

Patient Safety in Primary Care The Linneaus Collaboration

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**Why is patient safety
important in primary care?**

1. It's where most episodes of care take place

- 95% of all NHS contacts take place in primary care
- 300 million general practice appointments per year
- 750,000 people consulting GPs every day
- Primacy of primary care in most
- European countries

2. Mistakes happen....

- 5-80 safety incidents per 100 000 consultations
 - Between 37 – 600 incidents per day
 - 4 main categories
 - Diagnosis
 - Prescribing
 - Communication
 - Organisational
-

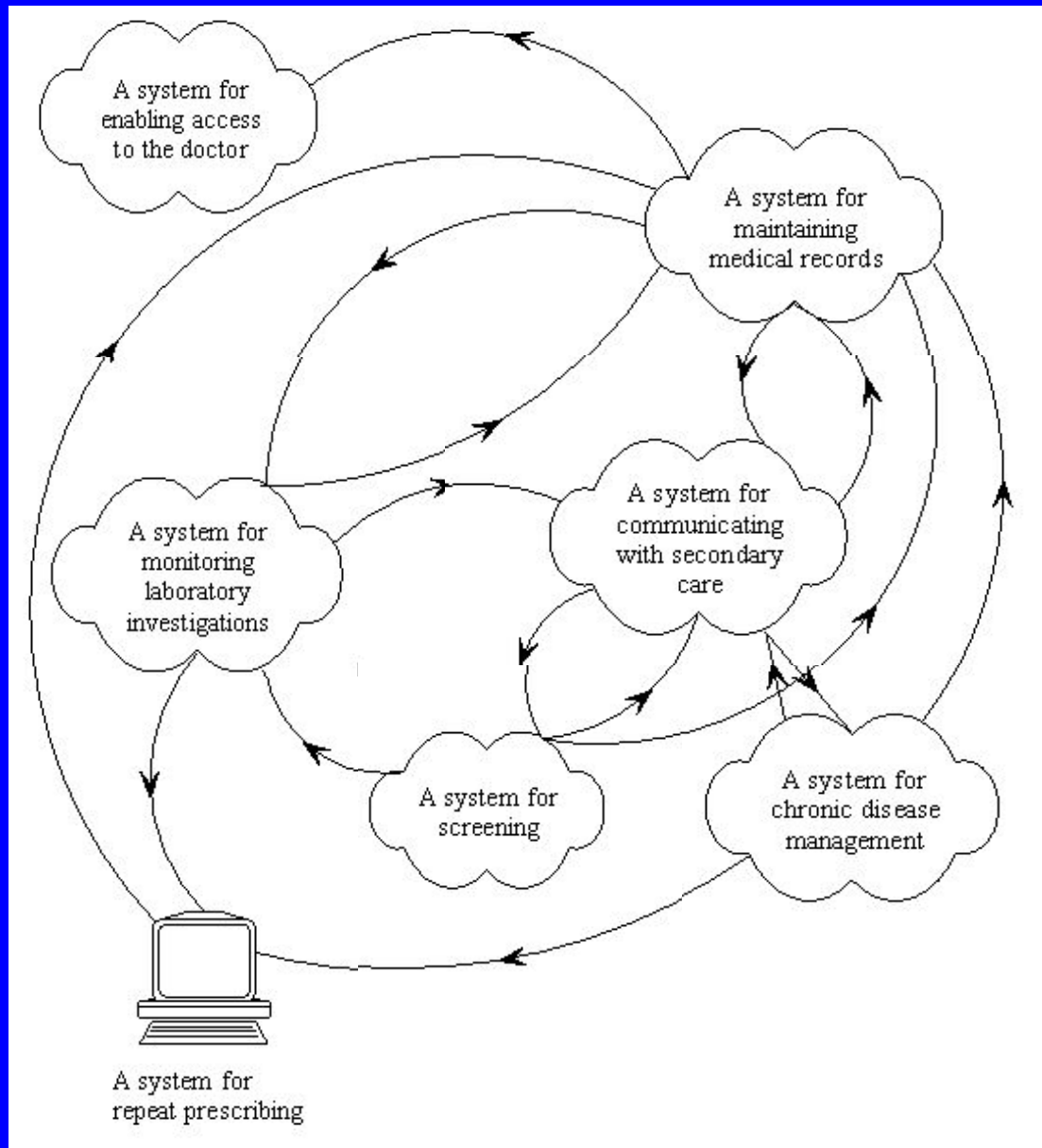
Sandars and Esmail, 2001

Why is primary care different?

1. The environment

- Lower profile than acute sector
- Low technology environment
- Different organisational structures
 - Mode and site of care delivery – telephone, home visits
 - Interfaces important
 - Increasing complexity
- Consultation skills and interpersonal skills critical

Practice Organization and its relationships



Why is primary care different?

2. The processes

- Less obvious implications
 - 50% no consequences
 - 20% non-clinically important delay in diagnosis
 - 10% upset patients
 - Up to 20% could have serious implications
- Less litigious
- Different professional dynamics

Frequency of errors (Primary Care)

Code	Error description	Frequency	%
14	Failure/delay in diagnosis	494	50%
48	Medication inappropriately prescribed	56	5.6%
23	Failure/refusal/delay in referral	51	5.17%
46	Failure to warn/recognise side effects of drugs	50	5.07%
22	Failure to monitor condition	46	4.66%
41	Unsatisfactory performance of procedure	42	4.26%
50	Failure to diagnose complications in pregnancy	24	2.43%

Frequency of outcomes (Primary Care)

Code	Outcome	Frequency	Percent
33	Death	178	20.7%
35	Deterioration in clinical condition	50	5.81%
86	Unnecessary pain	34	3.95%
3	Amputation of limb	31	3.60%
88	Appendicectomy	23	2.67%
10	Brain damage	20	2.33%

Why is primary care different?

3. The underlying philosophy

- Variation more acceptable
- Different approach to risk and uncertainty

Primary care....

Accept uncertainty

Explore probability

Marginalise danger

Marshall Marinker

Why so little progress

- Lack of corporate identity
 - Herding cats
 - small business mentality
 - Primary care as organisations in their own right
 - Individuality of general practitioners
 - Strengths and weakness
- Fear of centralisation
- Genuine concerns about confidentiality and anonymity

LINNEAUS collaboration

- Partners
 - Denmark (Patient Involvement)
 - Netherlands (Learning)
 - UK (Culture and Diagnostic error)
 - Germany (Reporting systems and taxonomy)
 - Poland (Framework for implementation)
 - Austria (Medication errors)
 - *Spain (indicators)
 - *France (?)
 - * Greece (curriculum for patient safety)
 - » *new partners

Linneaus collaboration

- Development of a taxonomy suitable for primary care
- Development of a unified reporting system
- Getting consensus on identifying prescribing errors and suitable interventions
- Increase our understanding of diagnostic errors
- Develop methods for assessing culture in primary care
- How to involve patients
- Develop a framework for involving new countries and primary care organisations

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Key actions

- 1st International Conference
 - 19-20 October 2010
 - How to engage with primary care
 - Using reporting systems
 - How to assess culture
 - How to involve patients
 - Lessons for learning from errors
- www.linneaus-pc.eu

Linneaus Collaboration

Key outputs

- Extending and building the network
- Getting consistency on data gathering, taxonomy, culture measurement, developing indicators, teaching for safety, ? handover
- Identifying key improvement strategies
- Developing a greater understanding of the contribution of diagnostic errors
- Putting patients on the agenda

What are we going to do?

- Understand where we are coming from
 - Who we are
 - What are the particular problems that we face
 - What do we need to learn from this conference
- Some specific things that we need to know
 - Culture, Diagnosis, Reporting & Taxonomy, Patient involvement

The Linneaus Model

- Understand the problem
 - Do we know the culture?
 - What is going on in my practice?
 - Reporting study
- What are we going to do about it?
 - Share information
 - Implement learning
- Ongoing monitoring and change

Other things that you will need to do (later!)

- Understand the importance of diagnostic errors
 - What can you do about it?
- What are the best improvement strategies?
- What are the best way of involving patients?
- What strategies do we need to have in place?
 - Techniques for assessment of the problem
 - Trigger tools, SEA, practice visits, using routine information, assessing culture