Patient Safety in Primary Care

Dr. Alison Cooper

Overview

- What is known about patient safety in primary care
- Challenges of improving patient safety in primary care
- How can healthcare professionals across the primary and secondary care interface develop systems to improve patient safety in primary care?

Who do we have in the room?

- Primary care healthcare professionals
  - GPs/Nurse Practitioners/Nurses/Paramedics/Opticians/Dentists/Pharmacists/ Physicians assistants/HCA
  - Managers/patient safety experts
- Secondary care healthcare professionals
  - Clinicians/managers/patient safety experts
- Health board leaders
  - Clinicians/managers/patient safety experts
- National or International leaders
  - Policy advisors/managers/commissioners/patient safety experts
- Anyone else?

Big safety focus in

HOSPITAL CARE

to date


90%

SAFER PRIMARY CARE EXPERT GROUP

2-3% of primary care encounters result in a patient safety incident

BMJ QUALITY & SAFETY

How Safe is Primary Care? A Systematic Review (2015):bmjqs-2015-004178

Panesar S, De Silva D, Carson-Stevens A, Cresswell K, Salvilla SA, Slight SP, Javad S, Netuveli G, Larizgoitia I, Donaldson LJ, Bates DW, Sheikh A, on behalf of the World Health Organization's Safer Primary Care Expert Working Group.

Incidents relating to ***diagnosis*** and ***prescribing*** were most likely to result in ***severe harm***.

NHS National Institute for Health Research

Characterising the nature of primary care patient safety incident reports in England and Wales: mixed methods study. Andrew Carson-Stevens

Explore the nature, range and severity of general practice-related incidents as reported to the NRLS from primary care in England and Wales

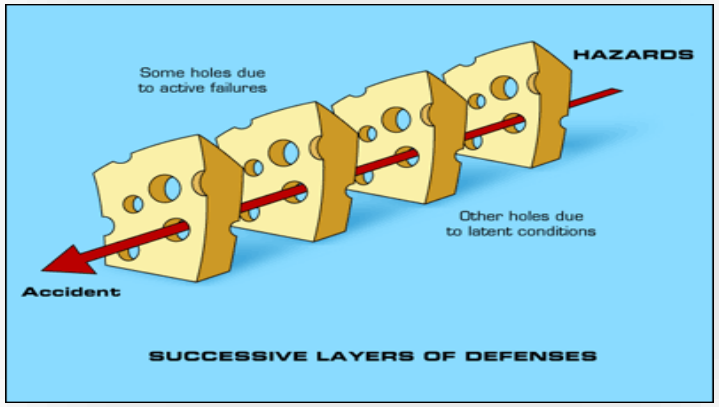
Patient safety incident, "any unintended or unexpected incident that could have harmed or did harm a patient during healthcare delivery"

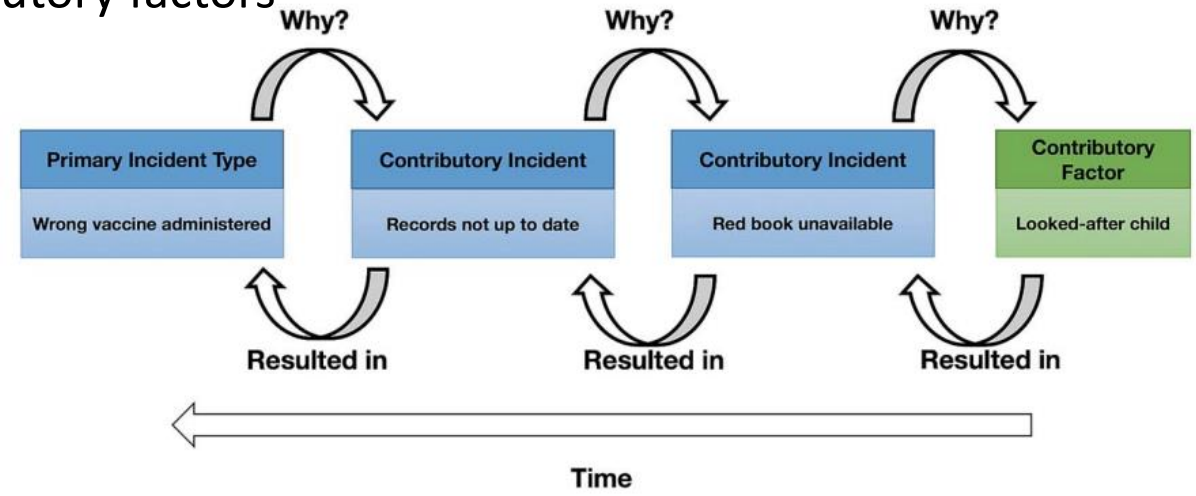
"***Recent admission, new medications added***. Medication list on ***discharge letter did not include some of the patient's previous regular medications*** so GP assumed they had been discontinued by hospital. ***1 month later, patient had CVA***. ***Very hypertensive on admission***. Subsequently discovered that hospital had intended her to continue antihypertensive medication, even though omitted from discharge medication list."

Methods

Data analysis

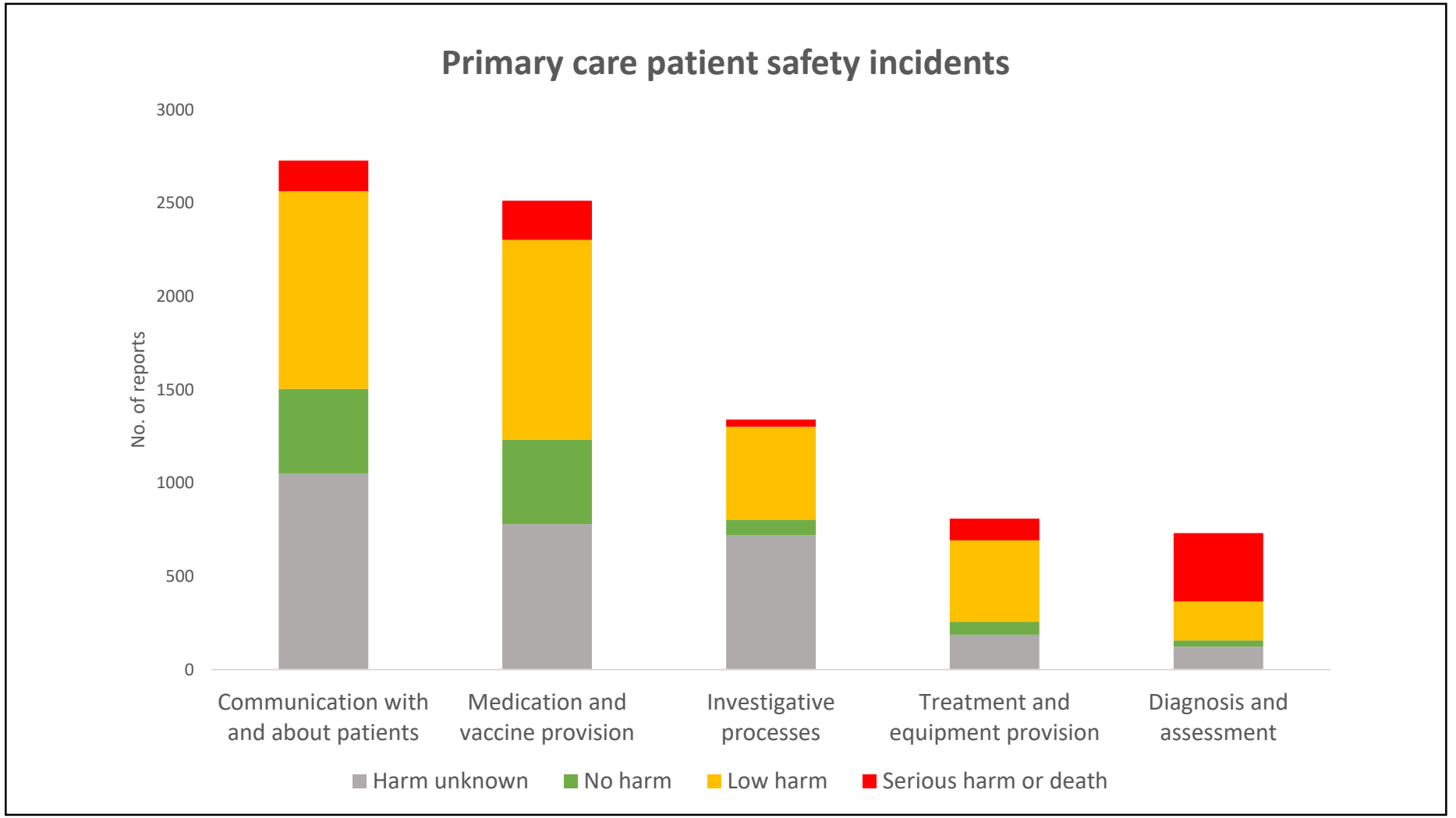
- National Reporting and Learning System
  - 13,699 patient safety incident reports
- Multiaxial PISA classification system
  - Based on the recursive model for incident analysis
  - Frequency distributions for most common incident type and cross tabulation for common causes
  - Thematic analysis of independent contributory factors



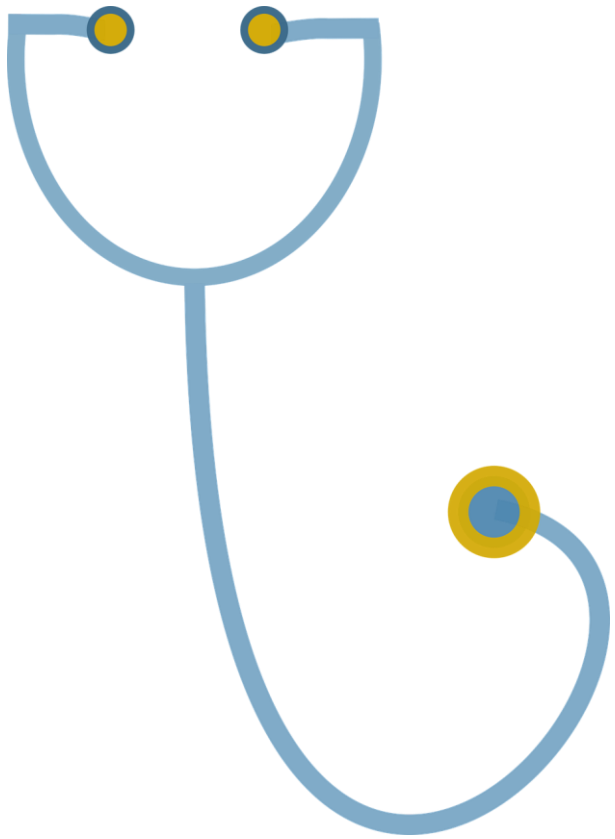


Main findings

- Two-thirds of reports did not describe reasons about why the incident occurred
- One in three reports were excluded
  - insufficient detail
  - did not describe a patient safety incident
  - the incident was not relevant to health care
- Aggregation of reports highlights key areas for interventions


Primary care patient safety incidents
No. of reports
3000
2500
2000
1500
1000
500
0
Communication with and about patients
Medication and vaccine provision
Investigative processes
Treatment and equipment provision
Diagnosis and assessment
Harm unknown
No harm
Low harm
Serious harm or death

Granularity of reports gives insight intc why these errors occur

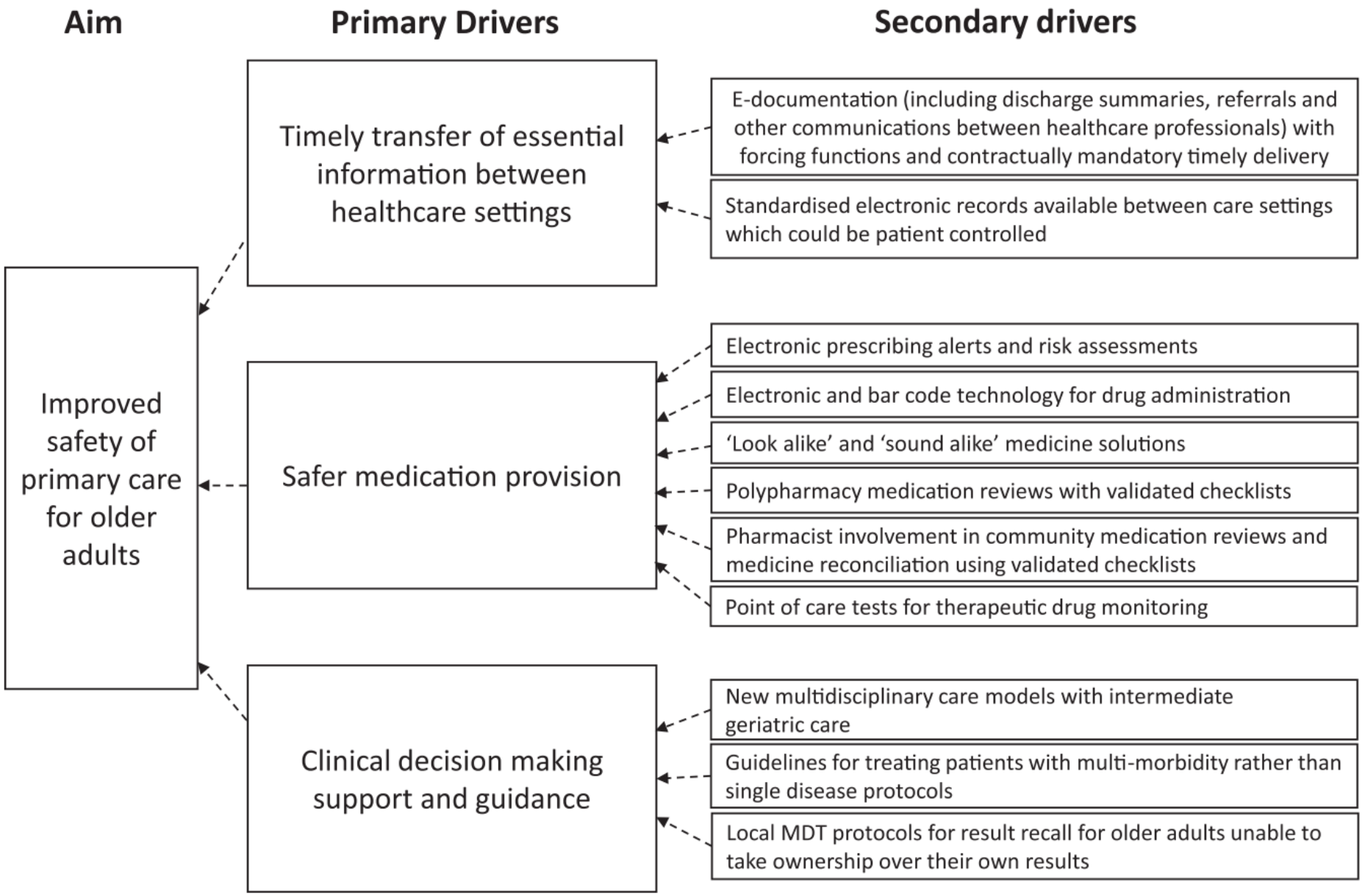


Diagnosis and ***assessment-related*** incidents accounted for the highest proportion of harm to patients

- communication errors in the referral and discharge of patients
- physician decision-making
- unfamiliar symptom presentation
- delayed management or mismanagement following failures to recognise signs of clinical deterioration.

Age and Ageing

Cooper et al. 2017 Sources of unsafe primary care for older adults: a mixed methods analysis of patient safety incident reports



Open Access Protocol

BMJ Open

Understanding the epidemiology of avoidable significant harm in primary care: protocol for a retrospective cross-sectional study

Brian G Bell,[1] Stephen Campbell,[2,3] Andrew Carson-Stevens,[4] Huw Prosser Evans,[4] Alison Cooper,[4] Christina Sheehan,[1] Sarah Rodgers,[1] Christine Johnson,[1] Adrian Edwards,[4] Sarah Armstrong,[5] Rajnikant Mehta,[5] Antony Chuter,[6] Ailsa Donnelly,[7] Darren M Ashcroft,[2,8] Joanne Lymn,[9] Pam Smith,[10] Aziz Sheikh,[11] Matthew Boyd,[12] Anthony J Avery[1]

Research

Carl de Wet, Catherine O'Donnell and Paul Bowie

Developing a preliminary 'never event' list for general practice using consensus-building methods

	Never event
1	Prescribing a drug to a patient that is recorded in the practice system as having previously caused her/him a severe adverse reaction
2	A planned referral of a patient, prompted by clinical suspicion of cancer, is not sent
3	Prescribing a teratogenic drug to a patient known to be pregnant (unless initiated by a clinical specialist)
4	Emergency transport is not discussed or arranged when admitting a patient as an emergency
5	An abnormal investigation result is received by a practice but is not reviewed by a clinician
6	Prescribing aspirin for a patient <12 years old (unless recommended by a specialist for specific clinical conditions for example, Kawasaki's disease)
7	Prescribing systemic oestrogen-only hormone replacement therapy for a patient with an intact uterus
8	Prescribing methotrexate daily rather than weekly (unless initiated by a specialist for a specific clinical condition, for example, leukaemia)
9	A needle-stick injury caused by a failure to dispose of 'sharps' in compliance with national guidance and regulations
10	Adrenaline (or equivalent) is NOT available when clinically indicated for a medical emergency in the practice or GP home visit

The Patient Safety Toolkit

Royal College of General Practitioners

Grwp PISA Group

The Patient Safety Toolkit plays an important role in preventing patients from being harmed. This toolkit allows your practice to look at different aspects of patient safety with a view to making improvements. It covers the following areas of general practice: safe systems, safety culture, communication, patient reported problems, diagnostic safety, prescribing safety.

The Patient Safety Toolkit is designed to be used by any general practice in the UK. These resources can be used flexibly, either as standalone materials or as part of an integrated package for patient safety.

New for 2017: **RCGP Reporting and learning from patient safety incidents in general practice - a practical guide** [PDF].

The Tools

- The Trigger Tool
- Primary Care SafeQuest
- Manchester Patient Safety Framework (MaPSaF)
- Prescribing Safety Indicators
- Patient Safety Questionnaire
- Concise Safe Systems Checklist

Scottish Patient Safety Programme

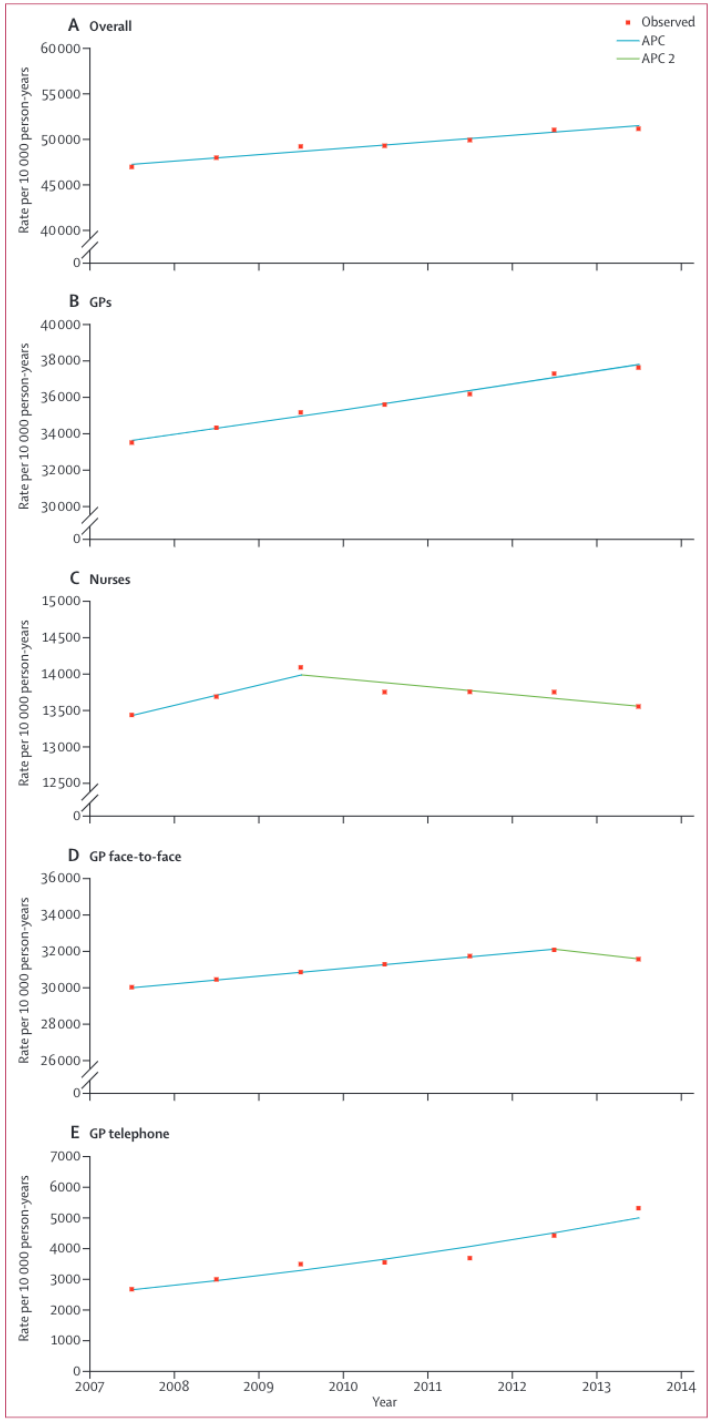
Primary Care

EVERY PERSON EVERY TIME

SCOTTISH PATIENT SAFETY PROGRAMME

Challenges

- Increasing workload



THE LANCET
Volume 387, Issue 10035, 4–10 June 2016, Pages 2323-2330

Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14

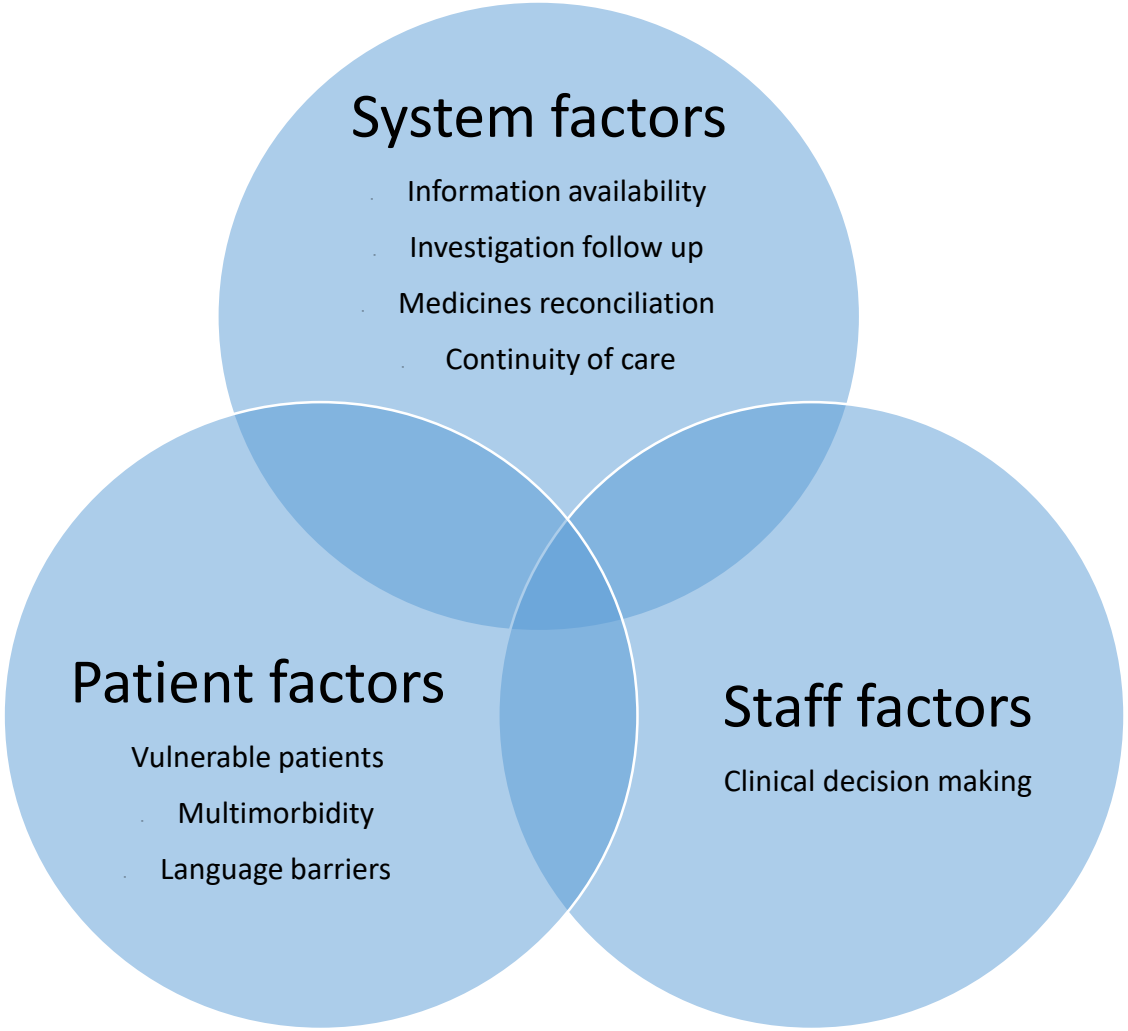
F D Richard Hobbs, Clare Bankhead, Toqir Mukhtar, Sarah Stevens, Rafael Perera-Salazar, Tim Holt, Chris Salisbury, on behalf of the National Institute for Health Research School for Primary Care Research

- Annual consultation rate per person increased by 10%
- Increase of 12% for GPs compared with 0·9% for practice nurses
- The mean duration of GP surgery consultations increased by 6·7%
  8·65 min (95% CI 8·64–8·65) to 9·22 min
- GP telephone consultation rates doubled
- Overall workload increased by 16%

Challenges

- Increasing workload
- Changing workload
  - Ageing population
  - Multimorbidity/Polypharmacy
  - Shift of chronic disease management to primary care
  - Service demands from society
- Changing workforce
  - Difficulty recruiting and retaining GPs
  - Merging practices
  - Nurse practitioners, practice nurses, HCA, pharmacists, paramedics, opticians

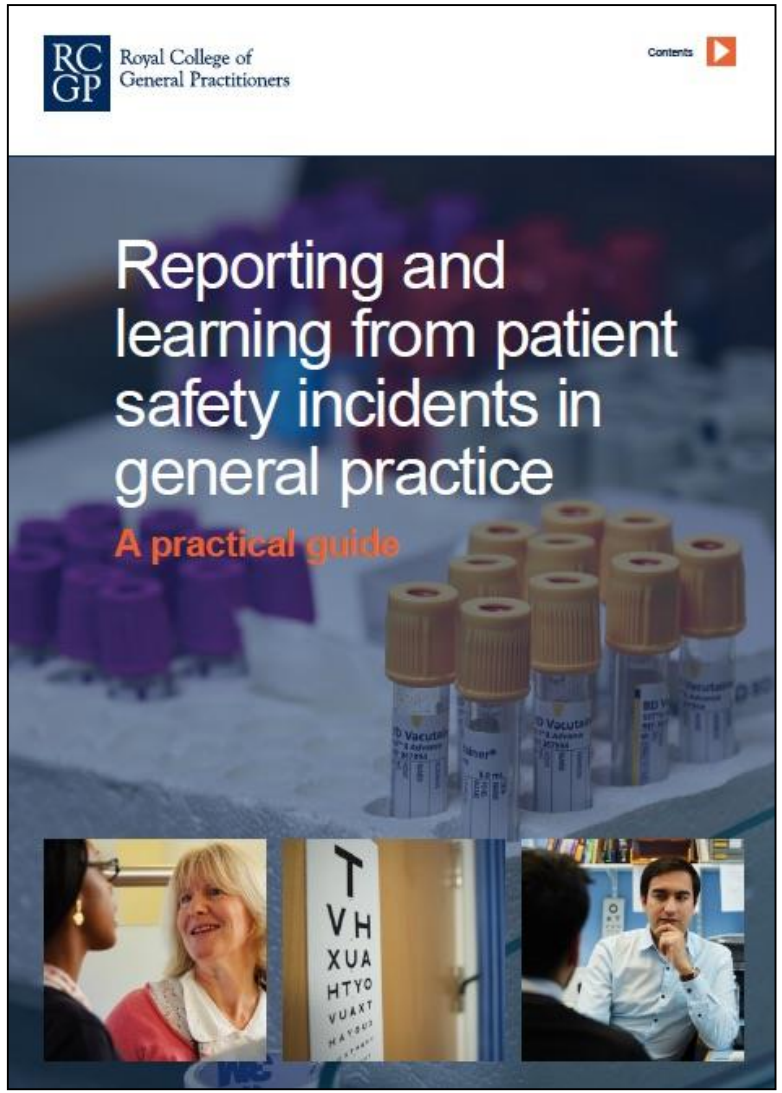
Develop systems to improve patient safety in primary care?



Your turn

- **What ideas do you have** for changes to your systems to improve patient safety in primary care?

  - Clinician level
  - Practice/Hospital level
  - Health board level
  - National level



Communication with patients
• Miscommunication e.g. inadequate safety netting advice
• Difficulties accessing clinical services e.g. telephone triage, message handling, appointments
• Parent-held records unavailable
Communication between professionals
• Unavailable or inaccurate medical records e.g. paper notes from previous practice
• Delayed referrals e.g. erroneously completed referral, delayed decision to refer
• Information transfer between care providers e.g. delayed discharge summary or clinic letter
Diagnosis and assessment
• Missed or delayed diagnosis
• Delayed assessment of care
• Delays assessing patients with serious mental health conditions
• Not identifying patients at risk of deterioration
Medication and vaccine
• Errors in prescribing, dispensing and administering medicines and vaccines
• Complications with therapeutic drug monitoring processes
Investigations
• Ordering inappropriate investigations to inform differential diagnosis
• Incorrect collection, or transfer, of specimens
• Administrative failures leading to delays, wrong results or failure to receive results
• Incorrectly interpreted results e.g. blood tests, imaging, other investigations
Treatment and equipment
• Complications of procedures
• Malfunctioning and unavailability of care equipment e.g. pressure mattresses, oxygen, walking aids.

Table 1. Summary of patient safety incidents reported from general practice in England and Wales [2]

Eliciting insights from staff

PURPOSE: The purpose of this form is to tap into your knowledge and experience of clinical and administrative staff to find out what risks are present in your practice that you think could jeopardise patient safety.

WHO SHOULD COMPLETE THIS FORM: Any staff working in the clinical and administrative area

HOW TO COMPLETE THIS FORM: Provide as much detail as possible when answering the two questions below.

Job Category: Unit:

Name (optional): Date:

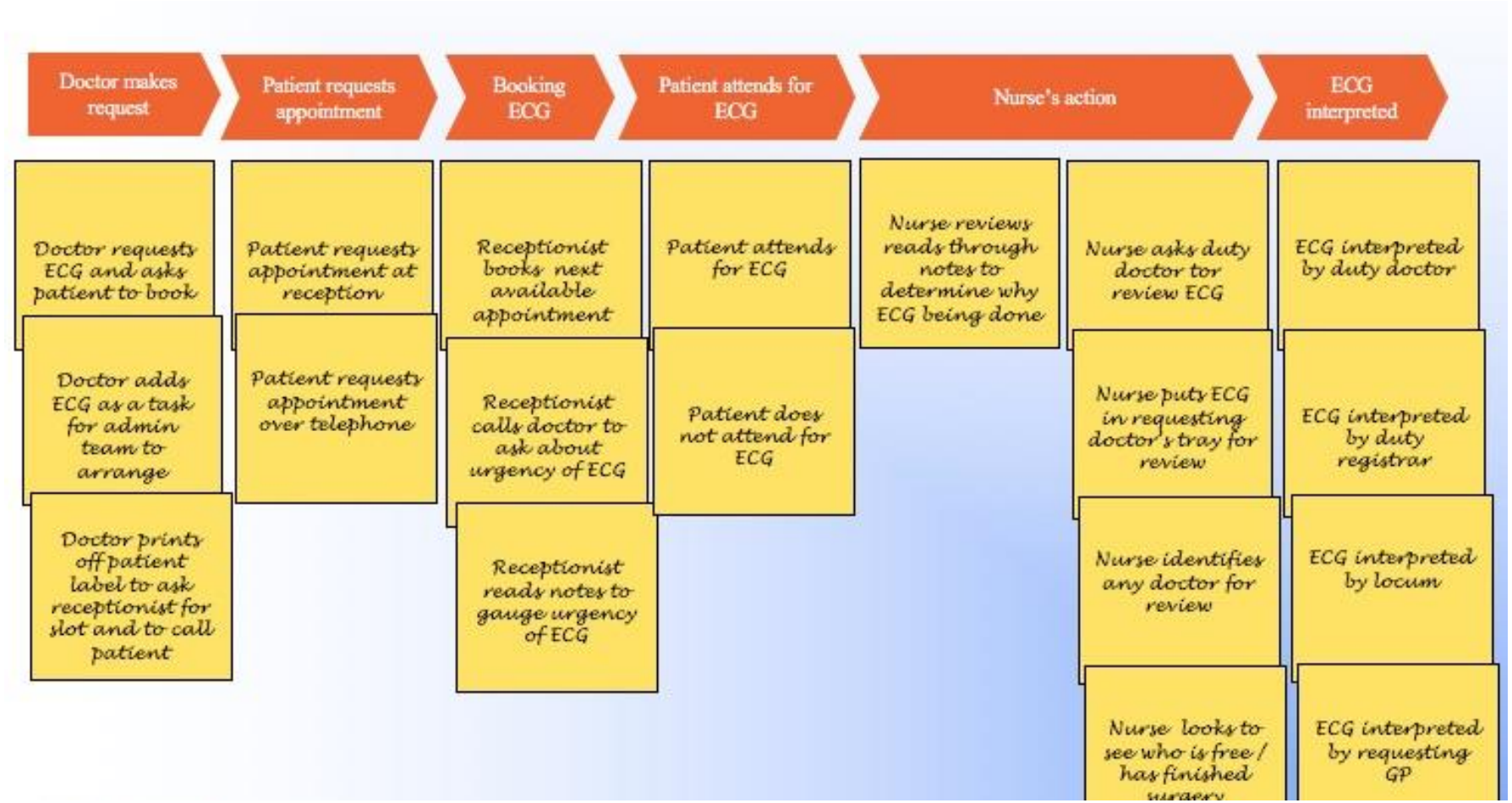
Please describe what you think is the most likely cause of harm to the next patient in your area

Please describe what you think can be done to reduce or eliminate this cause of harm

Source: Peter Hibbert

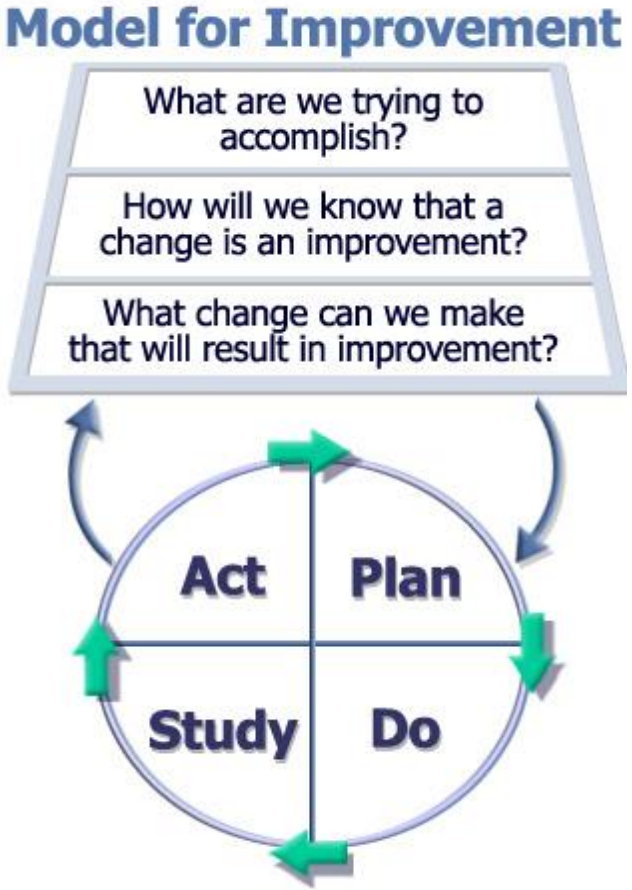
Eliciting insights from staff

Mapping the process

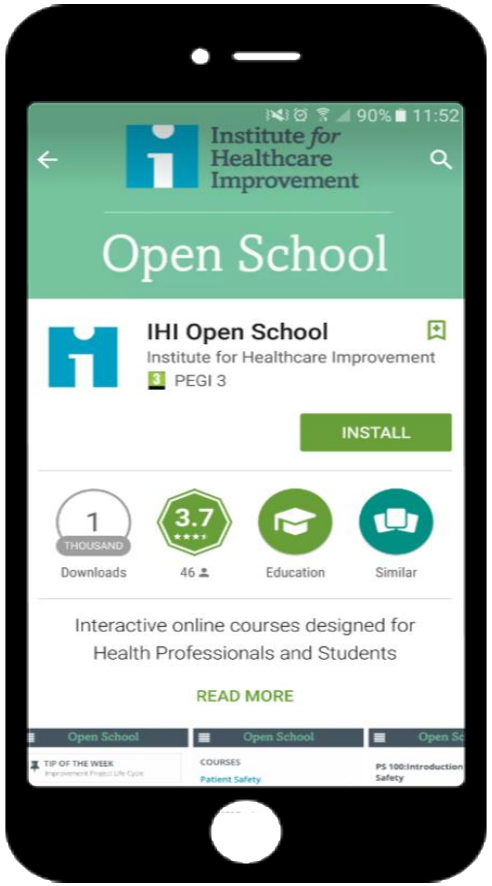


Source: Royal College of General Practitioners

From a theory to action…



The Improvement Guide, API, 2009



http:IHI.org/education/IHIOpen School

Any questions?

CooperA8@Cardiff.ac.uk