



AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE



Patient safety in primary care

Overview

- ▶ Patient safety as an issue
- ▶ Why worry about patient safety in primary care
- ▶ What is already being done
- ▶ Who are the players
- ▶ Where do we need to go next

About the ACSQHC

- ▶ Established in 2006 to lead and coordinate improvements in safety and quality
- ▶ Public / private sectors ; acute / primary care
- ▶ Small organisation that focuses on policy / knowledge / best practice / sharing information / strategy
- ▶ Need to be informed by and work with consumers, governments, providers, professional organisations and other stakeholders to effect change
- ▶ Majority of work so far in acute care – want to build on this in primary care

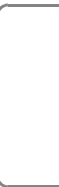
A bit of history

- ▶ A large number of harmful, but potentially preventable incidents occur in hospitals
- ▶ High profile enquiries into incidents at a number of specific hospitals
- ▶ Focus of early patient safety work – acute care; little examination of patient safety risks in primary care
- ▶ But most health care delivered in primary care settings – need to be sure it is safe

Safety and quality

- ▶ Quality – “degree to which health services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge”
- ▶ Safety – “the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum”
- ▶ Difference is relevant in primary care:
 - most work has been done in quality
 - area of safety is a gap – core business of the Commission

Is there a problem?



Primary care is different to acute care

- ▶ Part of a dispersed network – increasing risks associated with transfer and handover
- ▶ Treatments are less invasive
- ▶ Large number of occasions of treatment
- ▶ Contribution of patients and families is particularly important
- ▶ Patient safety infrastructure is different

Patient safety incidents in general practice

- ▶ Voluntary anonymous / confidential reports of patient safety incidents – “an event or circumstance which could have resulted, or did result, in unnecessary harm to the patient”
- ▶ Australia has led the way in this work

Incident reporting

- ▶ Patient and practice demographics
- ▶ What happened?
- ▶ What was the result?
- ▶ What may have contributed to the incident?
- ▶ Where did the incident happen?
- ▶ Was any patient harmed by the incident?
- ▶ How serious was the incident?
- ▶ How often does this type of incident occur?
- ▶ How could this have been prevented?

Patient safety incidents in general practice

- ▶ Two broad types:
 - processes of care (70%-90% of total)
 - administration
 - investigation
 - treatment
 - communication
 - knowledge or skills of practitioner
 - missed or delayed diagnosis
 - wrong treatment
 - errors in task execution

Patient safety incidents in general practice

- ▶ Accidental incorrect dosage instructions on Actonel prescription resulting in patient taking a weekly medication daily, not corrected by computer prescribing package or pharmacist
- ▶ Iatrogenic pneumothorax resulting from incorrect administration of pain relieving injection for fibromyalgia
- ▶ Attributed abnormal urine result to wrong patient with a similar name, treated wrong patient who was in a nursing home, plus had delay in treating original patient who had the abnormal result
- ▶ Prescribed antimalarials to a patient on antiepileptic medication which could have resulted in serious interaction if patient had not got a second opinion
- ▶ Used incorrect equipment when taking specimen for laboratory testing during minor surgery, resulting in accidental destruction of the specimen
- ▶ Delay in receiving pelvic ultrasound results when radiology practice forgot to send to requesting GP and had confusion over whether patient was to collect or they were to send films to practice

Medication safety risks in the community

- ▶ Prescribing – initiated during prescribing process
 - inappropriate selection of medication, dose, route of administration
 - inappropriate or inadequate instructions for use of a medication
- ▶ Supply – initiated during process of supply to patient
 - failure to prepare or supply a medication as it is ordered
- ▶ Administration – initiated during self or assisted administration
 - administration of incorrect medication, dose, or at wrong time
 - not following appropriate instructions
- ▶ Monitoring – occur during patient monitoring following prescription
 - failure to order appropriate tests to assess response
 - failure to change medication
- ▶ Documentation – occur during documentation of medication use
 - absent or incorrect information about medication or patient

The size of the problem

▶ Reported incidents:

- 80 per 100,000 consultations
- 1 per 1282 Medicare items billed
- 1 per 417 patients seen
- in average practice – at least one patient safety incident per week

▶ Medication errors:

- prescribing errors – 32 per 100 prescriptions
- supply errors – at least 1 error for between 8% and 20% of patients
- documentation – 52%-88% of transfer documents contained an error

Harm arising

- ▶ Types of harm associated with incidents:
 - time
 - financial cost
 - delay in care
 - pain
 - emotional or psychological consequences
 - temporary physical consequences
 - unexpected hospitalisation
 - permanent or very serious damage
 - death

Harm arising

- ▶ Proportion of incidents associated with harm ranges from 10% to 50%
- ▶ Example:
 - 96 of 330 reported incidents had some consequence to the patient (29%)
 - care delayed (21%)
 - care extended (1%)
 - financial / time costs (9%)
 - patient upset or lost trust (12%)
 - onset of illness (7%)
 - did not regain health (2%)
 - admitted to hospital (3%)
 - death (0.3%)

Is there a problem?



Patient safety solutions

- ▶ Patient safety solution – “any system design or intervention that has demonstrated ability to prevent or mitigate patient harm stemming from the processes of health care”
- ▶ Some application from acute care – not always successful
- ▶ Robust research and evaluation in primary care is limited

Patient safety solutions

- ▶ Some research into medication safety solutions:
 - medication review
 - medication reconciliation
 - patient education interventions
 - e-health interventions (including computerised prescribing and decision support)
- ▶ Most intervention did not demonstrate a significant impact on outcomes

- ▶ Accreditation standards for practices
 - draft 4th edition includes patient safety issues
- ▶ Other tools and resources:
 - analysing near misses
 - teamwork
 - leadership and human factors
 - infection control
 - supporting patients to be more actively involved in their care
 - undertaking procedures
 - regaining trust after an adverse event

Who else is doing work in this space in Australia?



International solutions

- ▶ Has become an issue for international patient safety organisations
- ▶ Some tools and resources exist that could be adapted for Australia

UK National Patient Safety Agency

- ▶ Seven steps to patient safety
 - Build a safety culture
 - Lead and support staff / practice team
 - Integrate risk management activity
 - Promote reporting in primary care
 - Involve and communicate with patients and the public
 - Learn and share safety lessons
 - Implement solutions to prevent harm

UK National Institute for Innovation and Improvement

► Primary Care Trigger Tool

- Medications
- General care
- DVT/PE
- Patient transfers
- Laboratory findings
- New key diagnoses
- Death

Key stakeholders

- ▶ Organisations that have a role in improving safety and quality in primary care in Australia
 - government
 - colleges
 - professional organisations and peak bodies
 - accreditation organisations and registration boards
 - universities
 - divisions
 - others...

Key stakeholders

- ▶ Large and fragmented field
- ▶ Can be difficult to get agreement about priorities and how they should be addressed
- ▶ Health reform will have a significant impact

Questions to consider

- ▶ What are the priorities for action?
- ▶ What needs to be done?
- ▶ Who should be involved?



Next steps

- ▶ Commission will be releasing a discussion paper soon
- ▶ Conducting national consultation – want to know what you think
- ▶ Aim to identify priorities for action
- ▶ National roundtable discussion in late 2010 – develop national action plan?
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