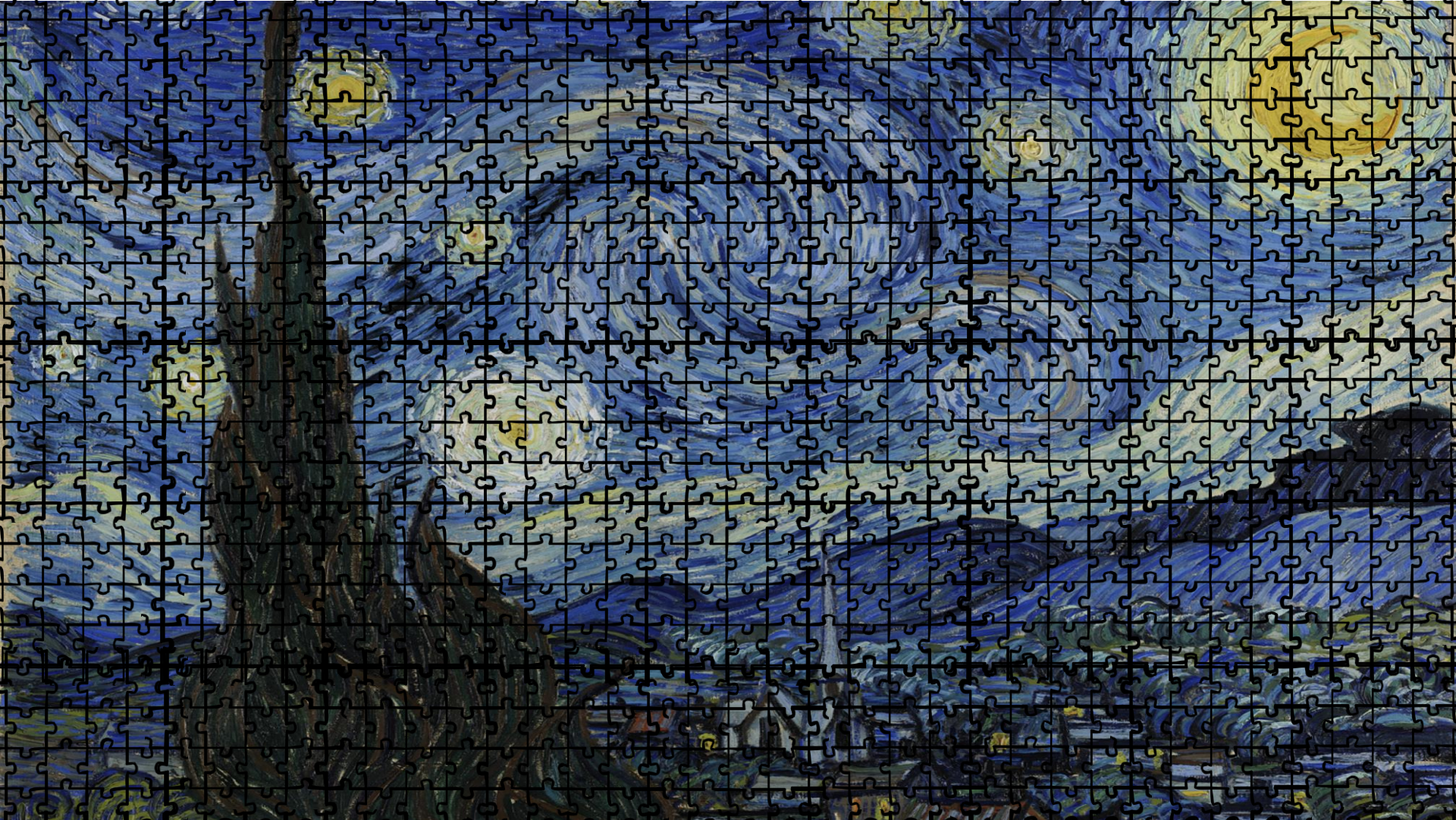
Sources of Unsafe Primary Care for Older Adults: Lessons from a National Patient Safety Reporting and Learning System

Andrew Carson-Stevens MB BCh PhD

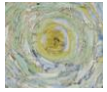


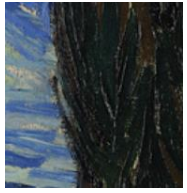
1 in 5 ‘pieces’ are not jigsaw shaped

1 in 5 ‘incident reports’ do not describe a patient safety incident

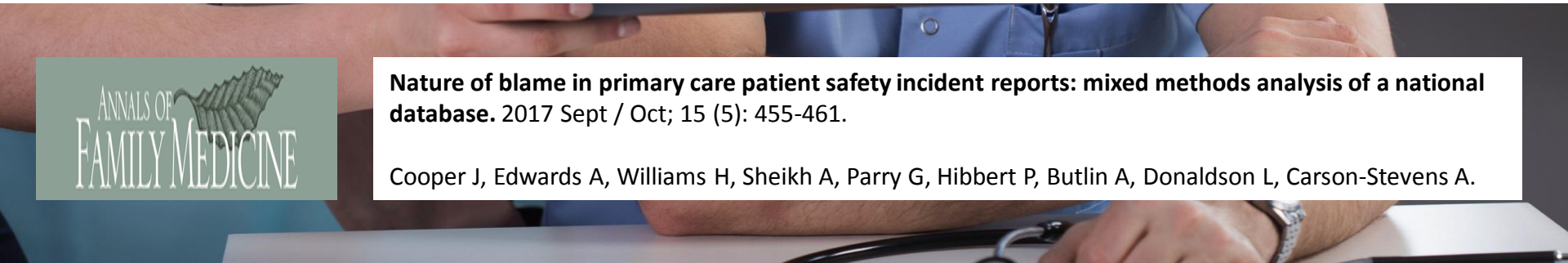
2 in 3 ‘jigsaw pieces’ are blank

2 in 3 reports do not describe why the incident occurred





45% are ‘blame reports’



Annals of Family Medicine

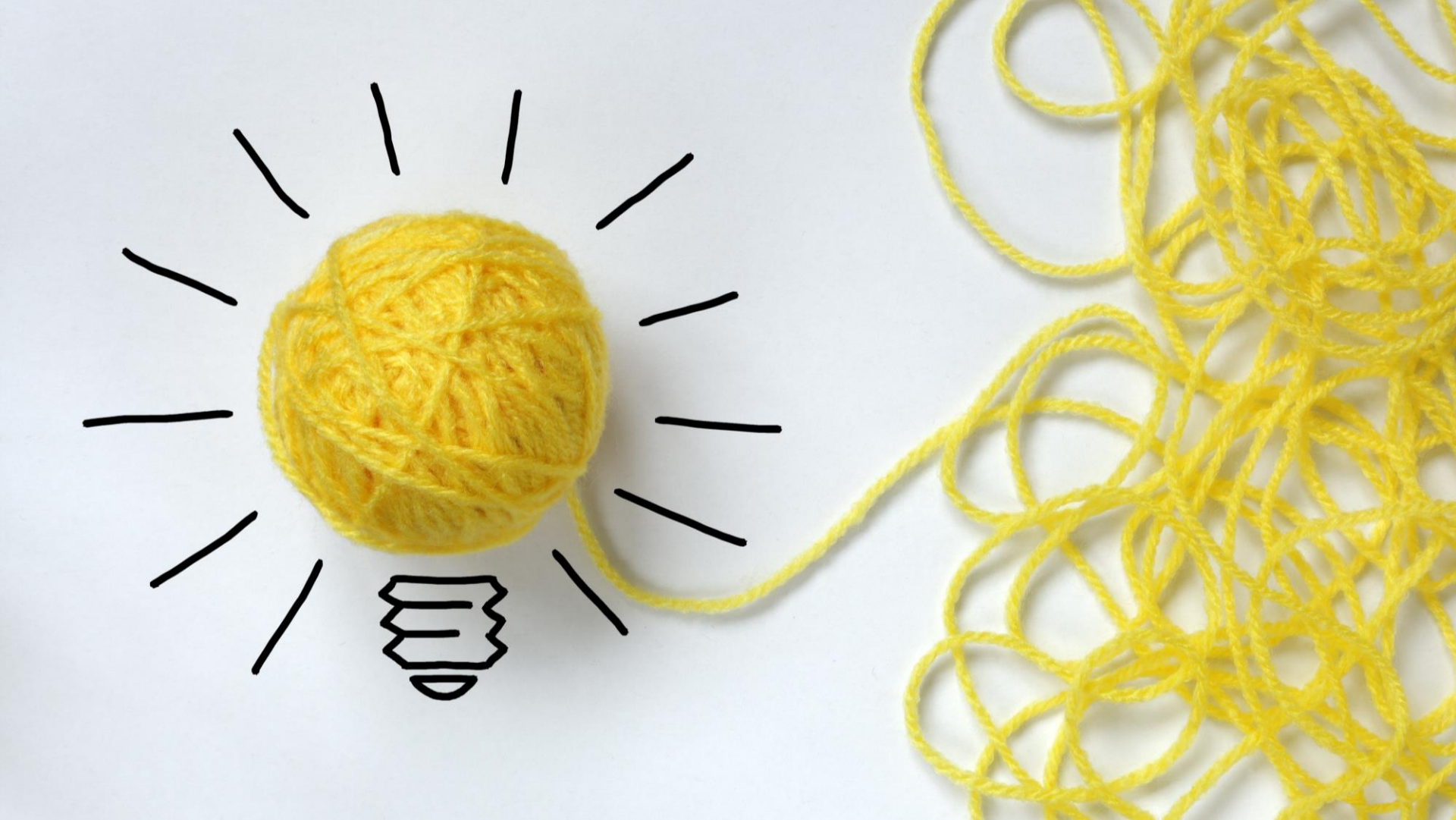
Nature of blame in primary care patient safety incident reports: mixed methods analysis of a national database. 2017 Sept / Oct; 15 (5): 455-461.

Cooper J, Edwards A, Williams H, Sheikh A, Parry G, Hibbert P, Butlin A, Donaldson L, Carson-Stevens A.

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Grŵp PISA Group

We use mixed methods research techniques to **generate learning from patient safety incidents** occurring in the healthcare system **to empirically inform quality improvement initiatives and projects to improve patient safety**.



PLOS | MEDICINE

2017 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.

NHS
National Institute for Health Research

Health Services and Delivery Research 2016 Sept; 4(27)

Characterising the nature of primary care patient safety incident reports in the England and Wales National Reporting and Learning System: a mixed-methods agenda-setting study for general practice

Carson-Stevens A, Hibbert P, Williams H, Evans H P, Cooper A, Rees P, Deakin A, Shiels E, Gibson R, Butlin A, Carter B, Luff D, Parry G, Makeham M, McEnhill P, Ward H O, Samuriwo R, Avery A, Chuter A, Donaldson L, Mayor S, Panesar S, Sheikh A, Wood F & Edwards A.

PEDIATRICS
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

2015 June; 135 (6)

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.

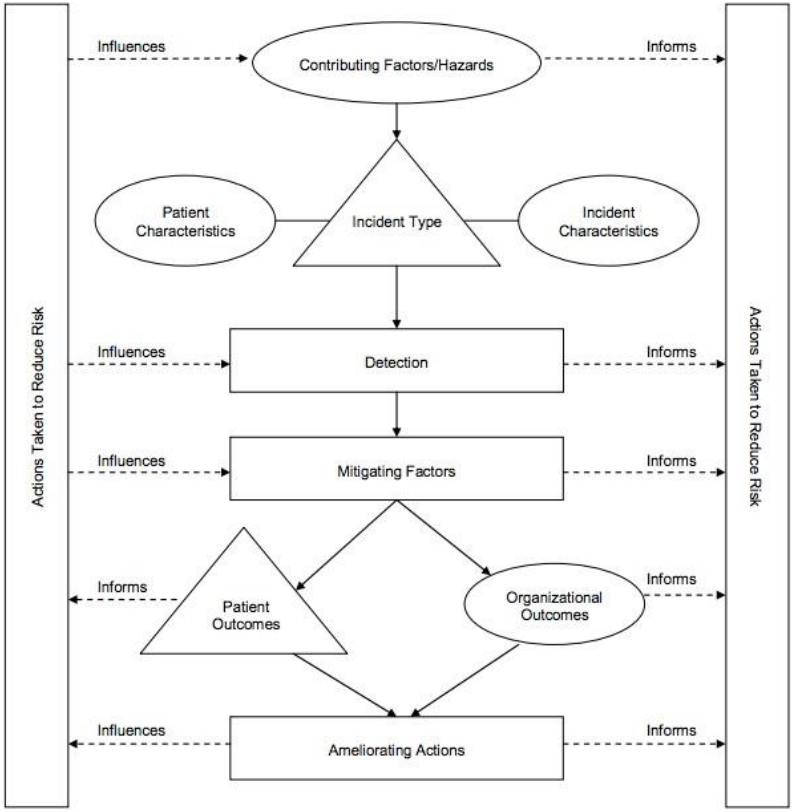
More than words

Conceptual Framework for the International Classification for Patient Safety

Version 1.1

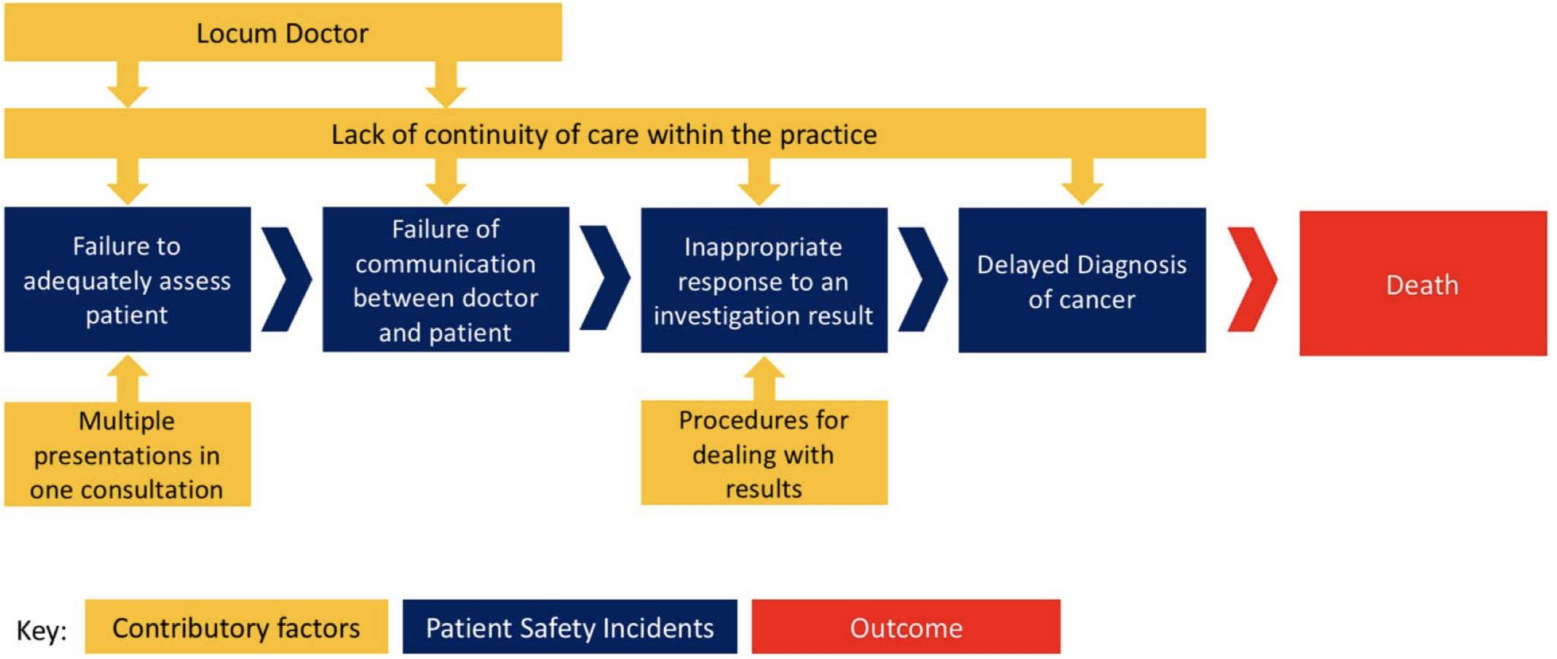
Final Technical Report
January 2009

World Health Organization | Patient Safety
A World Alliance for Safer Health Care



Recursive Model for Incident Analysis

Hibbert P, Runciman W, Deakin A. Australian Patient Safety Foundation; 2007.



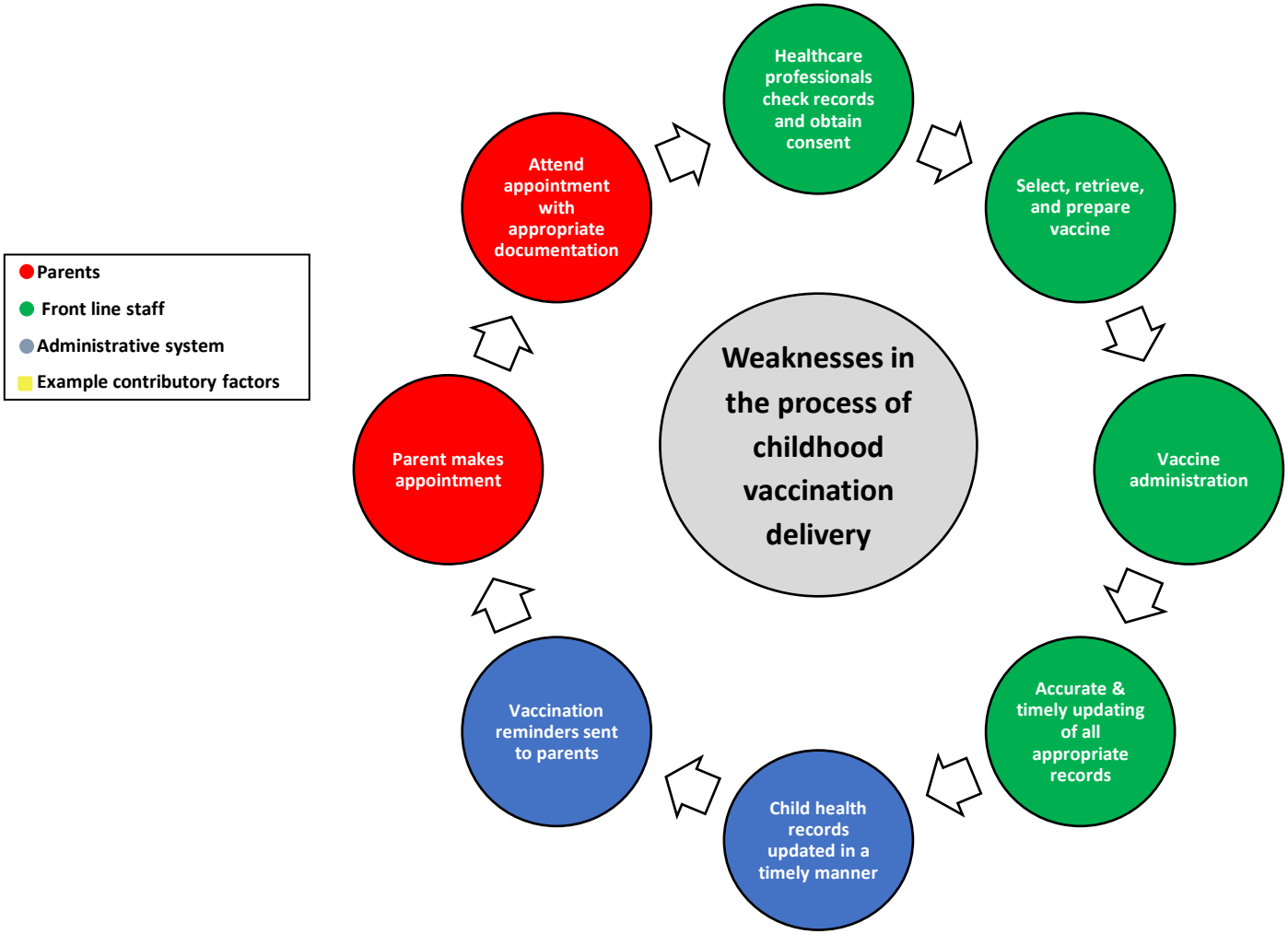
Vaccine

2015 June; 33(32)

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

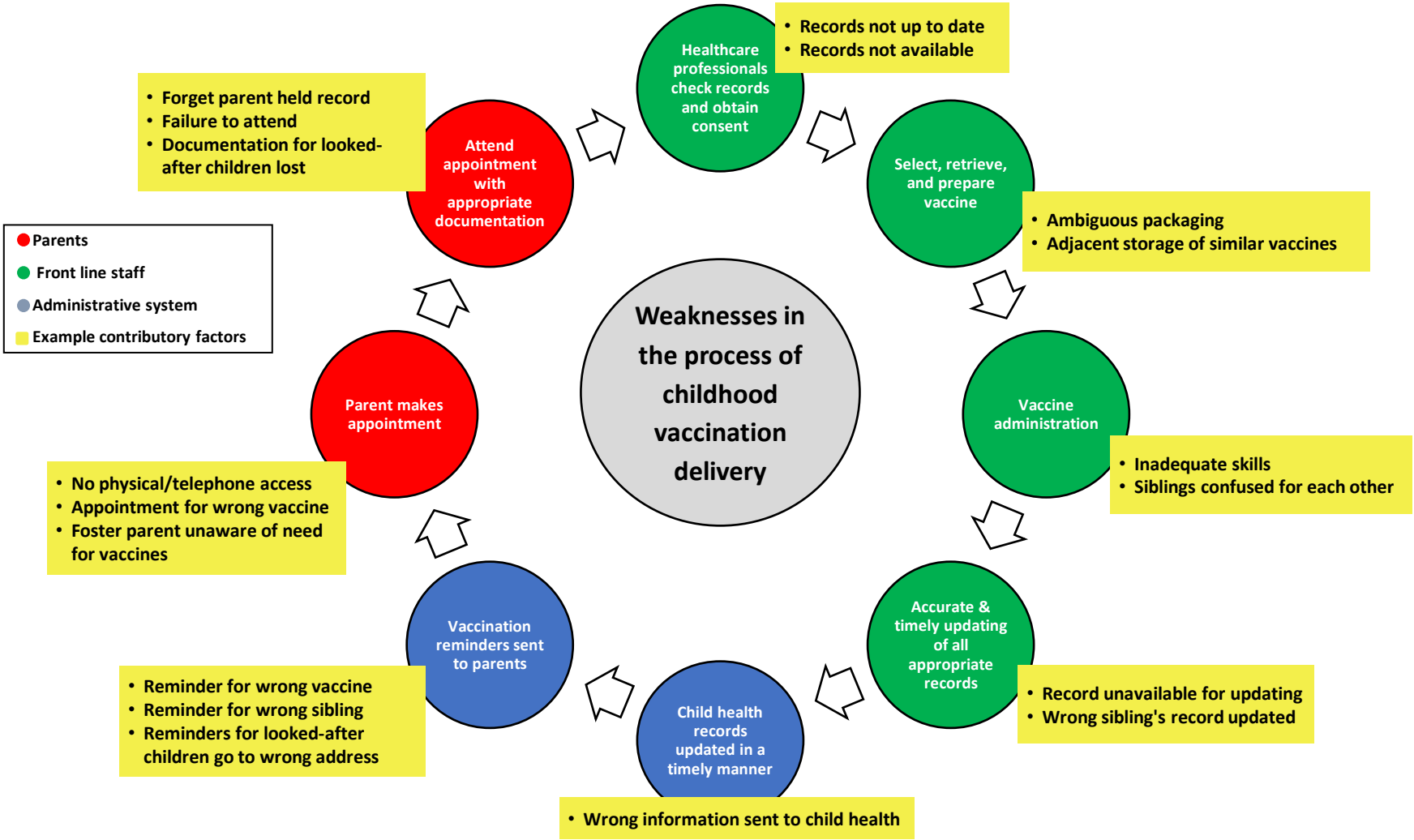
Rees P, Edwards A, Powell C, Prosser Evans H, Carter B, Hibbert P, Makeham M, Sheikh A, Donaldson LJ, Carson-Stevens A.

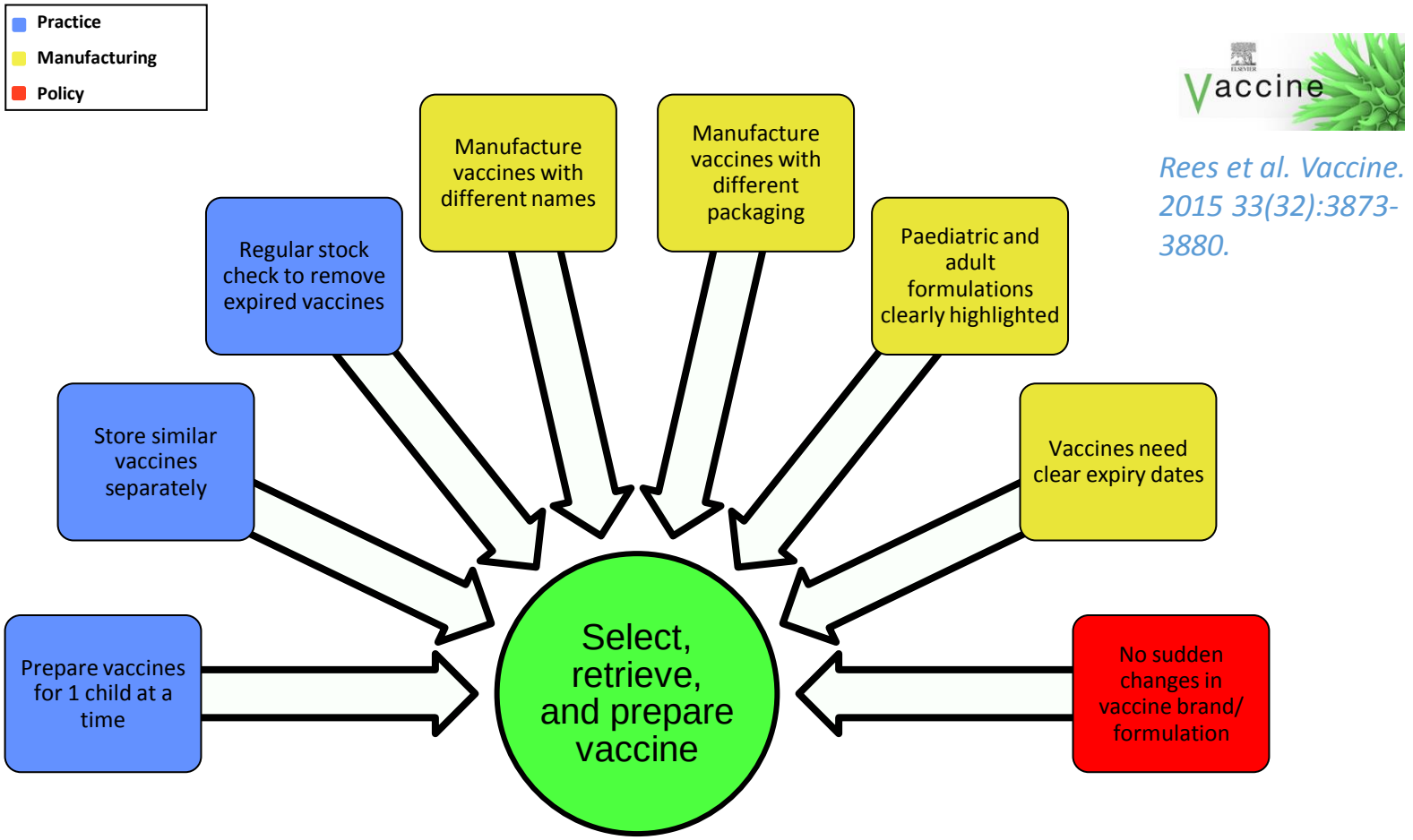
Weaknesses in the process of childhood vaccination delivery



Vaccine

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


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
• 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
Parents
Front line staff
Administrative system
Example contributory factors



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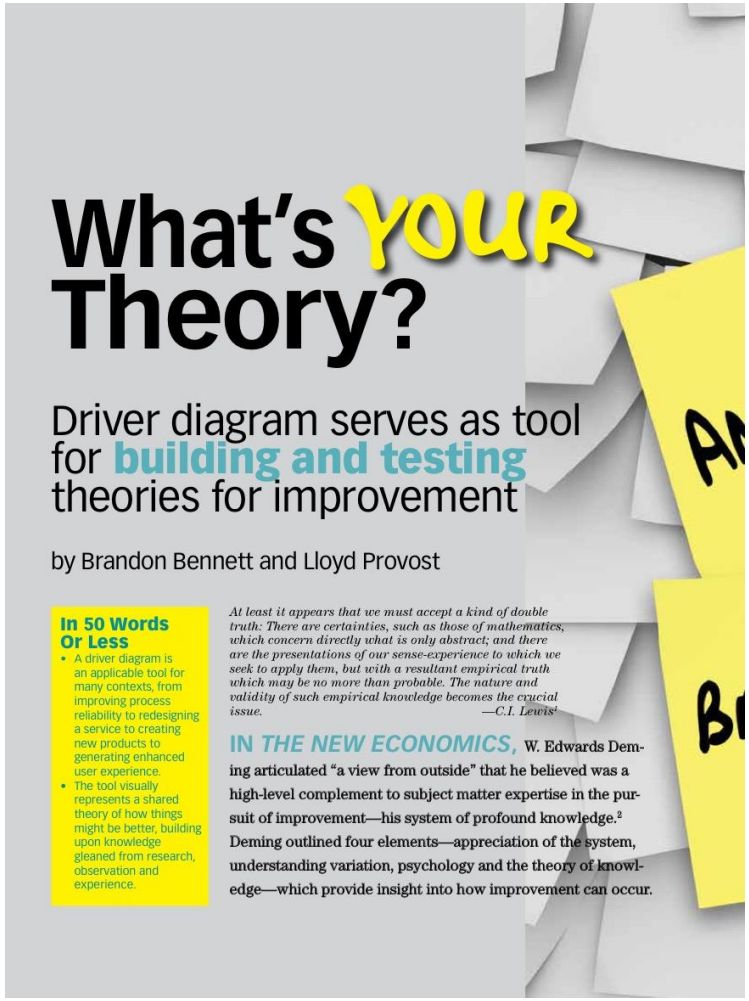
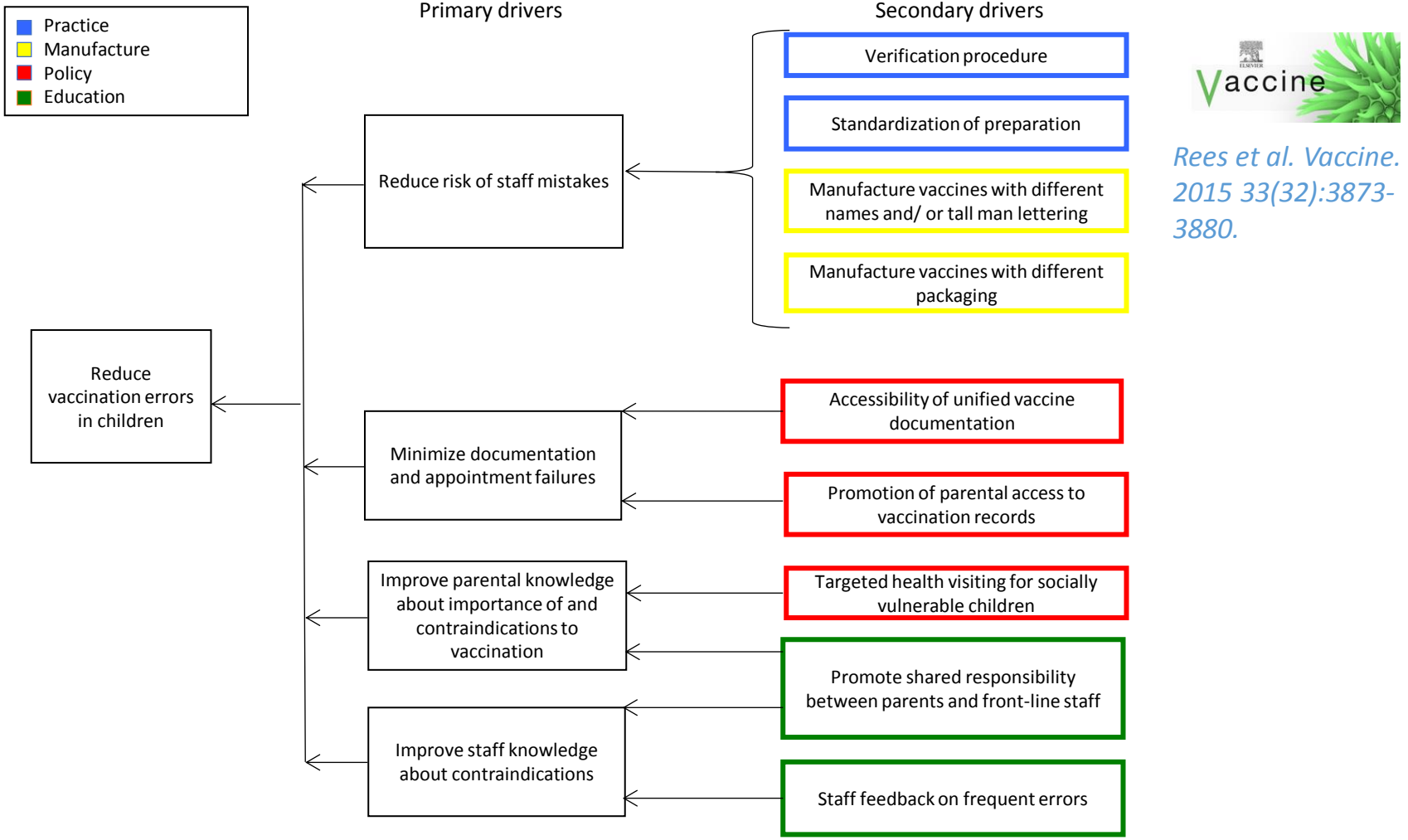


Provost L, Bennett B. What's your theory? Driver diagram serves as tool for building and testing theories for improvement. Quality Progress. 2015 Jul:36-43.



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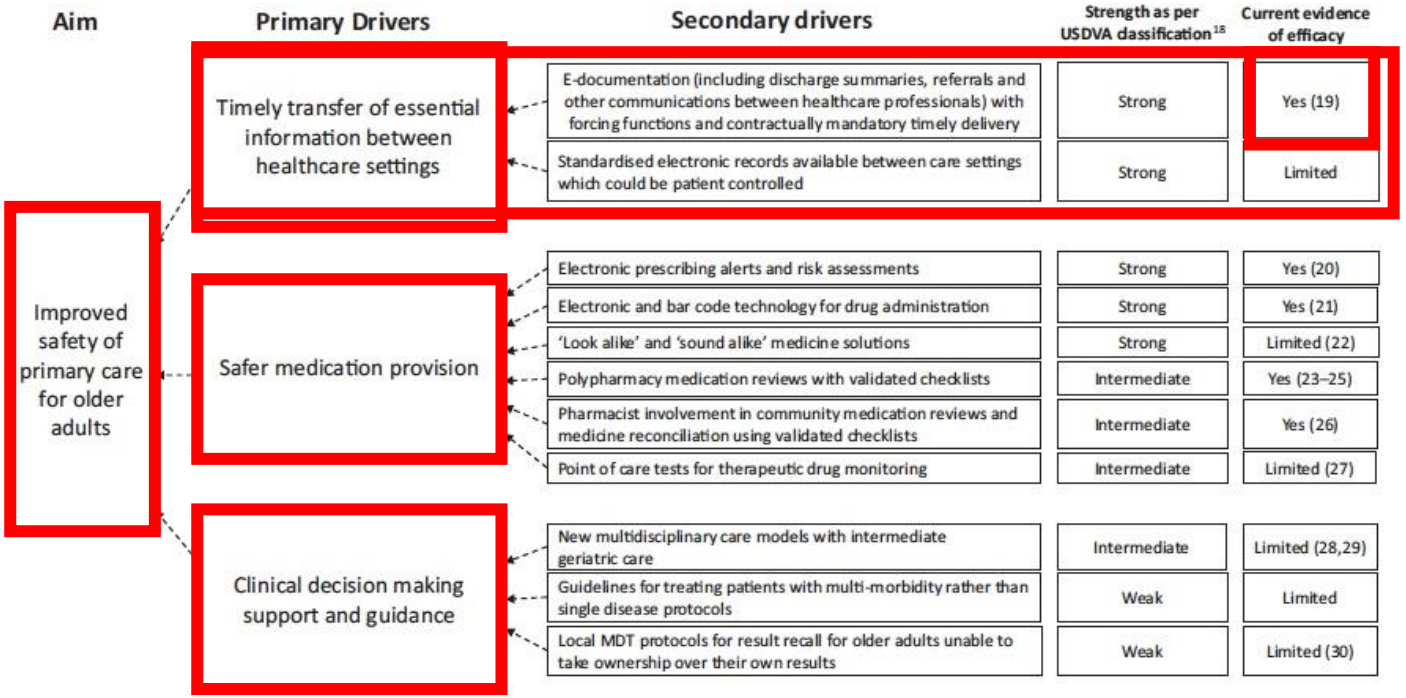


Figure 1. Driver diagram to show potential interventions to improve the safety of primary care for older adults.

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.

Cooper A, Edwards A, Williams H, Hibbert P, Makeham M, Avery A, Sheikh A, Donaldson L, Carson-Stevens A.

Reference 19

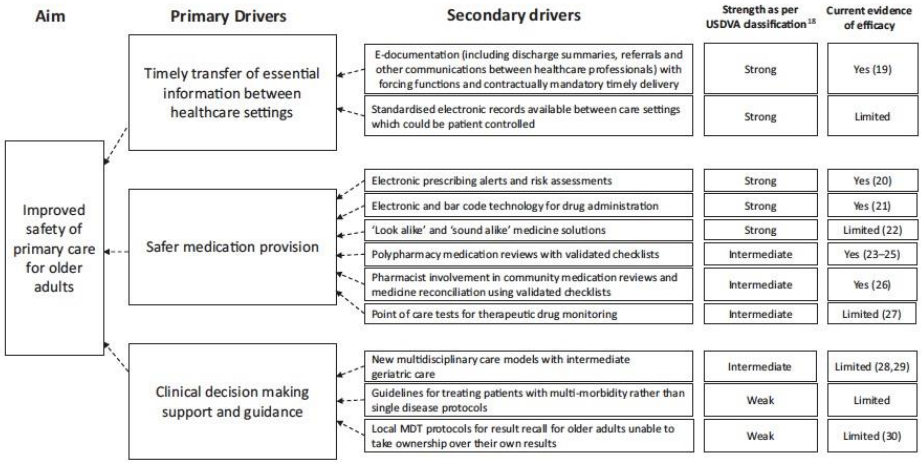
REVIEW

JAMA February 28, 2007—Vol 297, No. 8

Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians

Implications for Patient Safety and Continuity of Care

Sunil Kripalani, MD, MSc
Frank LeFevre, MD
Christopher O. Phillips, MD, MPH
Mark V. Williams, MD
Preetha Basaviah, MD
David W. Baker, MD, MPH



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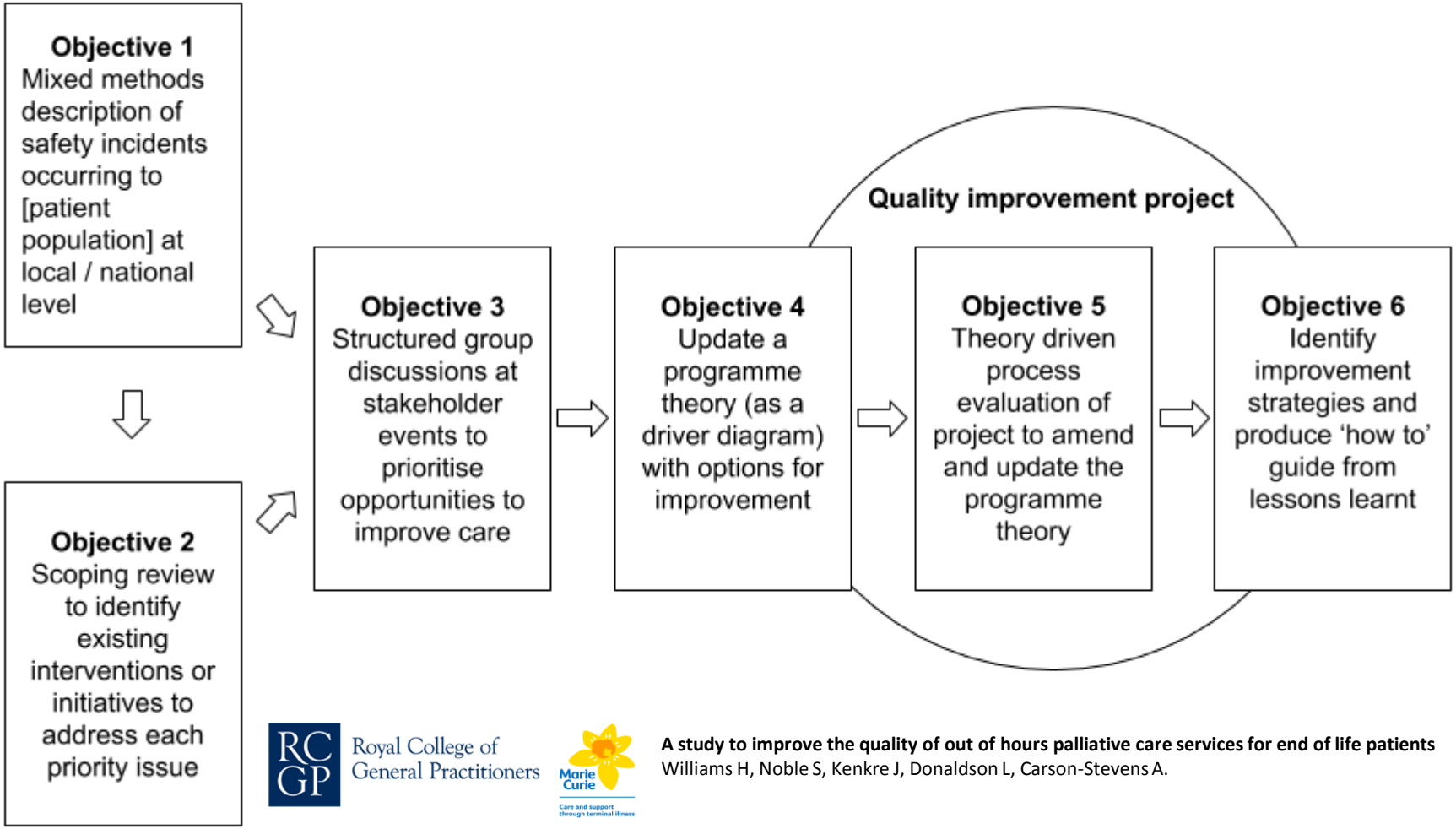
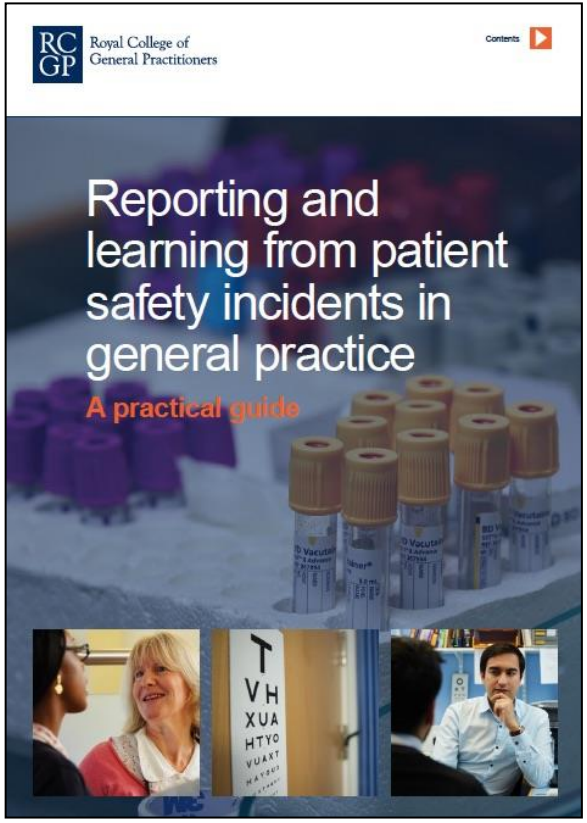
The Improvement Guide, API, 2009



Royal College of General Practitioners

A study to improve the quality of out of hours palliative care services for end of life patients
Williams H, Noble S, Kenkre J, Donaldson L, Carson-Stevens A.



Stages of the Primary Care Patient Safety (PISA) Learning for Care Improvement Model

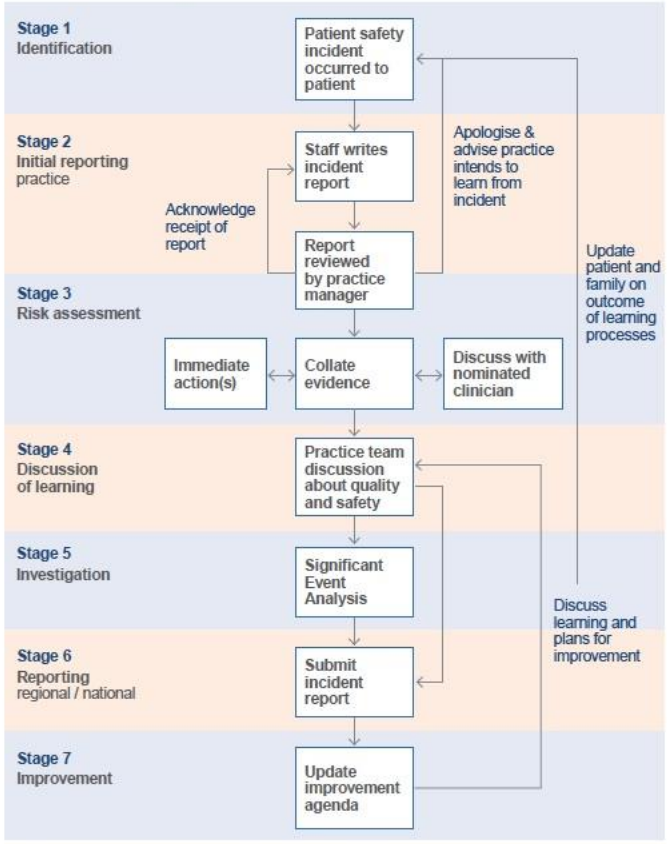
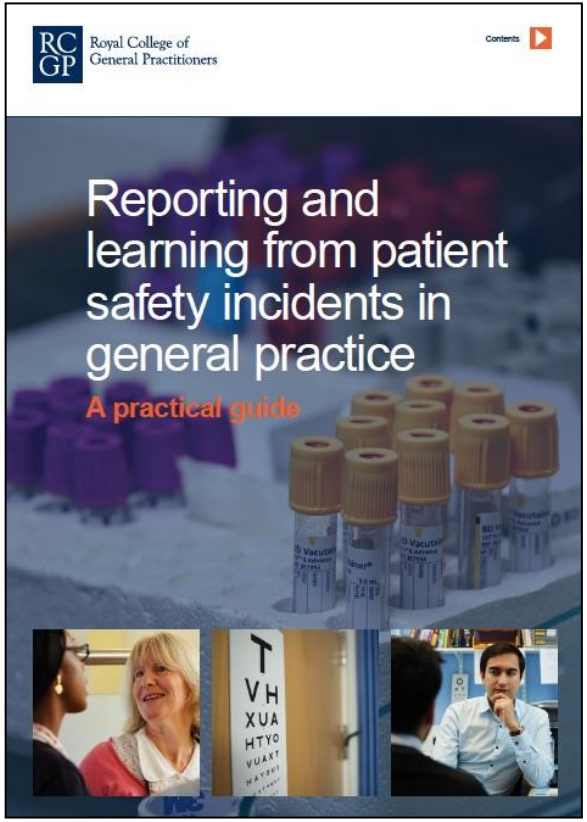


Figure 6. Stages of the Primary Care Patient Safety (PISA) Learning for Care Improvement Model



PISA Patient Safety Incident Reporting Form Template

Who

Patient affected:

Person reporting incident (including job title):

Where/When

Location:

Date/time of incident:

Date/time reported to manager:

What

Incident category type (please circle):

- *Medication process*
- *Diagnostic / clinical assessment*
- *Investigation process*
- *Communication process*
- *Equipment*
- *Other*

What happened?

Why?

Was immediate action necessary? If yes please document below

Were there any contributing factors? *(e.g. system, staff, patient)*

What was the patient harm severity outcome?
(please circle – refer to table on next page):

- No harm
- Mild harm
- Moderate harm
- Severe harm
- Death

What is the probability of recurrence?
(please circle — refer to matrix on the next page)

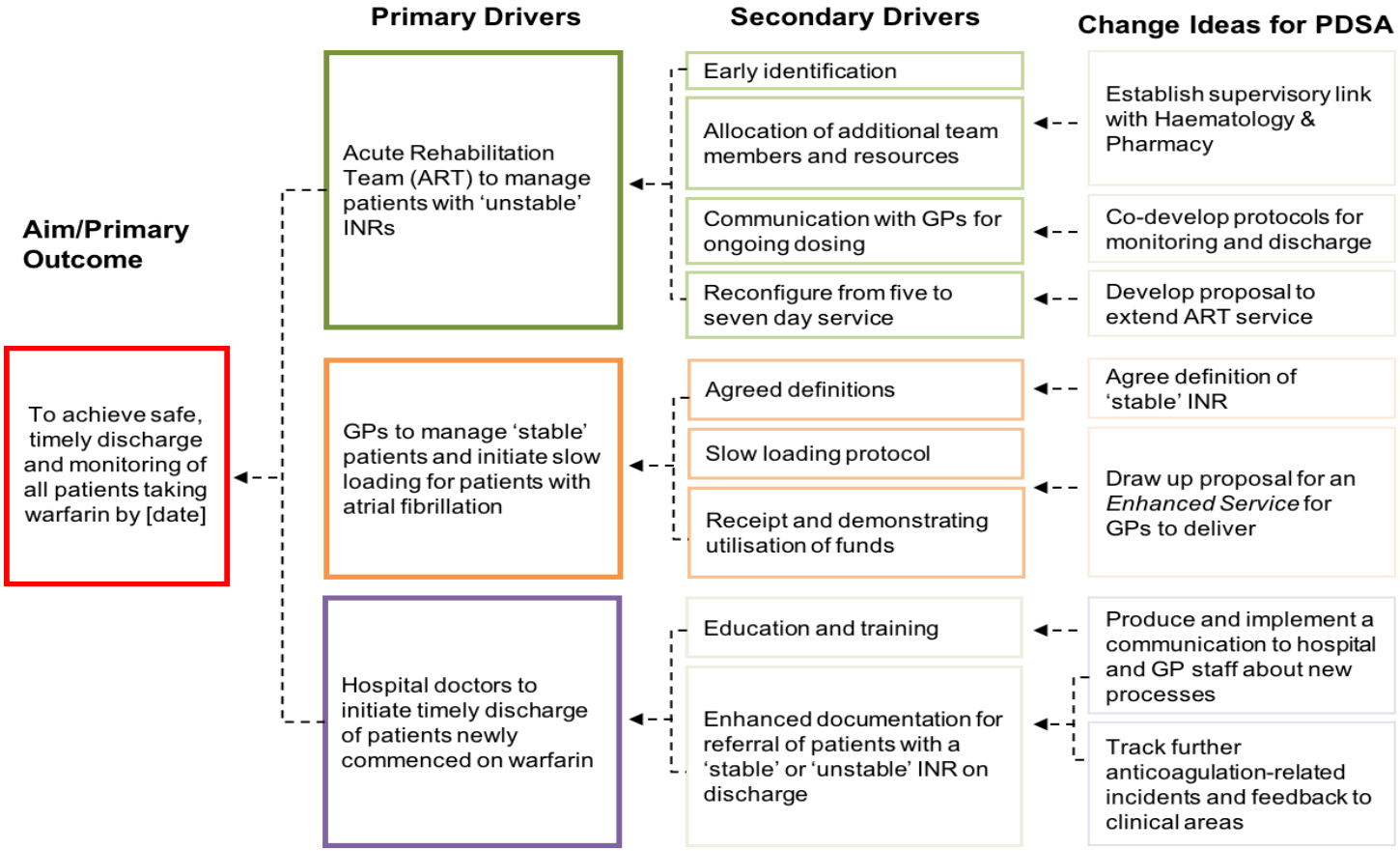
- Extreme risk
- High risk
- Medium risk
- Low risk

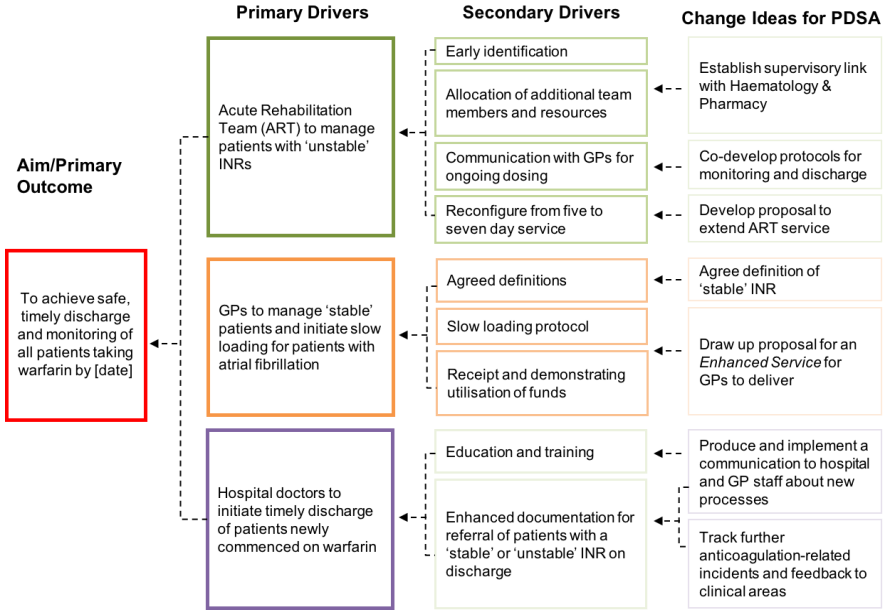
Actions to prevent recurrence and how this incident will be investigated?

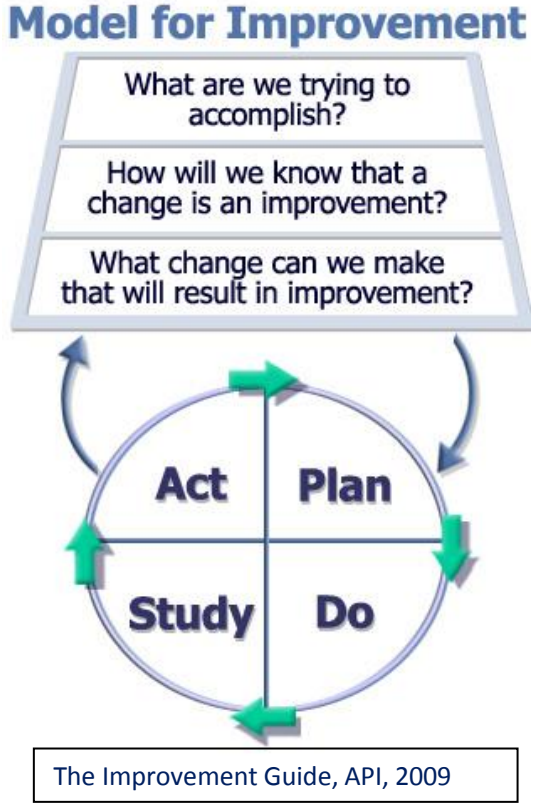
AWTTC
All Wales Therapeutics & Toxicology Centre
Canolfan Therapiwteg a Thocsicoleg Cymru Gyfan

Canolfan PRIME Cymru Wales PRIME Centre

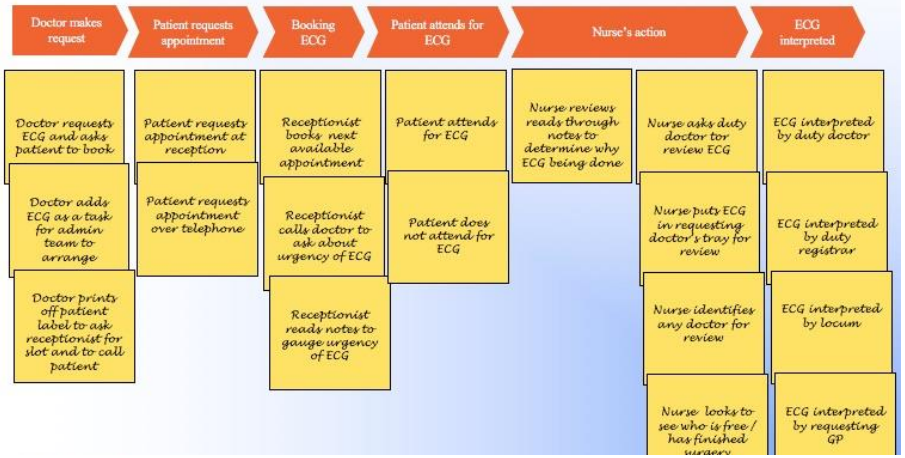
Supported by NHS National Institute for Health Research


Primary Drivers
Secondary Drivers
Change Ideas for PDSA
Aim/Primary Outcome
To achieve safe, timely discharge and monitoring of all patients taking warfarin by [date]
Acute Rehabilitation Team (ART) to manage patients with 'unstable' INRs
Early identification
Allocation of additional team members and resources
Establish supervisory link with Haematology & Pharmacy
Communication with GPs for ongoing dosing
Co-develop protocols for monitoring and discharge
Reconfigure from five to seven day service
Develop proposal to extend ART service
GPs to manage 'stable' patients and initiate slow loading for patients with atrial fibrillation
Agreed definitions
Agree definition of 'stable' INR
Slow loading protocol
Receipt and demonstrating utilisation of funds
Draw up proposal for an Enhanced Service for GPs to deliver
Hospital doctors to initiate timely discharge of patients newly commenced on warfarin
Education and training
Produce and implement a communication to hospital and GP staff about new processes
Enhanced documentation for referral of patients with a 'stable' or 'unstable' INR on discharge
Track further anticoagulation-related incidents and feedback to clinical areas

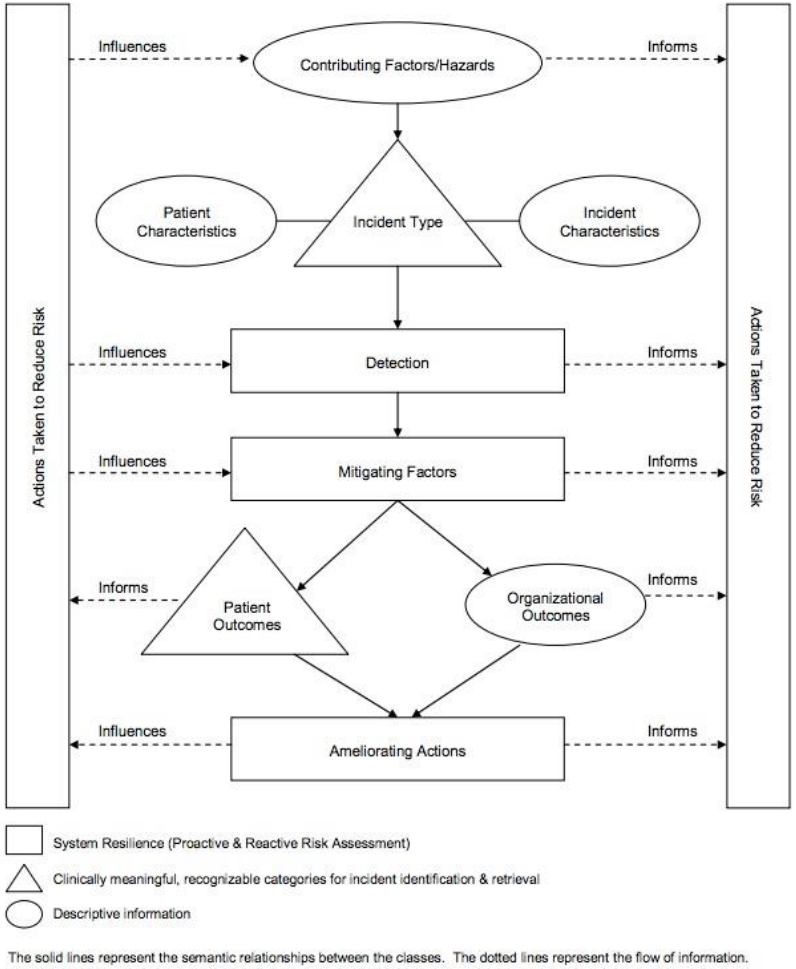




The Improvement Guide, API, 2009



http://elearning.rcgp.org.uk/course/info.php?popup=0&id=242



A challenge for every health care system

Use the WHO International Classification for Patient Safety to:

1. Realise the range and utility of the patient safety data you already have;
2. Appreciate the overlap in data, and where appropriate de-duplicate; and,
3. Identify the gaps in your understanding of patient safety, and explore new opportunities for data gathering / collection.

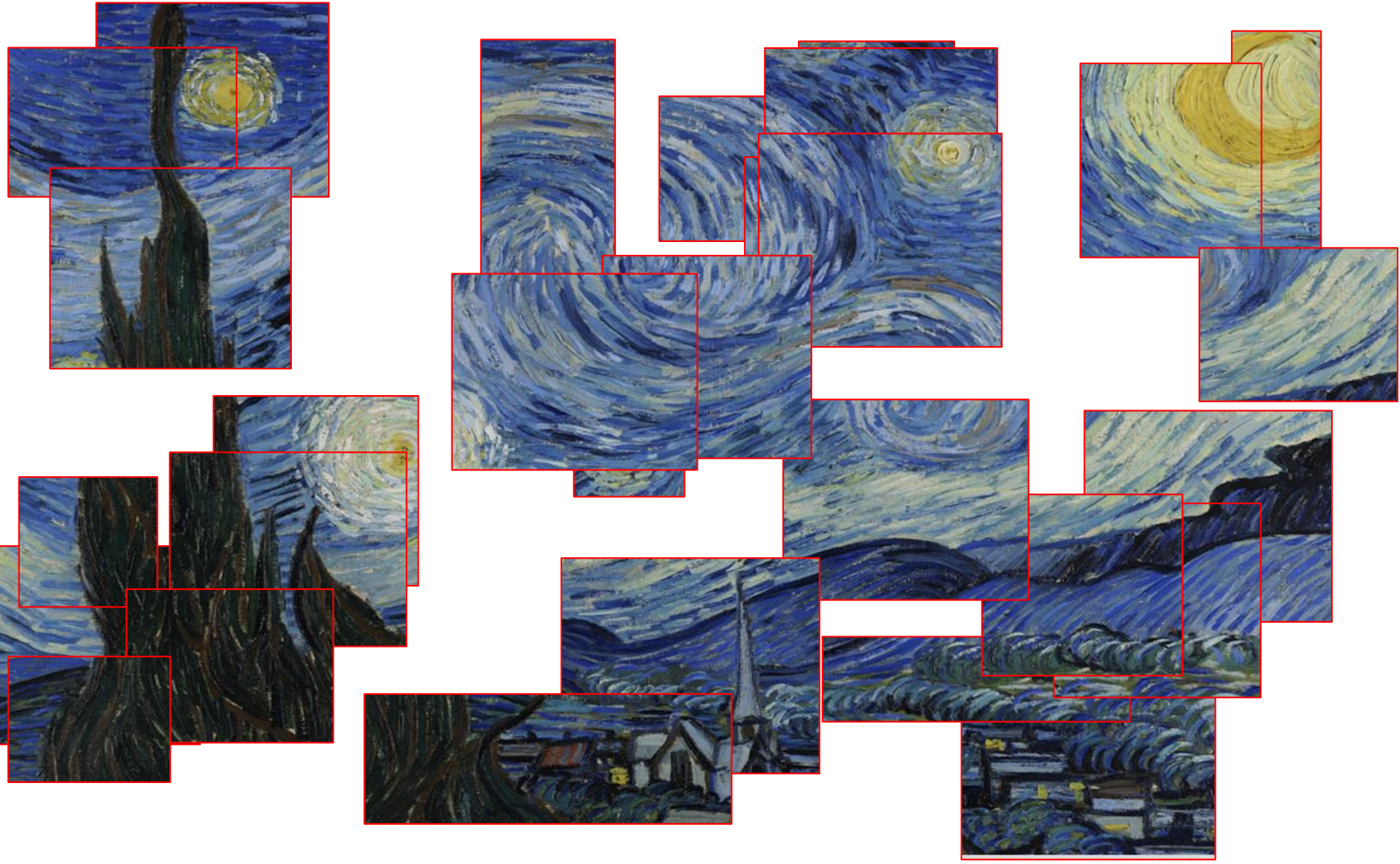
BMJ QUALITY & SAFETY
2015 Nov; 25: 133-134.

Opportunities for incident reporting

Williams H, Cooper A, Carson-Stevens A

Health care systems should aim to:

- *…maximise the usefulness of data provided by staff and patients*
- *…analyse data regularly to inform improvement agendas*
- *…engage staff with improvement projects informed by data they have provided*
- *…demonstrate to staff and patients how they have acted on the learning*



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