Royal College of General Practitioners

1000 LIVES i 0 FYWYDAU

Breathing life into patient safety incident reporting

Royal College of General Practitioners

Andrew Carson-Stevens

Clinical Lead for Quality Improvement in Patient Safety

Patient Safety Research Lead

Honorary Professor, Australian Institute of Health Innovation

Visiting Professor in Healthcare Improvement, Department of Family Practice

Royal College of General Practitioners

Alison Cooper

Clinical Research Fellow (PhD student), Cardiff University

GP, Rumney Primary Care Centre, Cardiff

GP Appraiser, Wales Deanery

Royal College of General Practitioners

Huw Williams

RCGP/Marie Curie Palliative Care Research Fellow

Clinical Research Fellow

GP Partner, Westway Surgery, Cardiff

Paul Gimson

National Primary Care Manager

Royal College of General Practitioners

Royal College of General Practitioners

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Welcome and why are you here today?

Paul Gimson

Royal College of General Practitioners

Overview of day

- Session 1: Why improve patient safety in primary care?
- Session 2: Reflections on generating learning from patient safety incidents
- Session 3: Team based learning from errors in practice
- Session 4: A primary care patient safety learning community for Wales

Royal College of General Practitioners

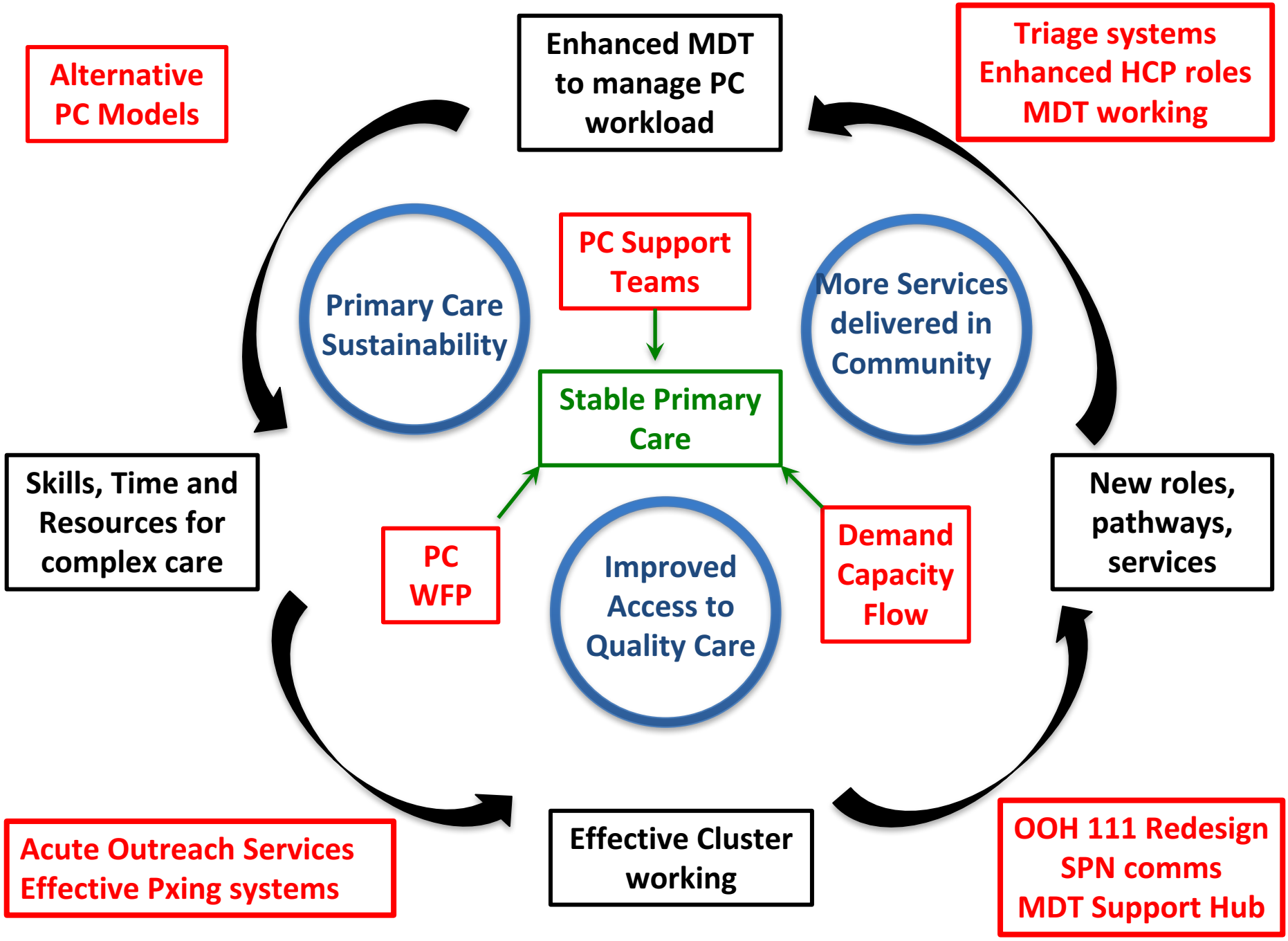
Paul Gimson

"Patient safety has evolved and developed in the context of hospital care. The concepts which guided the study of safety in hospitals remain relevant in primary and community care but new approaches to safety will be required in these more distributed forms of healthcare delivery."

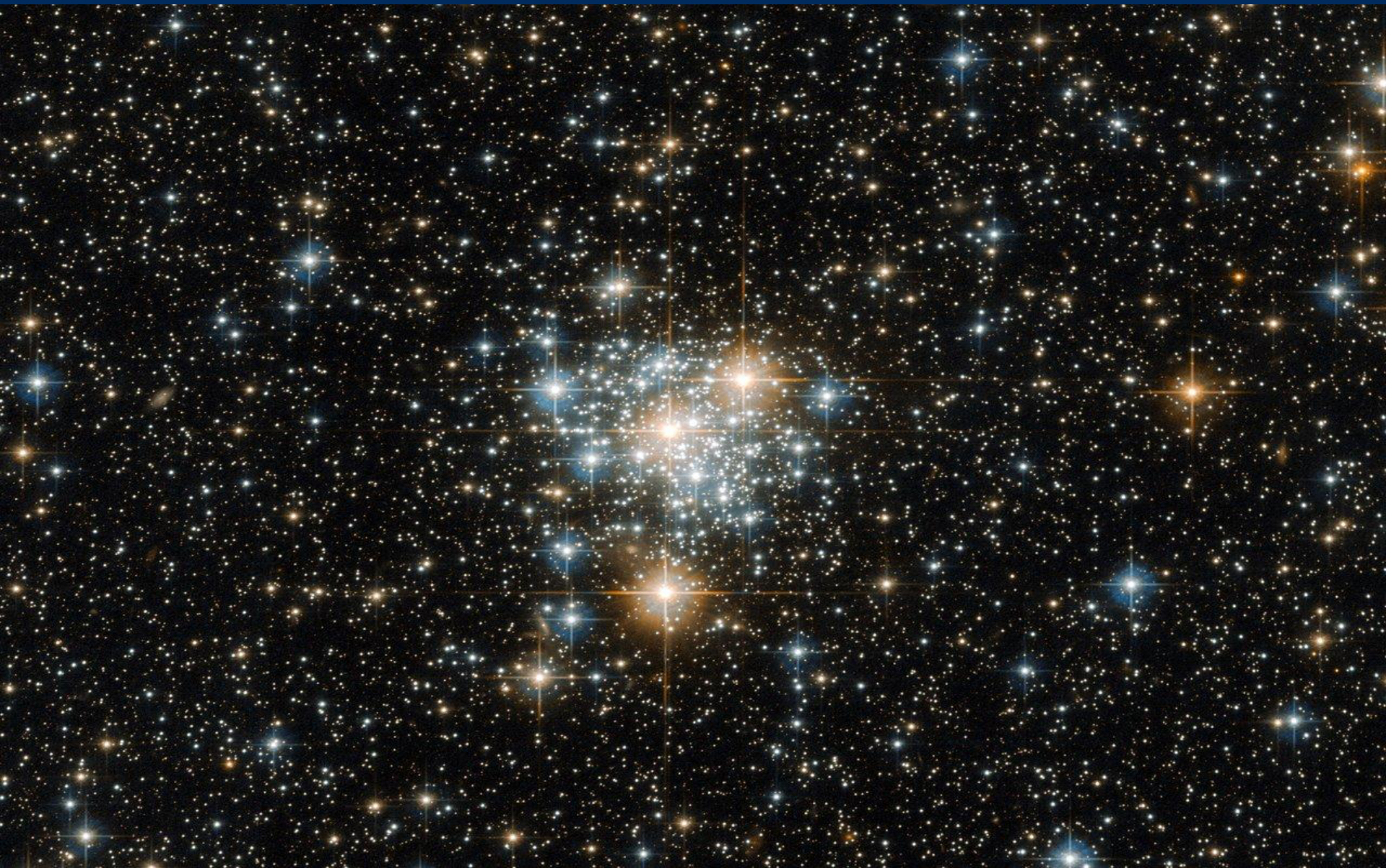
Safer Healthcare, Charles Vincent and René Amalbert

RC GP Royal College of General Practitioners

Ministerial Priorities


Alternative PC Models
Enhanced MDT to manage PC workload
Triage systems
Enhanced HCP roles
MDT working
Primary Care Sustainability
PC Support Teams
More Services delivered in Community
Stable Primary Care
Skills, Time and Resources for complex care
New roles, pathways, services
PC WFP
Improved Access to Quality Care
Demand Capacity Flow
Acute Outreach Services
Effective Pxing systems
Effective Cluster working
OOH 111 Redesign
SPN comms
MDT Support Hub

Primary Care Clusters...



A Welsh-Led solution?

Grŵp PISA Group

Canolfan PRIME Cymru
Wales PRIME Centre

Royal College of General Practitioners

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Why improve patient safety in primary care?

Andrew Carson-Stevens

Royal College of General Practitioners

RCGP Spotlight on Patient Safety

A huge thanks to our collaborating sponsors

AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

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Supported by
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Wales PRIME
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Royal College of
General Practitioners


90%

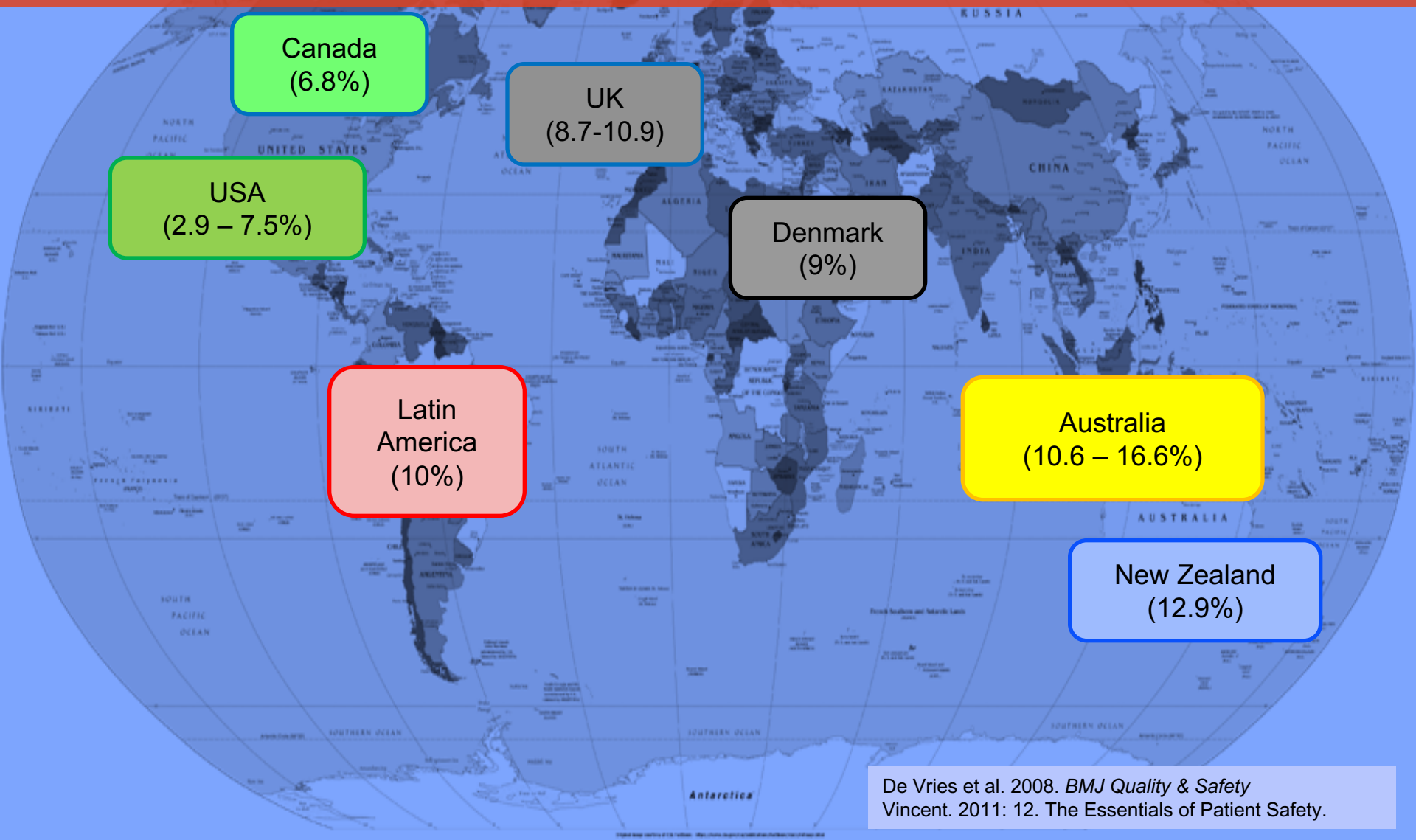
Big safety focus in

HOSPITAL CARE

to date

Royal College of General Practitioners

1 in 10 patients experience an adverse event in secondary care



De Vries et al. 2008. *BMJ Quality & Safety*
Vincent. 2011: 12. The Essentials of Patient Safety.

100k *lives* Campaign

SOME IS NOT A NUMBER. SOON IS NOT A TIME.

WWW.IHI.ORG

1 PATIENT SAFETY FIRST

EVERY PERSON EVERY TIME 24/7

SCOTTISH PATIENT SAFETY PROGRAMME

PROTECTING

5 Million *lives*

FROM HARM

SOME IS NOT A NUMBER. SOON IS NOT A TIME.

1000 LIVES O FYWYDAU +

Making patient safety a priority

If we can improve care for one patient,
then we can do it for **ten**.

If we can do it for ten,
then we can do it for a **100**.

If we can do it for a 100,
we can do it for a **1000**.

And if we can do it for a 1000,
we can do it for **everyone in Wales.**

GIG CYMRU NHS WALES

www.1000livesplus.wales.nhs.uk

Patientsikkert Sygehus

5s Alive!

A partnership to reduce under 5 mortality

RCGP Royal College of General Practitioners


Similarities *but* DIFFERENT

HETEROGENOUS

RC GP Royal College of General Practitioners

SAFER PRIMARY CARE EXPERT GROUP

Expert consensus study to determine priorities

OPEN ACCESS Freely available online

PLOS | MEDICINE

Guidelines and Guidance

Global Research Priorities to Better Understand the Burden of Iatrogenic Harm in Primary Care: An International Delphi Exercise

Kathrin M. Cresswell[1], Sukhmeet S. Panesar[2], Sarah A. Salvilla[2], Andrew Carson-Stevens[2,3], Itziar Larizgoitia[4], Liam J. Donaldson[5], David Bates[6,7,8], Aziz Sheikh[2,6,7]*, on behalf of the World Health Organization's (WHO) Safer Primary Care Expert Working Group[¶]

1 The School of Health in Social Science, The University of Edinburgh, Edinburgh, United Kingdom, **2** Centre for Population Health Sciences, The University of Edinburgh, Edinburgh, United Kingdom, **3** Cochrane Institute of Primary Care & Public Health, School of Medicine, Cardiff University, Cardiff, United Kingdom, **4** WHO, Geneva, Switzerland, **5** Department of Surgery and Cancer, Imperial College London, London, United Kingdom, **6** Division of General Internal Medicine, Brigham and Women's Hospital, Boston, Massachusetts, United States of America, **7** Harvard Medical School, Boston, Massachusetts, United States of America, **8** Department of Health Policy and Management, Boston, Massachusetts, United States of America

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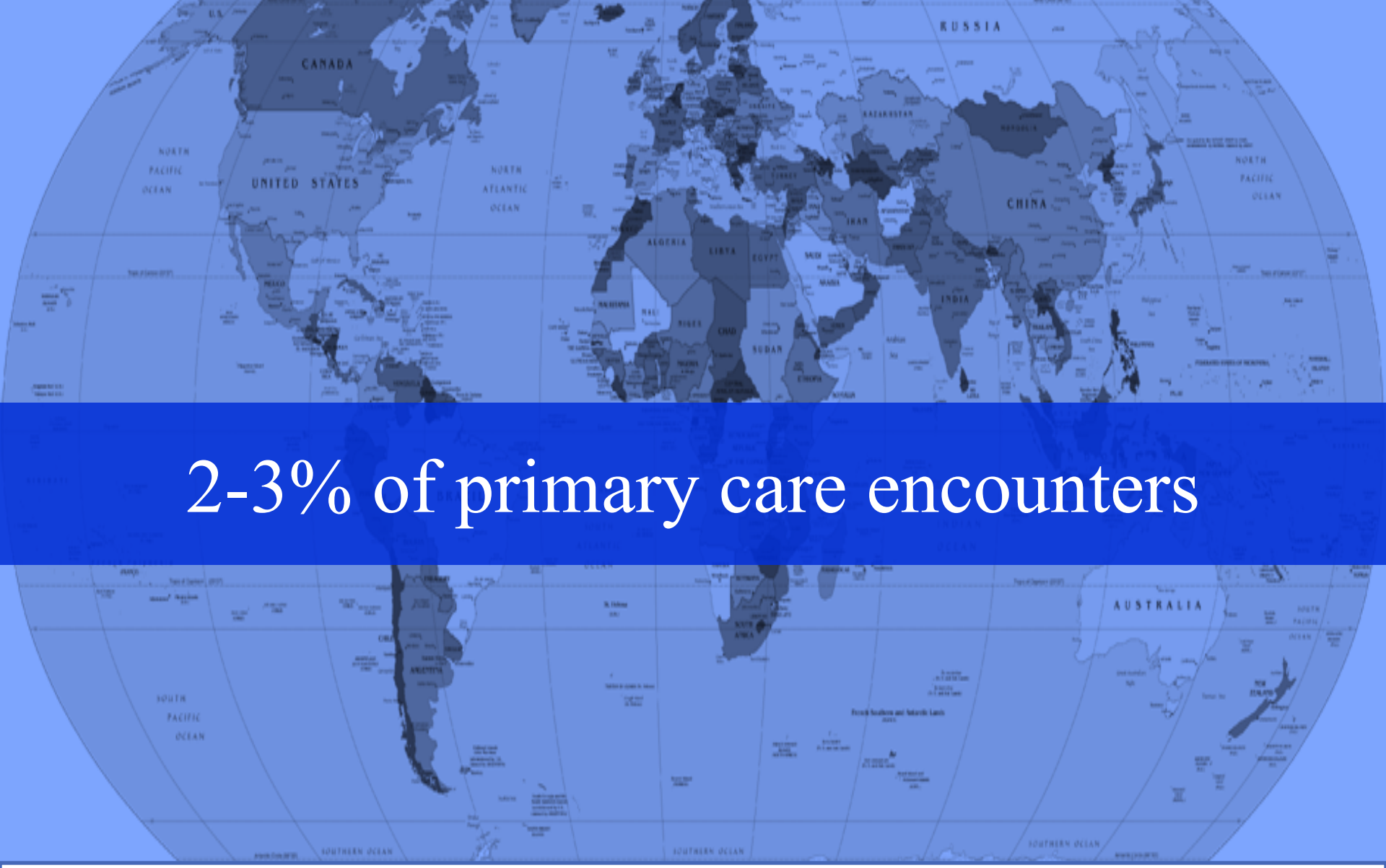
Expert consensus study to determine priorities

Table 6. Cross-cutting items that were considered to be important to focus on by over 80% of participants after round 3.

Education and training
Data collection methods
Developing policy to promote patient safety
Raising the public profile of patient safety
Greater clarity on definitions of errors in primary care
Facilitating learning from errors
Regulations to ensure that systems to improve patient safety are put into practice
Improved typologies/taxonomies (better ways of classifying errors in primary care)

doi:10.1371/journal.pmed.1001554.t006



2-3% of primary care encounters

BMJ QUALITY & SAFETY

How Safe is Primary Care? A Systematic Review. ***In press.***

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.

National Institute for Health Research

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

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

Cardiff University
Prifysgol Caerdydd
The University of Nottingham
Imperial College London
The University of Edinburgh
Harvard
Macquarie University

Sari et al. BMJ. 2007 Jan 13;334(7584):79.
Westbrook et al. Int J Qual Health Care. 2015;27(1):1-9.

PLOS | MEDICINE

RESEARCH ARTICLE

Patient Safety Incidents Involving Sick Children in Primary Care in England and Wales: A Mixed Methods Analysis

Philippa Rees[1,2], Adrian Edwards[1], Colin Powell[1], Peter Hibbert[3], Huw Williams[1], Meredith Makeham[3], Ben Carter[1,4], Donna Luff[5,6,7], Gareth Parry[7,8], Anthony Avery[9], Aziz Sheikh[7,10], Liam Donaldson[11], Andrew Carson-Stevens[1,3,12]*

1 Division of Population Medicine, Cardiff University, Cardiff, United Kingdom, **2** Institute of Child Health, University College London, London, United Kingdom, **3** Australian Institute for Healthcare Innovation, Macquarie University, Macquarie, Australia, **4** Department of Biostatistics and Health Informatics, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, United Kingdom, **5** Institute for Professionalism and Ethical Practice, Boston Children's Hospital, Boston, Massachusetts, United States of America, **6** Department of Anesthesia, Boston Children's Hospital, Boston, Massachusetts, United States of America, **7** Harvard Medical School, Harvard University, Boston, Massachusetts, United States of America, **8** Institute for Healthcare Improvement, Cambridge, Massachusetts, United States of America, **9** Division of General Practice, University of Nottingham, Nottingham, United Kingdom, **10** Usher Institute of Population Health Sciences and Informatics, University of Edinburgh, Edinburgh, United Kingdom, **11** Department of Non-communicable Disease Epidemiology, London School of Hygiene and Tropical Medicine, London, United Kingdom, **12** Department of Family Practice, University of British Columbia, Vancouver, British Columbia, Canada

* carson-stevensap@cardiff.ac.uk

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2017 PLoS Med 14(1): e1002217.

Patient Safety Incidents Involving Sick Children in Primary Care in England and Wales: A Mixed Methods Analysis

Rees P, Edwards A, Powell C, Hibbert P, Williams H, Makeham M, Carter B, Luff D, Parry G, Avery A, Sheikh A, Donaldson L and Carson-Stevens A.

Dispensing error – **prescription for erythromycin** 250mg, **dispensed chlorpromazine** 50 mg tablets. 16-year-old patient took wrong medicine for 3 days and **suffered serious side effects including catatonic seizures**. Different brand of chlorpromazine to be kept in pharmacy. Contacted manufacturer to request re-assessment of packaging. Similarity of packaging led to error in tablet selection.

PLOS | MEDICINE

2017 PLoS Med 14(1): e1002217.

Patient Safety Incidents Involving Sick Children in Primary Care in England and Wales: A Mixed Methods Analysis

Rees P, Edwards A, Powell C, Hibbert P, Williams H, Makeham M, Carter B, Luff D, Parry G, Avery A, Sheikh A, Donaldson L and Carson-Stevens A.

Call concerning a baby under 2 months with **worsening swelling in umbilical area**—baby was crying and had been unwell all day. **Nurse advisor used 'other symptoms' algorithm instead of unwell baby under 3 month algorithm** – she answered 2 questions and then **downgraded the call from 'GP same day' to 'GP next working day'**. The caller rang back a few hours later and swollen area was worsening, changing colour and baby still crying.

PLOS | MEDICINE

2017 PLoS Med 14(1): e1002217.

Patient Safety Incidents Involving Sick Children in Primary Care in England and Wales: A Mixed Methods Analysis

Rees P, Edwards A, Powell C, Hibbert P, Williams H, Makeham M, Carter B, Luff D, Parry G, Avery A, Sheikh A, Donaldson L and Carson-Stevens A.

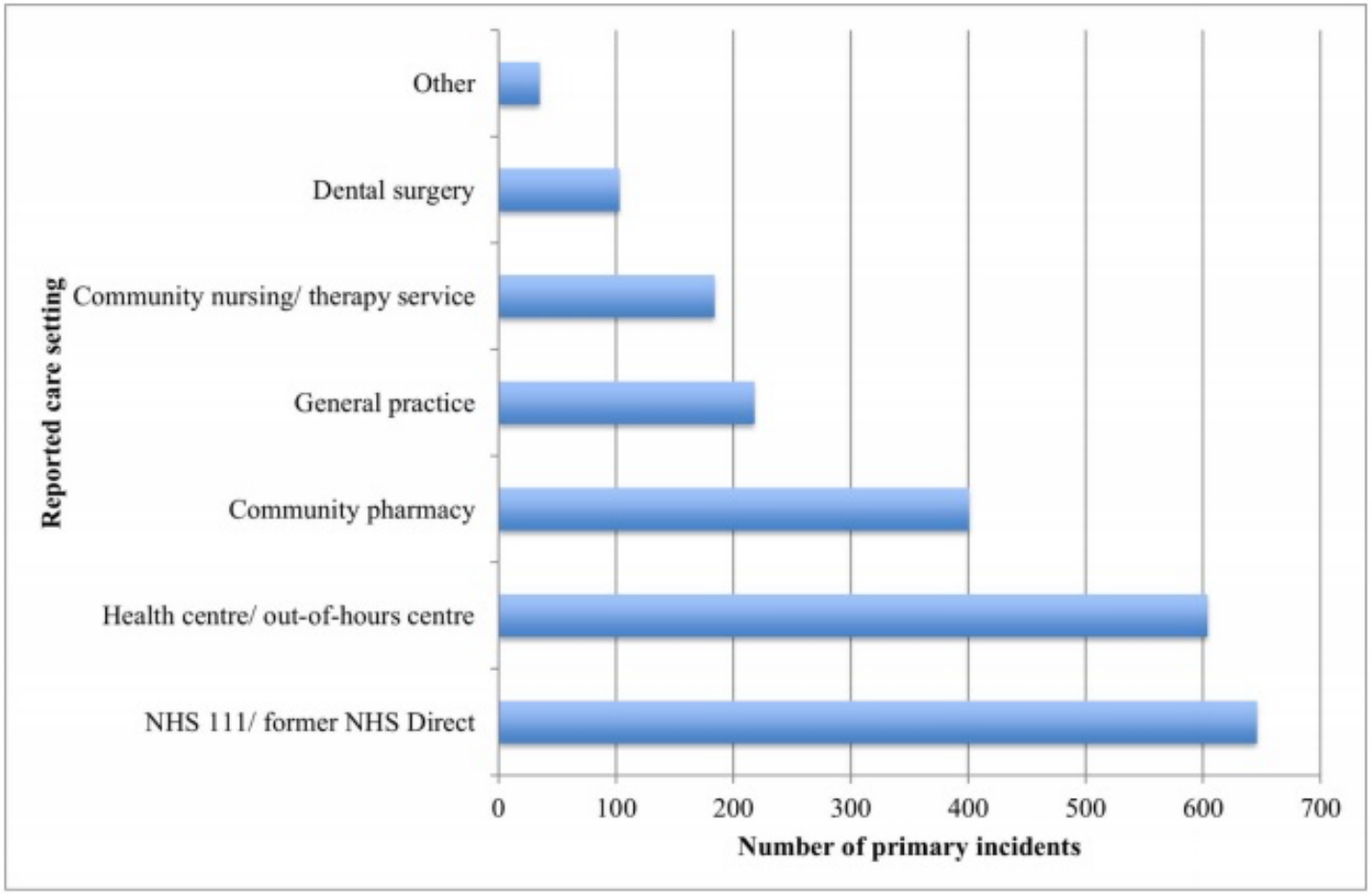

Fig 2. Settings where reported primary-care-related incidents involving sick children occurred. NHS 111 is the UK national telephone triage service.

doi:10.1371/journal.pmed.1002217.g002

PLOS | MEDICINE

2017 PLoS Med 14(1): e1002217.

Patient Safety Incidents Involving Sick Children in Primary Care in England and Wales: A Mixed Methods Analysis

Rees P, Edwards A, Powell C, Hibbert P, Williams H, Makeham M, Carter B, Luff D, Parry G, Avery A, Sheikh A, Donaldson L and Carson-Stevens A.

- Safer and more reliable **medication dispensing systems** are needed.
- **Out-of-hours telephone triage systems** are not fit for pediatric purpose and require improvement.
- Mandatory **pediatric training for all general practice trainees** is essential.

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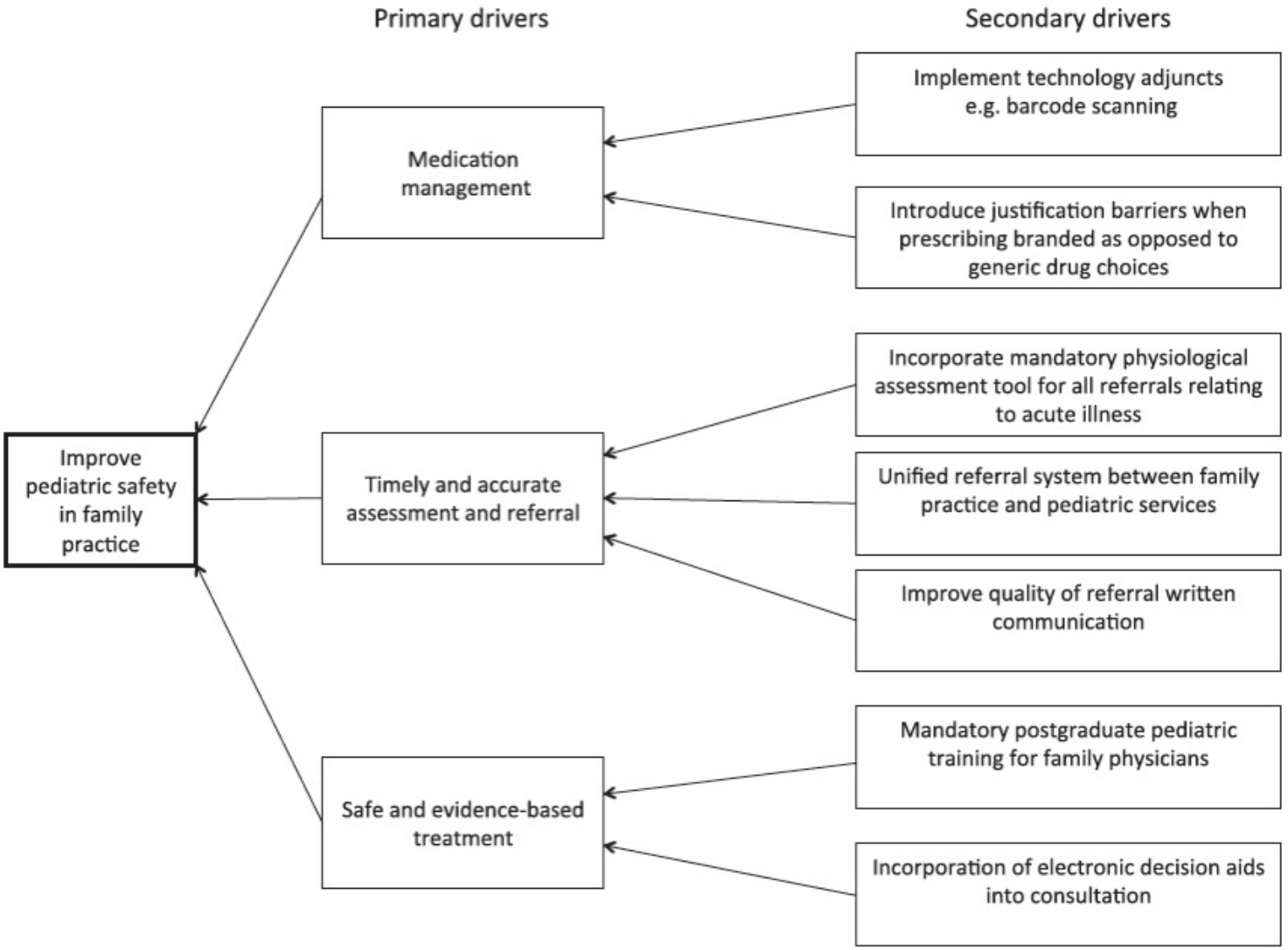
PEDIATRICS
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

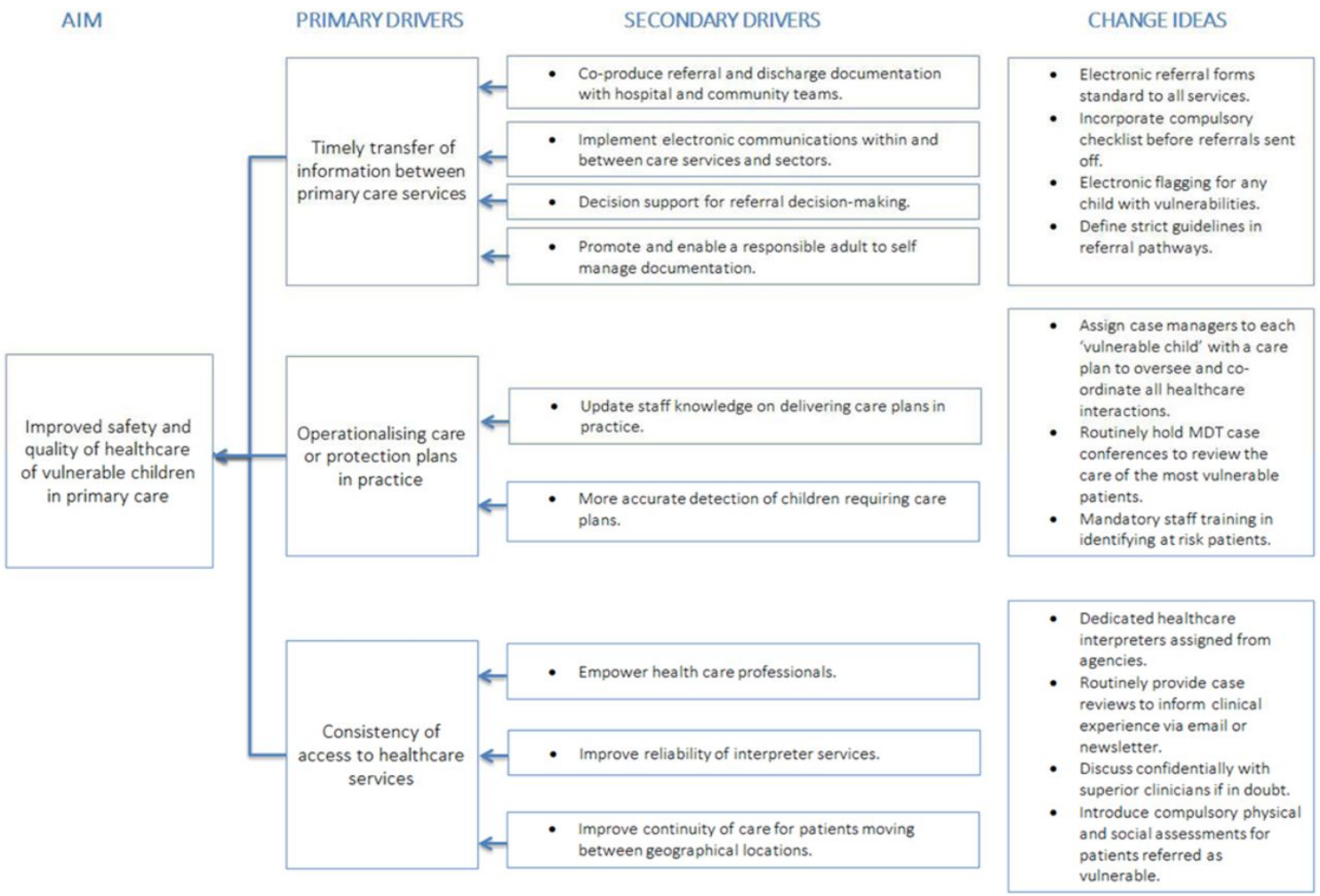
2015 May 24; peds.2014-3259.

Safety incidents in the primary care office practice setting.

Rees P, Edwards A, Powell C, Panesar S, Carter B, Williams H, Hibbert P, Luff D, Parry G, Mayor S, Avery A, Sheikh A, Donaldson L and Carson-Stevens A.



RC GP



Archives of Disease in Childhood

Disparities in the quality of primary healthcare for socially deprived children.
Rees P, Edwards A, Powell C, Evans H, Panesar S, Carson-Stevens A.

BMJ Quality & Safety

Vulnerable children and their care quality issues. A descriptive analysis of a national database.
Omar A, Rees P, Prosser Evans H, Williams H, Cooper A, Banerjee S, Hibbert P, Makeham M, Parry G, Donaldson L, Edwards A and Carson-Stevens A.

Wolfson PRIME Cymru
PRIME Centre Wales
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Funded by Welsh Government

Contents lists available at ScienceDirect

Vaccine

journal homepage: www.elsevier.com/locate/vaccine

Pediatric immunization-related safety incidents in primary care: A mixed methods analysis of a national database

Philippa Rees[a], Adrian Edwards[a], Colin Powell[a], Huw Prosser Evans[a], Ben Carter[a], Peter Hibbert[b], Meredith Makeham[b], Aziz Sheikh[c,d], Liam Donaldson[e], Andrew Carson-Stevens[a,b,c,f,*]

[a] Primary Care Patient Safety (PISA) Research Group, Division of Population Medicine, Cardiff University, Neuadd Meirionnydd, Heath Park, Cardiff CF14 4YS, UK
[b] Australian Institute for Healthcare Innovation, Macquarie University, Level 6, 75 Talavera Road, Sydney 2109, NSW, Australia
[c] Centre for Medical Informatics, The University of Edinburgh, Medical School, Teviot Place, Edinburgh EH8 9AG, UK
[d] Harvard Medical School, Harvard University, Department of Medicine, 1620 Tremont St, Boston, MA 02120, USA
[e] Imperial College London, 1090a, Queen Elizabeth the Queen Mother Wing (QEQM), St Mary's Campus, Norfolk Place, London W2 1PG, UK
[f] Department of Family Practice, University of British Columbia, 3rd Floor, 5950 University Boulevard, Vancouver, BC, Canada V6 T 1Z3

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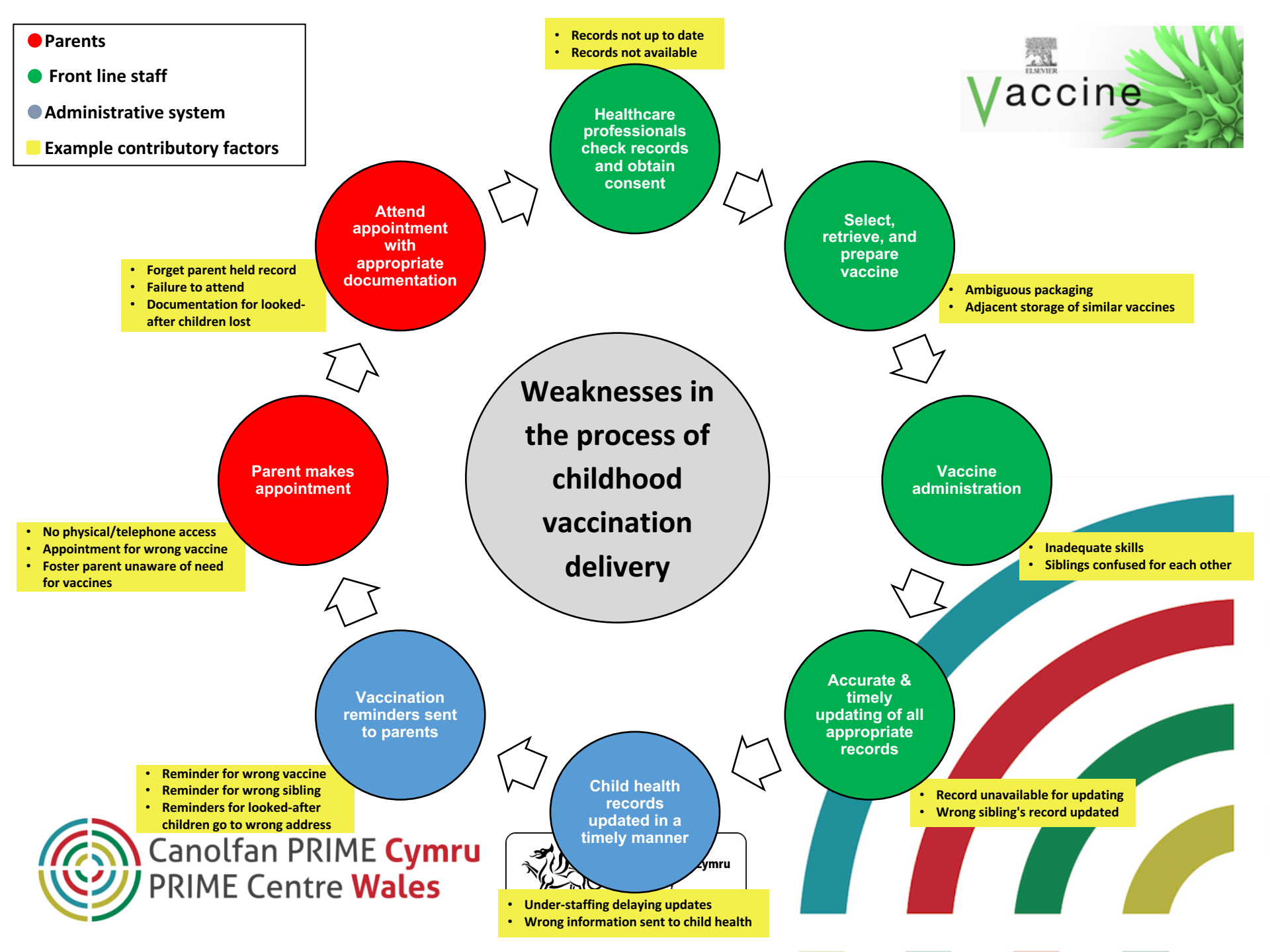
Parents
Front line staff
Administrative system
Example contributory factors
Vaccine
Weaknesses in the process of childhood vaccination delivery
Healthcare professionals check records and obtain consent
Records not up to date
Records not available
Select, retrieve, and prepare vaccine
Ambiguous packaging
Adjacent storage of similar vaccines
Vaccine administration
Inadequate skills
Siblings confused for each other
Accurate & timely updating of all appropriate records
Record unavailable for updating
Wrong sibling's record updated
Child health records updated in a timely manner
Under-staffing delaying updates
Wrong information sent to child health
Vaccination reminders sent to parents
Reminder for wrong vaccine
Reminder for wrong sibling
Reminders for looked-after children go to wrong address
Parent makes appointment
No physical/telephone access
Appointment for wrong vaccine
Foster parent unaware of need for vaccines
Attend appointment with appropriate documentation
Forget parent held record
Failure to attend
Documentation for looked-after children lost
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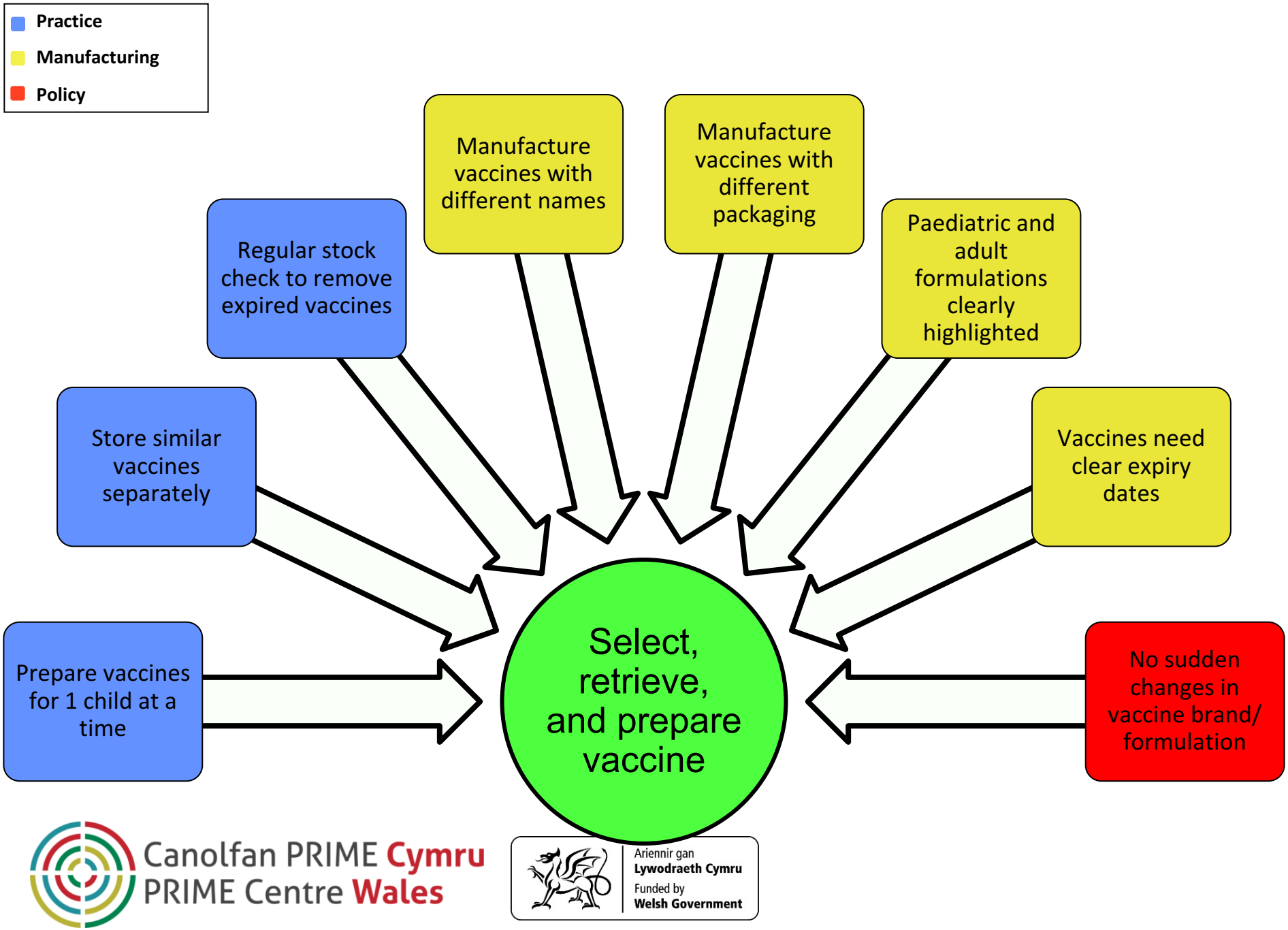

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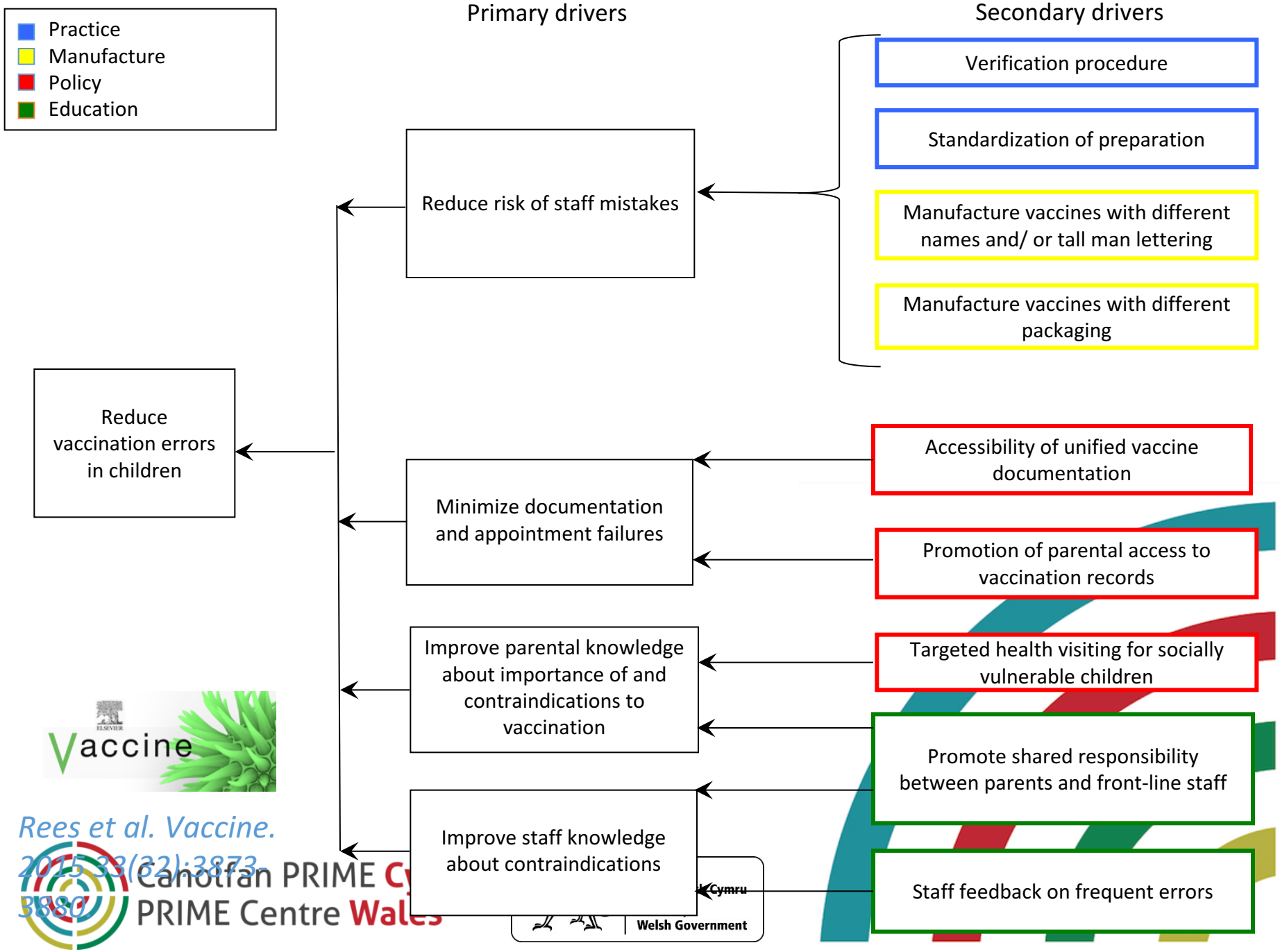

Vaccine

Rees et al. Vaccine. 2015 33(22):3873-3880

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- An international patient safety learning system is needed to:
  - *Describe care failures or safety incidents;*
  - *Shape priorities for improvement;*
  - *Corroborate insights from research studies;*
  - *Develop potential solutions for practice;*
  - *Share learning of context-specific application of solutions.*
- Develop infrastructures for data sharing in each country
- Develop an open culture of reporting from staff and consumers
- Build improvement capability amongst workforce to apply lessons learned

THE LANCET

2015 Apr 25;385(9978):1593-4.

Reducing the burden of iatrogenic harm in children
Carson-Stevens A, Edwards A, Panesar S, Parry G, Rees P, Sheikh A and Donaldson L.

THE LANCET

2014 Nov 29;384(9958):1923-4.

Paediatrics safety monitoring
Rees P, Edwards A, Panesar S and Carson-Stevens A

Cardiff University
Lywodraeth Cymru
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Welsh Government

Other publications

Age and Ageing
THE INTERNATIONAL JOURNAL OF THE BRITISH GERIATRICS SOCIETY

Sources of unsafe primary care for older adults: a mixed methods analysis of patient safety incident reports. *In press.*
Cooper A, Edwards A, Williams H, Hibbert P, Makeham M, Avery A, Sheikh A, Donaldson L, Carson-Stevens A.

THE LANCET

Unsafe opioid replacement therapy in England and Wales: a mixed-methods study. 2017.
Gibson R, Afzal M, Williams H, Edwards A, Hibbert P, Sheikh A, Donaldson L, Carson-Stevens A.

Archives of Disease in Childhood

Learning from excellence and patient safety incidents. 2017.
Cooper J, MacLeod N, Williams H, Carson-Stevens A.

human VACCINES & IMMUNOTHERAPEUTICS

Improving the safety of vaccine delivery. 2016.
Evans HP, Williams H, Cooper A, Carson-Stevens A.

BMJ QUALITY & SAFETY

Opportunities for incident reporting. 2015.
Williams H, Cooper A, Carson-Stevens A.

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Funded by Welsh Government

Our collaborators

University of South Wales
Prifysgol De Cymru

Lithium-related patient safety incidents
Joyce Kenkre, Carolyn Wallace, Sue Jordan (Swansea), Paul Deslandes, Simon Young, Jennifer Cooper, Andrew Carson-Stevens

Chief sponsor for RCGP Spotlight Award

AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

Developed new project for Year 5 medical students to explore medication non-adherence with patients on placement *(Alison Cooper, Jamie Hayes, Phil Routledge, Andrew Carson-Stevens)*

Project planning in progress:
High-risk medicines (PhD student identified)

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Improving GP out-of-hours care for end of life patients (RCGP / Marie Curie Fellowship)
Huw Williams, Joyce Kenkre, Sir Liam Donaldson, Simon Noble, Andrew Carson-Stevens

The University of Nottingham

Medication safety in primary care – PhD student, Mr Khalid Mohammad
Supervisors: Matthew Boyd, Tony Avery, Andrew Carson-Stevens

Culture of patient safety in community pharmacy – PhD student, Mr Mohammed Alsubaie
Supervisors: Matthew Boyd, Justin Waring, Andrew Carson-Stevens

THE UNIVERSITY OF EDINBURGH

an PRIME Cymru Centre Wales

Patient safety in primary care dentistry – PhD student, Dr Eduardo Ensaldo-Curasco
Supervisors: Aziz Sheikh, Kathrin Cresswell, Andrew Carson-Stevens

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90%

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General Practitioners

Reporting patient safety incidents can allow:

- Reflection on the incident by the reporter and enhanced professional development (individual level)
- Identification of opportunities to undertake SEAs (practice level)
- Collated reports at a Health Board or CCG can highlight local systems issues for change (system level)
- Collated reports can help identify rare issues (national level).

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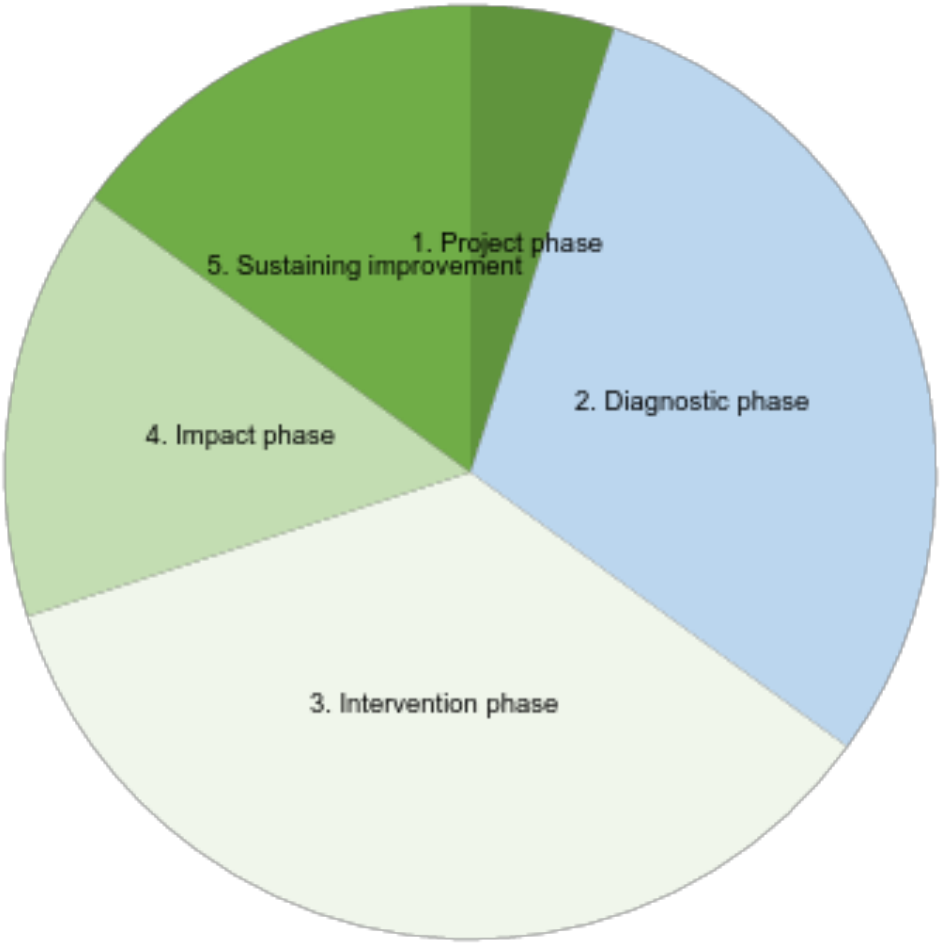
Reflections on generating learning from patient safety incidents

Huw Williams

Royal College of General Practitioners

Diagnostics of *Improvement*



What data do you have?

What data do you need?

Royal College of General Practitioners

From: Bernie Harrison. Clinical Excellence Commission. Sydney.

National Institute for Health Research

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

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

Cardiff University
Prifysgol Caerdydd
The University of Nottingham
Imperial College London
The University of Edinburgh
Harvard
Macquarie University

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

1

Incident characteristics

2

Contributory factors

3

Outcome & harm severity

Cardiff University Prifysgol Caerdydd

The University of Nottingham

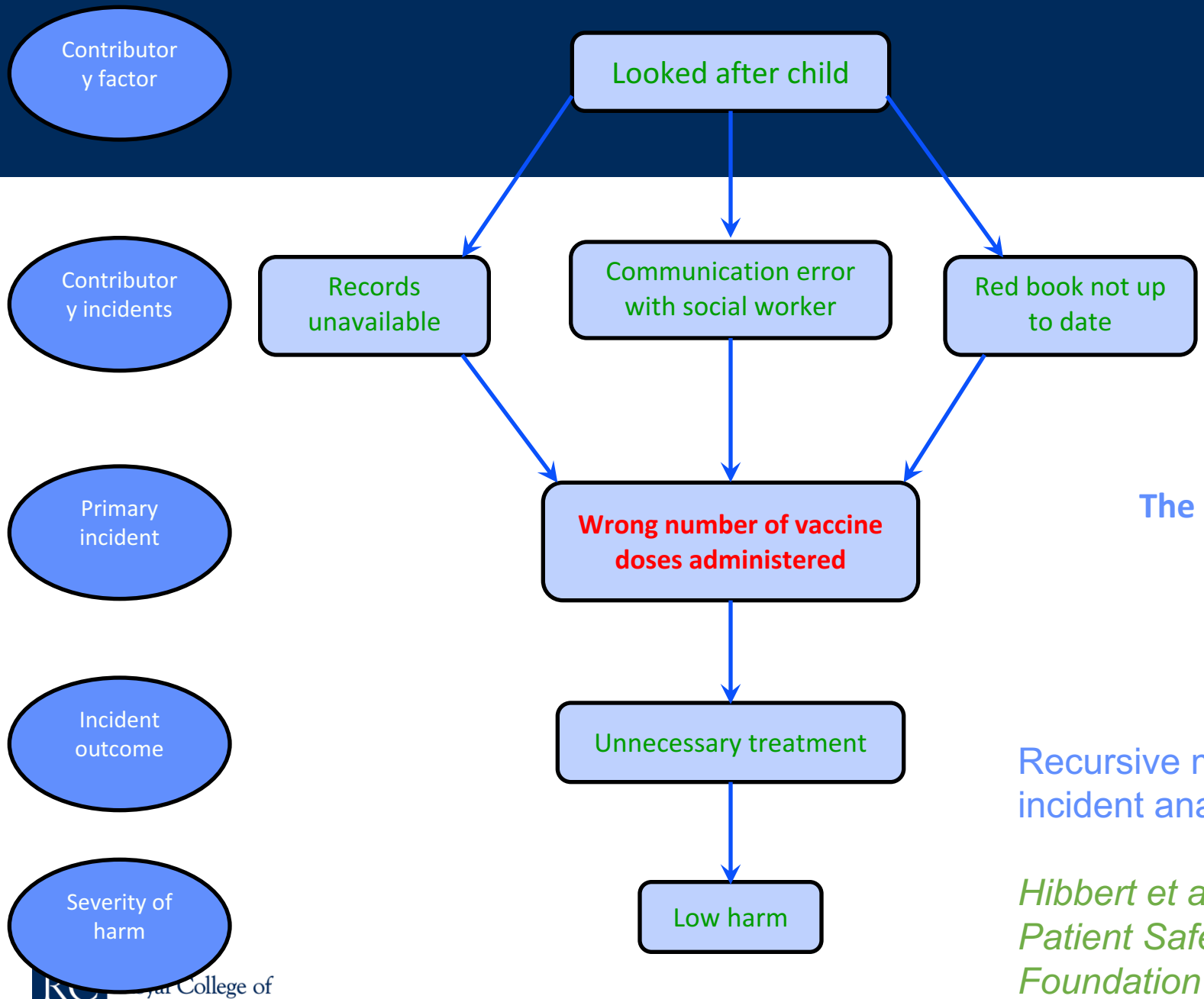
Imperial College London

The University of Edinburgh

Harvard

Macquarie University

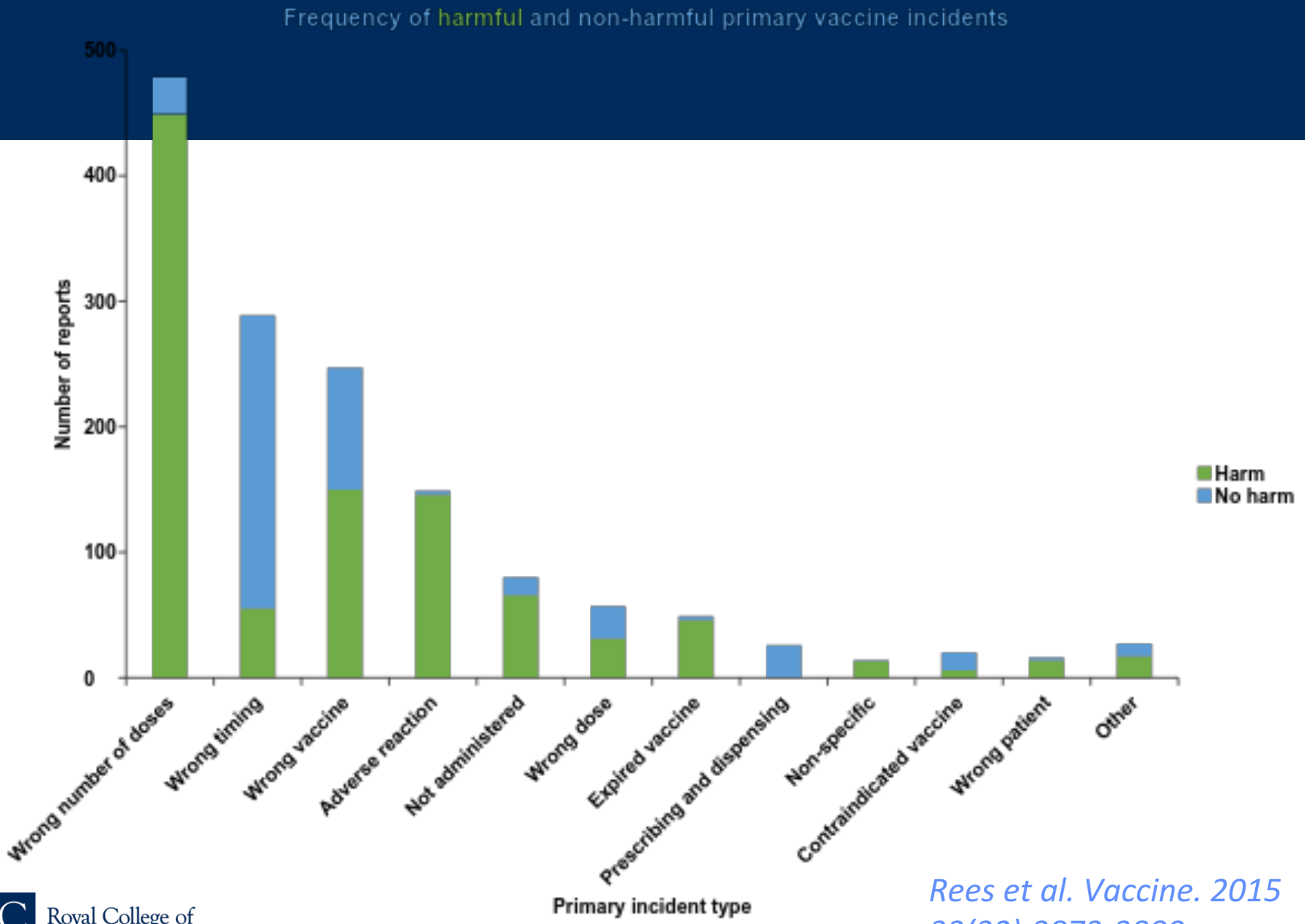
Child had been placed with **adoptive parents** and adopted mum had been **advised** by a **social worker** to attend family practice **to complete** primary vaccinations. Mum attended surgery with parental held record, **no** other family practice or child health **medical records available**. **Only two immunisations** had been **recorded** in the red book, remaining **immunisations given** with consent. Later informed by social services that child has **already completed** her primary immunisations.



The Story

Recursive model of incident analysis

Hibbert et al. Australian Patient Safety Foundation 2007.



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Rees et al. Vaccine. 2015 33(32):3873-3880.

	Severity of harm				
Incident type	**No**	**Low**	**Mod.**	**Death**	**Total**
Vaccine administration					
Wrong number of doses	28	447	1	-	476
Wrong timing	239	44	8	3	294
Wrong vaccine	97	150	2	-	249
Not administered	14	65	1	-	80
Wrong dose	26	31	-	-	57
Expired vaccine	3	46	-	-	49
Non-specific	10	13	-	-	23
Contraindicated vaccine	14	5	1	-	20
Wrong patient	2	14	-	-	16
Other	5	9	4	-	18

Rees et al. Vaccine. 2015 33(32):3873-3880.

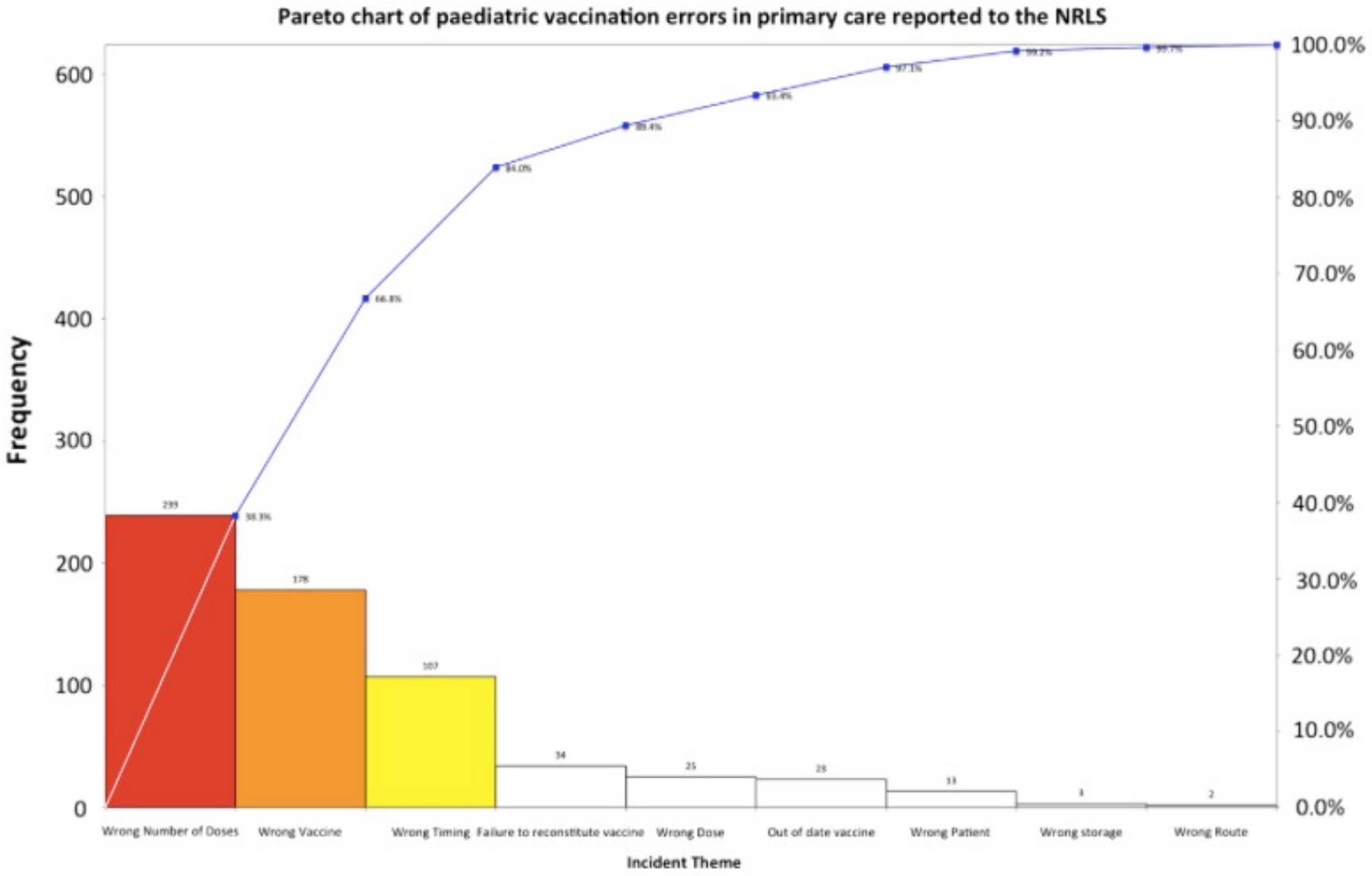
Contributory Factors	Frequency
Patient/ parent factors	
Patient/ parent behaviour	74
Patient/ parent geography	64
Patient health	37
Patient/ parent knowledge	48
Looked after child	18
Patient/ parent language	5
Staff factors	
Mistake	*240
Non-specific mistake	139
Similar vaccine appearances	45
Distraction	22
Misreading	18
Inattention	10
Similar patient names	9
Failure to follow protocol	174
Knowledge	19
Violation	12
Fatigue/ stress	5
Other factors	3

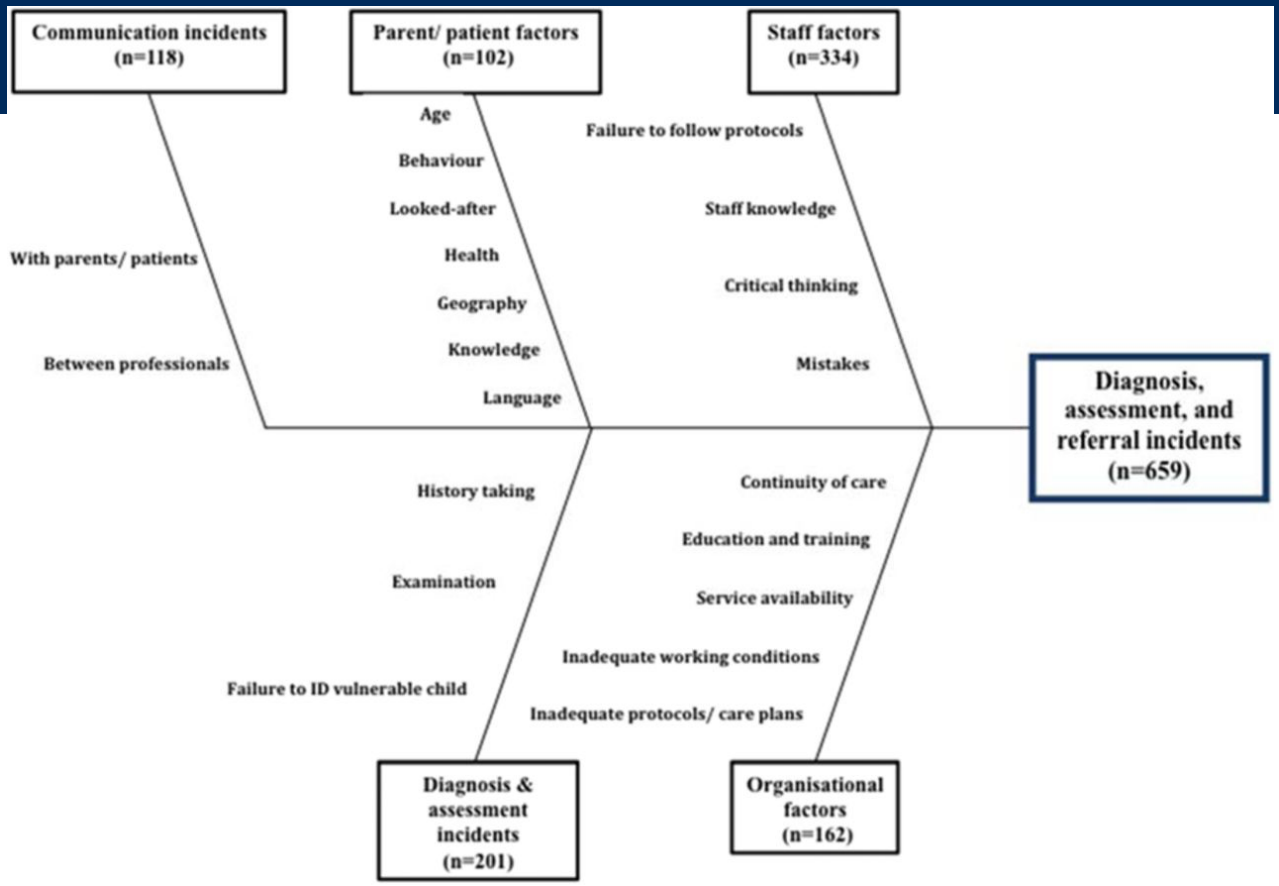
Archives of
Disease in Childhood

Quality improvement informed by a reporting and learning system.

Rees P, Carson-Stevens A, Williams H, Panesar S and Edwards A.

2014. 99(7):702-3.





Identifying priorities for improved child healthcare: a mixed methods analysis of safety incident report. *BMJ Qual Saf* 2015 24: 730-731.

Rees P, Edwards A, Powell C, Williams H, Hibbert P, Makeham M, Luff D, Parry G, Sheikh A, Donaldson L and Carson-Stevens A.

BMJ QUALITY & SAFETY

RCGP Royal College of General Practitioners

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Research

Huw Williams, Adrian Edwards, Peter Hibbert, Philippa Rees, Huw Prosser Evans, Sukhmeet Panesar, Ben Carter, Gareth Parry, Meredith Makeham, Aled Jones, Anthony Avery, Aziz Sheikh, Sir Liam Donaldson and Andrew Carson-Stevens

BJGP

Harms from discharge to primary care:

mixed methods analysis of incident reports

Br J Gen Pract 2015; 65 (641): e829-e837

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Overview of Williams et al. 2015.

BJGP

- 598 reports, 443 harmful – 83 moderate harm or worse
- 4 main types of incident:
  - Delayed, incorrect or non-existent **discharge communication**
  - Lack of, or poor quality **referrals to community teams** (mainly District nursing)
  - Discharge **medication** issues
  - Provision of **care adjuncts or equipment** (beds, mattresses, needles, oxygen)

Overview of Williams et al. 2015.

- Contributory Factors
  - Confusing referral criteria
  - Poor understanding of primary care capacity and role
  - Appreciation of who has responsibility for equipment provision
  - Lack of clear protocols and or policies for these transitions of care
- Primary care staff spend a lot of time putting these things right!

BJGP

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Overview of Williams et al. 2015.

BJGP

- Recommendations:
  - Development and testing of **e-Discharge** systems
  - Base these on existing **minimum information** standards
  - Unified systems for referral to community teams
  - Promote culture of safer discharge – family inclusion, discharge coordinators, discharge checklists for ward staff and patients

Table 4. Possible interventions to improve the discharge process

Intervention	Strength as per USDVA Classification	Current evidence of efficacy
Improved quality of discharge communication		
Electronically generated and transmitted discharge communication outputs	Strong	Yes [2, 48, 63]
Base new discharge communications on existing proforma	Strong	Yes [9, 44, 61]
Patient-controlled records	Intermediate	Some – weak [65]
Referrals to community teams		
Single, unified referral process to Community Nursing services	Strong	No
Promoting culture of discharge safety		
Use of patient discharge checklists	Intermediate	Yes [51]
Discharge coordinators producing individualised discharge plans	Intermediate	Yes [55, 56]
Include families on ward rounds/discharge planning	Intermediate	Yes [57, 58]

Table discussion

At your table:

- **Identify a scribe & a reporter**
- **Discuss:**
  - *How do you report a patient safety incident occurring in primary care in your organisation?*
  - *Discuss the pros and cons of this approach.*

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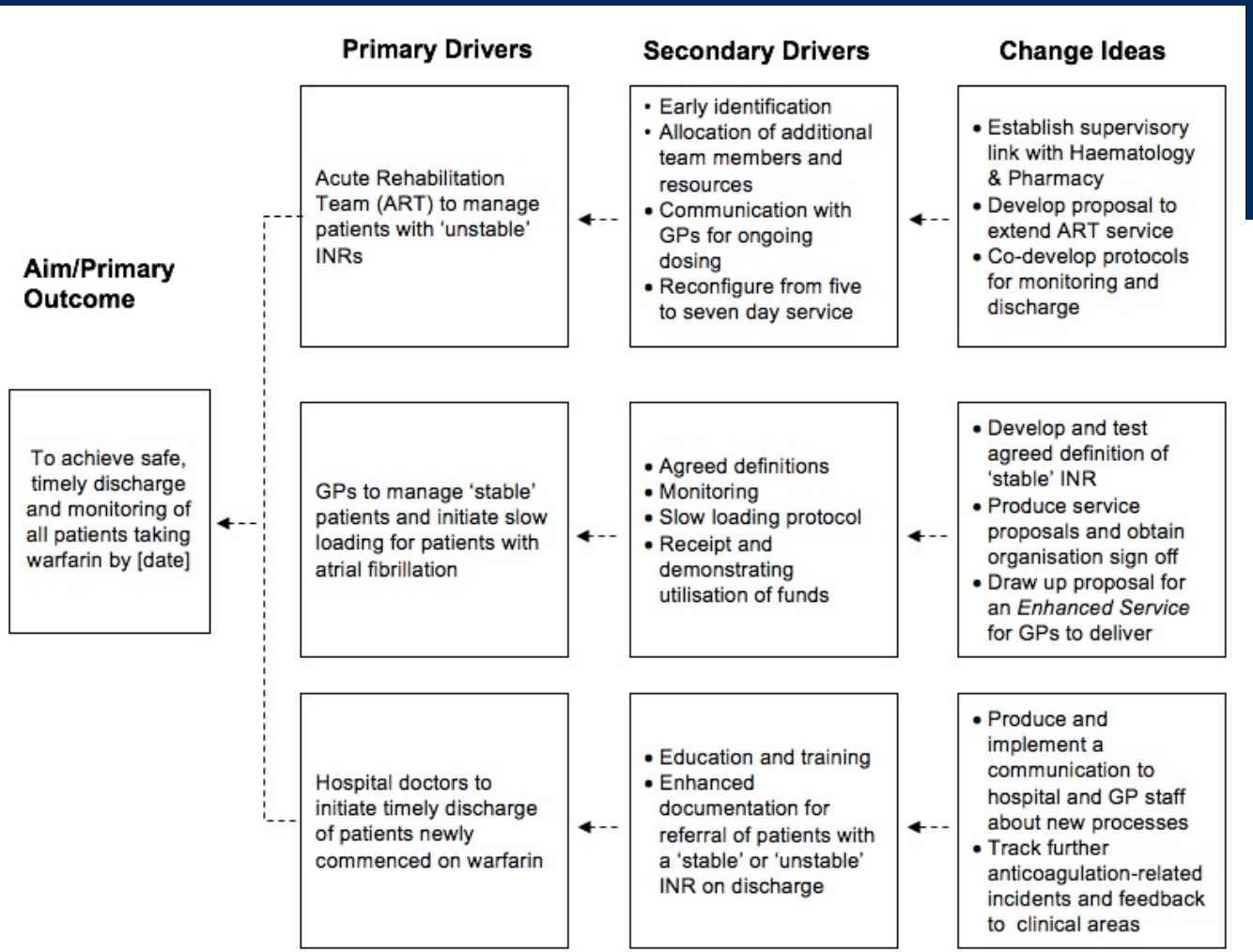
BMJ QUALITY & SAFETY

Opportunities for incident reporting
Williams H, Cooper A, Carson-Stevens A.
2015 Nov 11. pii: bmjqs-2015-004962.



Grŵp PISA Group

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Capturing and learning from incidents across the primary-secondary care interface. BMJ – IHI International Forum, Paris (April 2014)

Sian Rowlands, Huw Williams, Maureen Fallon, Nav Masani, Alice Casey, Graham Shortland, Adrian Edwards, Andrew Carson-Stevens

Table discussion

Now discuss:

- *How could this approach be improved?*
- *How can analysis of these data regularly inform your improvement agendas?*

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BMJ QUALITY & SAFETY

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Quality improvement reports: Prescribing and patient safety

David Mullett

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What this presentation will cover

- Project aim
- Introduction to the project
- What's in the reports
- How would you use these reports?
- How pilot participants used the reports
- How to get involved

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Aim

- To support quality improvement within general practice by developing and implementing innovative data reports for GPs, focusing on prescribing and patient safety

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About the project

- Collaboration between RCGP and CPRD
- Practice-level data reports
  - Focus on prescribing and patient safety
  - Enable benchmarking and case-finding
  - Come with a package of support material
- Extensive pilot period
- Open to all practices in the UK
- Based on CPRD data extract

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Indicators

- Taken from RCGP Patient Safety Toolkit
  1. NSAIDs in patients with Heart Failure
  2. Glitazones in patients with Heart Failure
- Under consideration for future:
  - Heart failure patients
  - NSAID prescription to other patient groups
  - CKD

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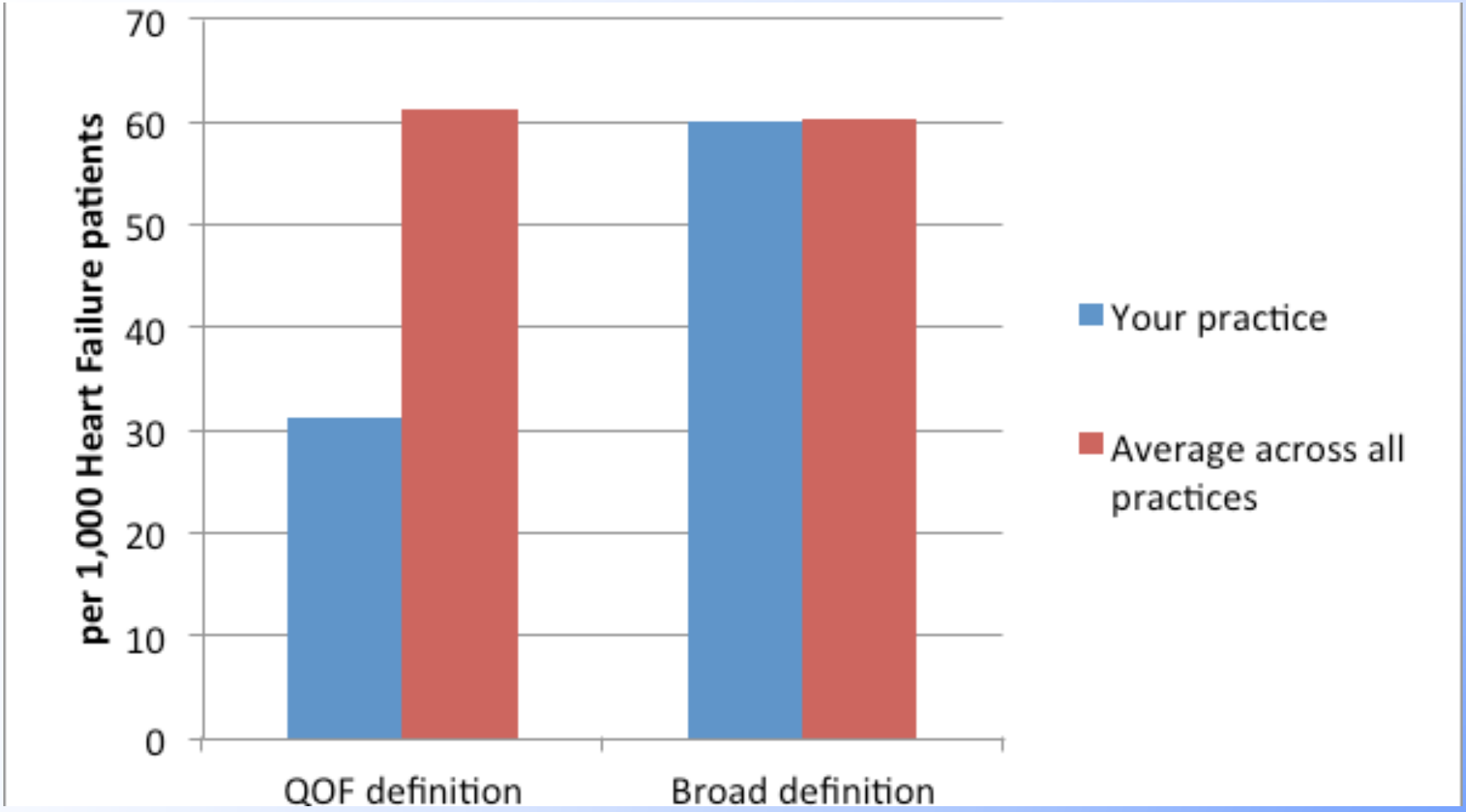
Rationale

- The prescribing of all NSAIDs are contra-indicated for patients with severe Heart Failure.
- Diclofenac, aceclofenac, ibuprofen (≥ 2.4 g daily), dexibuprofen (≥ 1.2 g daily) and the selective inhibitors of cyclo-oxygenase-2 (celecoxib, etoricoxib and parecoxib) are contra-indicated in mild to severe heart failure; they should be used with caution in patients with a history of cardiac failure.
- Other non-selective NSAIDs should be used with caution in heart failure.

Benchmarking



Case-finding

Patient Identifier (As seen in Vision)	Vision alpha phonetic	Age	NSAID type(s)
0qd@	zero quebec delta @	<65	Naproxen
1wfN	one whiskey foxtrot NOVEMBER	65+	Ibuprofen
2egM	two echo golf MIKE	65+	Naproxen Piroxicam
3rh0	three romeo hotel zero	<65	Ibuprofen
4tj1	four tango juliet one	65+	Naproxen
5yk2	five yankee kilo two	65+	Etoricoxib
6ul3	six uniform lima three	<65	Naproxen
7iZ4	seven india ZULU four	<65	Meloxicam
8oX5	eight oscar X-RAY five	<65	Ibuprofen
9pC6	nine papa CHARLIE six	65+	Naproxen
0aV7	zero alpha VICTOR seven	<65	Naproxen
1sB8	one sierra BRAVO eight	65+	Diclofenac Naproxen

Recommendations

- The decision to prescribe an NSAID should be based on an assessment of a person's individual risk factors, including any history of cardiovascular and gastrointestinal illness.
- Naproxen (1000 mg a day or less) and low-dose ibuprofen (1200 mg a day or less) are considered to have the most favourable thrombotic cardiovascular safety profiles of all NSAIDs.
- The lowest effective dose should be used for the shortest duration necessary to control symptoms.
- A person's need for symptomatic relief and response to treatment should be re-evaluated periodically.

Using the report in practice (1)

- Standard set: 90% of our patients with a recorded diagnosis of heart failure are not prescribed NSAIDs as a repeat prescription
- Checked numbers shown in report with those found in practice system:
  - 41 patients with heart failure based on the broad definition
  - 6 of these patients with a record of at least one dispensing of an NSAID during 2016

Using the report in practice (2)

- The medical record of each of the six patients identified was examined:
  - Two were only prescribed NSAIDs on an acute prescription
  - Two were prescribed NSAIDs on a repeat basis. They have been sent letters asking them to stop their NSAID if possible and have had their repeat prescription inactivated.
  - One patient has severe ongoing gout and is reluctant to stop his NSAID
  - One patient is a child with corrected CHD prescribed ibuprofen for fever.
- All patients with a diagnosis of heart failure, whether taking NSAIDs or not, have had a reminder added to their notes suggesting avoiding NSAIDs

Using the report in practice (3)

- 2 patients have had their treatment changed as a result of this audit
- 27 patients have had their notes flagged
- Practice clinicians have been reminded about the concerns about prescribing NSAIDs in patients with heart failure
- Process written up as evidence for appraisal

How to get involved

- david.mullett@rcgp.org.uk
- https://www.cprd.com/generalpractitioner/

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Team-based learning from errors in practice

Alison Cooper

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RCGP Spotlight on Patient Safety

AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Supported by NHS
National Institute for Health Research

Grŵp PISA Group

Canolfan PRIME Cymru
Wales PRIME Centre

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‘how to’ improve patient safety guide

- Step-by-step guide authored by *Carson-Stevens and Donaldson*
- Includes:
  - tools for risk assessment
  - options to maximise learning from incidents as a team
  - example incident report form

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Being on the same page

Does every member of your practice team know what is a patient safety incident?

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

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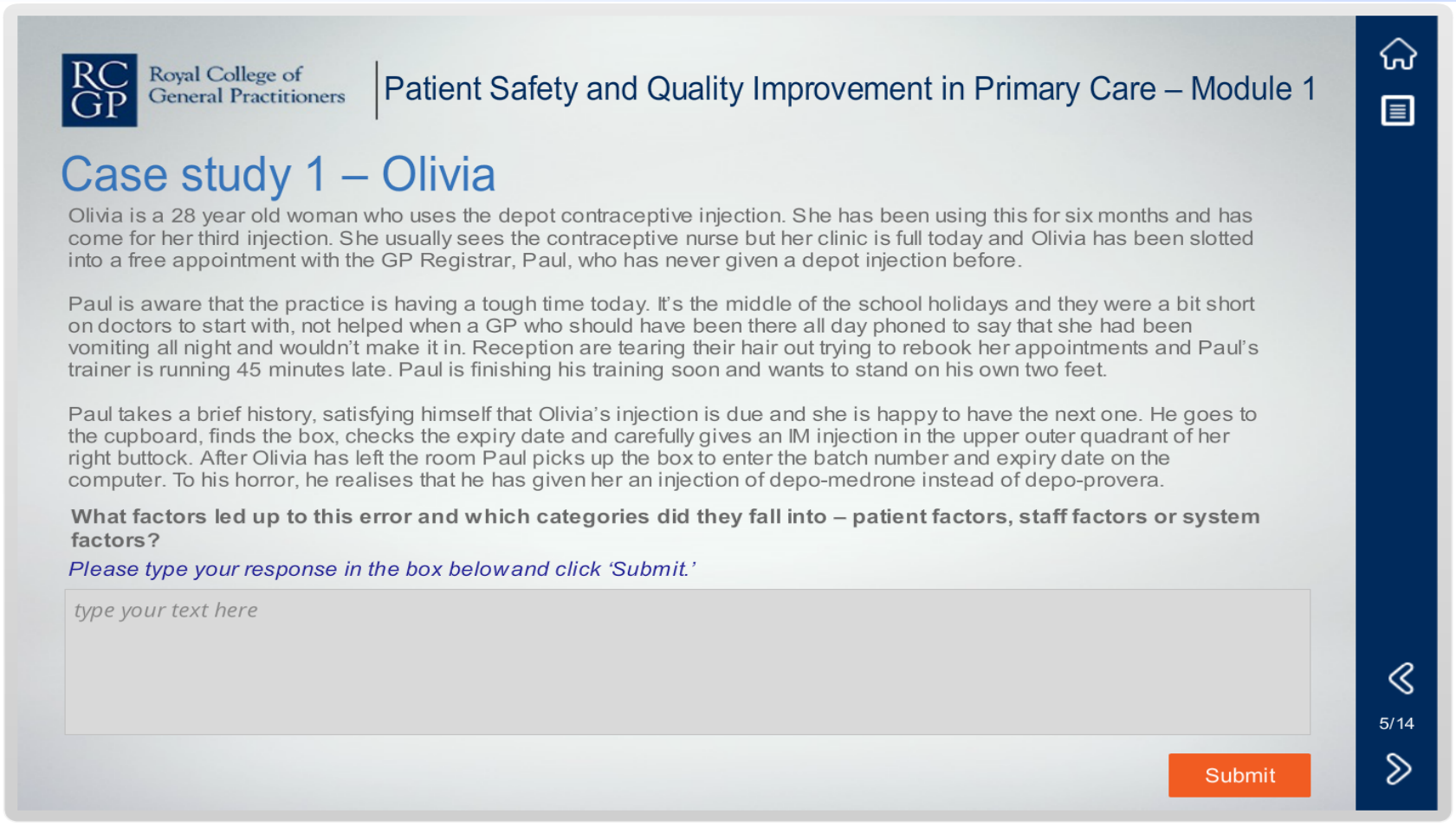
Questions for practice discussions

- “How many other incidents like this have occurred in our practice in the past month?”
- “What did we do when they occurred?”
- “How are we learning to prevent them?”
- “What changes can we make to ensure everyone can learn from patient safety incidents?”

Patient safety e-modules



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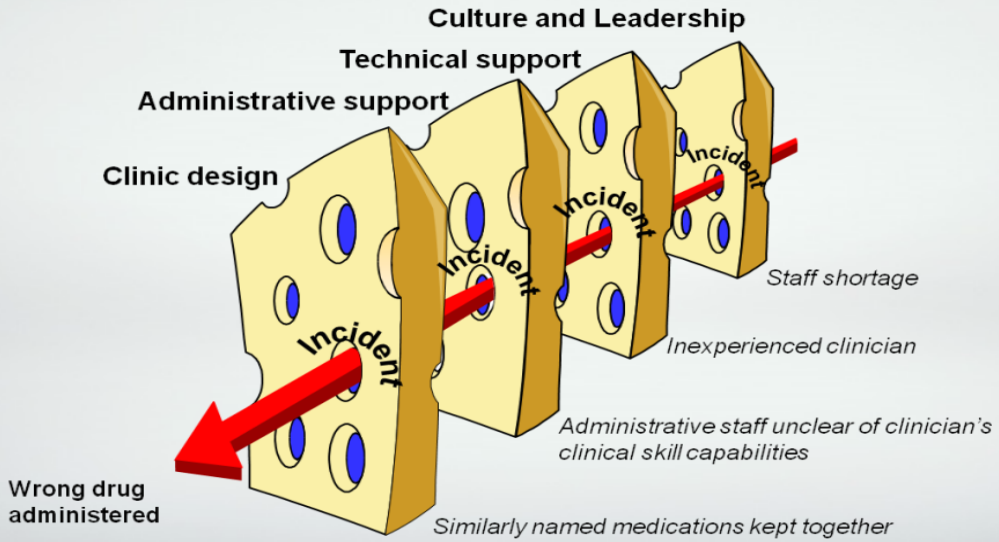
Patient safety e-modules

Royal College of General Practitioners | Patient Safety and Quality Improvement in Primary Care – Module 1

The Swiss cheese model

This diagram illustrates how Olivia received the wrong medication. Any of these factors could be present at any one time in your surgery. The "Swiss Cheese" model" shows how various aspects that in themselves may not lead to harm can combine to result in a patient safety incident. Being proactive about resolving these issues will make the practice a safer place to work and should make clinical staff feel more secure.



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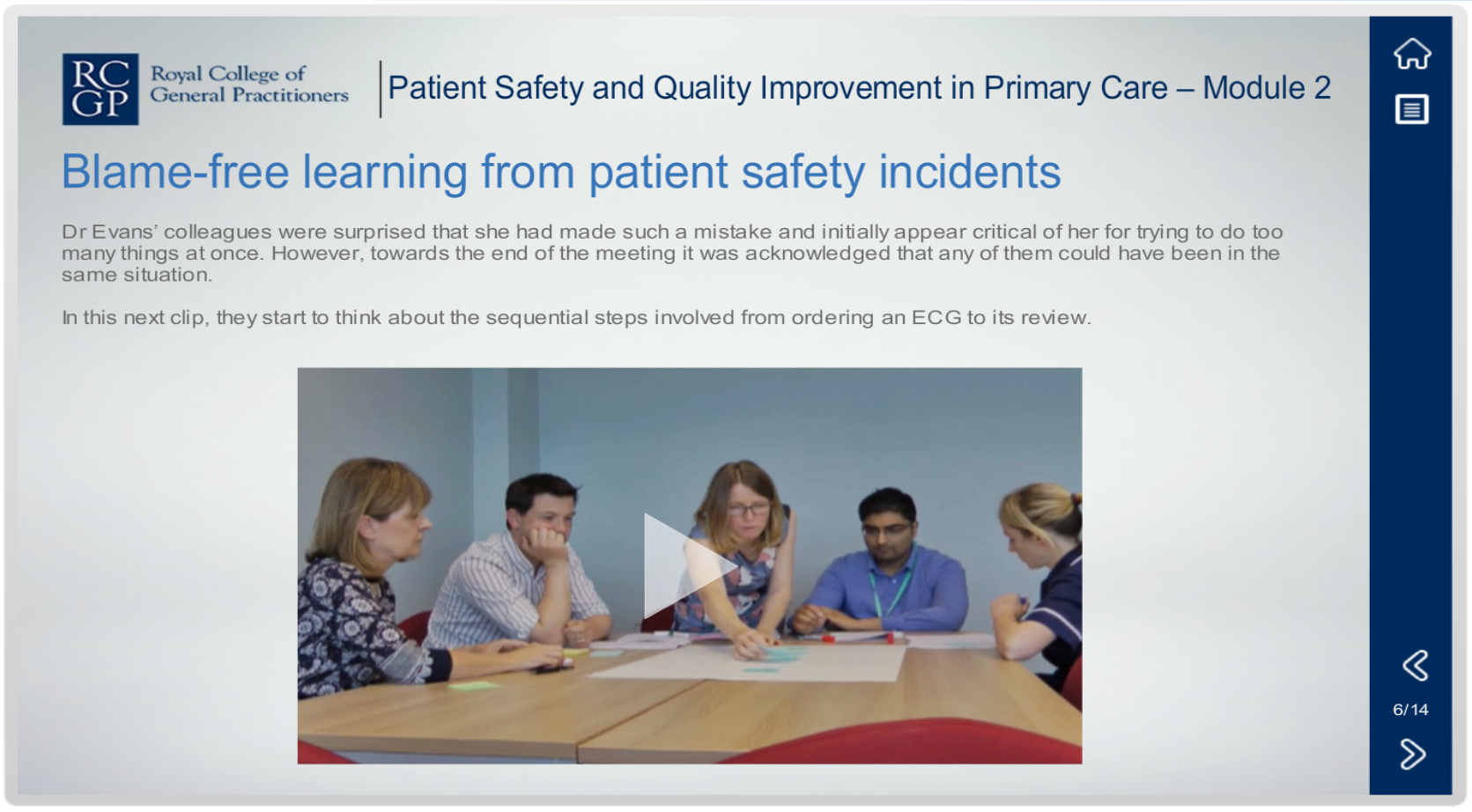
Patient safety e-modules



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For example

"A routine ECG was requested on a 25 year old psychiatric patient on olanzapine who had experienced several episodes of dizziness. The ECG was abnormal and showed a prolonged QT interval but had been signed as normal by the GP and scanned into the notes. Two weeks later the patient was admitted to A&E following a collapse where prolonged QT syndrome was diagnosed."

How did this happen?

Human Factors

Cognition and error

Personality and behaviour

Situation awareness

Communication and assertiveness

Leadership and team working

Fatigue and stress

Decision making

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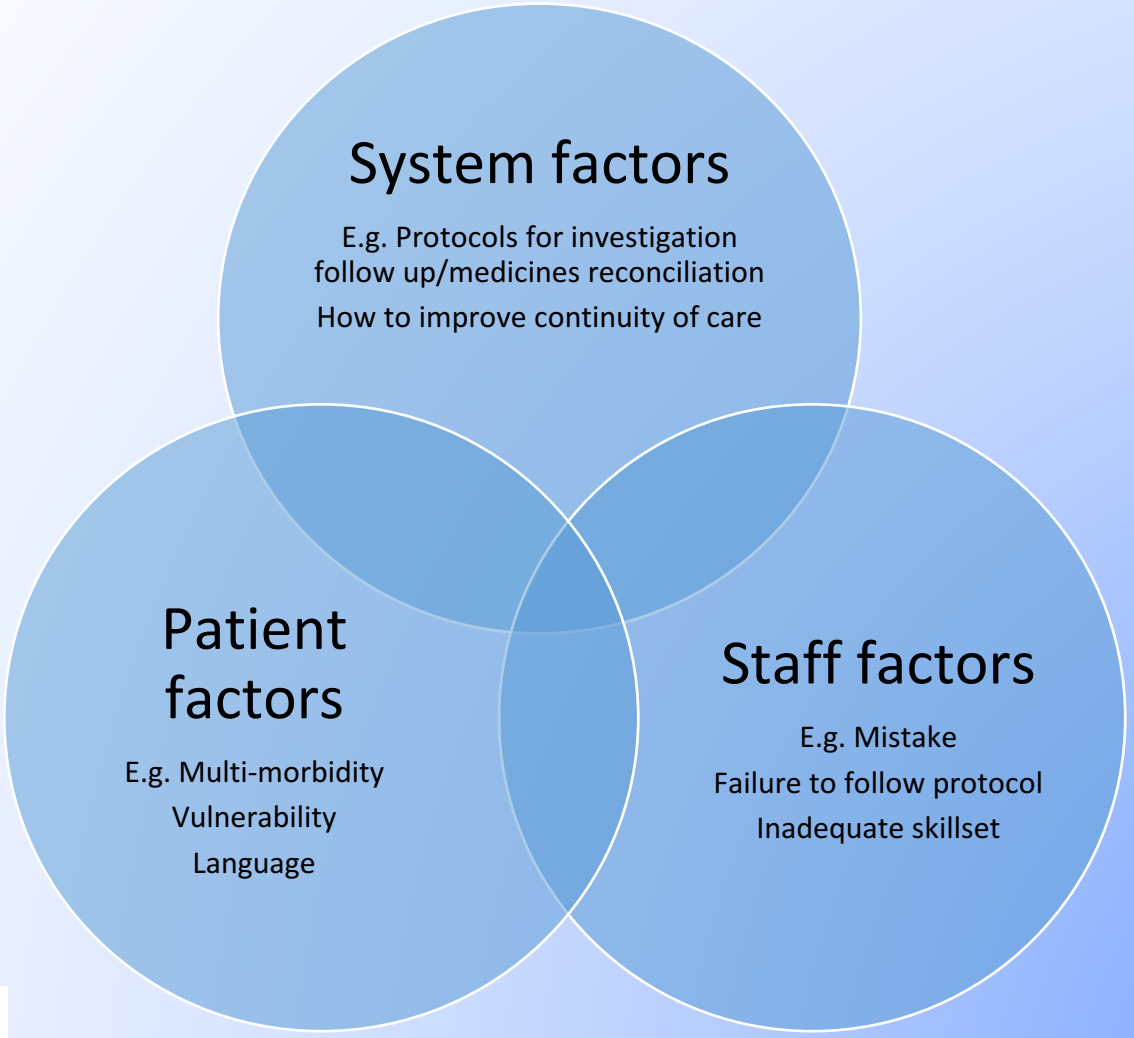
Designing systems with an understanding of human factors



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Blame-free learning from patient safety incidents

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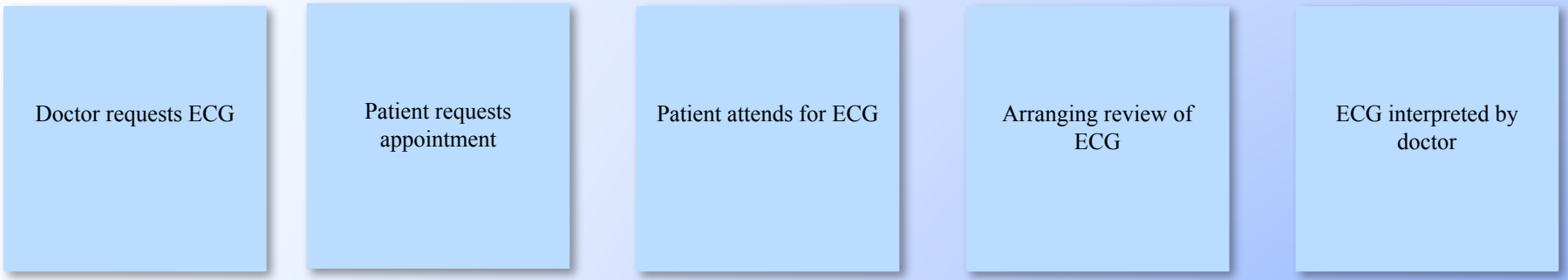
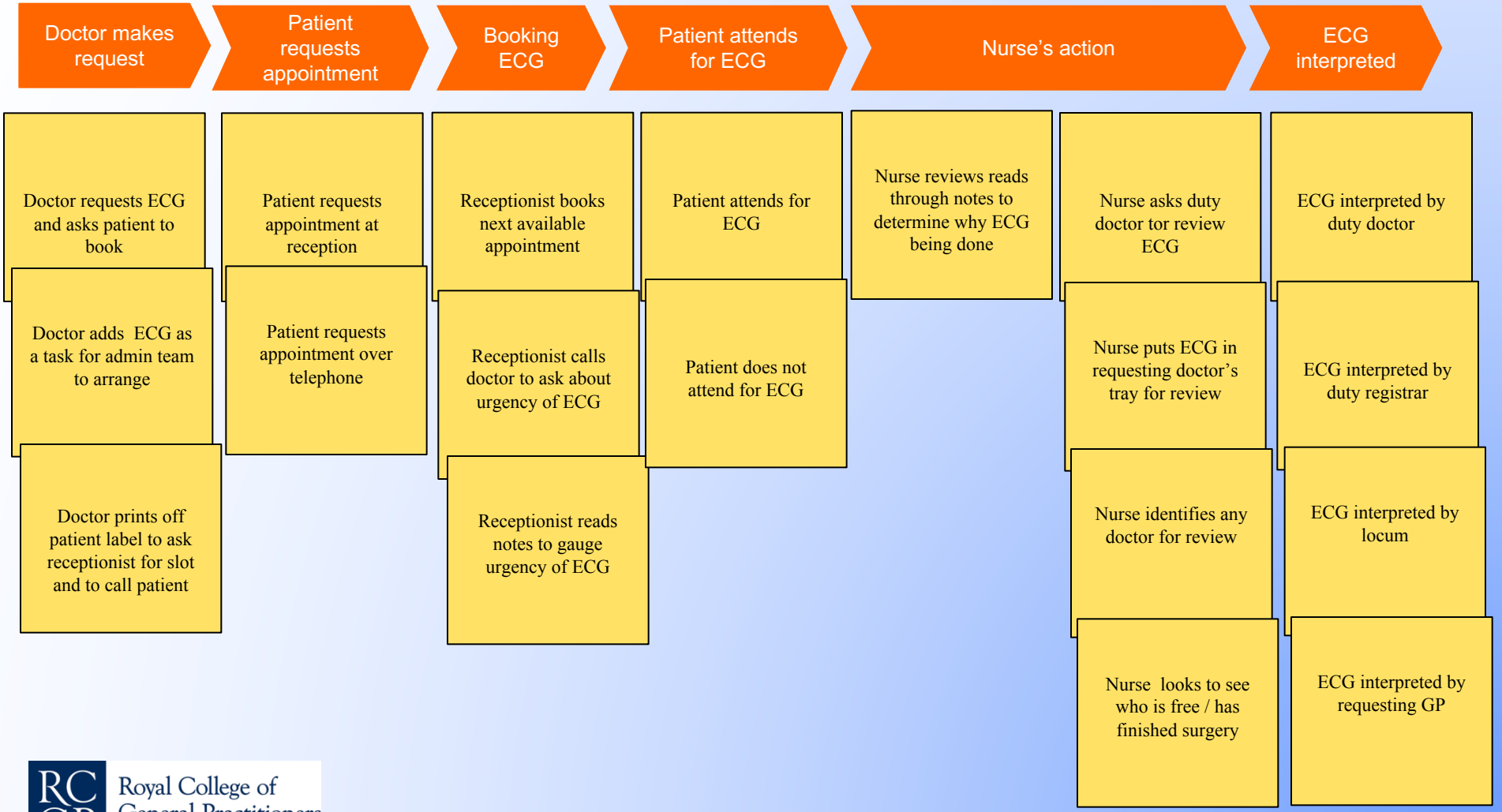
Insert Process_mapping_2.mpg 42 seconds

Process mapping



More than just a simple request



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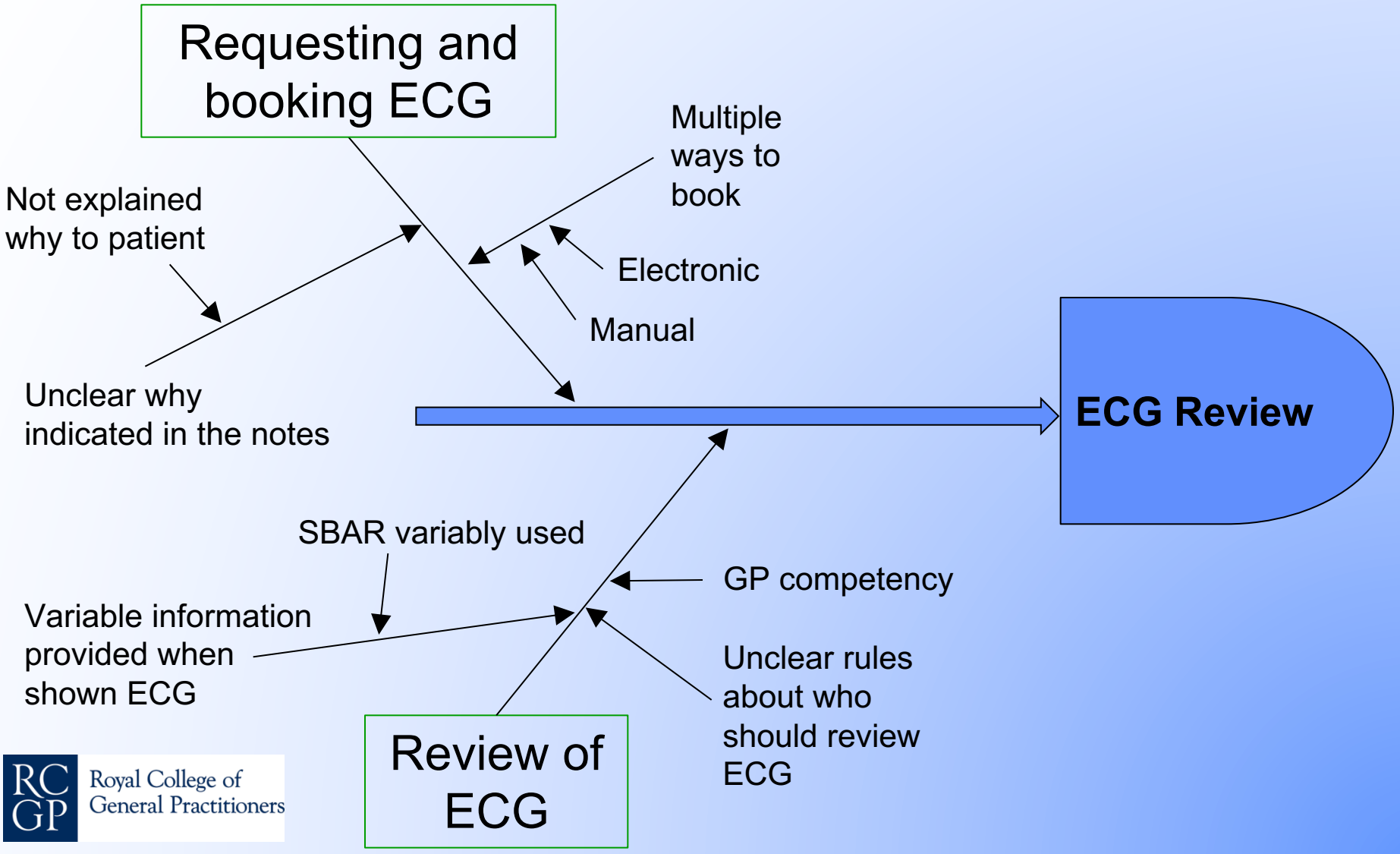
Other tools – fishbone diagram



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How do we know change is an improvement?

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Table discussion

A question to discuss:

- *How do we encourage learning from patient safety incident reports at a practice, cluster and health board level?*

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QI Ready

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QI Ready - Online Learning Network

- For all GPs, practice staff and primary care professionals
- Hosts a range of resources, case studies and a discussion forum
- Support GPs going through the QI Ready self-accreditation process

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QI Ready - Self-accreditation online tool

- Enables GPs to demonstrate their understanding and experience of QI.

- 3 steps to be RCGP QI Ready self-accredited:
  1. User provides information about themselves, their experiences of QI and information about their practice (if they are permanently based in a practice)
  2. User provides their RCGP membership number/pays for their accreditation
  3. User demonstrates how they meet various criteria

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QI Ready – How will this help?

- Further awareness and understanding of QI and the benefits within primary care and making the information as easy to access as possible.
- GPs will be able to use this tool, both the OLN and the self-accreditation tool, to contribute towards their appraisal.
- Facilitate discussion around QI and more promotion of the QI programme at the College.
- Hopefully, in the future, being ‘QI Ready accredited’ will be recognised by the CQC and reduce the burden of visits.

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QI Ready -

Online Learning Network available at:
https://qiready.rcgp.org.uk

Any comments/queries can be sent to:
QI.Ready@rcgp.org.uk

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A primary care patient safety learning community for Wales

Paul Gimson

Royal College of General Practitioners

What have we got?

- **1** Wales
- **7** Local Health Boards
- **64** Primary Care Clusters

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Developing a learning community to support a safer primary care?

What's your idea?

- What do we do know that we need to keep hold of and support?
- Is there anything new or different we should be doing?
- What is getting in our way? What should we stop doing?
- What needs to happen next?

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Appendix 1 – Template
PISA Primary Care Patient Safety Incident Reporting Form

Who	Where/When
Patient affected: **ML**	Location:Surgery
Person reporting incident (including job title): Mr Hashmi , PM	Date/time of incident: **23.12.16**
	Date/time reported to manager: **29.12.16**

What	
Incident category type (please circle):	
• Medication process	• Communication process
• Diagnostic / clinical assessment	• Equipment
• Investigation process	• Other

What happened?
Patient prescribed Penicillamine instead of Penicillin.

Why?
A locum GP diagnosed Tonsillitis and prescribed Penicillamine instead of Penicillin. The patient was unaware of the mistake and took the tablets as prescribed. He sought further medical advice as symptoms were not improving

Was immediate action necessary? If yes please document below
No , patient presented to OOH over Christmas weekend and was prescribed Pen V and recovered.

Appendix 1 – Template
PISA Primary Care Patient Safety Incident Reporting Form

Who	**Where/When**
Patient affected: **KO**	Location: Surgery
Person reporting incident (including job title): Dr Williams GP retainer	Date/time of incident: **14.1.17**
	Date/time reported to manager: **16.1.17**

What	
Incident category type (please circle):	
• Medication process	• Communication process
• Diagnostic / clinical assessment	• Equipment
• Investigation process	• Other

What happened?
Patient collapsed and sustained head injury for which she attended A&E where BP was noted to be 96/76.

Why?
Discharge summary the previous week had Bisoprolol 10mg daily and Atenolol 50mg daily (both Beta-blockers) which were both added to the repeat medication. Medication should have been Bisacodyl tablets 10mg and Atenolol 50mg.

Appendix 1 – Template
PISA Primary Care Patient Safety Incident Reporting Form

Who	**Where/When**
Patient affected: **SS**	Location: Surgery – notification of death received
Person reporting incident (including job title): Dr Paul GP Partner	Date/time of incident: **Death 10.1.17**
	Date/time reported to manager: **11.1.17**

What	
Incident category type (please circle):	
• Medication process	• Communication process
• Diagnostic / clinical assessment	• Equipment
• Investigation process	• Other

What happened?
Patient suffered GI bleed and died on 10.1.17, INR was >6

Why?
Patient discharged from local hospital on 2.1.17; no warfarin dose or INR results sent to us. INR checked 4.1.17 and information added to INRstar (but we were not aware dose had changed in hospital). Patient given 2mg daily (subsequently found dose in hospital was 0.5mg). Patient suffered GI bleed and died on 10.1.17."

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Closing remarks

Please complete the evaluation forms before leaving.

Contact details:-
Andrew Carson-Stevens – carson-stevensap@cardiff.ac.uk
Alison Cooper – coopera8@cardiff.ac.uk
Huw Williams – huw_penylan@gmail.com
Paul Gimson – Paul.Gimson@wales.nhs.uk

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