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POLICY OPTIONS

Patient Safety Collaborative Manual

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Policy context

Hospitals have made efforts to prevent iatrogenic harm by measuring and monitoring adverse events, learning from them and from morbidity and mortality meetings and implementing solutions in a systematic and structured way. In primary care this does not happen. There is an urgent need for Australian general practice to improve patient safety as we cope with increasing complexity of chronic disease management, multimorbidity and polypharmacy. Everyday general practice provides 345,000 patient encounters and writes over 287,000 prescriptions. Already, it is estimated that over 5,000 patients a day will experience an adverse event (1.5% of all consultations) and over 31,000 (11%) patients a day will experience an adverse event from all prescriptions. At least half, if not more are preventable.

Patient safety is a major theme in Australian Safety and Quality Framework for Health Care, Australian Commission on Safety and Quality in Healthcare recommendations and The Royal Australian College of General Practitioners Standards. Through accreditation there have been attempts to describe near misses, errors, and harm in general practice. A systematic mechanism to analyse, report and prevent adverse events in primary care is now needed.

Although there are endeavours to improve safety in primary care worldwide, this is the first evidence-based manual. It is based on input from a broad range of national and international experts, researchers, practitioners and policy makers providing a foundation for a national patient safety register with a bank of ideas for improvements in patient safety. Participating general practices will use an automated trigger tool and log book to identify adverse events. They will be guided to run team meetings to understand adverse events and prevent recurrence. The accuracy of clinic notes will be improved. The best system changes will be shared as part of a collaborative of practices. Critically, a culture of patient safety will evolve and mature leading to sustainable safer care.

The Australian Primary Care Collaboratives is an effective program to improve quality in primary care through monthly monitoring of outcomes and regular meetings to exchange ideas for improvement. This is the first Collaborative to develop change ideas and outcome measures on patient safety.

We now know the scale of the problem, we understand many of the causes and we have the knowledge to start improving it. Now is the time for action in a journey towards safer care.

Policy options

- Recommendation 1

  To improve the current 'softness' around patient safety indicators in the accreditation process for general practice by inclusion of tighter indicators that require verifiable evidence: for a) having a significant incidents register, b) providing documentation of near misses, slips, lapses, or mistakes, and c) engaging in regular clinical meetings to discuss incidents and how to avoid them in the future.

- Recommendation 2

  The Australian Primary Care Collaboratives (APCC) Program's success in improving quality is evident, and is well endorsed by participants in our research to be a possible program to promote and improve the patient safety culture in Australian primary care. Patient safety waves based on our manual will be required to improve the patient safety culture and develop a foundation for a national patient safety register with a bank of ideas for improvements in patient safety.

- Recommendation 3

  We recommend that incentives for participating general practices will increase the number of the practices joining the program

- Recommendation 4

  We recommend that the trigger tool that was developed during this study to identify clinical notes that might represent high-risk of harm, and the safety incident event log designed with this manual to be available online (free of charge) to Australian general practice.

- Recommendation 5

  We recommend that Australian general practice have free access to the Australian Primary Care Collaboratives (APCC) Program's online portal with de-identified Plan Do Study Act (PDSA) Cycles of patient safety as bank of improvement ideas (exemplar practices)

Key findings

General practice is the front-line unit of the healthcare system. Safe and high quality practice has been a focus of research since the release of *Err is Human*, *Crossing the Quality Chasm* and *An Organisation with a Memory*. Half to three-quarters (45%-76%) of adverse events in primary care are avoidable. In GP clinics there is rarely a systematic approach for the detection of errors that may have caused harm to patients, and without data on the number and type of safety incidents occurring in Australian general practice, there is no way to track problems or make improvements. A systematic mechanism to analyse, report and prevent adverse events in primary care is now needed.

We used Knowledge Translation and Exchange (KTE) as a framework for this manual. Firstly, we identified the gaps through a literature review and in consultation with our partners: Improvement Foundation (Australia) which runs the Australian Primary Care Collaboratives (APCC) Program, Australian General Practice Accreditation Limited (AGPAL), Australian Commission on Safety and Quality (ACSQHC), Royal Australian College of General Practitioners (RACGP) and the Chronic Illness Alliance (CIA). Secondly, we interviewed the frontline staff (GPs, practice nurses, practice managers and community pharmacist in high performing general practices). Thirdly, we obtained expert opinions through interviews with highly experienced surveyors who are involved in accreditation of Australian general practices and consultations with national and international experts on patient safety.

Gathering these views from frontline staff and experts, we found that there are major four concepts to improve patient safety in primary care:

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

In order to identify patient harm, as well as prioritise and record safety events, a digital auditing tool was developed to identify clinical notes that might represent high-risk of harm. A safety incident event log was also developed. Further reporting methods were implemented to improve patient safety, including team meetings to identify the root causes of safety events, automated audits of the accuracy of electronic medical records, and medication reviews focussing on high-risk medication classes.

The completed patient safety collaborative manual will now be used by the Australian Primary Care Collaboratives program. For the first time in Australia, participating clinics will engage in the open and systematic identification of internal safety incidents, with the aim of developing and sharing solutions to reduce patient harm.

We believe that this manual will be the foundation to improve patient safety in Australian general practice as recommended in Australian Safety and Quality Framework for Health Care, Australian Commission on Safety and Quality in Healthcare recommendations and the Royal Australian College of General Practitioners Standards.

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