



Patient Safety

One in a series of curriculum statements produced by the Royal College of General Practitioners:

- 1 Being a General Practitioner**
- 2 The General Practice Consultation**
- 3 Personal and Professional Responsibilities**
 - 3.1 Clinical Governance
 - 3.2 Patient Safety
 - 3.3 Clinical Ethics and Values-Based Practice
 - 3.4 Promoting Equality and Valuing Diversity
 - 3.5 Evidence-Based Practice
 - 3.6 Research and Academic Activity
 - 3.7 Teaching, Mentoring and Clinical Supervision
- 4 Management**
 - 4.1 Management in Primary Care
 - 4.2 Information Management and Technology
- 5 Healthy People: promoting health and preventing disease**
- 6 Genetics in Primary Care**
- 7 Care of Acutely Ill People**
- 8 Care of Children and Young People**
- 9 Care of Older Adults**
- 10 Gender-Specific Health Issues**
 - 10.1 Women's Health
 - 10.2 Men's Health
- 11 Sexual Health**
- 12 Care of People with Cancer & Palliative Care**
- 13 Care of People with Mental Health Problems**
- 14 Care of People with Learning Disabilities**
- 15 Clinical Management**
 - 15.1 Cardiovascular Problems
 - 15.2 Digestive Problems
 - 15.3 Drug and Alcohol Problems
 - 15.4 ENT and Facial Problems
 - 15.5 Eye Problems
 - 15.6 Metabolic Problems
 - 15.7 Neurological Problems
 - 15.8 Respiratory Problems
 - 15.9 Rheumatology and Conditions of the Musculoskeletal System (including Trauma)
 - 15.10 Skin Problems

Contents

Acknowledgements 5

Key messages 5

Introduction 6

Rationale for this curriculum statement 6

UK health priorities 6

Learning Outcomes 7

Primary care management 7

Person-centred care 7

Specific problem-solving skills 8

A comprehensive approach 8

Community orientation 8

A holistic approach 8

Contextual aspects 9

Attitudinal aspects 9

Scientific aspects 9

Further Reading 10

Examples of relevant texts 10

Web resources 10

Promoting Learning about Patient Safety 12

Work-based learning – in primary care 12

Work-based learning – in secondary care 12

Non-work-based learning 12

Learning with other healthcare professionals 12

References 13

Acknowledgements

This RCGP curriculum statement on patient safety was developed in partnership with the National Patient Safety Agency (NPSA). It has drawn on various national guidelines and policies, current research evidence and the clinical experience of practising general practitioners. The Royal College of General Practitioners would like to express its thanks to these individuals.

Authors: Dr Maureen Baker & Dr Christine Johnson

Contributors: Dr Amar Rughani, NPSA

Editors: Dr Mike Deighan & Professor Steve Field

Guardian: Dr Maureen Baker

Created: December 2005

Date of this update: June 2011

Version number: 1.2

Previous versions: 1.0 issued January 2006, corrected and re-issued February 2007; 1.1 issued February 2009

Key messages

- Patient safety concerns everyone in the NHS, and is equally important for general practitioners whether working as an independent contractor or for a Primary Care Organisation.
- Tackling patient safety collectively and in a systematic way can have a positive impact on the quality and efficiency of patient care.
- Safety in health care is a relatively young field internationally and, as such, it will be some time before we understand its full potential. It is likely that further training throughout a doctor's career will be required.
- General practitioners are well placed to be active members of the healthcare team and positively influence the safety culture within the practice and the development of the practice as a learning organisation.
- The knowledge and application of risk assessment tools must become part of general practitioners' skills and, whatever change occurs in their environment, they should assess the effects of change and plan accordingly.

Introduction

Rationale for this curriculum statement

The Department of Health publication *An Organisation with a Memory*¹ mobilised the patient safety movement in the NHS. It drew attention to the scale and pattern of potentially avoidable patient safety incidents and the devastating consequences these can have on patients, their family and the healthcare staff involved. (A patient safety incident (PSI) is defined as any unintended or unexpected incident that could have or did lead to harm to one or more patients receiving NHS-funded care.)²

This report also acknowledged that there has been little systematic learning from PSIs. It proposed solutions based on developing a culture of openness, reporting and safety consciousness. One of the key areas identified was ‘A much wider appreciation of the value of the systems approach in preventing, analysing and learning from patient safety incidents.’²

*Building a Safer NHS for Patients*³ required the NHS to establish agreed definitions of incidents for the purposes of reporting and recommended the establishment of the National Patient Safety Agency to instigate a national (England and Wales) system for reporting, and learning from, patient safety incidents.

The National Audit Office Report (*A Safer Place for Patients: learning to improve patient safety*, November 2005)⁴ acknowledges that 90% of patient contact with the NHS is in primary care services. It particularly identifies the need for progress in enhancing organisational learning and reporting to improve patient safety at both local and national level. The report states that it ‘is imperative that patient safety becomes a core part of professional training, including helping clinical staff understand their responsibility for patient safety’. It also recommends that the Department of Health needs to build on its work with the Royal Colleges to better embed patient safety training in curricula. Lastly, the need to engage with patients in identifying patient safety issues and designing solutions is emphasised.

Doctors are already familiar with the precepts upon which patient safety is based sometimes described as the ‘circle of safety’ built upon the audit cycle. This is then framed within a new culture that requires a deeper understanding and respect for the patient’s agenda coupled with the communication skills, teamworking and self-awareness to put patient safety into action.

UK health priorities

Huge numbers of people are treated and cared for in British general practice every working day and safety incidents of both clinical and non-clinical types occur. In primary care, medication errors are particularly important. For example, every day almost 1 million people visit their GP; 1.5 million prescriptions are dispensed (650 million prescriptions per year). Amongst all this complex activity things sometimes go wrong and patients are harmed as a result. With the volume of patients involved, this means that the number of PSIs from general practice is considerable. When patients move between primary and secondary care the potential for patient safety problems increases.

Studies have also shown that the best way of reducing error rates is to target the underlying systems failures, rather than take action against individual members of staff.

Learning Outcomes

The following learning objectives relate specifically to patient safety. This RCGP curriculum statement should be used in conjunction with the core curriculum statement 1, *Being a General Practitioner*, and the other clinically orientated statements. Specialty registrars (GP) should achieve these learning objectives during their GP training programme.

Primary care management

- Participate in meetings run by the practice that illustrate how a practice can start to build and enhance a safety culture.
- Describe how organisations and individuals can learn to be vigilant for PSIs.
- Know how organisations and individuals can learn to improve systems by analysing patient safety incidents and near misses
- Describe how the analysis of patient safety incidents can enhance rather than undermine professional integrity and performance
- Contribute to the regular significant event audit (SEA) meetings and observe the benefits of a multidisciplinary team.
- Be aware of the existing training tools available for SEAs from the defence associations^{5,6} and NPSA.⁷
- Participate in and write up an SEA from a patient seen during the general practice period of training.
- Reflect on the learning and consider whether reporting locally or nationally would be appropriate.
- Demonstrate the measures that the organisation takes to ensure that reports are dealt with fairly and that the appropriate learning and action takes place.
- Describe the elements that contribute to an appropriate infrastructure for risk management, such as: the essential features of a practice that create a culture that is open and fair; policies that commit the organisation to being open about serious incidents that involve permanent harm or death; policies that state the actions that staff should take following an incident; individual roles and accountability; the mechanism of investigation; support that should be given to patients, family and staff; staff training.
- Describe how changes in the IT structure of the NHS will impact upon the possibility for both reducing and increasing the chance of PSIs.

Person-centred care

- Communicate openly, listen and take patients' concerns seriously. Consider patient issues when reflecting on consultation experiences.
- Be aware of current clinical governance guidelines that impact on patient safety within a practice.
- Be prepared to consider the *Being Open Policy*⁸ as advised by the NPSA when a PSI has occurred or could have potentially occurred.

- Tell patients and their families as soon as possible when incidents occur and do so fully, honestly and compassionately.

Specific problem-solving skills

- List and identify the systems and processes that are in place in practices to manage risk in a primary care setting and compare these with colleagues in other practices.
- Know how to assess the organisation's reporting and learning culture.
- Demonstrate awareness of evidence-based tools to identify and assess risk. Give examples, from a personal educational portfolio throughout your current training, that show an understanding of the benefits and disadvantages of such tools.^{2,5}
- Describe the criteria for when the organisation should undertake a root cause analysis or significant event audit. These criteria should include all incidents that have led to permanent harm or death.
- Demonstrate an awareness of the limitations of your own skills in risk management and illustrate that you understand when the skills of colleagues trained more extensively in risk management should be called upon.

A comprehensive approach

- Demonstrate an awareness of the all-encompassing approach to patient safety; for example, by keeping a log diary of consecutive consultations for at least one day per month and comment on any actual or potential PSIs within those consultations.
- Describe the risks to patient safety by considering an illness pathway/journey in which a variety of health-care professionals have been involved. In particular, to reflect on the interface issues arising from the current multitude of such providers and be able to comment on the ways in which, as a GP, you can work to minimise these.⁹
- Describe the structures and processes for managing clinical and non-clinical risk, and how these are integrated with patient and staff safety, complaints, clinical negligence and financial and environmental risk.

Community orientation

- Demonstrate the ability to involve and communicate with patients and the public by practising the *Being Open* approach.⁸
- Be able to make contact with the local patient representative body (Healthwatch or equivalent) and be aware of the current pattern of patient comments.
- Describe the ways in which general practice and community pharmacy can minimise the potential for PSIs.
- Describe how patient groups may be put at increased risk of mishap by virtue of their particular characteristics, such as language, literacy, culture and health beliefs. The latter may be manifest through the patient's ability and willingness to work in partnership with the doctor in the management of the problem.
- Illustrate an awareness of the potential benefits for patient safety of good working relationships with colleagues from longstanding community services.
- Describe any new roles that have emerged in the community setting (e.g. community matrons) and give examples of how these new roles have impacted on patient safety.¹⁰

A holistic approach

- Describe how the lessons of patient safety can be applied prospectively to doctor–patient interactions, especially through the identification and discussion of risk.
- Describe the local clinical governance arrangements.¹¹
- Describe and show usage of the various options for reporting PSIs both locally and nationally.¹

- Comment on the participation of whole teams in significant event audit² within the practice and give reasons for inclusion or exclusion of different team members.
- If relevant to the training practice, help facilitate the implementation of solutions to prevent harm, by embedding any lessons learnt in the practice processes and systems.
- Describe how to share lessons from the analysis of PSIs within the team.
- Identify which other elements of patient services may be affected in future and share learning more widely on the basis of this.

Contextual aspects

- Identify how, as a specialty registrar (GP) within the team environment of general practice, his or her experiences gained in undergraduate and early postgraduate education can be shared with colleagues. Recognise that the formal Patient Safety Agenda¹ is relatively recent and still changing so may be unfamiliar to well-established colleagues in primary care.
- Describe the impact of the working environment on the care the doctor provides and the likelihood of adverse incidents as a result of this.
- Comment on the use of situational awareness theories.ⁱ

Attitudinal aspects

- Demonstrate a preparedness to admit when an error has occurred, apologise for failings in the delivery of care and to communicate this openly to patients and their families, reassuring them that the appropriate lessons have been learned.⁸
- Discuss examples that describe a clear appreciation of how a change in the behaviour and/or systems can influence patient safety.
- Describe experiences gained from discussing with colleagues in different practices how high-quality multi-professional working can benefit patient safety. Consider the steps needed to facilitate such co-working.²
- Help to shape an organisational culture that prioritises safety and quality through openness, honesty, shared learning and continual incremental improvement.

Scientific aspects

- Describe the tools that can be applied in risk management and patient safety issues accessible from sites such as medical indemnity sites.^{5,6}
- Describe the basic principles of human error.^{12,13}
- Describe the basic principles of risk assessment.²
- Demonstrate how to compile a simple risk matrix.²

ⁱ For example, 'the three bucket model' proposed by James Reason (www.npsa.nhs.uk) where each bucket is variably filled according to the context, the domestic feelings of the doctor and the complexity of the task.

Further Reading

Examples of relevant texts

Seven Steps to Patient Safety for Primary Care. The full reference guide (September 2005) is available at www.npsa.nhs.uk or call 08701 555455.

Web resources

General Medical Council

Principles of Prescribing; Who can prescribe; Prescribing safely; Guidance on prescribing medicines; Special Circumstances; Unlicensed medicines; Off licence medicines; Information for patients on licensing of medicines; Responsibility for prescribing for outpatients; Issuing repeat prescriptions; Remote prescribing by internet or telephone; Working in private clinics; Other sources of guidance on Prescribing.
www.gmc-uk.org/guidance/current/library/prescriptions_faqs.asp#p1

The Care Quality Commission

The Care Quality Commission is an independent body, set up to regulate care provided by the NHS, local authorities, private companies and voluntary organisations.
www.cqc.org.uk

NHS Evidence

This is a service that enables access to authoritative clinical and non-clinical evidence and best practice through a web-based portal. It helps people from across the NHS, public health and social care sectors to make better decisions as a result. NHS Evidence is managed by the National Institute for Health and Clinical Excellence (NICE).
www.evidence.nhs.uk

The National Patient Safety Agency

The National Patient Safety Agency (NPSA) aims to improve the safety and quality of care through reporting, analysing and learning from adverse incidents and ‘near misses’ involving NHS patients.
www.npsa.nhs.uk

Seven Steps to Patient Safety in Primary Care lists actions that primary care organisations, staff and teams can take to improve patient safety locally and help meet their clinical governance targets.
www.npsa.nhs.uk

The National Prescribing Centre

The National Prescribing Centre is a health service organisation, formed in April 1996 by the Department of Health. Its aim is to 'promote and support high quality, cost-effective prescribing and medicines management across the NHS, to help improve patient care and service delivery'.

www.npc.co.uk

Promoting Learning about Patient Safety

Work-based learning – in primary care

Being part of a multidisciplinary team is a particular feature of primary care. Understanding the influence of being a doctor in that team and the effect on the culture and systems within the practice is important. It is also useful to observe and be aware of the differing levels of influence arising from the different roles such as partner, sessional doctor and locum.

Experience of seeing significant event audit as a tool for reflection and celebration of good care as well as a method to look at patient safety incidents is a particular feature of primary care teams.

The observation of systems developed by each practice to manage its repeat prescribing system and decisions about how much risk to ‘tolerate’ in this process and how changes over time have been influenced by the National Prescribing Centre guidance and is unique to primary care.

Likewise, understanding the processes that occur during a consultation when a decision to seek advice from a referral is considered, as well as the practical systems in place to achieve it, are ideally explored within the primary care setting. Reflecting on cases that illustrate a delay in diagnosis using tools such as SEA can help understanding of the complex process of diagnosis both within the primary and secondary care setting.

Work-based learning – in secondary care

The clinical governance and risk management structures are different in secondary care. Understanding this is important to fully appreciate how to maximise the benefits for patients.

Root Cause Analysis (RCA) is the standard risk tool used in secondary care and familiarity with its application can be best observed in this setting. Likewise the particular role of risk managers in secondary care trusts is best appreciated in this environment.

The primary/secondary care interface is especially vulnerable to patient safety events. Observing and understanding how different systems and processes influence this can particularly be appreciated during a secondary care-based experience.

Non-work-based learning

There are many web-based sites that offer educational modules in patient safety (see above) as well as providing access to relevant tools such as the NPSA tools IPSEL (Induction to Patient Safety e-Learning), RCA toolkit and the *Incident Decision Tree*. In addition, there is the DH vincristine video or the *Delivering Patient Safety* DVDs.

Learning with other healthcare professionals

Primary care teams are highly sophisticated multiprofessional groups. The opportunity to participate in shared learning with such colleagues has particularly expanded given the extended roles seen following the pharmacy contract of 2005 and the extension of non-medical prescribing and the emergence of colleagues working with long-term conditions, such as community matrons, nurse practitioners and medical care practitioners.

The variety of models for out-of-hours delivery of care has also facilitated many opportunities for shared

learning with emergency care practitioners, paramedics, accident and emergency units, crisis mental health teams and walk-in centres.

References

- 1 DEPARTMENT OF HEALTH. *An Organisation with a Memory* London: The Stationery Office, 2000
- 2 NATIONAL PATIENT SAFETY AGENCY. *Seven Steps to Patient Safety for Primary Care* London: NPSA, 2005
- 3 DEPARTMENT OF HEALTH. *Building a Safer NHS for Patients* London: Department of Health, 2001
- 4 NATIONAL AUDIT OFFICE REPORT. *A Safer Place for Patients: learning to improve patient safety* London: The Stationery Office, 2005
- 5 MEDICAL DEFENCE UNION, www.the-mdu.com/section_GPs_and_primary_care_professionals/index.asp [accessed January 2007]
- 6 MEDICAL PROTECTION SOCIETY, www.mps-riskconsulting.com/content/default.asp?page=s6_1_12 [accessed January 2007]
- 7 NATIONAL PATIENT SAFETY AGENCY, www.npsa.nhs.uk
- 8 NATIONAL PATIENT SAFETY AGENCY. *Being Open Policy*, 2005, www.npsa.nhs.uk [accessed January 2007]
- 9 DEPARTMENT OF HEALTH. *Commissioning a Patient Led NHS* London: DH, 2005
- 10 DEPARTMENT OF HEALTH. Community matron policy in *Department of Health NHS Improvement Plan 2004: putting people at the heart of public services* London: DH, 2004
- 11 DEPARTMENT OF HEALTH. *A First Class Service: quality in the new NHS* London: The Stationery Office, 1998
- 12 REASON J (ed.). *Human Error* Cambridge: Cambridge University Press, 1990
- 13 REASON J. Human Error: models and management *BMJ* 2000; 320(7237): 768–70