Maximising harm reduction in early general practice specialist training (GPST): development of a preliminary checklist

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Introduction and Aim

- Knowledge of the scale and nature of harm in primary care is limited, but there is growing evidence that patient safety is a problem issue 1-2.
- In the general practice specialist training environment examples of the key threats to patient safety can include:
  - failures of, or inadequate, clinical supervision;
  - lack of joint review of the management of complex clinical cases;
  - limited feedback on drug prescribing performance;
  - poorly developed attitudes and behaviour continuing unchecked e.g. lack of insight;
  - trainees possessing different levels of clinical knowledge;
  - inability to prioritise clinical workloads and manage time;
  - variable quality of the learning environment in which trainees' work
  - doctors-in-training are known to be susceptible to medical error.
- There is some evidence that routine adherence to the use of safety checklists can improve reliability of healthcare tasks and mitigate risks 3-4.
- Against this background and given the scale and complexity of specialist training provision, we aimed to identify and prioritise the most safety-critical issues to be addressed by GP Supervisors in early GPST
- In doing this we can help maximize opportunities to address safety-critical issues proactively via a checklist reminder, which may lead to a reduced risk of patients being unintentionally harmed during and beyond the training period.

Methods

To achieve our aim we:

1. Undertook a rapid review of the literature in May 2010 to identify the key threats to patient safety in primary care.
2. We used the information collated to generate a small number of safety-critical themes and related items of potential relevance to GPST.
3. These were reviewed, added to, and refined by 72 NHS Lothian GP supervisors in 3 educational workshops lasting 90 minutes each.
4. Further refinement of the generated themes and items using a modified Delphi process was undertaken with six highly experienced west of Scotland GPST course organisers.

Results

We have thus far identified 15 safety-critical domains and 55 related items to be potentially prioritised and addressed by GP supervisors during the initial training period (see boxes 1-15).

Discussion and Next Steps

- We have developed a preliminary checklist for GP Supervisors to assist them in prioritizing and addressing essential safety-critical issues during the early period of specialist training in general practice.
- At a basic level, the domains and related items generated thus far have the potential to be used by GP Supervisors and Practice Managers to modernize existing Induction Packs, or help develop new Induction processes

We aim to further develop this work in the next 3 months through:

- Further refinement of the checklist in planned Educational Workshops with GPST Programme Directors and GP Supervisors with an interest in patient safety
- Triangulation of findings using planned Educational Workshops and Semi-Structured Interviews with Specialist Trainees who have recently completed the initial 4-month period of training in general medical practice.
- Expert content validation of the checklist using a modified Delphi technique
- Frontline testing of the feasibility and impact of the safety-checklist with a number of territorial GP training groups in the west and east of Scotland

1. PRESCRIBING SAFELY

1.1	HIGH RISK MEDICATION KNOWLEDGE (e.g. NSAID & Warfarin; Methotrexate Prescribing)
1.2	CONTROLLED DRUGS (e.g. knowledge of storage, dosage adjustment, format of prescription)
1.3	AWARENESS OF HEALTH BOARD/FORMULARLY PRESCRIBING GUIDANCE
1.4	KNOWLEDGE OF PRACTICE REPEAT PRESCRIBING SYSTEM
1.5	RISKS ASSOCIATED WITH SIGNING REPEAT & SPEACIAL REQUESTS WITHOUT CONSULTING RECORDS
1.6	MONITORING DRUG SIDE EFFECTS (e.g. myalgia with statins)
1.7	PATIENT MANIPULATION OF DOCTOR (e.g. drug misuser)

2. DEALING WITH MEDICAL EMERGENCY

2.1	ENSURING ADEQUATE EMERGENCY TREATMENT KNOWLEDGE
2.2	C.P.R. KNOWLEDGE & SKILLS
2.3	SURGERY EMERGENCY BAG/TRAY & EQUIPMENT
2.4	CONTENTS OF OWN MEDICINE BAG (WHERE APPROPRIATE)
2.5	USE OF EMERGENCY AMBULANCE SERVICE
2.6	OTHER EMERGECNY CONTACTS (e.g. Police, SWD, Ambulance)

3. SPECIFIC CLINICAL MANAGEMENT

3.1	RECOGNISING & ACTING ON RED FLAGS FOR SERIOUS ILLNESS (e.g. needs immediate admission/ urgent outpatient referral)
3.2	KNOWLEDGE OF GUIDELINES FOR ACUTE CLINICAL CARE (e.g. BTS Guidelines for Asthma)

4. DEALING EFFECTIVELY WITH RESULTS

4.1	NEED TO FOLLOW-UP & ACT ON RESULTS & HOSPITAL LETTERS
4.2	KNOWLEDGE OF PRACTICE SYSTEM FOR RESULTS HANDLING

5. PATIENT REFERRALS

5.1	NEED FOR REFERRAL (i.e. recognition of condition requiring further investigation and/or treatment)
5.2	REFERRAL SYSTEM (e.g. how and when to refer 'urgently' and 'routinely')
5.3	CLINICAL APPROPRIATENESS OF REFERRAL (e.g. ensure correct clinical priority and correct specialty)
5.4	QUALITY OF REFERRAL LETTER (e.g. past medical history, medication status, social circumstances)

6. EFFECTIVE & SAFE COMMUNICATION

6.1	KNOWLEDGE OF INTERNAL COMMUNICATION PROCESSES WITHIN PRACTICE (e.g. e-mail, message systems, practice meetings)
6.2	HOW TO LIAISE WITH AND DELEGATE TO TEAM MEMBERS: WHO, PURPOSE, HOW, WHERE, WHEN?
6.3	LIASING WITH OUTSIDE AGENCIES (e.g. SWD, Police)
6.4	SAFE COMMUNICATION WITH PATIENTS & RELATIVES (e.g. Consultations, phone calls and letters)

7. CONSULTING SAFELY

7.1	HOW TO SAFETY NET IN THE FOLLOWING CONSULTING SITUATIONS: - Face-to-face - Telephone advice - Triage
7.2	HOW TO DEAL WITH UNSCHEDULED PATIENTS
7.3	AWARENESS OF GUIDELINES FOR USE OF CHAPERONES

8. ENSURING CONFIDENTIALITY

8.1	AVOIDING BREACHES OF CONFIDENTIALITY
8.2	APPROPRIATE DISCLOSURE OF MEDICAL & PERSONAL INFORMATION

9. AWARENESS OF THE IMPLICATIONS OF POOR RECORD-KEEPING

9.1	FAILING TO KEEP RECORDS
9.2	FAILING TO KEEP ACCURATE RECORDS
9.3	FAILING TO CONFIRM PATIENT IDENTITY
9.4	FAILING TO DOCUMENT ALL PATIENT CONTACTS
9.5	KNOWLEDGE OF RELATED LEGAL ISSUES

10. RAISING AWARENESS OF PERSONAL RESPONSIBILITY

10.1	ACCOUNTABILITY FOR OWN PROFESSIONAL BEHAVIOUR
10.2	RECOGNISING LIMITS OF OWN CLINICAL COMPETENCE
10.3	HOW AND WHEN TO SEEK HELP
10.4	PERSONAL ORGANISATION & EFFECTIVENESS

11. DEALING WITH CHILD PROTECTION ISSUES

11.1	RECOGNITION OF HARM AND POTENTIAL FOR HARM
11.2	REFERRING TO OTHER AGENCIES
11.3	SEEKING ADVICE FROM OTHER AGENCIES
11.4	BREACHING CONFIDENTIALITY

12. ENHANCING PERSONAL SAFETY

12.1	EMERGENCY ALARMS
12.2	DEALING WITH AGGRESSIVE & VIOLENT PATIENTS
12.3	ENSURING HOME VISIT SAFETY & SECURITY

13. EMPAHSISING IMPORTANCE OF THE LEARNING ENVIRONMENT

13.1	ENSURE OPEN AND NON-THREATENING PRACTICE CULTURE
13.2	ENSURE RAPID ACCESS TO SUPERVISORY ADVICE, FEEDBACK AND SUPPORT (e.g. Experienced, contactable and approachable GP)
13.3	RAISE AWARENESS OF PRACTICE TEAM CONTRIBUTION AND SUPPORT
13.4	ENSURE REFLECTIVE LEARNING RECORDED IN E-PORTFOLIO

14. SAFE USE OF PRACTICE COMPUTRERISED SYSTEMS

14.1	ENSURING COMPUTER SYSTEM PROFICIENCY
14.2	HOW TO PRIORITISE SAFETY ALERTS (e.g. Yellow & Red Traffic Lights)
14.3	AVOIDING COMMON PITFALLS (e.g. leaving notes open and writing-up the wrong patient)

15. AWARENESS OF SAFETY & IMPROVEMENT CONCEPTS

15.1	SCALE OF ERROR AND HARM IN PRIMARY CARE
15.2	INTRODUCTION TO BASIC KNOWLEDGE OF HUMAN FACTORS & SYSTEMS THINKING
15.3	HOW TO BUILD A SAFETY CULTURE
15.4	LEARNING FROM ERROR AND SYSTEMS FAILURE (e.g. SEA)
15.5	IMPROVEMENT TECHNIQUES (e.g. Clinical Audit, PDSA Cycles)

References

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