

**patient safety  
in primary care**  
*it's no trouble at all*

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# the art of the possible

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***It's been a real success.* Arguably a world first, Scotland's Patient Safety Programme has been running in Scottish acute hospitals for over 4 years. During that time, it has achieved some remarkable results, including contributing to noted reductions in ventilator acquired pneumonia and central line infections in critical care units in test sites throughout Scotland.**

Safer care in Hospitals is only part of the answer. Increasingly, patients receive care from a range of services. We need to ensure Primary Care is safe and that – as patients move across the whole system – they don't fall through the gaps.

The majority of patient consultations are safe. However, because of the complexity of modern care, things can go wrong.

12% of hospital admissions are due to suboptimal primary care<sup>1</sup>. 6.5% of hospital admissions are due to the adverse effects of medication<sup>2</sup>, and 67% of these are thought to be preventable. That equates to around 14,000 avoidable admissions in Scotland per year...

***The numbers should not surprise any of us. Scotland's standard of primary care is superb, coping with over 90% of all NHS patient interactions<sup>3</sup>. That's a phenomenal achievement. Still, you can also see that just a few systematic flaws can create havoc for individuals as well as institutions.***

It's frustrating for everyone when results go missing or practice systems don't work. But when things go wrong, patients can suffer. So too do staff who want to do what's best for those in their care. So how can we identify and prevent the handful of scenarios which – time and time again – expose both patients and professionals to unnecessary risk?

***However, let's be clear. This is not about human error or individual 'blame'. We accept that mistakes happen. Our focus is very straightforward.***

This booklet is designed to give a brief overview of the 3 workstreams within the Scottish Patient Safety Programme in Primary Care. We've gathered the evidence and provided tools and resources to improve systems and processes. The aim is to improve whole system working – to reduce patient harm – but also to cut back on the stress, worry and workload which patient safety incidents create for healthcare professionals and the whole of the NHS in Scotland.

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1 Quality and safety in healthcare April 2007

2 Which drugs cause preventable admissions to hospital? A systematic review, Howard et al, british journal of pharmacology 2006

3 Health Foundation, 2011 – Research Scan – Improving Patient Safety in Primary Care

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patients, GPs,  
practice managers,  
practice nurses,  
receptionists  
and community  
pharmacists.

get support  
not ***grief.***

patient safety  
in primary care

*safety culture*

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# safety climate

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**It's essential that every staff member understands the key role they play in ensuring and *improving* patient safety. Only by instilling a culture of reflective learning and improvement can we create a positive and strong environment for patient safety.**

SafeQuest is an online Safety Climate tool which is simple to complete and administer. Once all team members have completed the survey, an individualised, anonymised practice report is produced automatically.

The report is solely for use within the practice and data will not be seen or shared nationally. The tool compares practice results against all other participating practices. It gives you comparisons between clinical and non-clinical staff, and management and non-management within the practice. The report also tracks the practice results. Each time the survey is completed, you can see whether there has been a change in the perception of safety culture within the practice. The report is then discussed at a team meeting. It provides a focus for discussing patient safety, thereby developing the safety climate in practice and improving care for patients.

The use of climate surveys have been tested in the Safety Improvement in Primary Care (1) project. This has led to improved awareness of safety culture, identification of harm and actions taken to improve safety and quality of care. SafeQuest and trigger tools are now accepted as evidence for GP Appraisal.

*"Many of us in the practice staff hadn't really made the link that failing to communicate with each other was a threat to patient safety... a lot of really good stuff came out of it, a lot of very open discussion"*

**Participant in SIPC1 work**



For more information, please visit our website:  
[www.healthcareimprovementscotland.org/psipc.aspx](http://www.healthcareimprovementscotland.org/psipc.aspx)

# trigger tool

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**Patient care isn't as safe as you think. Implementing the trigger tool will help you narrow down and focus on the issues within your practice, reduce patient safety incidents, and support your practice to deliver care you can be *proud* of.**

A trigger tool is a simple checklist for a number of selected clinical 'triggers'. A reviewer looks for these triggers when screening medical records for patients who may have been unintentionally harmed.

The trigger tool facilitates the structured, focused review of a sample of medical records by primary care clinicians. What's more, it's quick! The 6 monthly reviews can take less than 2 hours.

Practices involved in the SIPC project have found the tool helps bring around a cultural shift in practice. Many people are resistant to the idea of change, for many reasons, including competing priorities, time limitations, and a 'we already do it fine' attitude. However the trigger tool highlights areas for improvement – which should always improve patient safety.

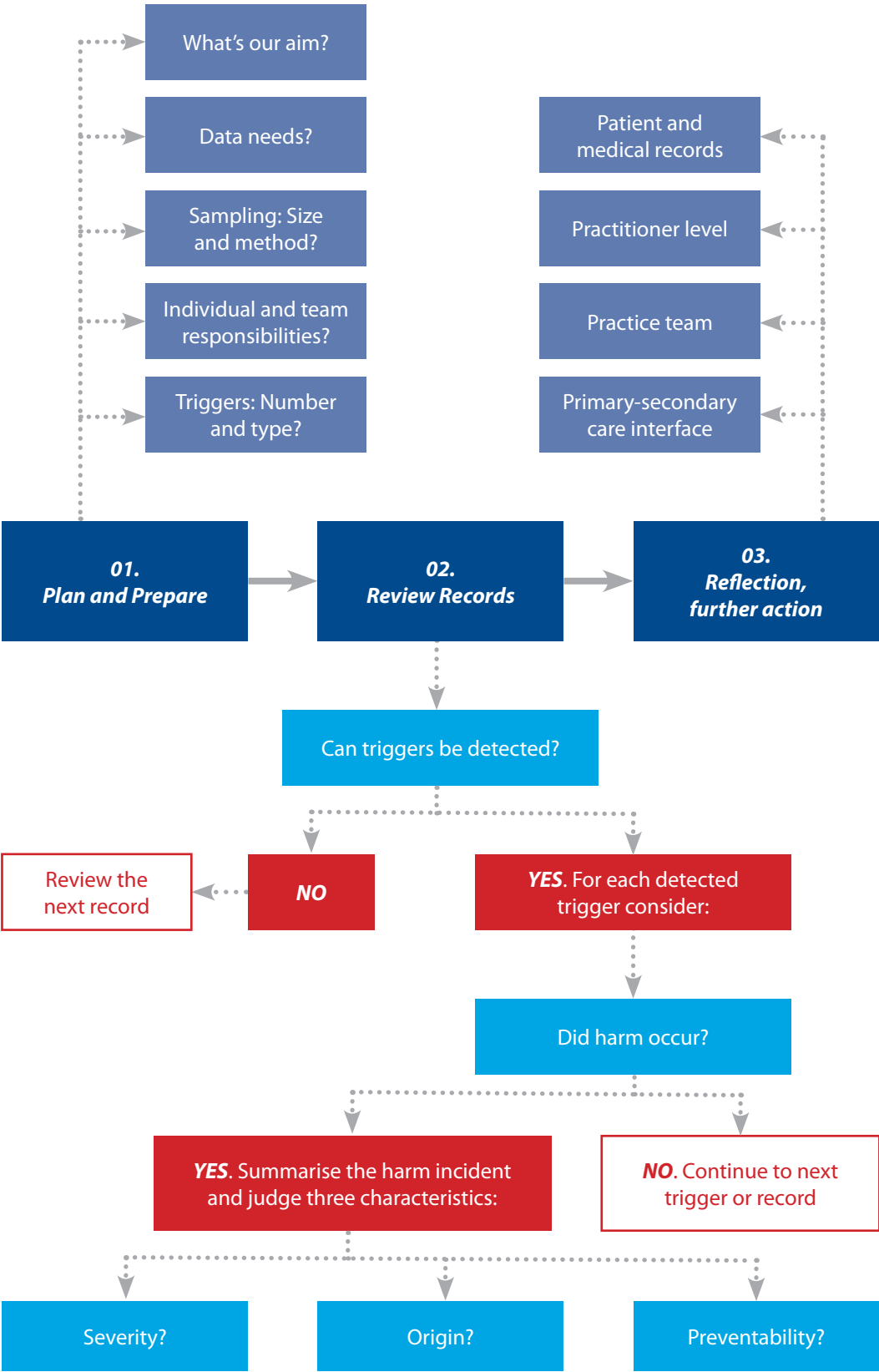
In the test sites, specific changes which were made in response to issues highlighted during reviews include:

- New protocol for recording adverse drug reactions
- Minimum annual full blood count checks for all warfarin patients
- Minimum annual Digoxin levels check
- Better systems for highlighting possible drug interactions when deciding the next dose of warfarin
- Much better at coding relevant read codes
- Checking and ensuring that locums are familiar with practice systems for warfarin patients

***"It seemed a bit intimidating when we first had it presented to a large group. It's much easier to use in practice... remarkably effective tool for reflective analysis on patient safety and other clinical issues. It's created a lot of interest from other doctors in the practice as a tool for professional development and for appraisals"***

**Doctor Gordon Cameron GP, Edinburgh**

# trigger tool



do you know  
which drug  
in primary care  
is most likely  
to give you  
the greatest  
*heartache?*

patient safety  
in primary care

safer medicines



# warfarin

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**It's been an effective treatment for almost 60 years.**

**But it's not just vitamin K that warfarin is *antagonising*.**

Warfarin is recognised as a high risk drug that causes harm to patients. It's also a high workload for practices with almost 1 million blood tests taken annually in Scotland.

As you know, warfarin is a vitamin K antagonist. It interferes with the operation of vitamin K in blood coagulation. But the effect does not kick in immediately, and a single dose can be active from 2 to 5 days. However, warfarin operates at such a fundamental level of body chemistry that, inevitably, the drug interacts with a wide range of other common medications as well as many basic foodstuffs.

As a result, achieving a dosage that's both safe for the patient and sufficient to prevent thrombotic events is no easy task. Too high an INR and there's a real risk of bleeding. Too low and there's a risk of blood clots.

That's why a systematic, safe and reliable approach to INR management and blood testing is fundamental to patient care and safety.

***But that's only part of the picture.***

Warfarin can interact with everyday substances, which the patient may regard as safe such as aspirin or ibuprofen – or even vitamin K rich foods such as kale or spinach.

A number of key processes need to be reliably delivered when prescribing warfarin. Our warfarin bundle will allow you to measure these processes and ensure you are delivering safe and reliable care.

Warfarin can cause serious **harm** and needs careful prescribing and monitoring. This intervention will allow you to measure your processes for prescribing and monitoring of warfarin to help you identify how you can deliver safer health care for these patients.

Are your patients receiving all elements of the warfarin bundle?		yes	no
01	<b>Warfarin dose is prescribed according to local guidance?</b> <i>Is there evidence that the last advice re warfarin dosing given to patient followed current local guidance or uses computer assisted decision making e.g Dawn or INR star software?</i>		
02	<b>INR test is planned according to local guidance?</b> <i>Is there evidence that the last advice re the interval for blood testing given to patient followed current local Guidance or uses computer assisted decision making e.g Dawn or INR star software?</i>		
03	<b>Patient complying with dosage instructions?</b> <i>Has patient been taking the advised dose since last blood test?</i>		
04	<b>INR is taken according to previous recommendation?</b> <i>INR is taken within 7 days of planned repeat INR?</i>		
05	<b>Patient receives regular education?</b> <i>Patient education recorded every 6 months.</i>		
06	<b>Have all the above measures been met?</b>		

The SPSP-PC will provide you with the tools, templates and guidance to implement this bundle within your practice, including templates for EMIS and Vision, all of which can be found on our website.

By implementing this bundle, and collecting data you will see increased reliability in this area, which will ensure safer care for patients.

For more information, please visit our website:  
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# dmards

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**Methotrexate and azathioprine are dangerous drugs which need to be *carefully* prescribed and monitored to keep patients safe and ensure they are properly treated.**

In treating several diseases, we increasingly rely on cytotoxic drugs (DMARDS such as methotrexate and azathioprine).

While clinically effective, such treatments require regular blood monitoring. They are much less commonly prescribed than, for example, warfarin, and cytotoxic drugs do not cause emergency hospital admissions on the same scale.

***However, their inherent toxicity means that they regularly cause severe harm, including death.***

As a consequence, they have been the subject of regular National Patient Safety Agency (NPSA) alerts. Practices need to ensure that these drugs are prescribed reliably, are appropriate and are carefully monitored to minimise risk.

Reliability in healthcare is a failure-free operation over time. This equates to ensuring patients receive all the evidence-based care to which they are entitled.

In relation to care bundles, this means ensuring that patients receive optimum care at every contact. A care bundle is a structured way of improving processes of care to deliver enhanced patient safety and clinical outcomes.

By applying this approach to the prescribing of high risk drugs such as methotrexate and azathioprine, you will see increased reliability in the delivery of optimum care for patients on these drugs.

This intervention will allow you to measure your processes for prescribing and monitoring of these drugs to help you identify how you can deliver **safer health care** for patients on these drugs.

Are you delivering all elements of our bundle?		yes	no
01	<b>Appropriate tests are carried out in correct time scale?</b> <i>Has there been a full blood count in the past 12 weeks (AZA) 8 weeks (MTX) as per local guidance?</i>		
02	<b>Appropriate action taken and documented for any abnormal results in previous 12 weeks.</b> <i>If any abnormal results in previous 12 weeks (WBC &lt; 4, neutrophils &lt;2, platelets &lt;150, ALT &gt;x2 normal upper limit (&gt;60).) has action been recorded in the consultation record?</i>		
03	<b>Blood tests reviewed prior to prescription?</b> <i>Is there a documented review of blood tests prior to issue of last prescription?</i>		
04	<b>Appropriate immunisation?</b> <i>Has the patient ever had pneumococcal vaccine?</i>		
05	<b>Patient asked about any side effects following last time blood was taken?</b>		
06	<b>Have all the above measures been met?</b>		

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# medicines reconciliation

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**Patients frequently move across different parts of the health service. It's vital that an accurate record of what medication a patient is taking is maintained and communicated appropriately. But medicines reconciliation is *not easy to do* when the service can be fragmented and there is no single patient record.**

Here's a conundrum.

The standard of primary care in Scotland is excellent. Patients also receive superb treatment in our hospitals. So, where do you think the biggest problem lies in terms of exposing patients to serious risk? It's blindingly obvious when you think about it.

*The problem is in the gap between hospital and general practice.*

The main issue is equally obvious: it's medicines reconciliation. You may not know what drugs the patient has received in hospital. The hospital might not know what you've prescribed. The community pharmacist might know. But the patient may use more than one pharmacy or take over-the-counter medication or alcohol...

Frankly, it's possible that no-one knows what the patient is taking. So, it's understandable that medicines reconciliation can seem like a task that's onerous and time-consuming, if not impossible.

Yet, we believe that by sticking to a simple procedure and working together, it's easy to get an accurate record of medicine prescribed for the vast majority of patients as they move between hospital and community care.

This will help avoid harm to patients and unnecessary prescribing and admissions.

After all, it's far easier to reconcile medicines than conciliate patients and their families.

## ***did you know?***

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- 38% of readmissions in one study (of 108 cases) were considered to be medicines-related. 61% were identified as preventable (Witherington et al 2008).
- Among older patients (65+ years) 14% are discharged with medication discrepancies and have a higher risk of being readmitted to hospital within 30 days (Coleman et al 2005).
- 72% of adverse events after discharge are due to medications (Forster et al 2004 p345).

Medicines reconciliation across the interface can cause both patients and staff unnecessary stress, and **waste time and resources**. If both primary and secondary care undertake the set of interventions below, systems and processes will be improved.

**In GP practices**

Complete the medicines reconciliation bundle to ascertain whether:		yes	no
01	The Immediate Discharge Document (IDD) has been workflowed on the day of receipt.		
02	Has Medicines Reconciliation occurred within 2 working days of the IDD being workflowed to the GP/Pharmacist.		
03	It is documented that any changes to the medication have been acted upon?		
04	It is documented that any changes to the medication have been discussed with the patient or their representative within 7 days of receipt?		
05	Have all the above measures been met?		

To improve hospital processes will require the primary care team to work with an acute team. Additional sets of measures for secondary care are available on our website.

The SPSP-PC will provide you with the tools, templates and guidance to implement this intervention within your practice, all of which can be found on our website, along with optional Medicines Reconciliation measures for secondary care.

By implementing this intervention, and collecting data you will see increased reliability in this area, which will ensure safer care for patients.

For more information, please visit our website:  
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to save a lot  
**of *bother***  
with written  
**communication,**  
simply follow  
**our advice to**  
the letter.

**patient safety  
in primary care**

*patient care*

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# written communication

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**“The cleaner found the consultant’s letter and thought it was *rubbish*.”**

In any scientific sector, it’s a truism that people are hired for their great technical skills and fired for their poor communication skills. But, even with the best ‘people skills’, the increasingly pressured, fast-moving, stressful environment across the entire healthcare system means that just ‘getting the job done’ is often tough enough.

*As a result, undervaluing the role of communication in effective teamwork is a serious risk*

From missing results to the mislaid letter, we all know that so much hard work can be undone by the simplest of lapses in communication. It creates risks and causes needless frustration and distress for patients and staff. And it makes extra work for everyone throughout the system.

People with too much on their plates already are chasing results, re-booking appointments, managing patient relationship issues, as well as dealing with medical consequences...

That’s why a systematic process for managing written communications and handling results will deliver safe and reliable care. It’s as much a question of mindset as procedure.

The programme will deliver all the tools, templates and tips you need to be more effective in handling communication.

Critically, to build efficiency and mutual trust across the whole team, we need to recognise the role communication plays in delivering safe, reliable care for every patient.

By following this set of interventions, you will see an improvement in electronic and written communication throughout your practice.

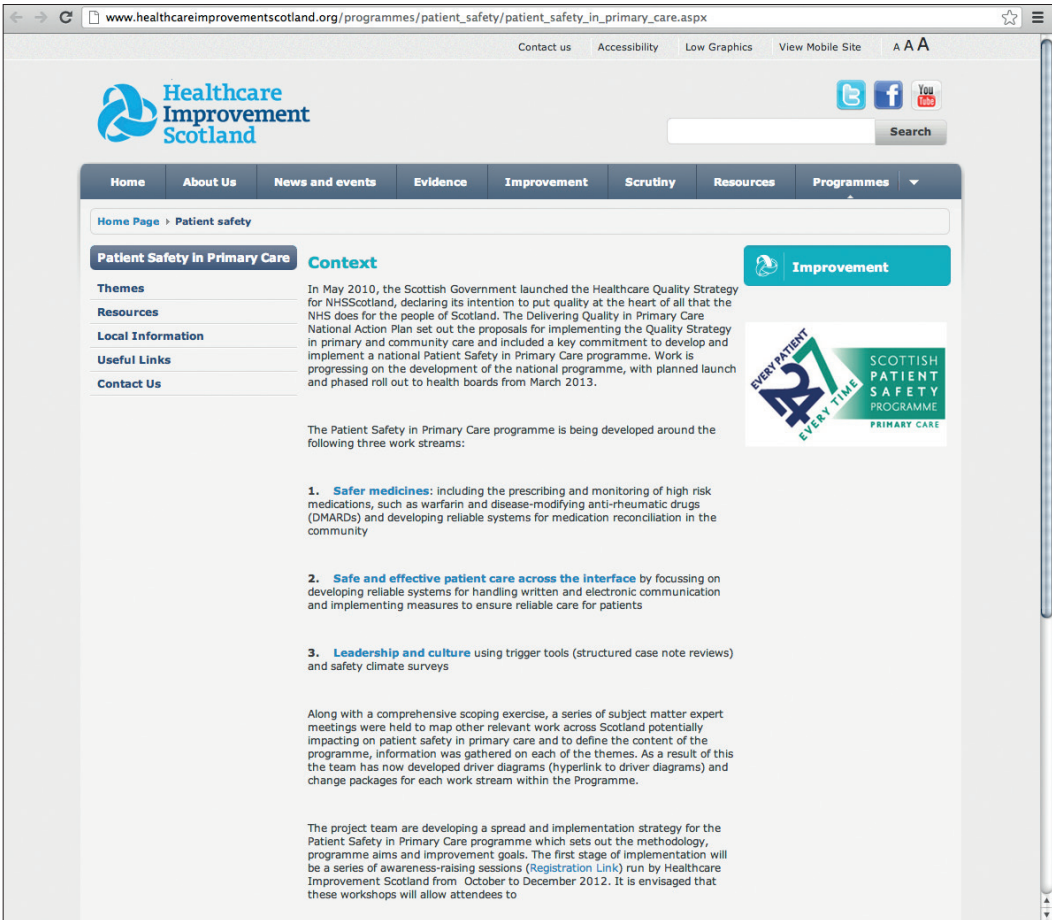
## **For outpatient communication**

GP practices to check:

- The letter has been actioned by the appropriate clinician within 2 working days
- The change in the management plan has been clearly implemented
- The patient has been notified of the change in the management plan

To improve hospital processes will require the primary care team to work with an acute team: additional sets of measures for secondary care are available on our website.

For more details, including all the tools and resources required to implement the programme, please visit our website.  
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# notes

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