

# Creating Permanence



**Enhance** quality improvement capability of General Practices, by focusing on patient safety.

**Augment** PHO capability in quality improvement methods and processes.

**Prevent** and/or reduce harm for patients through safer and better General Practice systems and processes.

**Promote** a culture of safety within General Practice working environments

## GPs harm patients ...

Error in 8% of consultations

Harm in 2% of consultations

Severe harm 0.3% (~50,000 cases pa in NZ)

## GP errors cause:

1 in 20 deaths in hospital

Up to 20% of admissions to hospital for harm

4% of hospital bed capacity

**70% of errors are preventable**

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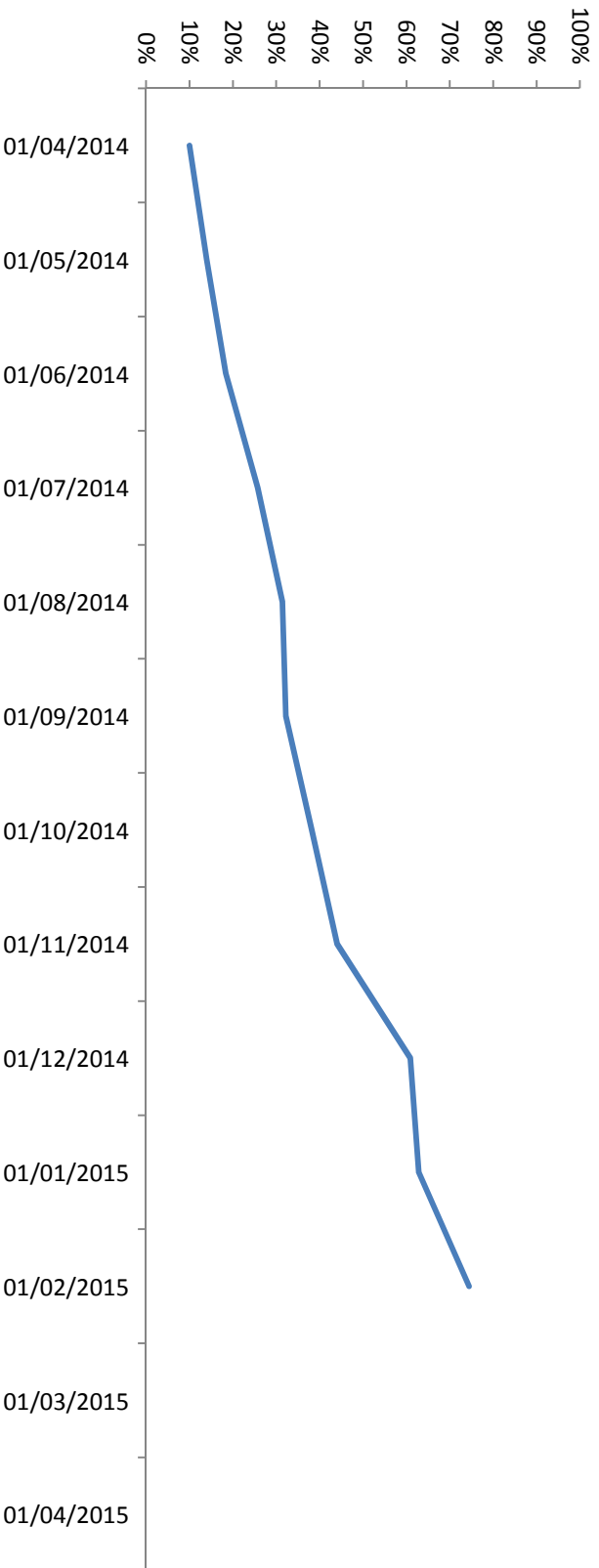


“Patients need  
to feel valued,  
safe and  
respected”

Shazza Mallie  
Aboriginal ED Liaison Officer

# We can show improvement

## Overall Compliance



# Results

	Before (1/10/12 – 1/4/13)	After (1/1/14 – 1/7/14)	Significance
Total number of patients monitored	1480	1946	
Total number of INR tests	13013	14663	
Mean INR tests per patient	8.79	7.53	p<0.05

# Results

	Before (1/10/12 – 1/4/13)	After (1/1/14 – 1/7/14)	Significance
Mean TTR (%)	66.25	69.10	p<0.05
Number of patients TTR>60% n(%)	896 (60.54)	1297 (66.65)	Chi-square test p<0.01
Number of patients TTR>75% n(%)	654 (44.19)	923(47.43)	Chi-square test p=0.06
Number of INR tests >5 or <1.5 n(%)	1070 (8.22)	856 (5.84)	Chi-square test p<0.01



- Process Mapping
- PDSA knowledge and confidence
- Data Interaction
- Meeting Facilitation



# Formalising Reliable Care

- MOPS
- Cornerstone
- “Aiming for Excellence”
- Integrated Performance and Incentive Framework



- Collaboration



## Collaboration

- 1) Trust
- 2) Understanding
- 3) Learning

# How

- IT systems: e.g. Forms, Alerts, Tasks
- Champions
- Data: repeat Audits – test yourselves
- Sharing: peer groups, PHO CME sessions





WHY NOT?

