

Patient safety in primary care: more data and more action needed

A better understanding of patient safety threats and incidents is needed to inform preventive action

Although most health care services are delivered in the community-based primary care sector, little is known about medical errors and near misses (here referred to as patient safety threats) and the consequent adverse events and harms (here referred to as patient safety incidents) in primary care. In Australia, research and data on patient safety comes almost exclusively from the hospital sector. The common assumption is that the problem is at least as common in primary care as in other areas of medical practice, but there is currently no mechanism to capture and analyse national data. A better understanding of patient safety threats and incidents in primary care is needed, along with resources to enable preventive action.

In Australia, little is known of patient risks of harm in primary care, and the few studies that have been done in this area are dated. Given the size of the sector, the diversity of providers, the frequency with which people access services, and the central role of primary care in the system, it is essential that the quality and safety of primary care are continuously improved and efforts made to prevent patient safety incidents. However, there is currently no mechanism to capture and analyse national data, and there is no agreed taxonomy to underpin effective incident monitoring; although as far back as 1997, Britt and colleagues developed a taxonomy and showed that an incident monitoring process could be successfully applied in general practice.¹

Most research is based on surveys and questionnaires of general practitioners. The overall incidence of GP-reported errors has been estimated at about one per 1000 Medicare services and two for every 1000 patients seen by a GP.² In 1998, Bhasale and colleagues used an incident monitoring approach to show that 76% of GP errors were preventable and 27% had the potential for severe harm.³ Fifty-one per cent of incidents related to pharmacological management, and the biggest contributory factor was poor communication. Despite the fact that diagnostic uncertainty is a key feature of general practice, most of the errors reported in this study were generated by basic oversights rather than uncertainty: failure to review the patient's history, or abnormal test results missed or not acted on.

A literature review prepared in 2009 for the Australian Commission on Safety and Quality in Health Care (ACSQHC)⁴ showed numerous and substantial gaps in current knowledge about threats and incidents that present a risk to patients in primary care, with most of this information relating to general practice and pharmacy. The gaps are even more serious when it



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comes to knowledge of interventions and strategies to improve patient safety in primary care, and the review found a lack of rigour in the research in this field.

The three most common factors thought to contribute to harm in primary care are clinical complexity, human factors and systems causes;⁵ and they are not mutually exclusive.

Human factors in the clinical setting are about "enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge".⁶ Put another way, "human factors are all the things that make us different from logical, completely predictable machines. In simple terms they are all those things that enhance or reduce human performance in the workplace".⁶ Understanding human factors is an important aspect of understanding the causes of patient safety threats and incidents and preventing them.

"Australia's lack of system-wide reporting on patient safety is a black hole that means there are no data and no contextual information for patient safety improvements"

Challenges related to clinical complexity include managing multiple conditions and multiple medications. As the prevalence of multimorbidity is high and increases with age, this is a growing problem for primary care.⁷ Studies to improve the management of these patients have focused on quality of care rather than safety and error prevention. Calls have been made to adapt guidelines to take account of multimorbidity⁸ and to make better use of electronic prescribing and medication reviews when multiple medications are involved.⁵

System causes that contribute to patient safety threats and incidents include a lack of coordination, including between primary and secondary and tertiary care sectors; cost-cutting measures; and environmental and design factors. For example, the transition from community to hospital and back into the community has been associated with duplications and omissions of tests and treatments, prescribing errors and adverse events.⁹

Adverse drug events (ADEs) constitute the most important subset of patient safety incidents in general practice, and one study has shown that 7.6% of ADEs result in hospitalisation.¹⁰ In older patients, ADEs resulting from commonly prescribed drugs at

therapeutic dosages are frequent and are associated with morbidity.¹¹ In Australia, it is not mandatory to report adverse drug events, so the true size of the problem remains unknown. The Royal Australasian College of Physicians, in its 2013–14 Budget submission, has called for making reporting of ADEs compulsory, but at the same time has requested reimbursement for physicians doing this.

Despite the potential size and impact of this problem, there is a conspicuous lack of information about what works in this area. A comprehensive review undertaken in 2009 found that neither community-based, pharmacist-led interventions (including medication reviews) nor primary care physician education programs were effective in reducing hospitalisation for ADEs.¹² Another article concluded that “deprescribing in older persons likely results in reduced medication usage and cost and is unlikely to cause harm to patients”, but there is a “lack of high-quality, long-term, prospective evidence to show that deprescribing results in clinically meaningful outcomes”.¹³

These complex patient safety problems require solutions across the whole health care system and not just a focus on acute care or general practice. In particular, there must be a greater focus on patient safety in allied health areas.

The one constant in all of these patient safety concerns is the patient. Putting patients at the centre of health care also means putting them — and their carers — at the centre of questions around quality and safety, reporting and management. Patients have a key role to play in helping to identify safety incidents and taking appropriate action to prevent them,¹⁴ but this is rarely done. Where such work has been undertaken, it shows divergences in views about what is important.

Interviews with primary care patients suggest that breakdowns in access to and relationships with clinicians may be more substantial than technical errors in diagnosis and treatment.¹⁵ Patients were more likely to report being harmed psychologically and emotionally, suggesting that the current preoccupation of the patient safety movement with adverse drug events and surgical mishaps could overlook other patient priorities. Problems such as failure to get a timely appointment, a busy doctor who does not take the time to adequately explain and educate, even perceived racism, can have harmful consequences and show that patient dissatisfaction and poor-quality care share common origins. They also highlight that a focus on technical errors is insufficient to ensure patient safety.

The goal of quality and safety initiatives is to reduce harm, and the stories that patients tell of their view of deficiencies in the system highlight system design flaws that are amenable to analysis and change. Harmful adverse events have consequences that linger. One study found that nearly a third of patients who reported adverse events causing harm also reported long-term or

permanent emotional effects, and over 20% described long-term physical consequences.¹⁶

This poses an awkward problem for GPs: the high levels of trust that Australians have in their GPs are translated into their positive attitudes to GPs’ role in patient safety. When adverse events occur, especially if the incident is not managed well, patients may experience considerable psychological trauma. Unintended adverse events can be confronting, even for experienced and skilled GPs, and patients who are harmed often experience the incident as a violation of trust and lose confidence in their GP and practice.

For now, Australia’s lack of system-wide reporting on patient safety is a black hole that means there are no data and no contextual information for patient safety improvements. The work done in this regard by the ACSQHC in 2009–2011 appears to have ceased with the publication of the Patient Safety in Primary Health Care — Consultation Report July 2011.¹⁷ This report called for work to be undertaken to ensure the development of a nationally coordinated, systematic and effective means of reporting errors and near misses in primary health care, based on an agreed set of safety measures. But it also chose to highlight the Australian Medical Association’s contrarian view, “Our view is that the organisation of primary care in Australia is in for such a shake up over the next two or three years that it is the worst time to be contemplating some sort of safety intervention or initiative”.¹⁷

That was a very prescient statement, given the changes proposed by the Australian Government with respect to the replacement of Medicare Locals with Primary Health Networks (PHNs). But quality and safety are too important to put aside any longer, and efforts must be made to advance the admirable but false start made in primary care. Quality and safety must be an integral aspect of the new PHNs and they can be further advanced by practice-based research networks and a primary care patient safety collaborative.

If Australia is to regain the momentum to improve patient safety in primary care, there needs to be:

- recognition that patient safety incidents in primary care matter;
- national data collection to evaluate the full extent of the harms caused;
- a concerted research effort to better understand the problems and their causes; and
- collaboration across jurisdictional and professional boundaries to implement improvements.

There needs to be action at every level of the health system and policy initiatives and resources to drive this. The role of the patient needs to be central and that of general practice paramount, and an opportunity needs to be provided for primary care networks to take the lead.

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