Risk assessment – long term condition management

Introduction

As we restart Long Term Condition (LTC) management we wanted to be able to identify and minimise risks to patients and staff.

Previously patients attended Health Care Assistants (HCA) to have bloods taken and blood pressure, height and weight recorded +/- urine and foot assessment.
Patients then attended the General Practice nurse (GPN) for long term condition management advice and to discuss their results. If indices such as blood pressure were not to target they would task a GP to contact the patient and alter medication.
Blood test results were sent to GPs who would interpret these and contact the patient if medication changes were needed.

We aimed to complete a risk assessment of this process with the team to identify hazards and reduce the risk of harm to patients and staff by redesigning out LTC management systems.

Step 1 – Identify Hazards

Infection transmission
•Attending practice
•Repeated attendance
•Mixing with other patients

Not performing LTC management effectively
•Delayed monitoring and actions
•Capacity higher than demand

Step 2 – Establish Risks

Infection transmission
•Attending practice risk of transmission of infection to patients from other patients, during travel or from staff.
•Increasing footfall in practice increases risk for staff

Not performing LTC management effectively
•Leads to poor control of LTC for patients - increase morbidity and mortality and increased risk from COVID
•Capacity higher than demand – delayed review of high priority patients
•Risk of complaint to practice
•Risk of not fulfilling contractual requirement post QOF
•Reputational risk of providing poorer care than other practices

Step 3 – Evaluate Risks

Infection transmission
•Patients with existing health conditions at higher risk from COVID.
•Increased risk if have to attend repeatedly
•Increased risk if mix with patients with acute illness

Not performing LTC management effectively
•Large number of patients requiring review – some patients at higher risk than others. Some will need review very soon, others can be delayed.

Step 4 – Control the Risks

Infection control
•Attend branch surgery (fewer patients and none reporting fever etc)
•Use telephone and video consulting if possible.
•Reduce number of attendances to one if possible (see below)
•Adhere to all recommendation regarding PPE and cleaning – build time into appointments to reflect this.

Not performing LTC management effectively
•Collect all data at one visit with Health Care Assistant (HCA)
•HCA records how the patient would like (and be able) to be contacted
•HCA informs patient when they will be contacted
•Results reviewed by GP, GPN and admin team member. Dependent on results contacted by GP, GPN or admin.
•Synchronise recall.
•Prioritise invites for LTC review.
•Calculate expected capacity -next 3/12 and subsequent 9/12
•As team agree priority patient characteristics - see table.
•Calculated approx numbers fall into each group to ensure capacity equals demand.

Step 5 – Document and Review

Formal evaluation of changes as a QI project looking at patient and staff satisfaction, attendance rates, number of appointments used and ultimately control of LTC.
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Conclusions

This was a useful way to get team involvement to identify what they were concerned about and identify risks for patients. By discussing the hazards we were able to develop a system that everyone is happy with.

Contact:

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Table 1 – Agreed recall in disease/ monitoring areas

Disease area	Priority 1 (Next 3 months)	Priority 2 (3-12 months)	Priority 3 (Next year)
Diabetes	Due review and HbA1c >7.8	Due review and HbA1c <7.8	X
Vascular (IHD, CVD, PVD)	Due review and BP >150/90 or cholesterol >5	Due review good control	X
Hypertension	Due review last BP <150/90	X	Due review last BP <150/90
CKD	Due a 3 or 6 month review due to deterioration at last test	Due annual review and last eGFR <45	Due annual review and last eGFR >45
Asthma/ COPD	High SABA ordering or 3 or more exacerbations in year	Expected SABA use or < 3 exacerbations in last year	x
Thyroid	X	TSH <0.01 or >5	Good control
Drug monitoring (Lithium, DMARDs)	Ongoing as per practice protocols	X	X
Impaired glucose tolerance/ gestational diabetes	X	X	Restart annual review
Learning disability reviews, mental health, epilepsy (inc sodium valproate)	x	By phone/ attend anywhere if possible	x
Drug monitoring (Mirabegron, allopurinol, testosterone)	x	x	Restart annual BP review next year
Monitoring of terbinafine and nitrofurantoin (LFT)	x	Start 3-9 months	x
DOAC monitoring	Start as many changed during COVID	x	x