

What's special about Out-of-hours Care

Environment

As a GP in the out-of-ours setting, you are likely to be working on an ad-hoc basis, and/or regular sessions and as self employed. The schedule of the sessions may be varied from time to time by the OOH service provider, according to service demands. Your place of work may vary. You are likely to be working with many more people than in the GP surgery setting. These other workers are likely to have somewhat different roles than in the GP surgery (e.g. OOH nurses may be spending 100% of their time on telephone triage as opposed to face to face work). There may be access to a patient transport service. You are likely to have chauffeur support on home visits.

Clinical Work – Unscheduled Care

1. Medical Records & Consulting.

There will be limited access to medical records. You may be able to access previous OOH consultations. OOH software systems do not have the same clinical structure as routine GP software systems. OOH software systems are primarily orientated around call management rather than clinical management. It is expected that you will be expedient and efficient with your work. You are expected to keep a clinical record, typing up salient clinical details usually on computer software. Record at least a brief history, important +ve/-ves from examination, and treatment or advice given. Because you don't (currently) have access to a structured clinical record (including medical summary) you have to regularly and routinely get used to asking about PMSH, regular medications and allergies. Compared with routine GP work, you won't have as much form filling to do, running CHD templates etc, so, your consultation rate is likely to be quicker than in hours. Be wary that drug addicts are more likely to target OOH services for opiates and benzodiazepines, they occasionally try to take advantage of the lack of continuity records.

2. Non-continuity of care.

OOH services do not aim to offer continuity of care. There can be some continuity within the process of care e.g. recommending the patient sees their own GP, but be wary of adding too much detail lest your recommendations generate expectations that would clash with the provisions of daytime GP services (i.e. try not to raise demands of secondary care referrals or specific treatments, the patient's own GP may have access to different skills and resources than yourself).

3. Less bureaucracy.

This bit is nice. You get chance to practice clinical medicine. No sick notes. No insurance forms. No DSS/DWP forms. No QOF targets. So fewer distractions from core clinical work. unless you get involved with management or organisational development!

4. The scheduling of work.

In daytime work, you are likely to have specific time ("surgeries") set for face to face and or telephone consultations, much of the rest of your time will be spent on administration, home visiting, audit and other developmental work. OOH work also involves face to face and telephone contacts and home visiting, but is likely to involve much less work on administration. Although you may be primarily allocated to one particular function for each OOH session, do be prepared to shift role when service needs demand. If the waiting room is empty and there are calls waiting for triage the join in and do some telephone calls!

5. Nature of the Cases.

A lot of overlap with the content of routine GP work, but no planned chronic disease management. 50% of cases are under 5's so there is a heavier paediatric component. There is a tendency to a higher level of anxiety in the worried well tempered by a greater proportion of callers with potentially acute serious illness. Expect a lot of snuffly, coughing feverish children, D&V etc. At the other end of the spectrum you will come across more death, hopefully only when home-visiting. You need to be familiar with how deaths are managed OOHs. You need to have well honed empathetic communication skills.

6. Targets

Largely time-framed and based on call management rather than clinical care.

The service needs to pass any immediate life threatening presentation through to the ambulance service within 3 minutes of starting to receive the call.

All triage calls should be assessed as quickly as possible, those labelled "urgent" within 10mins, all other preferably within 20mins (absolute audit targets are 20 and 60 mins respectively). There are other time banded targets for seeing patients either in the Primary Care OOH Centre or on home visits within defined time frames according to priority (emergencies within 1 hour, urgent cases within 2 hours, routine cases within 6 hours).

7. Prescribing and dispensing

Must ask about allergies and PMSH before prescribing. Be wary of opiate, benzodiazepine & hypnotic prescribing. You will need to familiarise yourself with which pharmacists are open OOH, and where they are. Hopefully your OOH service provider will produce a list of these. If you train in a rural area, you will be introduced to dispensing procedures in your "daytime" practice. You may have stock treatments in the OOH consulting room and OOH car. These items are provided by the OOH service provider organisation from a limited budget. They should only be used where the medication is needed before a routine community pharmacist is open i.e. the odd rare occasion (e.g. Prednisolone and fairly bad asthma at 1am).

8. Triage, Telephone Consulting and Disposal

Telephone consulting during routine GP work is becoming commonplace. It is encouraged as a means of improving access to primary care. Out-of-hours the majority of calls are handled by telephone triage; nearly half of these concluding with advice on the phone rather than triage to another "disposal".

When consulting on the phone remember that patients want to know who they are talking to (you should identify yourself by name, role and organisation name), to receive empathy and have their concerns acknowledged. Patients and their callers want to know what they can do about their problem, and what they should do if things change or get worse. Telephone consultations should conclude with safety-netting not "call back if you are worried" but more specific statements that reassure and empower.

Call disposition for triage may end in self management advice, advice about over-the-counter medications, or a formal prescription (which should be phoned or faxed through to the out-of-hours pharmacy, with the original prescription sent through the post).

Call disposition for triage includes

- Ambulance (arranged by you not them!) to A&E or specific secondary care location
- A&E (own transport if less urgent and feasible)
- Local community services e.g. intermediate care, mental health crisis team
- Home Visit (record the urgency)
- Pharmacy (prescription or OTC Rx)
- Out of Hours Primary care Centre (via own transport or patient transport service if available).