safety IN PRACTICE

# General Practice Orientation Manual 2020-21

*Every patient, every time*

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Waitematā District Health Board
Best Care for Everyone

ALLIANCE HEALTH+ Inspiring Health Transformation

AUCKLANDPHO

comprehensive care

National Hauora Coalition

ProCare

# Contents

## Abbreviations

| | |
|---|---|
| DHB | District Health Board |
| HQSC | Health, Quality & Safety Commission |
| IHI | Institute for Healthcare Improvement |
| PMS | Patient management system e.g. MedTech, MyPractice, ToniQ |
| LS | Learning Session |
| PDSA Cycle | Plan Do Study Act Cycle of improvement |
| PHO | Primary health Organisation e.g. Auckland, Alliance Health Plus, Comprehensive Care, East Health Trust, Total Healthcare, National Hauora Coalition, Procare |
| SiP | Safety in Practice |

## Welcome to Safety in Practice

Both Auckland and Waitematā DHBs consider patient safety a key priority. Safety in Practice (SiP) in primary care is an integral component of this. This is the first time DHBs have invested in supporting primary care teams to achieve greater capability in patient safety. So you are part of a programme that addresses issues at the very heart of healthcare.

SiP is recognised by the Royal NZ College of GPs, Pharmaceutical Society and the Health Quality Safety Commission. SiP is a key investment in primary care designed to provide tools and training in quality improvement methodologies to primary health care teams to enable them to reduce preventable harm to patients. .

We like to think that your involvement in the programme provides you with key skills, tools and know how that will help you provide quality care to the people that come and see you every day, as well as in the focus areas covered by the programme.

Our vision is for all these improvement activities to become embedded into your 'business as usual' and for the skills and capability developed to grow throughout your organisations.

We are looking at opportunities to link in with the hospital safety programme so we can have a focus on patient safety throughout the patient journey. We want to keep improving the programme so that it remains meaningful and valuable for you so your thoughts and feedback is always welcomed. We wish to expand this programme so that all primary care teams across Auckland can be involved. So please consider talking to your colleagues who are not participating about the benefits you have experienced and encourage them to engage.

Thank you for your participation, commitment and enthusiasm for this flagship programme. It is your individual efforts towards improving patient safety that makes a difference to the patient, their families and contributes to the overall success and expansion of this vital programme.

We hope you enjoy the programme.

Tim Wood
Deputy Director Funding, Auckland and Waitematā DHBs
Safety in Practice Programme Sponsor

## Purpose of this manual

The Safety in Practice (SiP) initiative is designed to reduce preventable harm within primary care by targeting an issue of clinical concern and gaining skills through practical experience and collaborative learning.

This manual is designed to support general practice teams enrolled in the Safety in Practice programme. It provides information regarding:

- Background to the programme
- How the programme works
- The Model for Improvement tool and Breakthrough Series collaborative method of learning
- The clinical modules
- The prescribing indicators
- The safety culture tools
- Support provided by the Safety in Practice project team
- Contract and Invoicing

It is designed to be a dynamic document so please provide feedback to the project team about any areas that would benefit from alteration or expansion.

## Contact details

General enquiries: info@safetyinpractice.co.nz
Submitting data: audit@safetyinpractice.co.nz

Website: www.safetyinpractice.co.nz

# Section 1: What is Safety in Practice?

The Safety in Practice programme provides tools and training to primary health care teams to reduce preventable harm to patients. It is an adaptation of the Scottish Patient Safety Programme in Primary Care.

The programme was first introduced to the Auckland Metro region in 2014 with 23 general practices involved and has since expanded to include 68 general practices and urgent care clinics as well as 45 community pharmacies across Auckland and Waitematā DHB.

## 1.1 Why bother with patient safety?

Consultations in primary care are usually safe. The rate of adverse events (events with the possibility of causing harm to a patient) occurs in an estimated 1-2% of consultations[1]. With 13.6 million GP consultations in New Zealand in 2017 however, this adds up to a significant amount of potential harm. The volume of harm occurring in primary care may be as high as or greater than that experienced in secondary care because of the volume.

The HQSC reported in 2017 that 8% of primary care patients in NZ report being given the wrong drug or dose in the last 12 months and 45% of them had to seek help for the error. [1]

Medicine-related harm is common, occurs both in hospital and in the community, and is a substantial burden for patients and our healthcare system. These authors found that medicine-related harm identified in a hospital setting occurred at a rate of 34.7 per 100 admissions, and of these 29% originated in the community and precipitated an admission to hospital.[4]

Research from Australia shows that of the 100,000 adverse drug events recorded as causing disability each year, 40-50% of these could have been prevented.[1] Similarly in the UK, 1 in 550 prescriptions have been associated with a severe error. [2] Research from the Queens Medical Centre, Nottingham (UK) indicates that 6.5% of hospital admissions over a 6 month period are medicines-related, 67% of these were considered preventable.[3] These admissions were mainly attributed to problems with prescribing, monitoring and patient adherence.[3]

## 1.2 Aim & Objectives

| To work with Primary Health Care teams to reduce preventable patient harm from the care they receive | | | |
|---|---|---|---|
| Reduce preventable harm to patients | Create safer and more reliable systems | Promote a culture of safety | Develop quality improvement skills to improve patient care |

The aim of SiP is to work with primary healthcare teams to reduce preventable patient harm from the care they receive. In order to achieve this goal, a range of tools and resources (adapted from the Scottish Patient Safety Programme in Primary Care), alongside support from improvement and clinical experts, are provided to general practice and community pharmacy teams to foster a positive patient safety culture.

## 1.3 The Safety in Practice approach

Safety in Practice uses the IHI Model for Improvement and the Breakthrough Series methodology.

### 1.3.1 Model for Improvement

The Model for Improvement is a simple yet powerful tool for accelerating improvement in healthcare teams.

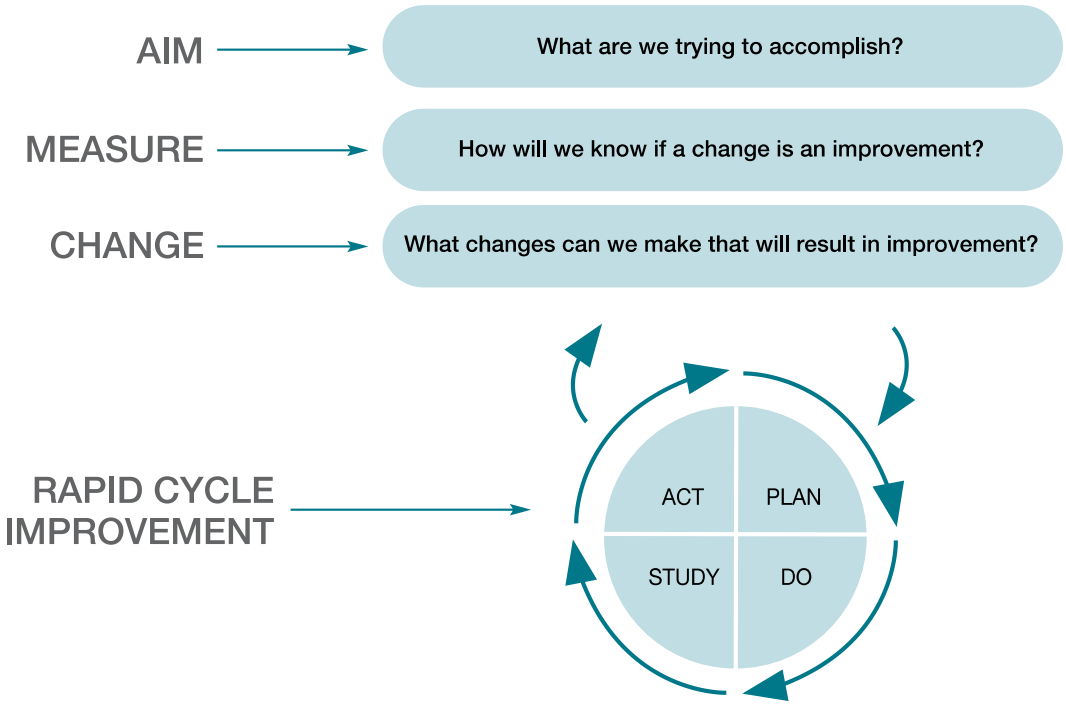


**Figure 1: IHI model for improvement**

The Model has three questions:

1. What are we trying to accomplish?
2. How will we know if a change is an improvement?
3. What changes can we make that will result in an improvement?

These questions lead us into a method of testing change, the Plan-Do-Study-Act (PDSA) cycle. This is used to test changes in real-world settings. The PDSA cycle guides the test of a change to determine if the change is an improvement. PDSA cycles enable you to test changes on a small-scale, building on the learning from these test cycles in a structured way before wholesale implementation.

Further information on the PDSA cycle is provided in each clinical module.

## 1.3.2 Breakthrough Series

A Breakthrough Series Collaborative is a short-term (six to 15 month) learning system that brings together a large number of teams from hospitals or practices to seek rapid improvement in a focused topic area.

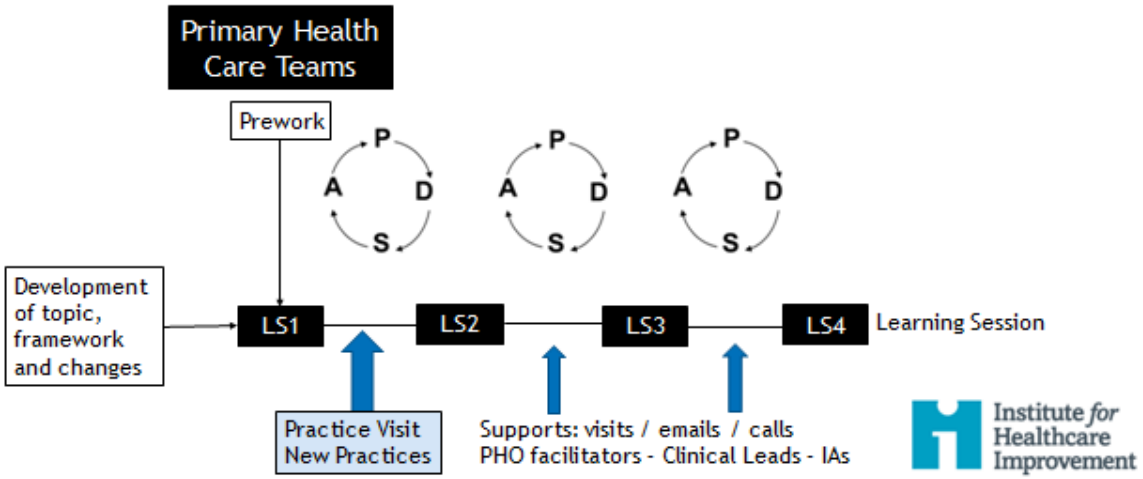


**Figure 2: The IHI Breakthrough Series methodology as applied to SiP**

Throughout the SiP year there will be four learning sessions. Each learning session is designed to teach you to use the improvement tools that you will need to complete your work in the subsequent 10-12 weeks. The different improvement tools taught over the three years of the programme are designed to provide you with the skill set to identify which tool is needed in each situation and apply it to your work. Each learning session and each year builds on previous work.

## Section 2: How does the programme work?

Safety in Practice is a three year programme.

Each year teams:

- Complete one clinical module.
- Complete one prescribing indicator module.
- Complete one safety culture tool.
- Attend quarterly evening learning sessions (should preferably comprise of a GP, a practice nurse and a senior administrator).

Practices in Year 1 complete one of the foundation clinical modules (Results Handing and Medicine Reconciliation), the NSAIDs prescribing indicator and the Safety Climate Survey or Trigger Tool as a safety culture tool. In years 2 and 3 teams can select which of the other modules, tools and prescribing indicators they wish to focus on [Figure 3].

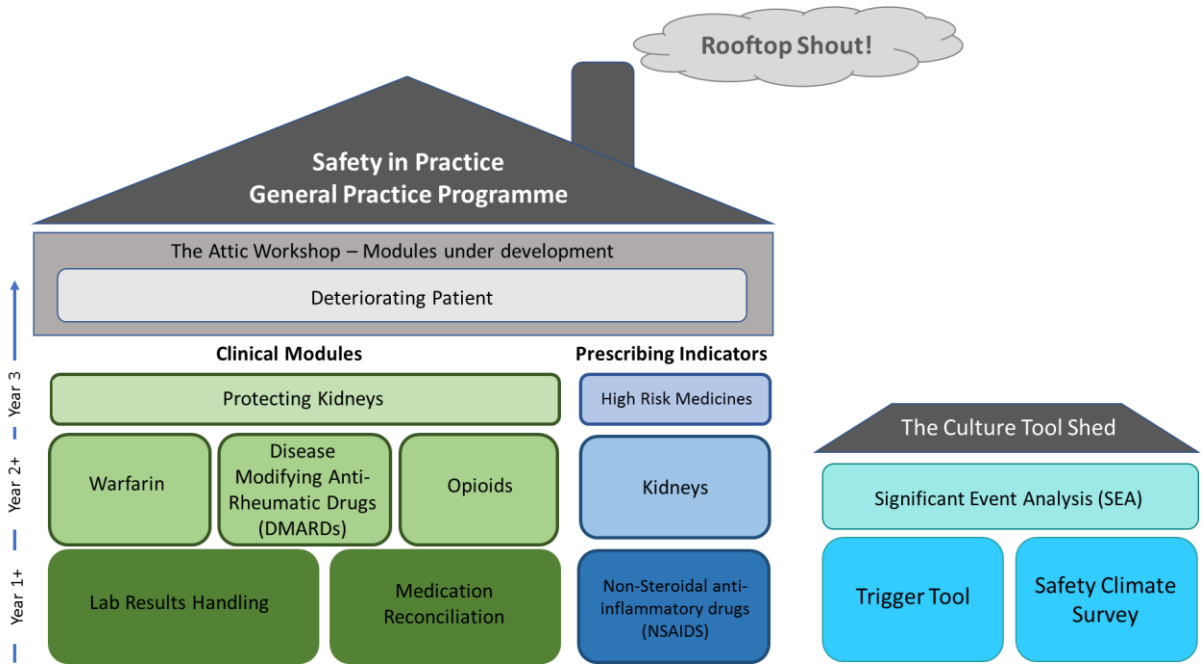


**Figure 3 Safety in Practice GP Programme**

## 2.1 Clinical Modules

Each of the areas identified as presenting the highest risk to patients within the community have been developed into clinical modules. Each month practices randomly audit 10 patients for compliance against established measures of best practice in one of the clinical areas, as outlined below. As teams enter their audit data, they can view their results and identify areas for improvement. The SiP team and your PHO can then support you to plan, implement, and evaluate changes in your practice to improve these systems.

Practices in year 1 complete one of the foundation clinical modules (Results Handing and Medicine Reconciliation). This is because these modules build core skills within the entire practice team, laying a foundation for work in year 2 and 3. In year 2 and 3 practices are welcome to complete any module, including another Foundation Module if they wish.

### 2.1.1 Medicine Reconciliation (Foundation Module)

Adverse Drug Events (ADE) are the most common post-discharge complication with 20% of patients experiencing an ADE within three weeks of discharge from the hospital.[6] According to the Institute of Medicine's 'Preventing Medication Errors' more than 40% of medicine errors are believed to result from inadequate reconciliation in handovers during admission, transfer, and discharge of patients.[7] Many of these errors could be prevented if more robust medicine reconciliation processes were in place. This clinical module helps teams develop reliable processes for ensuring medicine reconciliation occurs.

### 2.1.2 Laboratory Results Handling (Foundation Module)

The World Health Organisation identified that the rates of laboratory test follow-up globally remains sub-optimal, resulting in seriously compromised patient care, delays to treatment and poor patient experience. A lack of integrated systems to oversee the management of lab test ordering and results handling is a key contributor to the rate of error in primary care worldwide. For patients and their whānau this may contribute to avoidable harm. This module helps teams to develop robust processes to ensure all lab results are actioned within seven working days and patients are reliably and appropriately informed of their results when required.

Harm is frequently associated with medicine errors. Improvements in prescribing and management of medicines could reduce hospital admissions due to adverse drug events[8]. The medicines considered to pose the highest risk to patients in New Zealand have been developed into the following modules:

### 2.1.3 Warfarin

This module helps team develop safe and reliable prescribing and monitoring of warfarin.

### 2.1.4 Opioids

This module focuses on the safe prescribing of opioids.

### 2.1.5 Disease modifying anti-rheumatic drugs (DMARDs)

Prescribing and monitoring patients on DMARDs, particularly methotrexate and azathioprine, is risky and difficult. This module helps teams develop reliable systems for keeping patients safe while taking these medicines.

### 2.1.6 Protecting Kidneys

Medicine-induced acute kidney injury (AKI) reportedly contributes to up to 26% of cases of hospital-acquired AKI and 18% of cases of community-acquired AKI globally[12]. This module helps practices ensure that patients who are at increased risk of AKI are reliably monitored, that prescribing is appropriate to their clinical risk, and that patients have the education and understanding to actively participate in protecting their own kidneys from harm. It is also developing tools and guidance for practices to identify and manage AKI earlier.

## 2.2 Prescribing Indicator Modules

Prescribing indicator modules provides health professionals insights into their prescribing practices that are recognised as being high risk. Prescribing safety indicators have been developed and used internationally to identify patients who are at risk of harm through drug interactions or interaction between medicines and their medical condition.

In collaboration with clinical audit tool providers such as Dr Info and Mohio, practices are provided with monthly reports detailing patients who may be at risk from a selection from specific high risk prescribing practices. SiP provides suggestions for changes in practice. Practice teams decide how they want to address these within their practice environment to reduce risk of harm to patients.

### 2.2.1 Non-steroidal anti-inflammatory drugs (NSAIDs)

Non-steroidal anti-inflammatory drugs (such as naproxen, ibuprofen or diclofenac) are the most commonly implicated medicine resulting in hospital admission.[13] Adverse effects include renal damage, gastro-intestinal bleeding and worsening of pre-existing heart failure[3,4]. This prescribing indicator gives practices insights into patients who may be at increased risk of harm from these medicines.

### 2.2.2 High Risk Medicines

This indicator helps practices identify patients who are on medicines recognised to be high risk if they are not appropriately prescribed and/or monitored. Medicines of focus include sodium valproate, warfarin, methotrexate and amiodarone.

### 2.2.3 Kidneys

Damage to kidneys from medicines is a common cause of patient harm. This indicator helps practices identify patients who have been prescribed medicines which increase their risk, or which require monitoring to ensure they are used safely.

## 2.3 Safety Culture Tools

Successful, sustained improvements in patient safety within healthcare organisations need a strong, open and honest culture of safety. Globally and nationally the safety culture of an organisation is frequently cited as significantly contributing to serious events and significant patient harm.

The programme has identified a series of tools to help teams measure and improve their safety culture. The report generated from these tools provides an opportunity for teams to meet and discuss openly how they can improve their systems, team safety culture, and allows issues to be raised and prioritised for action.

### 2.3.1 Safety Climate Survey (SCS)

The Safety Climate Survey comprises 5 subject areas (Communication, Workload, Leadership, Teamwork and Safety Systems & Learning) with 4 to 8 questions for each area. All staff are encouraged to complete an anonymised survey, the results are analysed by the SiP team and returned to the practice to assess opportunities for improvement.

### 2.3.2 Trigger Tool

A simple checklist used as markers to identify patient records where harm is more likely to have occurred. This facilitates structured, focused and rapid review of higher risk medical records by primary care clinicians in order to identify potential harm that may otherwise go unidentified.

### 2.3.3 Significant Event Analysis (SEA)

A technique used to reflect on individual patient safety incidents to identify areas for improving the quality of care overall. Significant event audits form part of individual and practice-based learning and quality improvement.

## 2.4 Learning Sessions

Once teams have chosen an area of focus they will send 2 to 3 Patient Safety champions from their team to attend learning sessions. Sessions are designed to be collaborative, bringing together safety champions from each enrolled primary care team to learn about quality improvement and facilitate sharing of knowledge and experiences. This method of collaborative learning has been widely demonstrated as an effective method of accelerating change within primary care.

Learning sessions are held in August, November, March and June. The August Learning session is only a requirement for new teams, not for returning teams. Some of these sessions may be offered via zoom instead.

The purpose of the learning sessions is to:

- Develop skills and capabilities in quality improvement methodologies and processes – see diagram below.
- Share experiences and learn from other programme participants.
- Emphasise the importance of safety in patient care.
- Share successes to encourage continued engagement and participation in the programme.
- Learning session one is a quality improvement workshop to give you the skills you need to take part in the programme.

## 2.5 Practice Visits

In order to support teams in the programme we offer new practices a visit from a Safety in Practice clinical lead, improvement advisor and/or PHO facilitator.

## 2.6 Contact Details

General enquiries: info@safetyinpractice.co.nz
Submitting data: audit@safetyinpractice.co.nz

## 2.7 Contracts & Invoicing

### 2.7.1 Contracts

When joining the safety in Practice programme you will need to sign a contract outlining the key deliverables of the programme for which you will be remunerated. These contracts are developed by the Ministry of Health. In order to generate this contract the SiP team needs to enter your organisations details into the MoH system.

To do this we need the following from you:

- A completed and signed PerOrg form (located in your welcome pack)
- A copy of your bank deposit slip
- A certificate of incorporation

**NOTE**

Please ensure the trading name on all three documents match up, particularly the bank deposit slip and the name on the PerOrg form. If this is not the case we will require a letter from the bank confirming the bank account details are associated with the organisation in question.

### 2.7.2 Invoicing

Invoices must be submitted on the SiP invoice template. This can be found on the SiP website. Invoices should be submitted and paid according to the schedule below:

| Payment period | Invoice Amount | Submission Date | Payment condition 1 | Payment condition 2 |
|---|---|---|---|---|
| July 2020 – June 2021 | $5,400 excl. GST | 30th June 2021 | **FIRST YEAR TEAMS:**<br>Attendance to Learning session 1 – Quality Improvement Skills Workshop (Usually in August/September).<br><br>**ALL TEAMS:**<br>Attendance to Learning session 2 (Usually in November)<br><br>Attendance to Learning session 3 (Usually in March)<br><br>Attendance to Learning session 4<br>(Usually in June) | Audit data received for:<br>August – submitted in September<br>September – submitted in October<br>October – submitted in November<br>November – submitted in December<br>December - submitted in January<br>January - submitted in February<br>February - submitted in March<br>March - submitted in April<br>April - submitted in May<br>May - submitted in June |

**Please Note:** The DHBs will conduct annual audits and final payments may be withheld if these deliverables are found to not be met.

**Where to send your invoice:**

**Email:** providerinvoices@health.govt.nz
**Cc:** info@safetyinpractice.co.nz

**Post:** Provider Payments
Ministry of Health
Private Bag 1942
Dunedin
9054

Any queries please contact info@safetyinpractice.co.nz

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