due to a life threatening cause (such as aortic aneurysm) and the patient had the sense to ring back.

What are the learning points?

Take a full history no matter how trivial – telephone encounters remove the ability to eyeball the patient and make a visual assessment. My clinical records of the encounter were inadequate and I had not used the safety net of advising recall as required.

What changes have occurred as a result?

I now make every effort to treat my last telephone triage with equal importance to the first. I will also examine my record keeping in particular with respect to telephone triage. This is a potential "near miss" and I will use this as a learning point and change my practice and try not to be short with patients that call with seemingly trivial or short-lived symptoms.

Emergency care

As an OOH doctor you are likely to encounter emergency situations. You may use this section to demonstrate that you are up to date in this area (eg resuscitation course etc), to identify learning needs or to demonstrate your skills in practice. The recording of a significant event would be an alternative when demonstrating your practice.

Description of event

What happened? What was learned/demonstrated?

Reflection on event, are there further learning needs?

Example

Description of event
I attended a resuscitation course organised by the OOH provider, this included training in the use of the new resuscitation kit and defibrillators.

What happened? What was learned/demonstrated?
The OOH service has recently updated its resuscitation kit, with new oxygen bottles, resuscitation bags and defibrillators. I updated my knowledge of basic life support and am now aware of latest guidance from the resuscitation council UK http://www.resus.org.uk/pages/guide.htm *. This information alone was important, as there have been changes since my last update. More importantly I gained two major learning points. : -*

- *I found out that there are now two valves on the particular oxygen cylinders used. I was amazed that none of my colleagues had been given this information either. Initially I struggled to get the oxygen to flow. As a group we have asked the OOH provider to have stickers made pointing this out to potential future users.*
- *The use of the new defibrillators – this was vital to my work in OOH as the new style machines are very different to the ones I have used before. This traini8ng session allowed me to have supervised instruction in their use and indeed they do appear to be foolproof.*

I have a certificate of satisfactory completion for inspection.

Reflection on event, are there further learning needs?
Previously I have found resuscitation updates a bit boring with very little or no new information imparted. This session did however impart some vital knowledge and practical skills. I would not have attended this event if it had not been mandatory to continue working in OOH as I have regular updates in my own practice. If I had not attended then I am sure that at a subsequent resuscitation thins would not have run so smoothly (please see significant events). I will now make an effort to attend the annual updates arranged by the OOH provider.

Example

Description of event

I was working in the base surgery when a 57 year old man attended, he had a PMH of type 2 DM and had been feeling light headed and sweaty for 4 hours. On arrival it was plain that he was experiencing some sort of cardiac event and I immediately asked the receptionist to call a 999 ambulance and ask the other base doctor to join me. The patient then arrested and the two of us started resuscitation.

The resuscitation pack was complete, an appropriate size airway easily found. Both my colleague and myself had attended a resuscitation update organised by the OOH provider (certificate available for inspection) and had been trained in the base defibrillator. We successfully resuscitated this patient and he was conscious when the ambulance arrived. I later discovered he left hospital 10 days later.

What happened ? What was learned/demonstrated ?

I feel this demonstrates a number of issues ☐

- *Appropriate training*
- *Appropriate use of equipment*
- *Teamwork*
- *Personally acting quickly and efficiently in an emergency*
- *Recognising a sick patient immediately*

Reflection on event, are there further learning needs?

My immediate reaction was one of relief that my colleague was also present at the base which made the resuscitation more effective and a deal less "scary" for me. Looking back now I am able to see the importance of regular updates in training, these events do not happen often but when they do the appropriate training is vital.

I will attend annual updates and training days and hope it never happens again!

Section 3- Communication, partnership and teamwork

Communication skills

A Doctor involved in OOH care may exclusively or mainly deal with patients via the telephone. Different skills are required for this task as there is no direct patient contact, body language is lost and the Doctor will not usually know the patient. Educational events dealing with telephone triage are usually available however the analysis of your telephone skills may be appropriate. It is suggested that you record 10 consecutive telephone consultations and analyse them in the template below. It is probably best to do this on a recording of the consultation rather than "live".

Opening	Elicited patients problem	Formulation of plan	Check patient understanding	Advice given clearly and safety netting	Documentation

Opening

- Introduction by name
- Speaks to patient if appropriate
- Checks demographics.

Elicits patients problem including

- HPC
- PMH ☐ SH
- DH/Allergies.

Formulation of plan- Diagnosis and plan documented.

Check patient understanding – did the patient seem satisfied.

Advice clearly documented including safety netting.

Documentation- does the documentation support the triage discussion.

Reflections on results/exercise

Do I need to do anything different/learning needs identified?

Example

Opening	Elicited patients problem	Formulation of plan	Check patient understanding	Advice given clearly and safety netting	Documentation
Yes full	*Yes – earache in 3 yr old otherwise well*	*Yes – diagnosis of ear pain analgesia alone*	*Parent agreed with plan of action – advised contact own doctor if appropriate in next few days on listening to the recording parent happy*	*Clear worsening advice given.*	*Yes*
Yes but no demographics	*Yes longstanding abdominal pain in 45 year old man*	*No diagnosis – is awaiting specialist opinion pain no worse tonight – advised analgesia*	*I seemed a bit irritated that he had called at 11pm about a problem that was present for 3 months Not really satisfied he actually said "no one seems to be able to give me an answer to this pain doctor" and I seemed to ignore this statement*	*No safety netting*	*Yes*

Not completely – "hello Mrs X this is the doctor"	*Yes – feverish child (aged 2). No allergy status*	*Yes – elicited the fact that child reasonably well and that no antipyretic administered – advised paracetamol and cooling*	*Yes partially satisfied, concerned re lack of obvious focus of infection but happy to try cooling measures*	*Advised to ring back if fever worse or new symptoms*	*Yes*
No – patient very short of breath and more concerned re onward referral	*Yes – severe SOB in patient with diabetes and pre existing angina. No social history but patient unwell.*	*Yes 999 ambulance*	*Yes*	*Clear advice given re 999 and advised to ring 999 if worse himself.*	*Yes*
Yes	*Yes – 24 year old man with back pain of 2 hours duration – caused by lifting*	*Yes – analgesia I had to issue "stock" codydramol as pharmacy shut*	*No – I again seemed irritated with this patient as no analgesia taken before call made Not satisfiedexpected visit and "injection"*	*No clear advice as short history. No safety netting*	*Yes*
Did not ask if better to speak to the patient	*Yes - Nursing Home patient with cough, nurse requesting antibiotics*	*Yes – no prescription issued (12 midnight) advised symptoms (1 day cough) did not warrant intervention at present*	*Sort of – came to agreement with the nurse but she felt antibiotic more appropriate despite lack of systemic upset*	*Advised verbally to contact GP id worse.*	*Not clear regarding worsening advice . Needed more documentation.*
Yes	*Yes – 6 month baby off food high temp and vomited x1*	*Yes – I asked appropriate questions to exclude serious illness and base appointment given for 1 hours time*	*Yes – I checked the mums understanding of the appointment and checked that she actually knew where the base was*	*Clear advice about appointment in base and worsening advice while waiting to be seen*	*Yes*

No – again I called myself "the doctor"	*No – difficult telephone call with patient obviously under the influence – not really sure why they rang*	*No – bit of garbled conversatio n which ended with "well I'm going to bed now" – the patient's words not mine!*	*Not possible Not sure if patient satisfied.*	*No clear advice but patient put the phone down*	*No. Could have documented what had happened more.*
Partially – I introduced my self and discovered that the caller was the patent's sister but not her name	*Yes – confusion and falling – had previously due to a chest infection reoccurred this evening. No social history*	*Yes – elicited no current danger to herself and no apparent injury – arranged mobile doctor to call semiurgently*	*Yes sister aware that doctor would call within next hour or so Satisfaction - Yes – very relieved*	*Clear advice to sister if patient worsens*	*Yes*
Yes – recall from earlier – (see above 3rd case) this time I introduced	*Yes fever worsening no effect with paracetamo l and*	*Yes – to be examined – base consultation very hard as on her own*	*Yes understands doctor will call later. Patient satisfied as*	*Yes. No safety netting documented .*	*Yes*
myself but not before the patient asked "are you the doctor I spoke to as they didn't give a name?"	*bathing. I elicited a full history of red flag signs (all negative)*	*with 2 other children – mobile doctor to visit*	*wanted home visit*		

Reflections on results/exercise

This was a valuable exercise for me and it is the first time I have listened to myself consulting by phone. The first thing that struck me was how difficult it was to judge how I was feeling at the time, the lack of visual input made it difficult for me to judge how appropriately and indeed how seriously I was taking the patients concerns. I have watched video of myself consulting and then because of body language you can get a better idea. The patients must therefore be in a very difficult situation.

I was surprised that I did not introduce myself to everyone (something I thought I did every time). I was happy that I had elicited sufficient information each time

to formulate a diagnosis and/or plan and that I had acted appropriately. There were a few consultations that I was obviously a bit short with the patients; this also seemed to be picked up by the patients. This shortness may be appropriate sometimes but it is clear from the recordings that the patients were genuinely worried regarding their problems.

Was disappointed that not clear in documentation in some cases.

Overall I seemed to be able to come to a negotiated settlement and resolution with the patients although the patient with the abdominal pain and the one with the back pain expected more than I could or would do for them.

Do I need to do anything different/learning needs identified?

Firstly the difficulty in gauging the mood of the "doctor" – yes me! The lack of visual stimuli was a problem even though I had performed the consultation. I will in future be more aware of this difficulty and try to introduce more verbal cues "mms, ums and yeas".

Secondly many of the consultations were shorter than I imagined at the time, I displayed a tendency to dominate the closing section – I used the phrase "that's OK then Yes?" four times and concluded the consultation in that fashion.

To try to ensure that the patient is truly satisfied with the outcome of the triage.

Overall I am happy with these ten consultations, there is some room for improvement and I will repeat the exercise in one or two years time.

Analysis of referral letters – content

It is suggested that you look in detail at 10 consecutive acute referral letters you have written. The person to whom you have referred will be meeting the patient for the first time (usually) and a full patient history is important. The patient is likely to be acutely ill and you may be able to impart important information to the admitting doctor. Check the referral letters for the following details and if appropriate suggest changes. As an OOH GP you may not have access to al the information the patients own doctor would normally have and this may be an interesting point to reflect on. You may wish to include your reflections on the issues identified and the learning points on MARS, and include your analysis as additional supporting documentation, to help cover your whole practice.

Reason for referral	**History of complaint**	**Medication history, allergies**	**Examination findings, tests performed**	**Relevant psychosocial history**	**Past medical history**

Issues identified

Learning points

<u>Example</u>

Reason for referral	***History of complaint***	***Medication history, allergies***	***Examination findings.***	***Relevant psychosocial history***	***Past medical history***
Y	*Y*	*Y*	*Y*	*N*	*N*
Y	*Y*	*N*	*Y*	*N*	*Y*
Y	*Y*	*Y*	*Y*	*N*	*N*
Y	*Y*	*Y*	*N*	*Y*	*Y*
Y	*Y*	*N*	*Y*	*Y*	*N*
Y	*Y*	*Y*	*N*	*N*	*N*
Y	*Y*	*N*	*Y*	*N*	*Y*
Y	*Y*	*Y*	*Y*	*Y*	*Y*
Y	*Y*	*N*	*Y*	*N*	*Y*
Y	*Y*	*Partial*	*Y*	*Y*	*Y*

Issues identified
When I looked at my referral letters I was quite happy that there was adequate evidence of reason for referral and a history of the presenting complaint in all letters examined. The medication history was reasonable in most but lacking in a few which could have been important. I was much worse at recording psychosocial and past medical history this is probably a reflection of not knowing the patient prior to the consultation. I would however perhaps be in a better position to obtain this information compared to the admitting doctor.

Learning points
My referral letters were sometimes of high quality but there was some scope for improvement, there was one in particular that contained insufficient information. The OOH service provides us with structured admission letters and I have simply been ignoring the headings and writing free hand. I will endeavour to "fill in the blanks" even with negative comments (e.g. no past medical history of note). I will re-examine this next year.

Teaching and Training (educational supervisors OOH)

Your out of hours work may involve you in the educational supervision of GP registrars. If you are a GP trainer In-Hours you just need to record the last time you had a re-approval visit. If you are not a trainer the following section will help you to record your input into training OOH.

Date of training course for educational supervision

How often do you have a registrar to supervise?

Short summary of how this works in your case

Reflections on the process

Do you need to change your practice in this area?

<u>Example</u>

Date of training course for educational supervision
January 2012

How often do you have a registrar to supervise?
I work 2 shifts per week and registrars attend on average about every other session

Short summary of how this works in your case
The session the registrars attend is usually my mixed base and telephone triage session. This works extremely well as the registrar has exposure to both types of consultation. The registrar initially performs triage with me sitting next to them and when they become more experienced they triage alone and report back to me between cases. There is undoubtedly an initial reduction in the volume of work but this is more than compensated later when we are able to work in tandem. The base consults are a mixture of supervised and independent practice and the workload issue mirrors that of the telephone triage.

I have 30 minutes built into the end of my shift to complete any paperwork and to discuss cases with the registrar.

Reflections on the process
I enjoy sessions with the registrar in the main, there is a lightening of my workload and I then have the opportunity to use the time saved to supervise and help the registrar to the appropriate extent. I sometimes need to take over to speed up the consultations if demand is high but this is the exception rather than the rule. I would be happy to do more of this.

Do you need to change your practice in this area?*I don't think so – I am learning about the process of supervision and feel that I have sufficient time to do this.*

Section 4- Maintaining trust.

Many doctors perform duties both in and out of hours, this could have an impact on health if hours are overly long or stressful. You may wish to discuss this with your appraiser, in particular dealing with the extent of your working week, strategies to deal with stress and any particular issues around balance between in-hours and out of hours working times.

If you are working only in OOH you may wish to reflect on any health issues arising out of shift work and how you avoid stress related to possible "professional isolation"

Summary of working week

Does work impinge on home and social life?

Are there any issues that need further discussion?

Example

Summary of working week
I work both for my practice and perform some out of hours duties (as detailed in form 2). I work four days a week in practice with Tuesdays off. I tend to relax on my day off either doing gardening or DIY around the house, swimming or occasionally I do some locum work in practices locally (I have done this for the past 3 years).

My out of hours work consist of a regular Monday evening session (6-12pm) and occasional weekend work when usually I am contacted at short notice to cover other colleagues that are unable to fulfil their sessions.

Does work impinge on home and social life?

I have a young family and I would like to keep my weekends free, the regular Monday evenings have some impact in that usually I attend the OOH centre straight from work at the surgery. Apart from that I have the Tuesday evening to myself and usually pick the children up from school and more often than not we will have an activity planned that evening. I also finish early on a Thursday and am home just after the children. Overall there is some impact but not significant and as time progresses it is less and easier. OOH is now less onerous than previous arrangements.

Are there any issues that need further discussion?
As declared in my main appraisal documents I have no current health issues and my