safety IN PRACTICE

every patient, every time

"best care for everyone"

everyone matters | with compassion | better, best, brilliant | connected

Improving Patient Safety in General Practice

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1. Planning & Funding, WDHB 2. Institute of Innovation and Improvement, WDHB 3. ADHB

Introduction

The Safety in Practice (SiP) programme is an initiative designed to provide tools and training to primary health care teams, enabling them to reduce preventable harm to patients. The project is sponsored and run by Planning & Funding. Our work is in collaboration with the Auckland Metro DHBs and our PHO partners.

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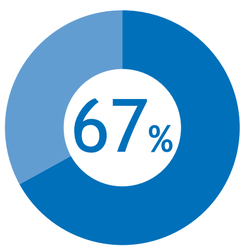
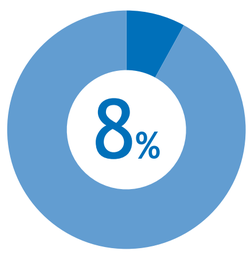
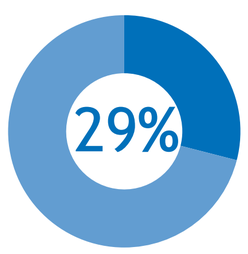


of medicine-related admissions are considered potentially preventable[1].



of patients reported receive the wrong dose or medication in primary care[2].



of medication errors are estimated to occur in community settings[3].

Aim

To work with Primary Health Care teams to reduce preventable patient harm from the care they receive.

Objectives

- Reduce preventable harm to patients.
- Create safer and more reliable systems.
- Promote a culture of safety.
- Develop quality improvement skills.

Methods

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In 2017-18 **77 general practice**s and urgent care clinics enrolled.

The programme has identified **6 core clinical areas** selected according to current evidence as presenting the greatest risk to patient safety in the community:

- Non-Steroidal anti- inflammatory drugs
- Warfarin/ Anticoagulants
- Disease Modifying Anti-Rheumatic Drugs (DMARDs)
- Opioids
- Lab Results Handling
- Medication Reconciliation

Figure 1: Areas of clinical focus as determined by current evidence.

Training and support specific to each clinical area are delivered via the following methods:

Learning sets

- Collaborative learning sessions.
- Run quarterly.

Change packages

- Materials for affecting change in one of 6 key areas of clinical focus.
- Monthly audits.

Culture tools

- Validated tools to empower practices to improve their safety culture.

Expert support

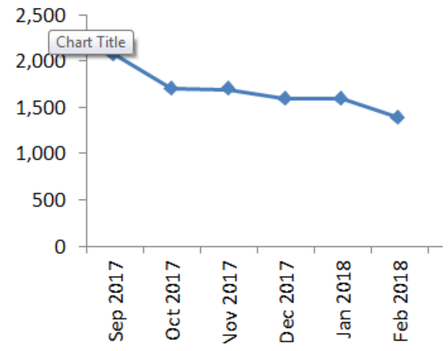
- Improvement advisors and clinical leads provide site visits and support as required.

Figure 2: SiP interventions.

Results

"everyone matters"

Number of patients prescribed NSAIDs without adequate gastroprotection



Audit measures are set by the SiP team based on established best practice.

In this example the risk of bleeding stomach ulcers when prescribed an NSAID increases 10-fold after the age of 65 compared with middle age[4,5]. This graph shows the numbers of patients in this high risk group falling over time.

Figure 3: An example of improvement in one of the 6 clinical areas of focus. Overall compliance of practices within WDHB enrolled within SIP.

Over the last 6 months practices have shown dramatic improvement in compliance in multiple high-risk areas :

▲45% Improved results handling

▲53% Improved medication reconciliation

▲65% Improved warfarin management

A full evaluation of the 2017-18 programme is awaited however practices report an improved understanding of quality improvement skill, improved communication within their team and an increase in awareness in patient safety:

"Our quality improvement knowledge has improved incredibly"

Mary Baldwin, *Apollo Medical Practice Manager*

"It's brought our team together"

Katie Harrison, *Practice Nurse Swanson Medical*

Conclusions

Formal evaluation is awaited mid-2018 however it appears the SiP programme is improving the management of high-risk processes, QI capability, teamwork and efficiencies within practice, therefore improving safety for our patients in the community.

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