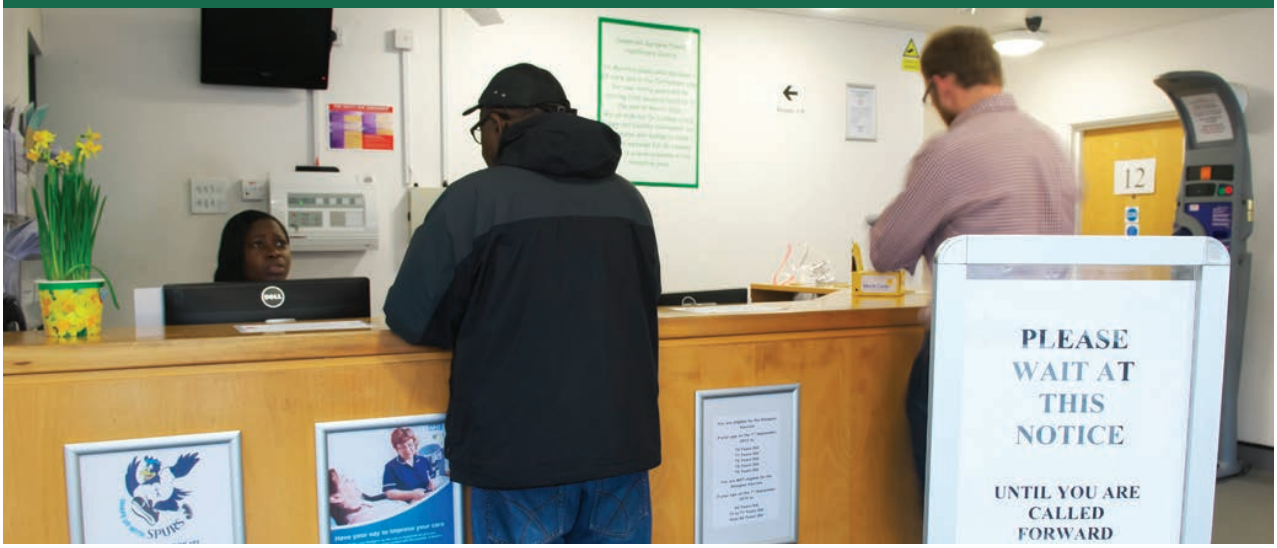
Practice and finance

Advice on running a practice effectively

pulse-intelligence.co.uk



Addressing systems errors in primary care

Systems errors are inevitable but practices can develop an approach to address and learn from them, explains **Dr Jonathan Inglesfield**

Improving quality and safety in primary care means learning lessons. Most GPs are aware of the importance of investigating significant events, where a patient has been placed at risk or suffered harm. To make real improvements to quality we need to look further, thinking about how the systems in our practice affect efficiency and patient safety.

Systems errors are mishaps that occur from the structures we create. We design systems all the time, often without realising it. We may decide, for example, on a new process for handling prescriptions or test results to ease workload or increase efficiency. The consequences may not immediately be apparent but over time we see there are potential risks, perhaps as minor errors are identified.

Make a plan for initial responses

Such systems errors can be overlooked if they result in minimal inconvenience without apparent serious consequences. Staff may feel they are not worth highlighting, or might dismiss them as 'one of those things', a natural product of a busy environment – for example, an occasional lost prescription request.

However, minor issues, if left unaddressed, can contribute significantly to major adverse events. The RCGP's guidance on learning from patient safety incidents refers to the 'Swiss cheese' model of risk (see figure 1, right): it is unlikely that a major error can get through one hole, but if there are a number of holes, there could be serious harm.[1] The model suggests scrutinising systems and eliminating as many 'holes' as possible, thereby minimising the risk of significant error.

Follow checklists

So how can system errors be understood and addressed? There are areas of support available, such as the safe systems checklist in the RCGP Safety Toolkit.[2] This allows practices to look at common processes to identify potential risk. There is also a list of suggested processes to examine (see box B, below right). The purpose of the checklist is to identify the need for change, not to provide an immediate solution.

An alternative approach discussed in the toolkit is the use of patient experience safety questionnaires. These are designed to pick up warning signs of safety issues and invite the patient to report freely on their experience of the care they received.

As well as examining risk proactively, it is important that your practice reacts to safety concerns or near misses that are identified day to day. This is a way to promote a learning and safety culture. The airline industry has developed a strong safety culture, which has been replicated in the NHS through the Healthcare Safety Investigation Branch (HSIB). HSIB's key principle is never to apportion blame or liability.

This is the approach to developing the culture of the practice. Meet with your practice team to discuss the importance of patient safety and of identifying risk. Encourage openness by reassuring staff that where errors are identified, the practice will not attribute blame.

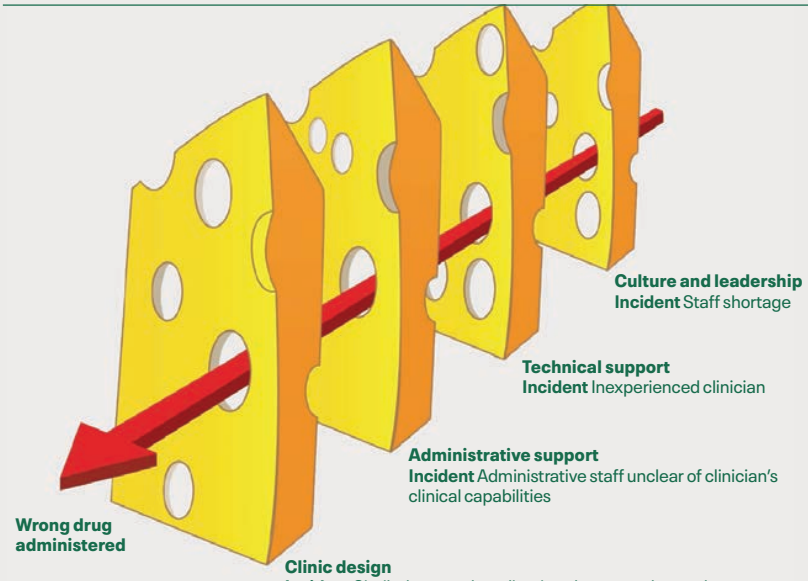
References

1 RCGP. *Reporting and learning from patient safety incidents in general practice: A practical guide*. 2017 tinyurl.com/yc3x24mf

2 RCGP Learning. *Patient safety toolkit*. 2017 tinyurl.com/2w52cf3b

3 World Health Organization. Surgical Safety Checklist. 2009 tinyurl.com/3mrc9ncx

Figure 1 Swiss cheese model applied to a clinical incident



Source: RCGP[1]

Box A Top 10 tips for identifying systems errors

1 Create a culture of learning and improvement in the practice, explaining that safety is everyone's business
2 Make it easy to report errors and near misses – ensure everyone knows how to do this
3 Nominate a motivated and interested individual as the practice administrator for error reporting
4 Consider proactively reviewing high-volume processes or those with perceived risk, using a safety checklist
5 Review error reports regularly, identifying themes and patterns in minor issues
6 Hold regular all-practice safety and improvement meetings to discuss reports and themes
7 Ensure these meetings are inclusive, and never make any individual feel vulnerable to criticism
8 Discuss issues openly, trying to identify causes before considering solutions
9 When implementing solutions, remember the Swiss cheese model, and build in multiple controls
10 Review new or amended processes regularly, to proactively identify any emerging risks

Find a reporting system that works for your practice
Develop a system of risk and error reporting. This can be electronic or paper based, but should be easy to access. Nominate a member of your team to collate the reporting – ideally someone who has a real interest in this area and can encourage ongoing reporting, which may fade after initial enthusiasm. Reassure staff that nothing is too small to report (see Box C, page 42).

Develop a process to act on reports. A useful template is the Primary Care Patient Safety (PISA) Learning for Care Improvement Model (see figure 2, page 42) – also in the RCGP guide.[1] It starts with identification of an incident and internal reporting. Reports are then reviewed and collated, discussed internally and, if necessary, become the subject of a significant event discussion, or even an issue to be reported externally.

Host regular meetings
It may be useful to establish a regular safety and learning forum to discuss issues with the whole practice team. Such meetings can be similar to significant event meetings. It is important that they are open to all staff and are chaired sensitively and inclusively, with a no-blame approach. Invite all participants to contribute equally, bearing in →

Box B Processes that may contain risks

- Management of prescription requests, especially those that are urgent
- Handling of inbound results, including normal results and when responsible doctors are absent
- Management of clinical triage in the practice
- Two-week rule referral process, where referrals might be lost or delayed
- Requests for visits, allocation to clinicians, note keeping and assurance of completion
- Immunisation and vaccination processes
- Clinical communication in the practice, and messaging between clinicians

1 CPD HOUR

Key points

- Systems errors are mishaps that occur from the structures that we create. Improving quality means looking further, thinking about how the systems in our practice affect efficiency and patient safety
- Minor errors should not be ignored – a sequence of minor errors can lead to a major one
- Encourage openness by reassuring staff that when identifying errors, the practice will not attribute blame
- Develop an accessible system of risk and error reporting and nominate a member of your team to collate the reporting
- Consider establishing a regular safety and learning forum to discuss issues with the whole practice team

ONLINE
To read the full article and complete the module visit: **pulse365.uk**

SCAN ME

Box C Case study: The wrong waiting area:

Mrs Jones attended for her phlebotomy appointment one Monday morning. The practice was busy, with a long queue for reception. She decided to use the automatic screen to check in.

She walked to her usual waiting area. After a few minutes, a clinician called her and she entered the consulting room.

'So, you are here for your asthma check?,' the clinician asked. Mrs Jones explained she had a phlebotomy appointment. She was directed to the other waiting room where the phlebotomist was working. Then the clinician realised another Mrs Jones was waiting outside for an asthma review and made a mental note to check date of birth as an identifier, to prevent patient misidentification.

The first Mrs Jones was seen by the phlebotomist. As they joked about the minor error, the phlebotomist realised the potential danger if patients waited in the wrong area and sent an email to the practice administrator responsible for risk, highlighting a system error.

The practice reviewed the incident. It was recognised that having the right patient in the right place was an important safeguard against a potentially serious error, such as the wrong patient being given an immunisation. They changed the patient flow system by strengthening the automatic screen notification of the waiting area and updating the signage for the waiting rooms, taking into account the needs of patients with visual or literacy impairments.

mind that discussions dominated by the GPs could narrow the perspective. Again, take a lead from the airlines, which use a concept called crew resource management to promote a culture of listening to ensure that all voices are heard.

The body of the discussion should focus on why the issue occurred – not on solutions. Use the principle of 'root cause analysis' to look at the origins of the incident, rather than stopping at an intermediate 'cause' – which itself is likely to have other underlying causes.

Keep human factors as an important part of the discussion, but don't consider them as the root cause of the error. Doing so risks attributing blame and failing to understand the reasons for a particular behaviour or action.

If an individual acted in a way that resulted in an error, change the system so that the person is less likely to make the same error in the future.

As an example, consider the design of the electricity mains plug. The shape of the plug means it is not possible, in normal use, to plug the earth pin into the live socket. Therefore, the risk of human error in reversing the connections has been eliminated by the system design.

The conclusion of a cause analysis discussion should be a clear understanding of the reasons why the practice system allowed an error to occur.

The next part of the discussion is to consider what changes will make the system safer. This solution-focused discussion should involve the wider practice team, who should be invited to comment on the practicality and usefulness of the proposed change.

Take notice if anyone raises concerns about workload. The imperative is to understand and relieve those pressures, not to accept increased risk in the light of the pressures. You might be interested to know that the introduction of the WHO surgical safety checklist in hospitals resulted in a small increase in workload for theatre staff, but a major improvement in patient safety.[3]

Finally, complete the learning loop by reviewing changes in systems and processes periodically to check that the risk of error has been reduced. Adopting such methods not only promotes quality improvement but can be satisfying – and help team working towards the common goal of better care for patients.

Dr Jonathan Inglesfield is a GP partner in Surrey

Figure 2 Stages of the Primary Care Patient Safety (PISA) Learning for Care Improvement Model[1]