Developing Safety in Primary Care

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Outline

- Background
- National Programme
- Learning from Development Work
- Role of IT

Patient Safety in Primary Care - Why Bother?

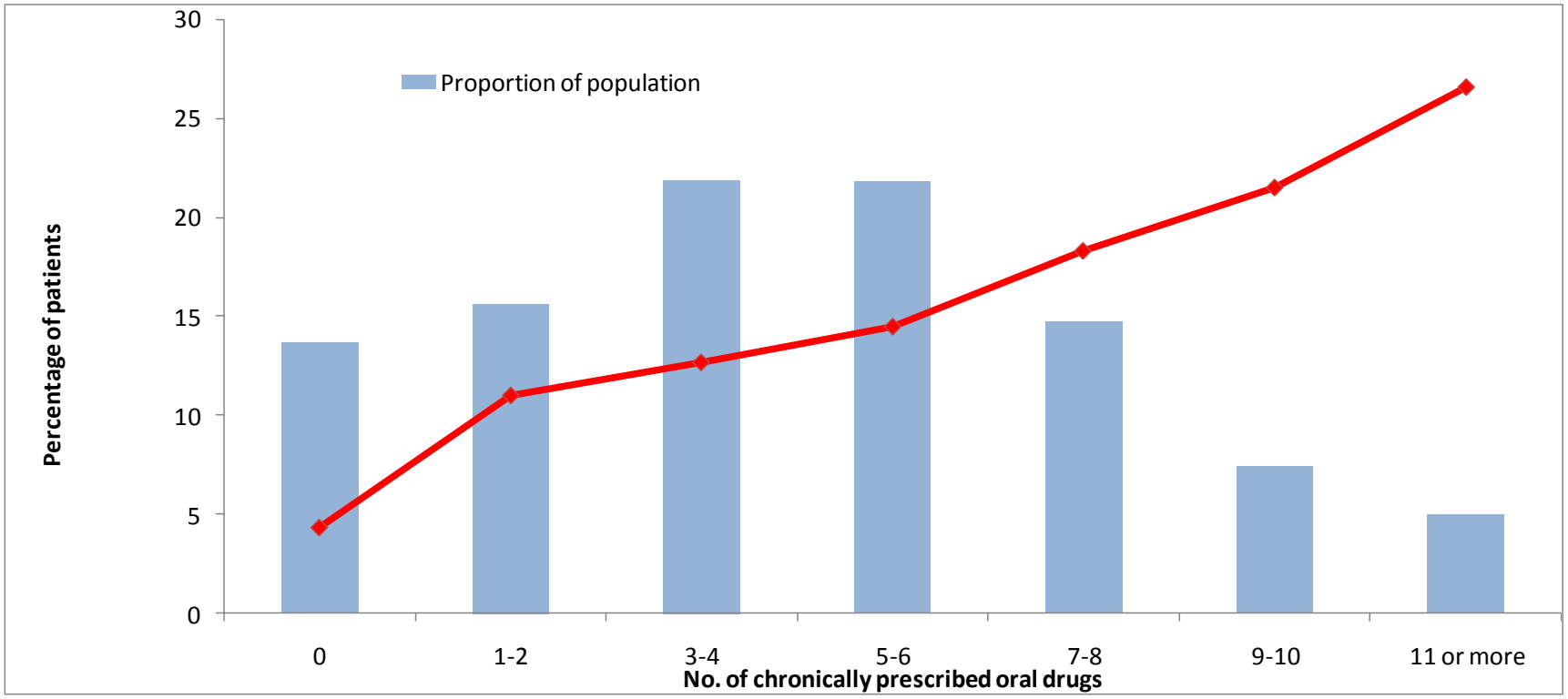
- High Volume
- Adverse event rate 2% of consultations
- Increasingly complex

Adverse Events cause:

- Morbidity
- 1 in 8 Admissions to hospital
- 1 in 20 Deaths
- Largely preventable

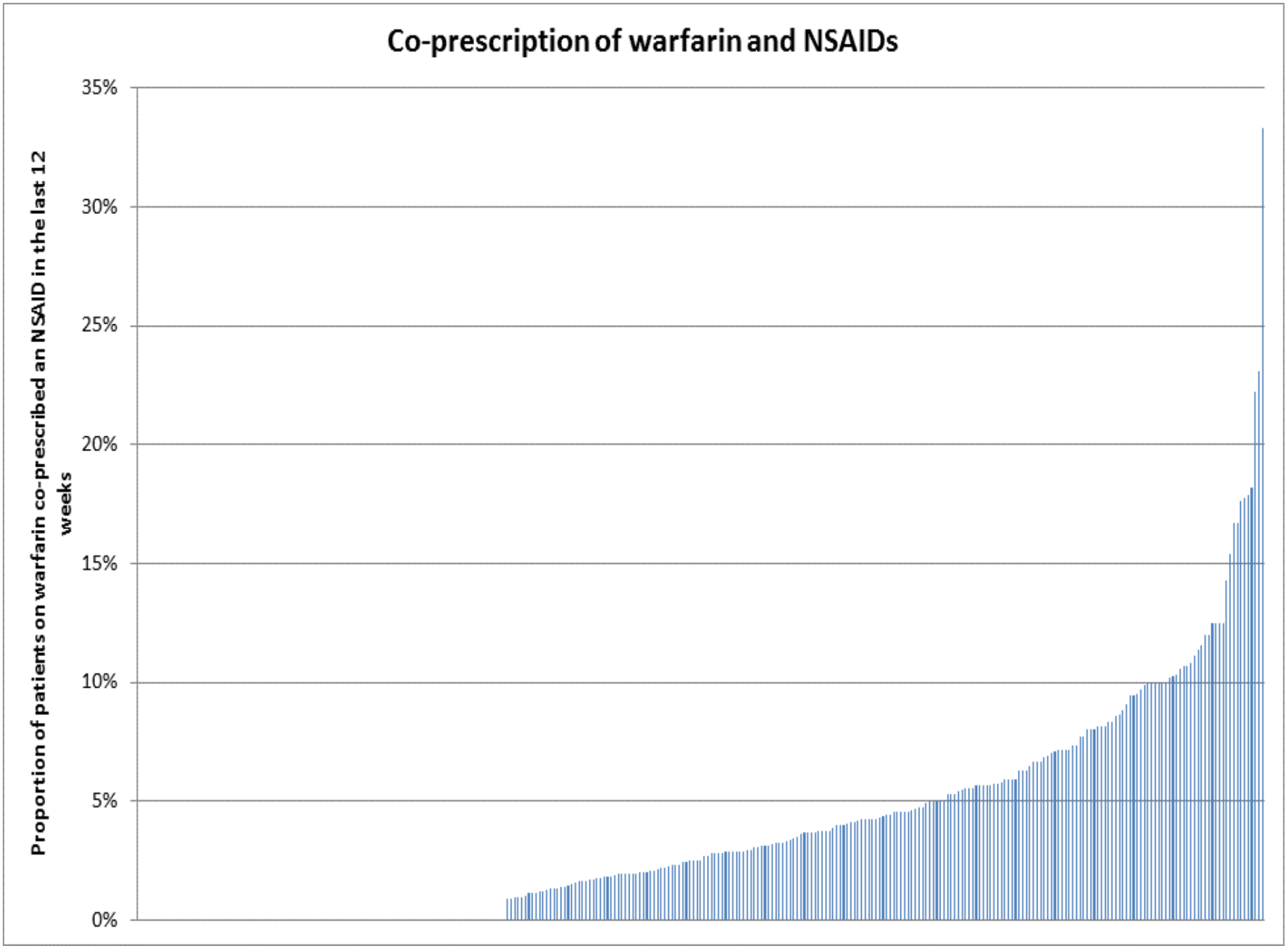
Statistics- Comission

- 11% prescriptions contain errors
- In a care home - 50% chance of ADE
- NHS Scotland 60,000 patients - receive high risk prescription pa


30
25
20
15
10
5
0
Proportion of population
Percentage of patients
0
1-2
3-4
5-6
7-8
9-10
11 or more
No. of chronically prescribed oral drugs

Omission
Lack of reliable care

- Warfarin – admissions to hospital
- Methotrexate – 12% not monitored
- Mix of strengths 30%
- Not prescribed weekly


Co-prescription of warfarin and NSAIDs
Proportion of patients on warfarin co-prescribed an NSAID in the last 12 weeks
35%
30%
25%
20%
15%
10%
5%
0%

(un)Reliable Heart Failure Care

ACE inhibitor 88%

B Blocker 70%

B blocker at target dose 28%

Pneumococcal 71%

NYHA 71%

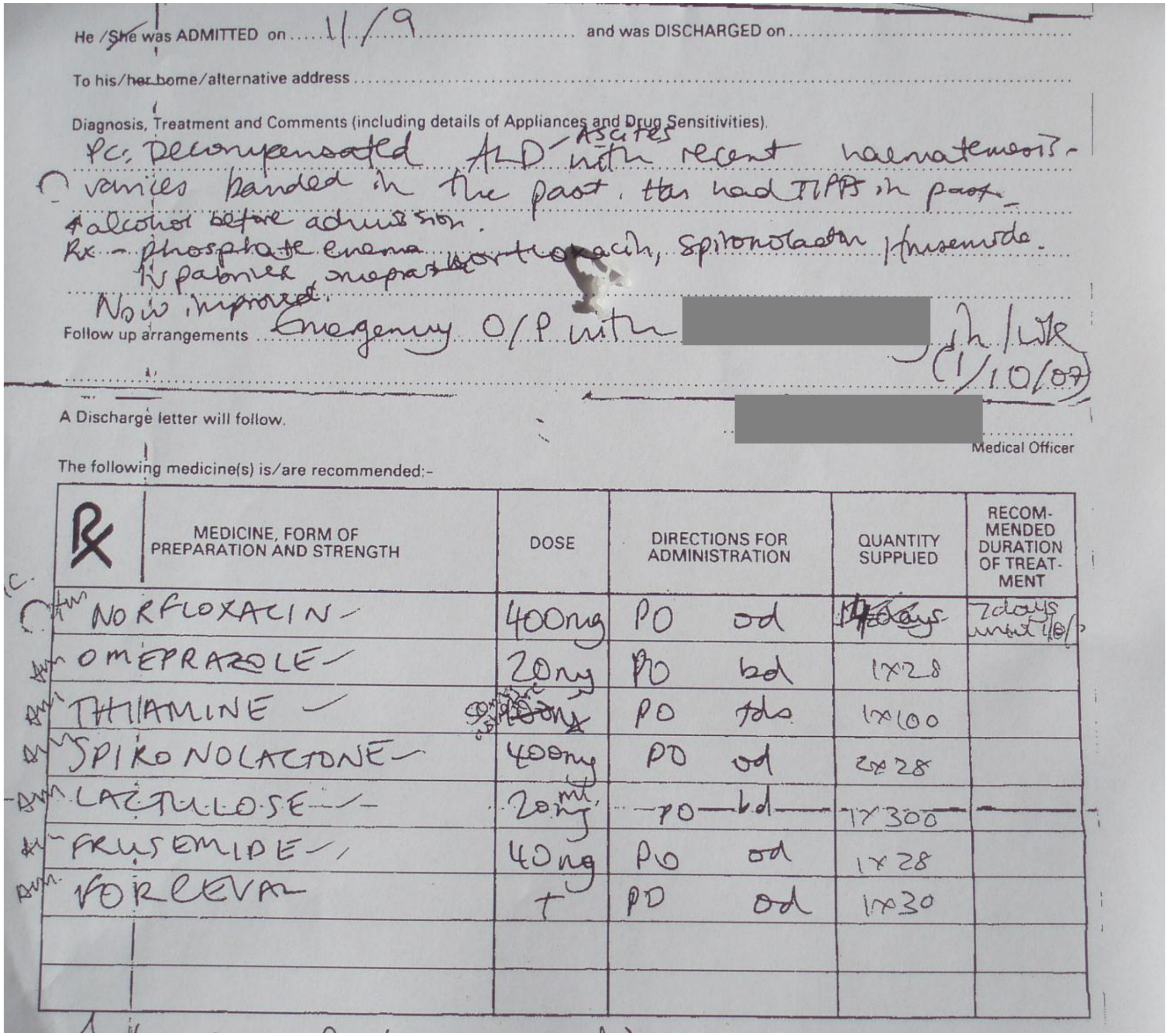
All 5 - 23%

Reliable Care??

38% of patients with Type 1 Diabetes receive 9 key interventions

NICE 2008/9

Medication Reconciliation


He /~~She~~ was ADMITTED on 1/9 and was DISCHARGED on

To his/~~her~~ home/alternative address

Diagnosis, Treatment and Comments (including details of Appliances and Drug Sensitivities).

Pc: Decompensated ALD with recent haematemesis - ascites
varices banded in the past. Has had TIPPS in past.
↑ alcohol before admission.
Rx - phosphate enema, norfloxacin, spironolactone / frusemide.
IV pabrinex, omeprazole
Now improved.

Follow up arrangements Emergency O/P with [redacted]

(1/10/07)

A Discharge letter will follow.

[redacted]
Medical Officer

The following medicine(s) is/are recommended:-

℞ MEDICINE, FORM OF PREPARATION AND STRENGTH	DOSE	DIRECTIONS FOR ADMINISTRATION	QUANTITY SUPPLIED	RECOMMENDED DURATION OF TREATMENT
NORFLOXACIN	400mg	PO od	14 days	7 days until 4/10
OMEPRAZOLE	20mg	PO bd	1x28	
THIAMINE	100mg	PO tds	1x100	
SPIRONOLACTONE	400mg	PO od	2x28	
~~LACTULOSE~~	~~20ml~~	~~PO bd~~	~~1x300~~	
FRUSEMIDE	40mg	PO od	1x28	
FORCEVAL	1	PO od	1x30	

Med Rec

- Unreliable at admission
- Inaccurate and delayed at discharge,
- Unreliable systems in place in primary care for updating
- Causes harm/ admissions

A patients story – with luck!

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SAFETY IMPROVEMENT IN PRIMARY CARE

"Design and implement a Patient Safety Programme in Primary Care"

- Who
- What?
- How?

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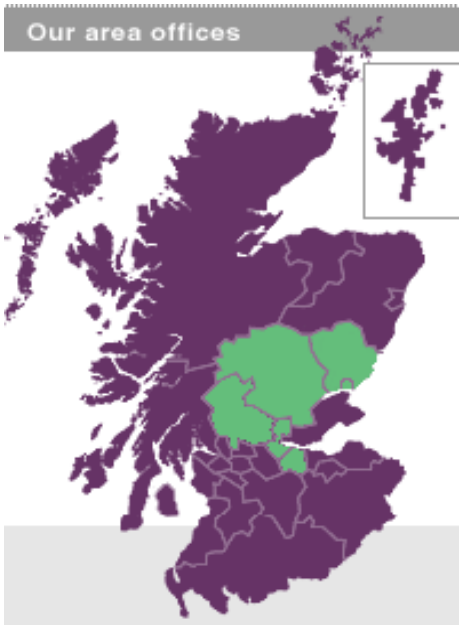
SAFETY IMPROVEMENT IN PRIMARY CARE

Not a new agenda…….

- Significant Event Analysis
- Complaints reviews
- IT systems
- Prescribing Systems
- Managing Results
- Communication and Culture

High Risks



- Warfarin
- Methotrexate

- Patients with complex conditions

- Medication Reconciliation
- Results
- Communication

Patient Safety in Primary Care Programme (PSPC)

4 Workstreams:

- Safety Culture and Leadership
- Safer Medicines
- Improving Safety across the Interface
- Healthcare Acquired Infection

Patient Safety in Primary Care Programme (PSPC)

Developing Practice Teams Safety Culture:

- Patient Involvement
- Identify and reduce harm via Structured case review (Trigger Tools)
- Safety Climate Surveys

Patient Safety in Primary Care Programme (PSPC)

Safer Medicines:

- Prescribing and monitoring of high risk medications (DMARDs)
- Avoiding harmful co-prescribing (Warfarin)

Patient Safety in Primary Care Programme (PSPC)

Safe and Reliable Patient Care across the Interface focussing on:

- Medication Reconciliation at discharge from hospital
- Improving shared care of patients attending outpatient clinic
- Safe management of test results
- Chronic diseases/leg ulcers

Patient Safety in Primary Care Programme (PSPC)

Reduce healthcare acquired infections:

- Improve anti microbial prescribing
- Promote hand hygiene

Patient Safety in Primary Care Programme (PSPC)

Process:

- Consultation on themes
- Scoping
- Develop aims/measures/tools
- Implementation strategy
- Phased roll out by 2013

Patient Safety in Primary Care Programme (PSPC)

Who and When?

October 2011 to April 2012

- Focus on activities that involve General Practitioners, District Nurses, Health Visitors and Community Pharmacy

From Summer 2012

- Expand to include Dentistry and Optometry

Safety Improvement in Primary Care (SIPC 1)

Aims

- To enable 80 Primary Care teams to:
- **1. Identify and reduce harm** to patients
- **2. Improve reliability of care** for patients
- On High Risk Medications
- With Heart Failure
- **3.Develop safety Culture**
- **4.Involving Patients in QI**

Model for Improvement

Source: Langley *et. al.* (1996) The Improvement Guide. San Francisco: Jossey Bass

Figure 1

Knowledge

- Topics
- Tools
- What to spread?
- How to spread?

The Tools

- Bundles
- Patient Involvement
- Trigger Tools
- Safety Climate
- PDSAs

1. Reliable Care
Care Bundles

- 4 or 5 elements of care
- Evidence based
- Across Patients Journey
- Creates teamwork
- Done reliably
- All or nothing
- Small frequent samples

Heart Failure Bundle

1. **Maximise medical therapy** –

   On a licensed B Blocker?

   B Blocker at max tolerated dose?

2. **Functional assessment** - NYHA recorded in last year?

3. **Immunisation** - pneumococcal vaccine ever?

4. **Self Management-** information given to patient on recognition of deterioration?

DMARDS

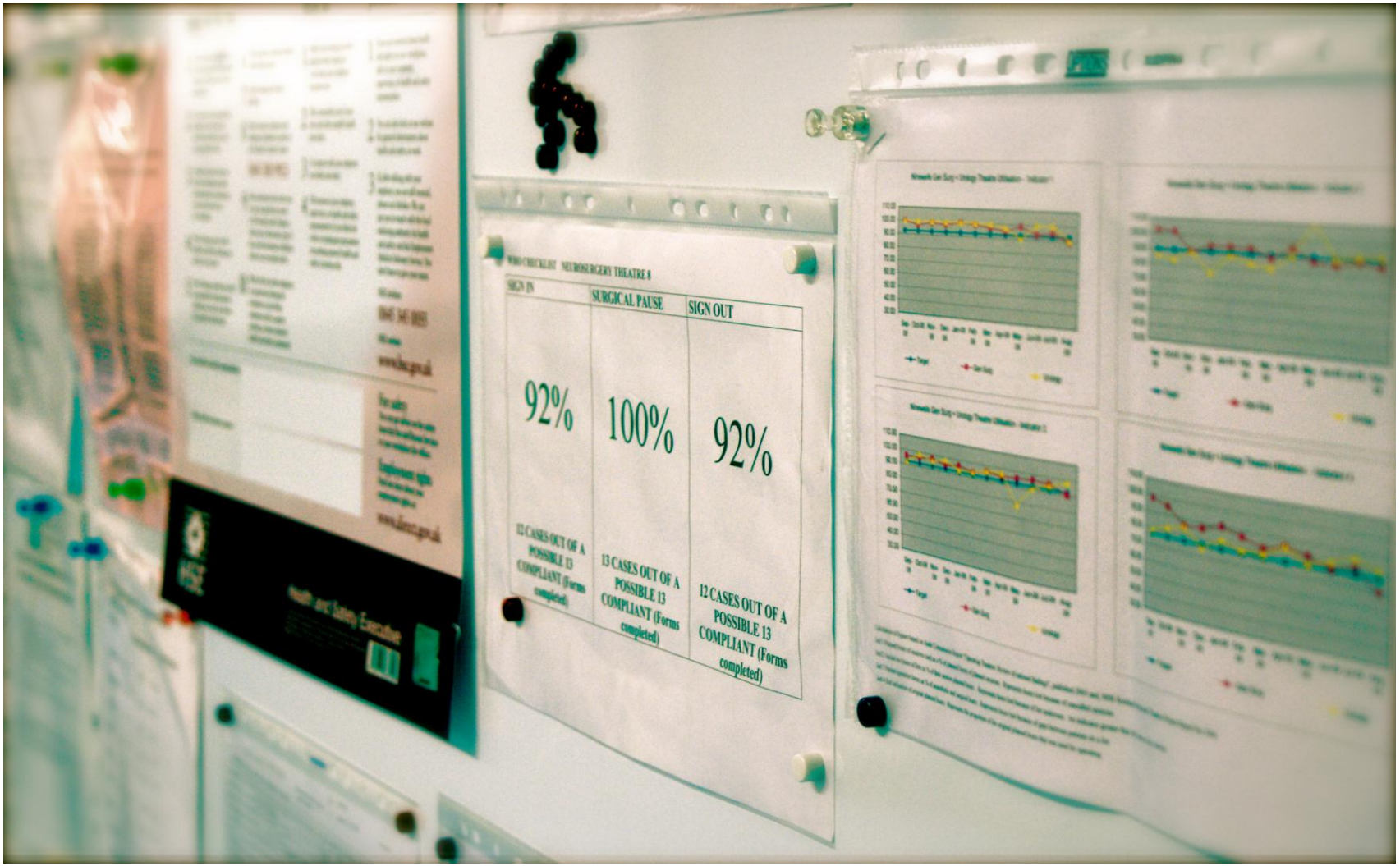
- Full blood count in the past 6 weeks?
- Abnormal results acted on?
- Review of blood tests prior to issue of last prescription?
- Had pneumococcal vaccine?
- Asked re side effects last time blood was taken?

Experience

- **Revealing unreliable practice**
  - *"The care bundles were useful because it identified gaps"*

- **Indicating areas for improvement**

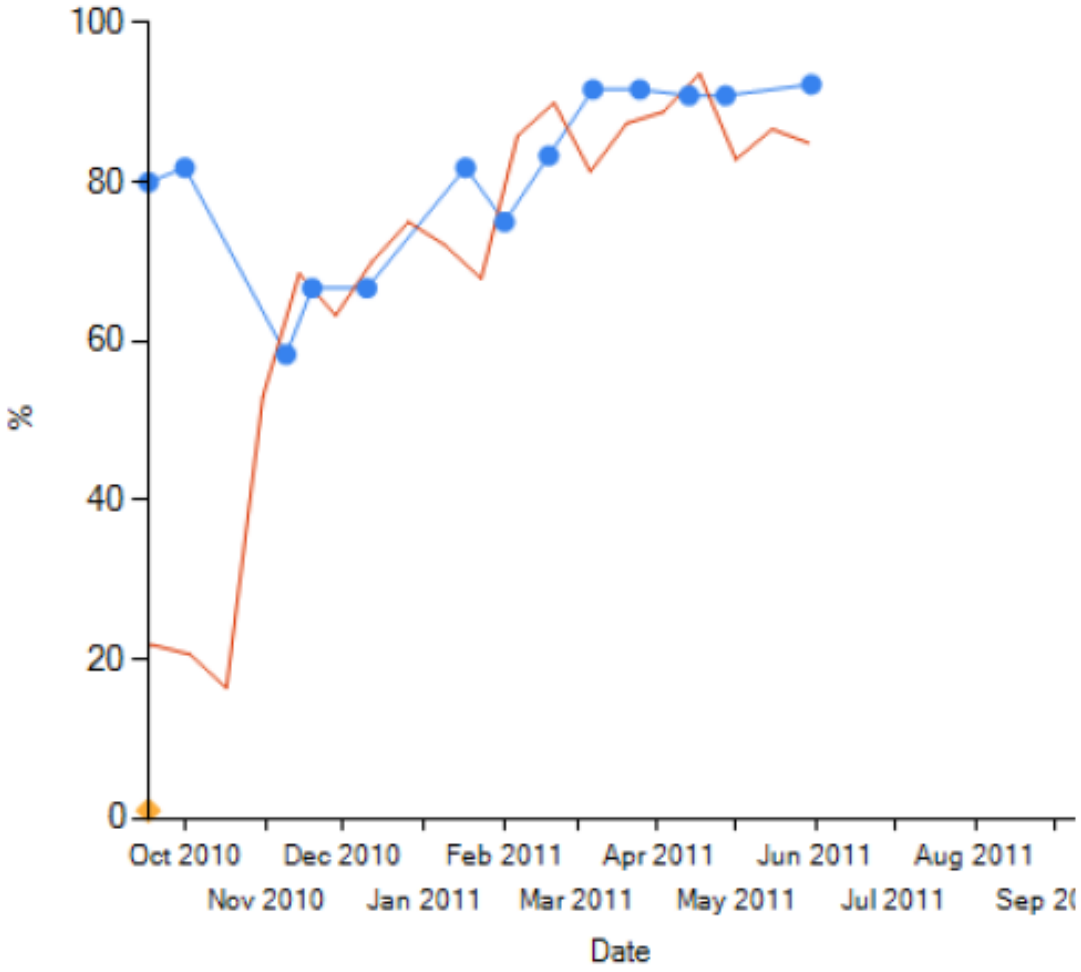
2 - Data


WHO CHECKLIST NEUROSURGERY THEATRE 8
SIGN IN
SURGICAL PAUSE
SIGN OUT
92%
100%
92%
12 CASES OUT OF A POSSIBLE 13 COMPLIANT (Forms completed)
13 CASES OUT OF A POSSIBLE 13 COMPLIANT (Forms completed)
12 CASES OUT OF A POSSIBLE 13 COMPLIANT (Forms completed)

Seeing Improvement

"You can see week by week, month by month, whether or not you are showing any improvement, we seem to be improving and that's good"

DMARDS Composite

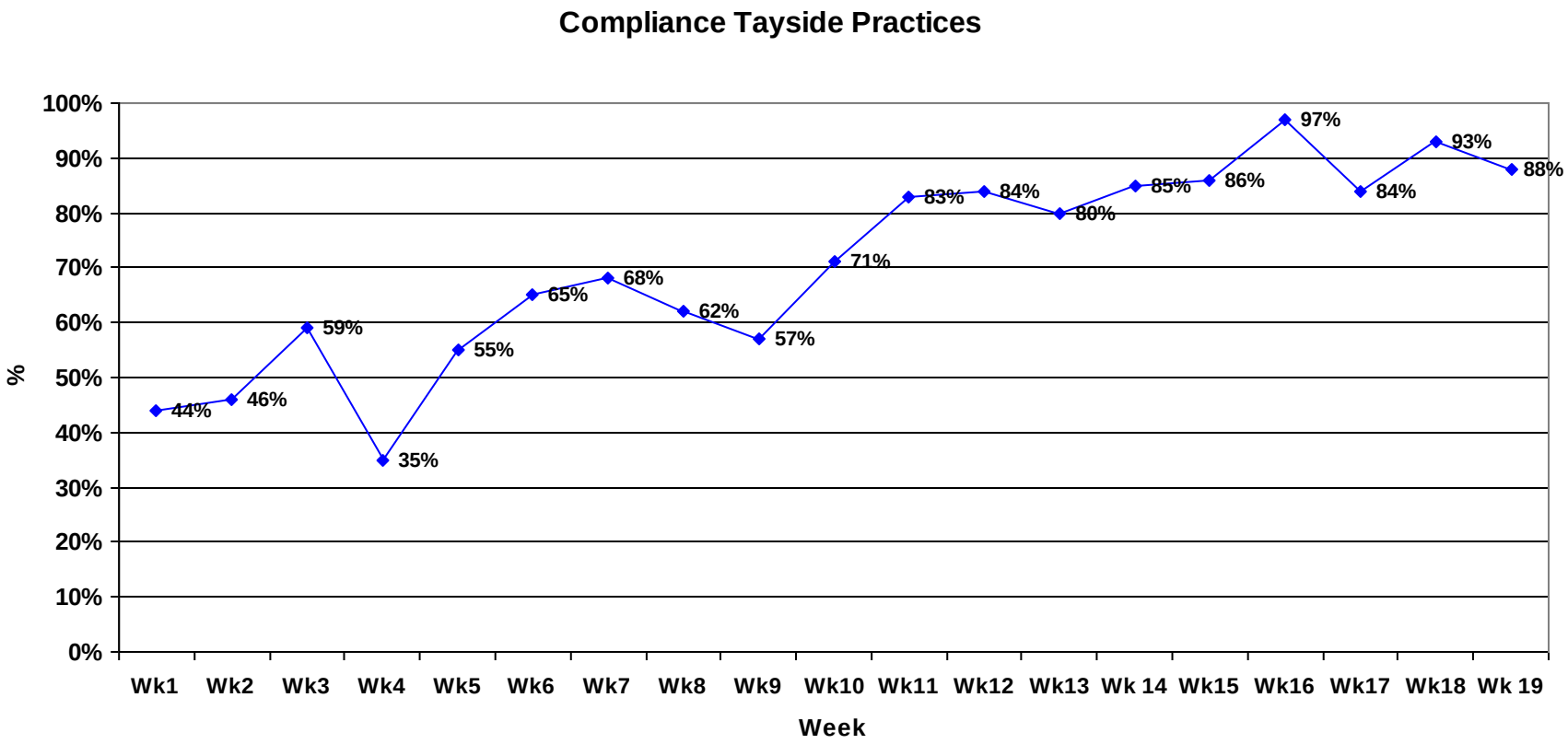


Key

Practice Data

Board Data

Tayside


Compliance Tayside Practices
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
%
44%
46%
59%
35%
55%
65%
68%
62%
57%
71%
83%
84%
80%
85%
86%
97%
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93%
88%
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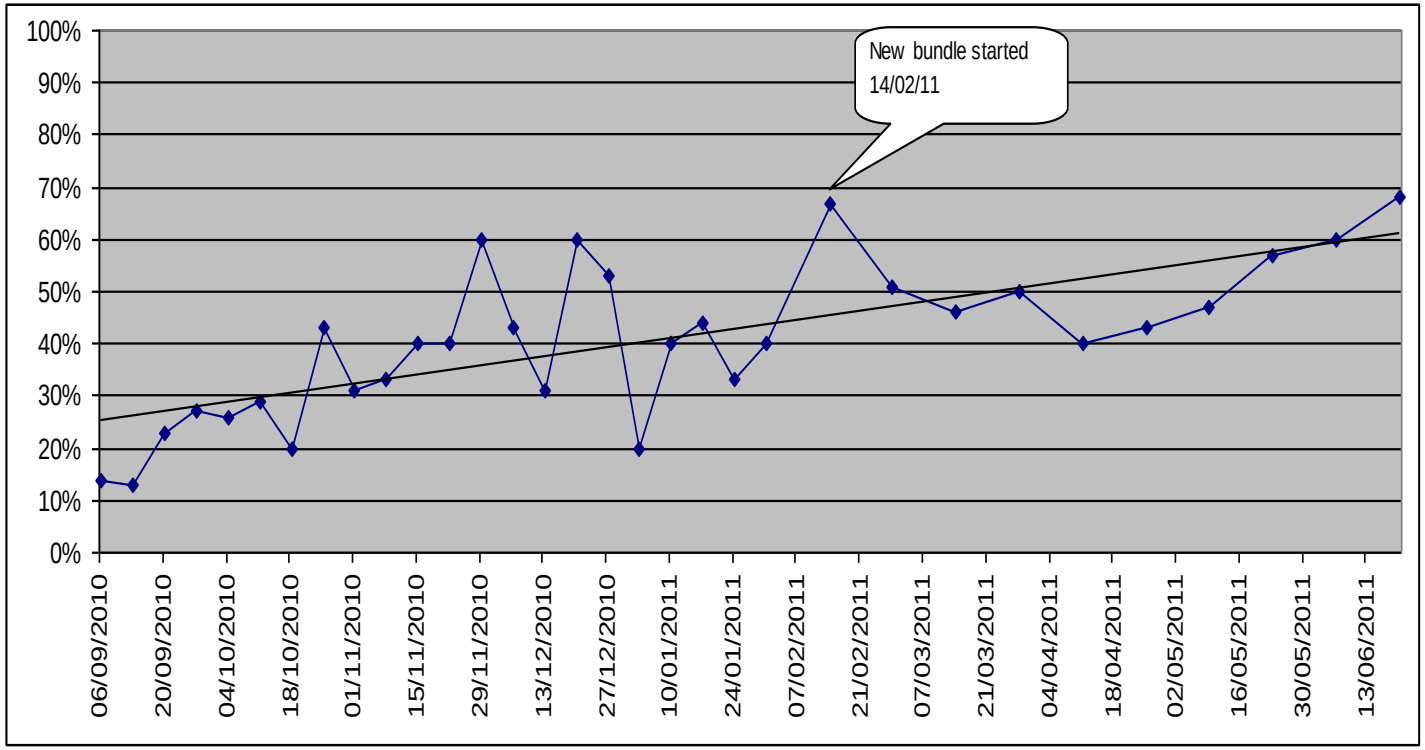
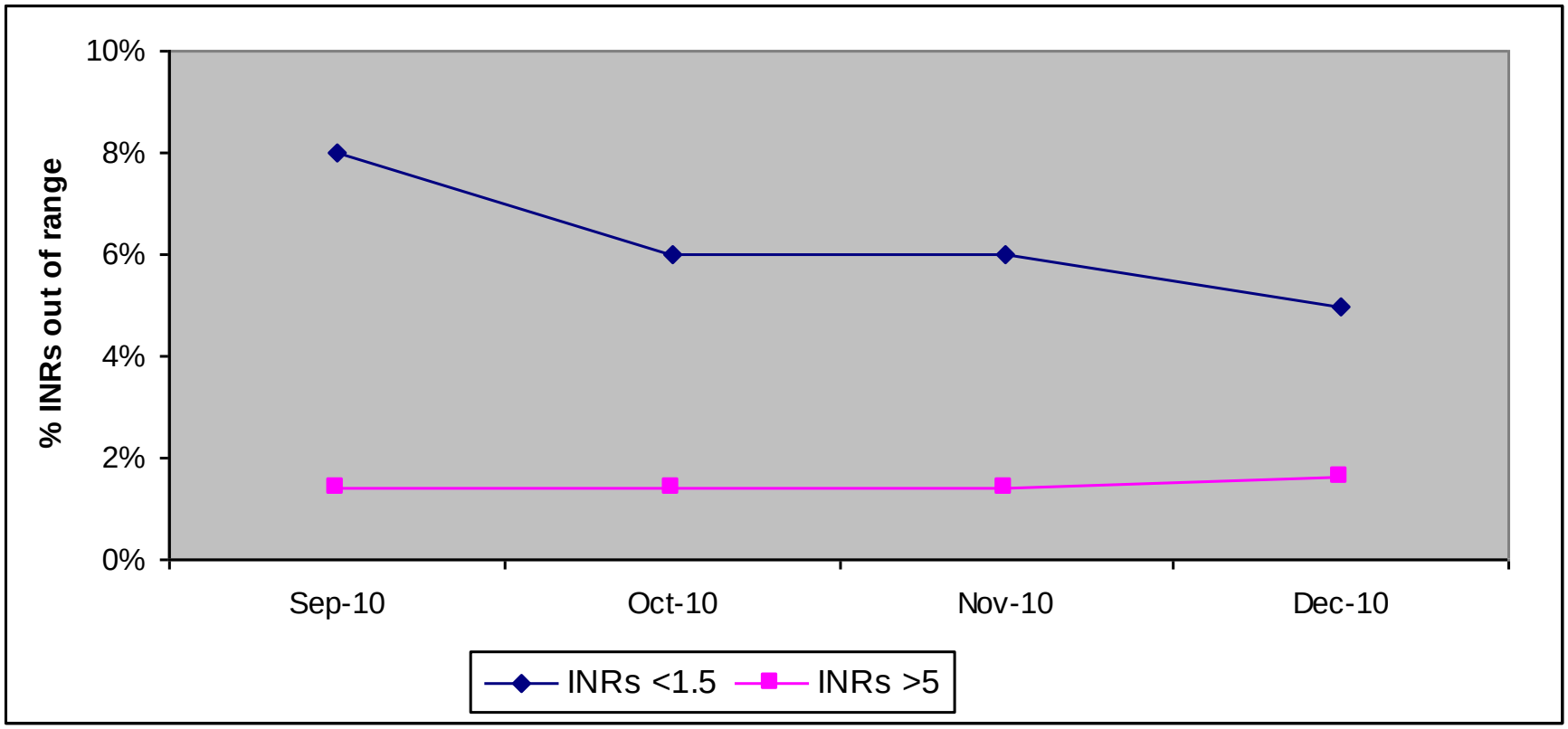
Wk18
Wk 19
Week

Lothian


New bundle started
14/02/11
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
06/09/2010
20/09/2010
04/10/2010
18/10/2010
01/11/2010
15/11/2010
29/11/2010
13/12/2010
27/12/2010
10/01/2011
24/01/2011
07/02/2011
21/02/2011
07/03/2011
21/03/2011
04/04/2011
18/04/2011
02/05/2011
16/05/2011
30/05/2011
13/06/2011

Outcome data

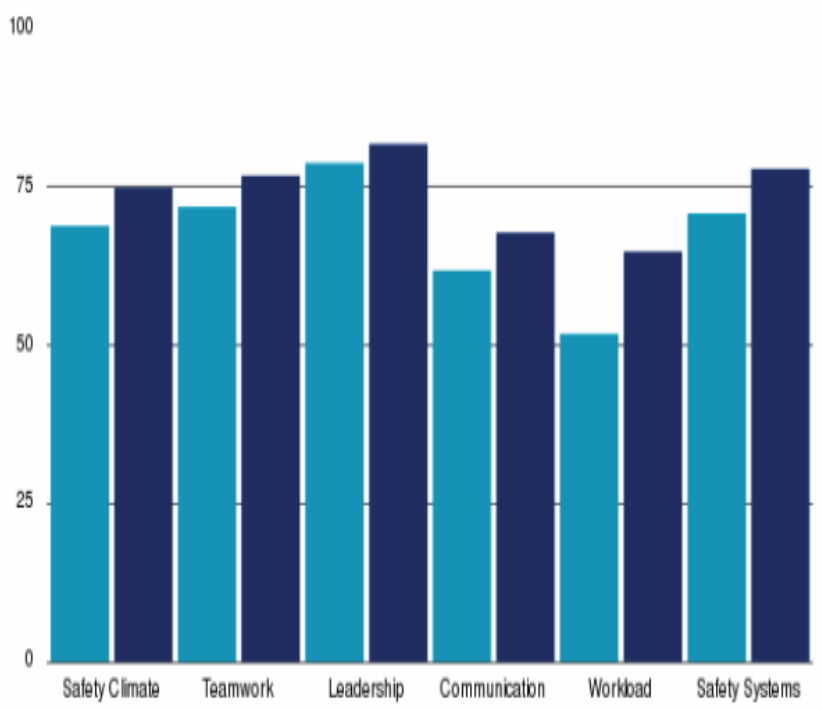


IT issues

- Templates
- Data collection and feedback
- All or nothing measures
- Outcome measures
- Admissions / INR / Co prescribing rates

Safety Culture

Safety Climate Survey



- On line
- Practice report
- Measurement
- Diagnosis
- Catalyst for change

Insights

- *“Many of us in the practice staff hadn’t really made the link that us failing to communicate in was a threat to patient safety ….we had a lot of really good stuff came out of it, a lot of very open discussion”*

Safety Improvement in Primary Care 2

- “Look at three areas of major clinical risk to patients as they move across the health system.”

Areas of Focus

- Medication Reconciliation
- Managing results
- Shared care and communication at out patients

Develop Knowledge

- What does the evidence say?

Process mapping

- Areas of risk?
- Key reliable processes?

Improvement

- Improvement What? How?
- Measure?
- Patients – partners in safety

Themes

- Efficient accurate timeous 2 way communication
- Reliable systems to implement changes
- Involving informing patients
- What I do /not do in my part of the system impacts on someone else

IT issues

- Communication accurate timeous structured – SBAR
- Requesting bloods - urgent
- Tracking of Investigations
- Reliable follow up
- Coding – Med rec / patient informed
- Informing Patients - text email

Challenges

- The Big Dot
- Leadership and Prioritising
- Training
- Support
- Levers
- Alignment

IT - Making it hard to do the wrong thing

- Methotrexate
- Alerts
- Co prescribing
- Co- morbidities

- eLearning

IT - Making it easy to do the right thing…

- Coding
- Templates
- Extracting data - bundles
- Reporting
- Results tracking
- Interface Communications
- Patients

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SAFETY IMPROVEMENT IN PRIMARY CARE

How else could IT support the National Programme in Primary Care?

How can we influence IT providers to support this work?