The Safety in Practice initiative is committed to helping General Practices achieve outstanding levels of service.

Our *Safety in Practice* (SiP) Objectives

Augment General Practice capabilities through quality improvement methods and processes.

Actively prevent or reduce harm to patients.

Improve General Practice systems and processes to ensure critical high-risk processes are carried out safely and reliably.

Promote a culture of safety within the General Practice environment.

The *Safety in Practice* initiative provides valuable tools for General Practices that want to improve the delivery of services. These include:

- Training in quality improvement skills, tools and techniques to make patient care safer.
- Quality improvement support and facilitation to assist with re-designing Practice systems and processes.
- Opportunities to share knowledge and experiences with other General Practices.
- Unique opportunities to inform the future direction of patient safety development.
- Reimbursements toward staff time of $5400 in instalments if all the above requirements are met throughout the year.

Next steps

General Practices that wish to take advantage of the *Safety in Practice* programme should follow the steps outlined below.

To enrol your Practice in the *Safety in Practice* programme:

Fill out an expression of interest form which can be obtained from your PHO or by going to the Safety in Practice website **www.koawatea.co.nz/project/safety-in-practice/** where you can fill in the form online.

Timeline for enrolment

Programme commences July 2016 to July 2017

Expression of interest forms due in by Monday 23 May

Practices notified of acceptance into programme by Friday 10 June

Practice visits by Clinical Lead, Improvement Advisor and PHO facilitator will begin after Engagement Session on 21 July

In addition, participation in the initiative will contribute to RNZCGP Cornerstone® accreditation, RNZCGP MOPS (Maintenance of Professional Standards) and NZNC Professional Development Hours (PDRP).

For further information, contact your PHO facilitator or visit SiP website: **www.koawatea.co.nz/campaigns/ safety-in-practice/**

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Safety in Practice

www.koawatea.co.nz/project/safety-in-practice/

Existing Care Bundles

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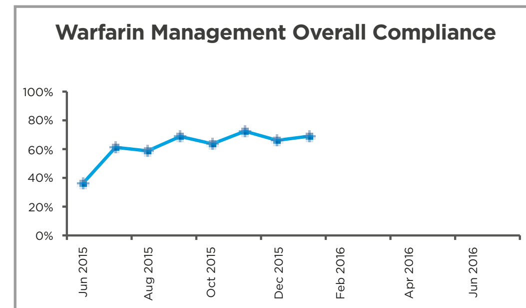
A Care Bundle is a set of evidence-based interventions that when used together significantly improve outcomes. They usually include 4 to 5 elements of care across a patient's journey. Practices select one care bundle against which they audit their compliance on a monthly basis to provide a focus for improvement efforts and to understand if the changes they are making are having an impact.

Warfarin prescribing

100% of patients on Warfarin must be managed within safe margins around the therapeutic target. All practices must also have developed consistent processes around INR testing.

Comments from participating Practices regarding this Care Bundle include:

- This enables safe prescribing and clear care planning for each patient, with increased communication between staff members.
- Our GPs feel more confidence in safely prescribing dosaging based on online BPAC guidelines.
- Doctors and nurses have improved awareness of the importance of following an algorithm.



Opioids prescribing

100% of prescribing for Opioid Derived Analgesics must follow a safe standardised process.

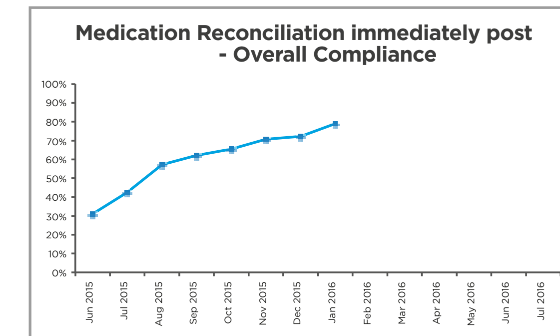
Comments from participating Practices regarding this Care Bundle include:

- Our team know what their responsibilities are and what is expected of them. The team is focused and provides resource information for all other practice staff.
- We now have a process in place that will help us to comply with Cornerstone practices.
- Our team is implementing the Pain Ladder.

Medication reconciliation

Following discharge, 100% of General Practice records must accurately and consistently reflect the med summary of the Electronic Discharge Summary (EDS).

Any identified differences within the EDS must be addressed within 48 hours of receipt of the EDS.



Comments from participating Practices regarding this Care Bundle include:

- Being aware that the system we create needs to be resilient and sustainable and not reliant on any individual.
- Opening up of communications regarding medication reconciliation between secondary care pharmacists and general practice.
- Using regular reporting to the practice team, both on current compliance levels, and on medication incidents.
- General improvement in maintenance of medication lists, and marking of regular drugs, has been a positive spin off.

Results handling

100% of all lab results must be acted upon within 7 days.

Comments from participating Practices regarding this Care Bundle include:

- It has been motivating to see the staff buy-in in general on providing a more streamlined results handling process within the Practice.
- As a large practice with both A&M and medical patients, we often found that results handling was haphazard. The Results Handling Care Bundle, together with advice from the IAs, Clinical Lead and insights gained through collaborative learning opportunities have improve the process.

All results (even those ordered by a locum) are now viewed within 2 days of receipt, and a definitive decision outlined by the reviewing clinician. We have also noticed that all our decisions are now actioned appropriately, with patients informed of their results more efficiently.

We also developed hot keys, which were standardised across the practice so all admin, nursing and medical staff used the same keys (for example .n means the result is normal and no further action is needed, while n3 means the result is normal but needs repeating in 3 months).

These initiatives provide all members of staff with the confidence that they are handling results safely and efficiently, and reduces anxiety for the admin and nursing staff when patients call in for news of their results.

Other elements

Trigger tool

A trigger tool is a simple checklist used to screen medical records for potential harm. They facilitate the **structured, focused** and **rapid review** of a sample of medical records by primary care clinicians.

'Triggers' are warning signs for potential patient harm. They act as a prompt to the reviewer to search the record in more depth for a potential unintended consequence of treatment.

New Zealand Triggers:

- More than two consults with a Prescriber in 7 days
- A new diagnosis of cancer within 3 months
- A new Allergy/ Adverse reaction add to PMS
- The cessation of medications
- A Reduction in medication
- Out of hours or A&E attendance
- Hospital discharge
- Hb < 100
- eGFR <35
- Death within review period

Safety climate survey

The Safety Climate Survey is a Tool for involving all staff in the Practice in a discussion around safety culture and systems.

The team discussion typically looks at what's going well and areas for improvement. It comprises five subject areas: Communication, Workload, Leadership, Teamwork and Safety Systems & Learning), with between four to eight questions for each area.

Benefits

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Patient Story

Mrs. X, a 72 yr old patient on Warfarin for Atrial Fibrillation (Target INR 2-3) was noticed to have fluctuating INRs seldomly being in the therapeutic range. Using the Safety in Practice tools and Warfarin Prescribing Care Bundle her GP practice was able to streamline their process of Warfarin prescribing. This meant that local guidelines were followed for each dose of Warfarin prescribed and a careful discussion with patients or their carers was undertaken before they were advised of their Warfarin dose. It also transpired that Mrs. X had never fully understood why she was on Warfarin and what the regular monitoring meant but as the practice gave her written information about Warfarin she was able to make an informed decision about her medication. As a consequence, Mrs. X was found to have less frequent INR testing, less fluctuations and spent more time in the therapeutic range.

Practice feedback

- New ideas, contact with other practices.
- Improved communications between clinical staff.
- Raised profile and awareness of inconsistencies in current system we create needs to be resilient and sustainable.
- Improved patients outcomes, compliance.
- Patient Safety process now part of clinical meetings.
- Focusing on the process has made us aware of problem areas.

Proposed New Care Bundles

Reliable Management of COPD Patients

COPD is the fourth leading cause of premature death and impairment in New Zealand after heart disease, anxiety/depression and stroke. It affects approximately 1 in 7 New Zealanders over the age of 40.

This bundle looks at the processes in place to help prevent the progression of COPD and in turn reduce the morbidity of patients.

Reliable System for Managing Cervical Smears

Cervical Cancer is considered a predominantly preventable disease as it has a 10-20 year latency and regular cervical smears have been proven to effectively identify pre-cancerous lesions and thereby reduce the risk of cervical cancer by 90%.

This bundle will help practices identify if their population is up to date with smears and if best practice is being followed when planning tests and communicating smear results. This can also profile an opportunity to include patients voice.