APPENDIX D – Annual Review Report Form (May 2022)

Oral Anticoagulation Clinic Details			
Service Provider Name			
Address Of Anticoagulation Clinic			
Telephone Number		**Facsimile**	
E-Mail			
Name of Lead Clinician			
Name of Person Compiling Report		**Position/Post**	

Patient Statistics		
1.	**Total Number of Patients managed in the service during past 12 months**	
2.	**Number of Initiations by the Service Provider / within Primary Care**	
3.	**Number of Referrals Received from Secondary Care**	
4.	**Number of Referrals referred back by the Service Provider to Secondary Care**	
5.	**Number of adverse incidents reported**	
	Clinical outcome:	
	Death	
	Severe (permanent harm)	
	Moderate (significant, but not permanent harm, requiring increase in treatment)	
	Low (temporary harm, requiring extra observation or minor treatment)	
	No harm	
	Total	
	Type of report:	
	Prescribing	
	Dispensing/medicine preparation	
	Administration	
	Monitoring	
	Total	
	Type of incident:	
	Wrong dose	

	Wrong frequency	
	Omitted medicine/dose	
	Wrong drug	
	Wrong quantity	
	Mismatching of patient and their medicine	
	Wrong/transposed/omitted medicine label	
	Wrong/omitted/passed expiry date	
	Wrong storage	
	Wrong route	
	Contraindication	
	Patient allergic to treatment	
	Wrong formulation	
	Wrong method of preparation/supply	
	Adverse drug reaction – when used as intended	
	Wrong or omitted verbal patient directions	
	Other	
	Total	
6.	**Number of Serious Untoward Incidents reported**	
7.	**Number of Episodes Requiring the Administration of Vitamin K**	
~~**8.**~~	~~**Total Number of Domiciliary Patients**~~	
9.	**Number of Domiciliary Visits undertaken**	
10.	**Number of individual INR Tests Completed**	

Patient Experience		
11.	**Number of formal patient complaints received by Service**	
12.	**Number of informal patient complaints received by Service**	
13.	**How many patient complaints have you received during this time period which related to:**	
13a.	**Communication / information to patients**	
13b.	**Clinical treatment**	
13c.	**Attitude of staff**	
13d.	**Appointments, delay / cancellation**	
13e.	**Patient privacy, dignity**	
13f.	**Referral, discharge and transfer arrangements**	
13g.	**Please give an example of actions taken in response to a complaint**	

14.	**Number of patients included within the Patient Satisfaction Survey within the year**	
	Of those patients, number of responses received	
15.	**Any issues of low patient satisfaction (e.g. waiting times / accessibility / continuity of care**	Yes / No*
16.	**If you have answered YES to question 6, provide details in the space provided below** (Additional space is available on Page 7 of this document)	

******questions 14-16 are not required IF the service is participating in the PROM Light CQUIN*

17.	**Service changes made in response to patient feedback**	Yes / No*
17a.	**If you have answered YES to Question provide details in the space provided below** (Additional space is available on Page 7 of this document)	

Risk Assessments & Reporting Procedures		
18.	**Are Clinic Risk Assessments Up-to-date?**	Yes/No*
18a.	**If you have answered NO to Question 12 give details of the date of last assessment and any remedial actions that are being taken in the space below** (Additional space is available on Page 7 of this document)	
18b.	**If you have answered YES to Question 12 enter the date of the most recent assessment**	
19.	**Has the Service Provider completed 2 6 monthly cycles of the audit toolkit (Appendix D)?**	Yes/No*
20.	**At the time of writing have <u>all</u> Adverse Incidents been investigated, lessons identified and responded to, and the incident completed satisfactorily?**	Yes/No*
20a.	**If you have answered NO to Question 14 give BRIEF details in the space below** (Additional space is available on Page 7 of this document)	

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Equipment & Service		
21.	**Which Computer Assisted Decision Support Software is used?**	
21a.	**Give details of the software below & any issues arising**	
21b.	**If you have answered YES to Question 16 give brief details about how you consider its efficiency compared to clinical decision making** (Additional space is available on Page 7 of this document)	
22.	**In the space below give detail of the Point Of Care Testing (POCT)equipment used in the service** (Additional space is available on Page 7 of this document)	
23.	**In the space below describe what quality assurance checks are carried out to ensure that the POCT equipment is functioning correctly** (Additional space is available on Page 7 of this document)	
23.a	**Confirm registration with NEQAS & provide a copy of the annual report or evidence of data submitted**	
24.	**In the space below give BRIEF details of any equipment failures and what contingency actions were taken or if failures have not occurred what contingency plans are in place** (Additional space is available on Page 7 of this document)	
25.	**Were any equipment failures reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) during this period**	Yes / No*
Training And Accreditation		

26.	**Are the training needs of all staff assessed and documented on an annual basis.**	Yes/No*

27.	**As a minimum, are all staff involved in the delivery of clinical care to patients, trained in accordance with the relevant stated NPSA Workforce Competencies**	Yes/No*
27a.	**If you have answered NO to Question 22 give BRIEF details of Training Plans in the space below** (Additional space is available on Page 7 of this document)	
28.	**Have any staff members completed e-learning packages or attended any courses relating to Oral Anticoagulation Therapy.**	Yes/No*
28a.	**Please give details below, of courses attended and the designation of the attendee. (Details to include the full name of the course, the accrediting authority and date the course was completed.)** (Additional space is available on Page 7 of this document)	
29.	**Do you hold a copy of the latest NPSA Alert pertaining to Oral Anticoagulants and is this document readily available to all staff?**	Yes/No*
30.	**Are documented procedures for all key areas identified within paragraph 4.3.6 of the specification, held by the service provider and readily available to all staff**	Yes/No*
General		

31.	**In the space below enter any other observations regarding the Oral Anticoagulation Service relevant to the Annual Review.** (Additional space is available on Page 7 of this document)

(* Please delete as appropriate)

Additional space for answers. Please annotate the question number clearly in the margin	