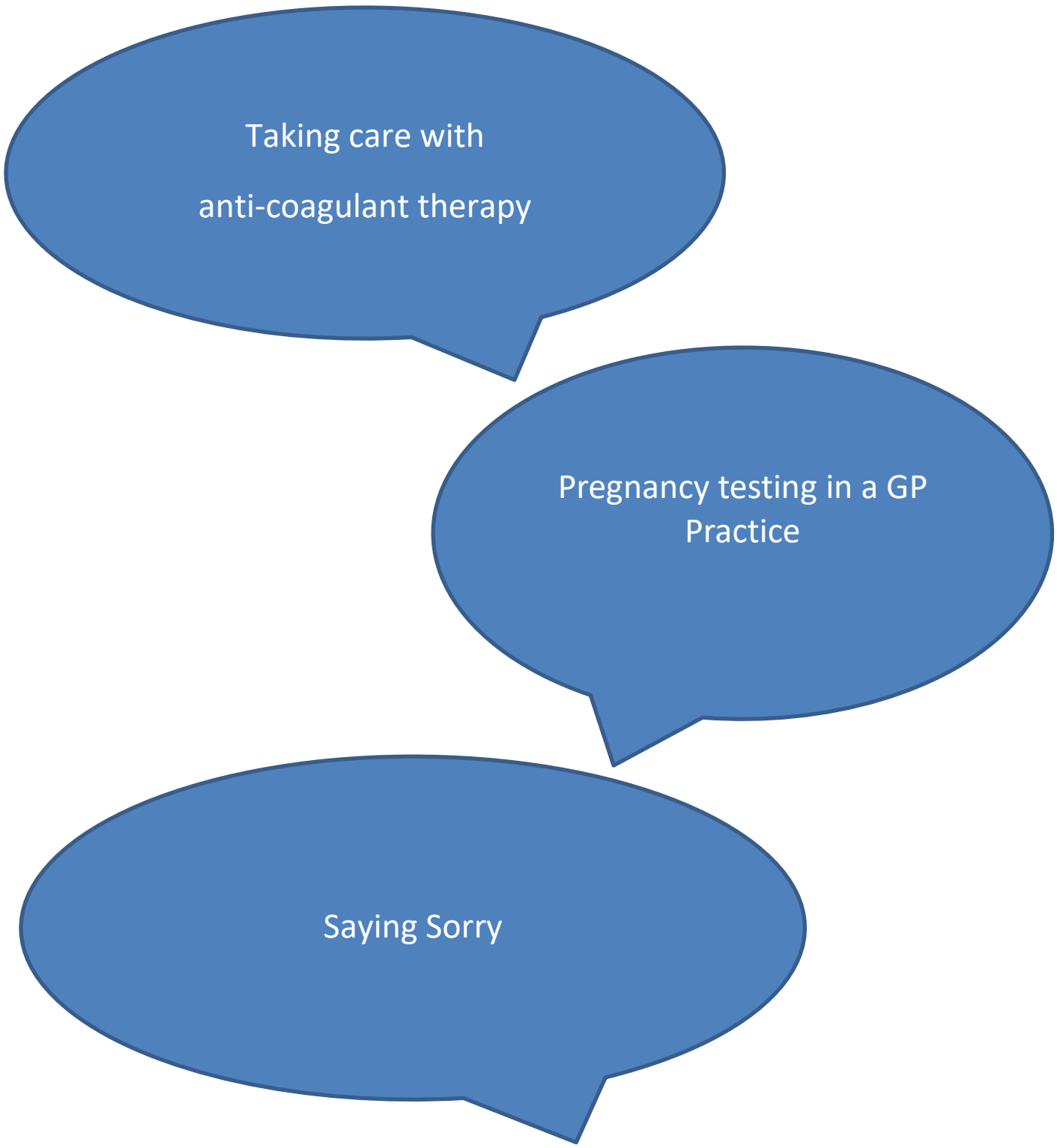
NHS ENGLAND SOUTH WEST

GP PAG PIECES – Issue 4, November 2019

Bringing you snippets to share learning from the GP Performance Advisory Group meeting in the SW, where concerns raised about GPs are reviewed, including information from serious incidents, SEAs and complaints.



Compiled by Nicola Mayo (Quality and Safety Manager)

1 – Taking care with anti-coagulants

The GP PAG has discussed a number of cases relating to incidents that have occurred involving anti-coagulant therapy:

- A prescription for Warfarin was changed to Rivaroxaban (at the patient's request). The patient had a prosthetic valve, a contra-indication for the prescribing of Rivaroxaban, subsequently suffering a CVA. There was no clarification during the consultation whether they had a valve replacement and no flag on their patient record https://cks.nice.org.uk/anticoagulation-oral#!scenario:3
- A patient had an unwitnessed fall in a care home which resulted in a head injury. The patient was on Warfarin but was not conveyed to the local A&E department following a GP visit. NICE guidance, Head injury: assessment and early management, includes warfarin as a risk factor requiring assessment and timely treatment, if required, and indications for and timings of CT head scans - https://www.nice.org.uk/guidance/cg176 . This guidance has recently been updated (September 2019) to include **all** anti-coagulant therapy as a risk factor and not just Warfarin.
- An on-line prescription for 5mg tablets of Warfarin was received by a practice and prescribed, even though only 1mg tablets had been requested for at least the last 4 years for a regular dose of 1.4mg and INRs had been within therapeutic range and stable for a long period of time. It was practice policy to have 1mg, 3mg and 5mg tablets available to order. Presented with a choice, the patient's elderly carer accidentally ordered 5mg tables instead of 1mg, the INR increased undetected and the patient suffered a subdural haemorrhage and permanent brain damage following a fall. An available drug/dose was ordered with no cross checks in place. Most patients reach a 'steady state' with warfarin so do not need the option for 3 strengths of tablets.

There is a whole raft of NICE guidance covering anti-coagulation therapy. Clinical Knowledge Summaries are also available to provide concise, accessible summaries of current evidence for primary care professionals at: https://cks.nice.org.uk/anticoagulation-oral

2 – Pregnancy testing in a GP Practice

PAG discussed a case that involved the patient requiring multiple blood and urine tests, including a pregnancy test, for abdominal symptoms in a pre-menopausal woman. The patient rang for the results, to be told by reception staff that all the tests had been reported as normal; in fact, the pregnancy test had not been done as the expectation by the practice was that the patient would carry out this test herself. This had not explained to the patient at her GP appointment. A subsequent pregnancy test some weeks later proved positive and unfortunately an ultrasound revealed potential foetal abnormalities at 20 weeks gestation. The opportunity to offer 1st trimester termination had been lost potentially due to the administration issues related to conveying accurate and comprehensive feedback about test results. Practices are invited to consider how their own protocols would have prevented this occurrence. As a rider to this case, it is understood that pregnancy tests can be purchased in bulk very cheaply from on line commercial (rather than medical) providers if a factor in not providing in-surgery pregnancy testing is due to the perceived prohibitive cost.

3 – Saying Sorry

As with all incidents, there is a moral as well as statutory, regulatory and professional requirement to say sorry for what has happened. A number of practice responses that GP PAG have reviewed have appeared less than empathetic when replying to patients. NHS Resolution has written a document to support with the process of apologising and can be found at https://resolution.nhs.uk/wp-content/uploads/2018/09/NHS-Resolution-Saying-Sorry.pdf . The CQC's Duty of Candour document can be found at https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour