Helping To Improve Patient Safety In General Practice

Patient Safety was an RCGP Spotlight Project for 2015-16. The project was led by Clinical Lead, Professor Tony Avery, and was a collaboration between the RCGP and NIHR Greater Manchester Primary Care Patient Safety Translational Research Centre. This report explores the impact of the year-long project.

Background

Although the nature and frequency of errors in primary care can be between 37 - 600 incidents per day in the UK\(^1\), primary care has lagged behind secondary care in taking positive steps to improve patient safety in general practice.

Patient safety is a complex, multidimensional concept and encompasses many different dimensions, including diagnostic and prescribing safety, communication (both within and between practices and other healthcare settings), organisational safety culture, and patient reported problems. Each of these dimensions requires different methods of assessment. Funded by NIHR School for Primary Care Research, the Patient Safety Toolkit we have developed is the first ever comprehensive method to support UK general practices to engage with the different safety issues encountered within practice. The tools included have been tested for feasibility and reliability with specific focus given to their relevance to UK general practice. The Patient Safety Toolkit could therefore play a major role in identifying potential safety issues within practices. With these issues brought to light effort can then be made to rectify and prevent future issues and consequently preventing patients from being harmed while being cared for.

The main aim for us undertaking this Spotlight Project was to enable us to widely publicise and raise awareness of the Patient Safety Toolkit amongst practice staff as a whole. We were keen for practices not only to be aware of the existence of the Patient Safety Toolkit, but also to provide them with an opportunity to access and use these tools in practice; for the benefit of their practices and their patients.

Beneficiaries

We believe that this programme has had an impact on members of the practice team such as GPs, practice managers and other practice staff involved in patient safety initiatives. The programme allowed us to host four patient safety workshops across the UK which provided us with a platform to highlight the availability and role of the Patient Safety Toolkit as a means for supporting and auditing of safety practices. Bringing together practice staff with an interest in patient safety to discuss and trial out some of the tools within the Patient Safety Toolkit resulted in the exchange of experiences and ideas in tackling the challenging issue of patient safety. Acknowledging that safety is an issue and having means to identify and rectify these safety issues is a key step to delivering safer health care to patients.

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Measurable Difference

The Patient Safety Toolkit, hosted on the Royal College of General Practice’s (RCGP) website (www.rcgp.org.uk/clinical-and-research/toolkits/patient-safety) was successfully launched in August 2015. Engagement with the Patient Safety Toolkit has been demonstrated through a review of the website statistics.

The two tools that received the top most views included the Safety Checklist for General Practice and the Trigger tool with 24% and 21% of the views respectively. Figures also indicated that over half of all page views resulted in a download taking place. Increased engagement with the Patient Safety Toolkit has been demonstrated by the fact that users are spending more time viewing pages on the Toolkit which has increased to 3:19 minutes per visit from the previous figure of 2:09 minutes.

As part of the Spotlight project we delivered four patient safety workshops through the RCGP Faculties across the devolved nations. Altogether a total of 81 primary care staff attended these four events (range 13 – 41 participants). Those attending included GPs (trainers, registrars and locum GPs), practice managers and a medical student. Overall, the questionnaire feedback collected from those attending the workshop were positive in affirming the relevance of the workshop attended to their current roles, the likelihood that the training they received would improve their practice, and the likelihood that they would recommend the workshop to a colleague.

Further exploration of the event feedback questionnaires (responses provided on a 4-point Likert scale anchored at 1=Very High and 4=Low) shows that at the start of the workshop (pre-workshop assessment) the participant’s level of knowledge and understanding of tools available on the Patient Safety Toolkit website was low (median 4 (IQR 0)). By the end of the workshop (post-workshop; same day of the workshop) the participants reported a high level of confidence to identify and use these tools (median 2 (IQR 0)). Similar pre- (level of ability) and post- (level of confidence) workshop scores were reported for the use of the Trigger Tool, Safety Checklists and tools for assessing patients’ experiences of safety in practice.

Supporting information

Selected illustrative quotes:

Participants attending the Patient Safety workshops to promote the Patient Safety Toolkit mentioned that they valued having time set aside for learning and appreciated gaining new insights from others. There was renewed enthusiasm for patient safety and a number of ideas for implementing learning were put forward:

- *(liked) The time and space to look at the tools and the enthusiasm it generated to go away and use them.* (Practice Manager)
- *(liked) Time away from work to network, gather new ideas and feel re-enthused about patient safety.* (Practice Manager)
- *It was very useful as I had seen the toolkit before but the session was helpful for me to get better understanding.* (GP)
• Thought provoking, took a potentially humdrum topic and kept my interest. Gave good tools, practical, applicable and relevant. (GP)

• Excited about using/implementing this in practice to enforce quality & safety. (Practice Manager)

• Awareness of the Patient Safety Toolkit, will consider using this as an audit. (GP)

Sharing and promoting the Toolkit and its success:

The Patient Safety Toolkit was a topic that featured in a number of RCGP’s Chair’s blogs and a radio interview conducted with Professor Tony Avery. Various news articles featured the toolkit and this included a newsletter by the School of Primary Care which listed the launch of the Patient Safety Toolkit on the RCGP website as one of the top 10 achievements for the School over the last 10 years. The Toolkit has also been mentioned in two RCGP clinical news articles, articles in Local Medical Committees newsletters and an article in the NIHR Greater Manchester Primary Care Patient Safety Translational Research Centre newsletter. Furthermore, mail outs were made to various stakeholders informing them of the Patient Safety Toolkit.

Legacy

The Patient Safety Toolkit has brought together a variety of tools which have been assessed for their applicability for GP practices. This ‘one-stop’ site addresses many aspects of patient safety including prescribing and diagnostics safety, communication (within and beyond the practice), organisational culture, and patient reported problems. By having all these appropriate tools on one site enables GPs and their staff to assess which tool they may require.

Continuing access to the Patient Safety Toolkit via the RCGP website will provide that ongoing impetus and encouragement for GPs and their practice staff to actively promote patient safety by using these available tools.

In response to feedback received from participants attending the workshops we are working on developing an electronic version of the Patient Safety Questionnaire. This development aims to making the administration and compilation of patient responses more practicable for practitioners working in busy practices.

As the need to improve patient safety continues to impact on primary care so the value of the Patient Safety Toolkit will increase. Its position on the RCGP website will continue to support, influence and encourage practices to examine and improve their role in patient safety.
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The views expressed are those of the author(s) and not necessarily those of the NIHR, the NHS or the Department of Health.