Patient Safety in Australian General Practice

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### Australian general practice

<table>
<thead>
<tr>
<th>Process errors (79%)</th>
<th>Knowledge and skills errors (21%)</th>
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<tbody>
<tr>
<td>Errors in office administration (20%)</td>
<td>Errors in the execution of a clinical task (5%)</td>
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<td>Investigation errors (13%)</td>
<td>Errors in diagnosis (14%)</td>
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<td>Treatment errors (29%)</td>
<td>Wrong treatment decision with right diagnosis (2%)</td>
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<td>Communication errors (15%)</td>
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<td>Payment errors (1%)</td>
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<tr>
<td>Errors in healthcare workforce management (2%)</td>
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- 32% of these errors resulted in patient harm and 9% of these harms were very serious or extremely serious. (Makeham, Dovey et al. 2002)
Does Your Practice Have a Process for Identifying Adverse Events and Taking Follow-up Action?

Sources: The Commonwealth Fund 2009 International Health Policy Survey of Primary Care Physicians in Eleven Countries; C. Schoen et al., “A Survey of Primary Care Physicians in Eleven Countries: Perspectives on Care, Costs, and Experiences, 2009.” Health Affairs Web Exclusive, Nov. 5, 2009, w1171–w1183 Data collection: Harris Interactive, Inc.
Patient safety – why Collaboratives?

• Funded workshops to develop a shared focus for change and to allow thinking time
• Systems approach – doctor and nurse or manager
• Change management tools
• Indicators to measure change
• Learning from each other
• Manual - usually based on existing guidelines
Patient Safety Collaborative

Change Concepts

1. Engaging the team
2. Data quality
3. Finding harm
4. Preventing harm
Change Concepts

1. Engaging the team
2. Data quality
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4. Preventing harm

Medical Office Survey of Patient Safety Culture
- All staff have shared commitment to safety
- Patient safety events are logged
- Root causes are identified – openness encouraged
- Actions taken are recorded and confirmed
- Each person can contribute
- Training, workload and infrastructure optimised to support all activities within the practice
Change Ideas

- Develop system to continuously update records
- Ask patient to verify summary or GP Mx plan
- Upload verified record to e-Health

Measures

- Monthly automated audit of entire clinical record
- Count of e-Health uploads
Change Concepts

1. Engaging the team

2. Data quality

3. Finding harm
   (a)

1. Preventing harm

Change Ideas

• Identify 25 clinical records for review using a ‘trigger tool’
• Identify any harms and assign priority score (product of severity and likelihood)

Measures

• Trigger rate, harm rate, recurring themes
Change Concepts

1. Engaging the team
2. Data quality
3. Finding harm

Change Ideas

• Install event log eg.
  ➢ Patient complaint
  ➢ Confidentiality breach
  ➢ Patient transfer to nearby clinic
  ➢ Delayed/missing result
  ➢ Equipment/supplies failure
  ➢ Clinical error such as wrong vaccine

• Prioritise recorded events (product of severity and likelihood)

Measures

• Spread of different staff types recording events
• Types of events and recurring themes
**Change Concepts**

1. Engaging the team
2. Data quality
3. Finding harm
4. Preventing harm (a)

**Change ideas**
- Develop a registry of > 75 yr olds on 10 med
- Arrange funded community pharmacy review
- Identify de-prescribing opportunities
- Add annual recall

**Measures**
- Proportion of these patients with med review
- Proportion of these patients on high risk meds

**Additional change idea for renal impairment**
- Identify patients with persisting low eGFR
- Record diagnosis
- Perform and add recall for annual kidney check
Change Concepts

1. Engaging the team
2. Data quality
3. Finding harm
4. Preventing harm (b)

Change ideas
- Significant event analysis (5 events/month)
- Upload actions taken in Plan-Do-Study-Act format

Measures
- De-identified narratives uploaded to web portal describing what happened, root cause, what learnt and what actions have been taken.
Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

The Lancet Volume 380, Issue 9836 2012 37 - 43

Figure 1  Number of chronic disorders by age-group
Trigger Tool

- Sodium <130
- Potassium >6.0
- Haemoglobin <100
- INR <1.6 or > 5.0
- eGFR <60 and reduced by 10 in last 12 months
- Death
- Acute vascular event
- New cancer diagnosis
- More than 3 GP in same clinic in last 3 months
- Fractures in over 70 year olds
- Urinary Catheter
- Patients on triple whammy NSAID/ACEi or ARB/Diuretic
Thank you

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