AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

PATIENT SAFETY IN PRIMARY HEALTH CARE

Consultation Report

July 2011

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Introduction

The Commission

The Australian Commission on Safety and Quality in Health Care (the Commission) was formed in 2006 to lead and coordinate improvements in safety and quality. The focus of the Commission's work is on areas of the health system where current and complex problems or community concerns could benefit from urgent national consideration and action.

To date the Commission has largely focused on safety and quality issues relevant to the acute care sector as this is where more is known about the types of risks and the prevalence of harm. However, given the frequency with which Australians utilise services within primary health care,[*] and the coming changes to the way in which primary health care is delivered, there is a strong imperative for the Commission to investigate ways to support safe care in this sector.

In August 2010 the Commission released the *Patient Safety in Primary Health Care Discussion Paper* (the discussion paper) that broadly mapped potential patient safety issues in primary health care, the type of work that is currently being undertaken both nationally and internationally to mitigate patient safety risks in primary health care, the national primary health care policy environment and identified key stakeholder groups.

Consultation process

The discussion paper was circulated widely for consultation. In early August 2010 a letter inviting a submission was sent to 136 key stakeholders including professional bodies and organisations, consumer groups, accreditation and standards agencies, government agencies, safety and quality organisations, research groups and universities.

In addition, an open invitation for written submissions was issued via the Commission's website and the Commission's emailing database, which consists primarily of researchers, clinicians and policy makers.

The consultation period was intended to be open for nine weeks, however approximately twenty organisations requested extensions. Consequently all submissions provided before 31 December 2010 were included in the development of the consultation report.

The specific points the Commission sought feedback on in the consultation paper were:

- evidence about patient safety in primary health care and gaps in knowledge
- the types of safety risks that were relevant to the sector and priority areas for action
- exemplar models for improving patient safety in primary health care
- action and activities that could be implemented at a local, state or national level to improve patient safety in primary health.

Ten questions were asked that reflected these topics and feedback was also encouraged on any other issues relevant to patient safety in primary health care.

[*] When referring to primary health care, the Commission is including all primary and community health care services, organisations and professionals.

The outcomes of the consultation process will be used to inform the Commission's consideration of activities it, or other organisations, could support or undertake to strengthen patient safety in primary health care in Australia.

Types of respondents

The Commission received 66 written submissions regarding the discussion paper (Table 1). The Commission also offered twelve key organisations the opportunity to meet to discuss the discussion paper in depth. Teleconferences were held with four of these key organisations to ensure that their views were comprehensively and accurately captured. Three of these four organisations also provided a written submission.

Table 1: Number of submissions by source type

Type of organisation	Number of written responses	Proportion of overall responses
Professional or member organisations including associations	20	30%
Researcher or university	11	17%
Safety and quality organisations including accreditation organisations and complaints	9	14%
Government departments or agencies	9	14%
Professional colleges	6	9%
Clinician or health service worker or individual not representing an organisation	4	6%
Health service or organisation	4	6%
Consumer organisation	3	4%
Total	**66**	**100%**

Respondents represented a broad range of primary health care professions and disciplines, providing perspectives that address the social, emotional and physical health and wellbeing of Australians. A list of organisations and individuals that provided submissions can be found at Appendix A.

The consultation report

This consultation report provides a summary of the issues identified by those who provided submissions during the consultation process for the discussion paper. The report identifies a series of key themes which emerged from the responses and describes suggestions for future action identified by stakeholders.

Part One:
Overall Consultation Findings

The responses to the discussion paper were very positive overall, and there was strong support for the Commission undertaking work in this field. Respondents agreed that patient safety is critical to the delivery of high quality care; it is an important but often unknown aspect of primary health care.

General comments on the discussion paper

Many of those who provided responses agreed that there is limited research and evaluation of the nature of risks to patient safety in primary health care and that this was an area where it was identified that further work would be beneficial to the whole sector.

There was a call for work to be undertaken to ensure the development of a nationally coordinated, systematic and effective means of reporting errors and near misses within primary health care, based on an agreed set of safety measures.

There was agreement that in order to improve the safety and effectiveness, including the integration and continuity of care within primary health care, there needs to be greater cohesion and collaboration across the sector. A number of organisations suggested that this could start with clarification and agreement on the roles, responsibilities and boundaries of the sector.

One organisation raised concerns about the Commission undertaking work on patient safety in primary health care at this time. It was suggested that it would be more appropriate to delay work in this area until the outcomes or actions under the National Health and Hospital Network Agreement are further developed, and that the Commission could instead focus on the impact of reforms to the primary health care sector on patient safety.

> 'Our view is that the organisation of primary care in Australia is in for such a shake up over the next two or three years that it is the worst time to be contemplating some sort of safety intervention or initiative.'
>
> ***Submission 29***

However, the Commission considers that working on patient safety in primary health care during the developmental stages of the primary health care reform will provide an opportunity to reinforce and influence the safety and quality agenda within new organisations and structures such as Medicare Locals, Local Hospital Networks and Lead Clinicians Groups.

Contextual variables

Primary health care is not a uniform sector. There are a range of very important variables related to the context in which primary health care services are delivered and received that can significantly influence the types of safety risks a patient may be exposed to. These contextual variables can relate to the provider (e.g. the education and training of the professional), the care setting (e.g. services in a rural or urban location) or the patient (e.g. level of health literacy).

There were many comments made on the different roles, expectations, qualifications and levels of professional development and support provided for different types of primary health care professionals. For example, primary health care providers can be licensed or unlicensed and even when providers are licensed there may be differing licensing requirements such as the need for specific qualifications and continuing professional development.

To complicate matters further there has been a shift towards the dispersal of tasks traditionally undertaken by specific health professionals, such as general practitioners, to other health care workers which can lead to confusion about the roles and responsibilities of different health care professionals within the sector.

When developing options for improving patient safety, particularly at a national level, it is important to be aware of the influence these variables may exert at the local level. National policies and strategies should provide an evidence-based framework for nationally consistent practices while still allowing the flexibility for adaptation to the local context.

Key themes

There were many specific patient safety issues raised in the submissions, as well as a number of broader issues that reflect general concerns with the state of primary health care in Australia. Despite the multiplicity of providers, professions and services within the sector, there were a series of common underlying themes that emerged from these submissions. The submissions tended to reflect four key themes:

Theme 1: **Lack of knowledge and understanding of the scope and extent of patient safety risks** in primary health care including limited coordinated systems to identify, analyse, respond to, monitor and prevent risks and adverse events.

Theme 2: **Confusion about the scope, roles and responsibilities within the sector**, including confusion about the roles and responsibilities of different profession types, understanding of the definition of the sector and issues around inconsistent standards for qualification, licensing and registration.

Theme 3: **Need for improved communication and consumer education**, including professional to professional, service to service and professional to patient communication, consumer education and poor health literacy.

Theme 4: **Limited accessibility of consistent guidance and standards for evidence-based care** that are designed for the sector and account for the diverse needs, settings and professions involved in the delivery of primary health care services, including guidance, guidelines and/or standards on clinical care, risk management or governance and accountability for patient safety risks and incidents.

There were also two system-level issues that were consistently raised when discussion the risks to patient safety in primary health care:

- Access to primary health care services, including availability of services, professions and care types and the disincentive of increasing co-payments.
- Integration and coordination of care, including referral, transition between care sectors and coordination of multidisciplinary care.

These system-level issues were also seen as factors that influence the capacity of healthcare organisations to implement changes to improve patient safety.

Part Two:
Responses to Specific Questions

As part of the consultation process the Commission asked stakeholders to respond to ten questions. The questions were designed to elicit information about evidence relevant to patient safety in primary health care, perceptions of where the risks to patient safety may lie in primary health care and opportunities to address those risks.

When reviewing the responses to these questions it became apparent that there was significant overlap between many of the questions and responses, which led to the identification of the key themes outlined in Part One.

Part Two of this consultation report provides detail on the responses to the ten individual questions.

1. What evidence currently exists about patient safety in primary health care?

The vast majority of those who provided a submission acknowledged that there is limited evidence on the type, extent and consequences of patient safety risks and incidents which exist in primary health care.

In addition, the evidence that does exist is not representative of, or relevant to, the whole of primary health care but rather focuses on specific areas related to either profession, discipline or patient type. The evidence is not comprehensive and there is a belief among stakeholders that risks to patient safety in primary health care are much broader than those identified in the discussion paper.

> 'Further research and evaluation is clearly required across the breadth of primary health care to gain a greater and more accurate understanding of the size, nature and context of the consumer/patient safety problem in this sector.'
>
> ***Submission 32***

Some respondents provided sources of evidence which demonstrate some additional patient safety concerns within primary health care including the:

- *2006 Australian Bureau of Statistics Audit of Adult Literacy and Life Skills*[1] which found that 60% of Australians, and 75% of people born of a non English speaking background, are health illiterate.
- *2008 Aboriginal and Torres Strait Islander Health Performance Framework Report*[2] which indicates that Aboriginal and Torres Strait Islander peoples are discharged from hospital against medical advice at thirteen times the rate of other Australians.
- 2008 AusHEART study[3] which demonstrated that large evidence-practice gaps exist in primary and secondary prevention of cardiovascular disease for older Australians.
- *2007 Australian Bureau of Statistics National Survey of Mental Health and Wellbeing: Summary of Results*[4] which shows that in 2006/07 two thirds of people with mental illness who attended hospital emergency departments reported that they did not receive mental health care and that they had unmet needs in counselling, social intervention, skills training and medication.

- 2009 WoundsWest and Hunter New England Area Health Service study (unpublished) showing the pressure ulcer prevalence rate in community based home care settings was 8.9%.

Those who responded also noted some relevant research that is currently being undertaken including work to explore patient safety culture in Australian community pharmacies,[5] international pilots integrating pharmacists into general practices[6-7] and a study of the role of health and social care professionals in communication, collaboration and risk management in community aged care.[8]

Various organisations and individuals also provided examples of qualitative evidence they had gathered including case studies, interviews and feedback which identified safety issues such as communication failures, procedural failures and qualification/educational concerns. For example, the Consumers Health Forum has undertaken qualitative research which identified concerns regarding the misdiagnosis of chronic conditions, incorrect interpretation of pathology tests, mistaken identity about diagnostic images, adverse events from medications and medication errors within primary health care.

This kind of qualitative evidence can provide a rich source of information at the service level, which can be used to identify and manage potential risks to patient safety.

When talking about evidence it is also important to acknowledge that many primary health care organisations have quality systems in place, such as accreditation and governance arrangements which require the collection of information on the safety and quality of the services delivered. These organisations often use tools and processes such as incident reporting, root cause analysis and safety indicators as a way of informing their local risk management processes. However, many respondents broadly acknowledged that these types of systems, processes and tools are under-utilised in parts of the primary health care sector.

2. What are the gaps in knowledge that need to be addressed?

The extent of the risk to patient safety

Few studies have been undertaken on patient safety in primary health care, and even where there is research the findings are not always clear cut or actionable.

In Australia there is no systematic and coordinated collection of information about incidents of patient harm in primary health care. Respondents suggested that further work needs to be undertaken to better describe and quantify the risks to patient safety within the primary health care sector so that appropriate safety and quality procedures and processes, similar to the work that has been undertaken in the acute care sector, can be put into place.

> 'There is a need for systematic monitoring and reporting of feedback and actions undertaken in the Australian primary health care system. The information we have currently is only available from spontaneous reporting systems which are underutilised.'
>
> ***Submission 53***

A recent Canadian international literature review of the frequency of patient safety incidents in primary health care indicates that the numbers vary substantially depending on the research questions, the study approach, the patient group and the terminology used.[9] Many of those who provided a submission suggested that establishing a nationally consistent data collection, research and management system would be beneficial. One respondent suggested the development of some basic patient safety indicators for primary health care as a first step in this process.

In addition, stakeholders generally believe that further research is needed to truly understand where strategies could best address patient safety risks; and that this could include a review of current local level strategies and their impact.

A number of respondents cited the multiple accreditation standards within community and primary care services which can provide some evidence of types of safety risks and strategies used to manage them. However, some respondents also noted that there is no integrated approach to compiling this type of evidence so that it can be used to inform both strategy and broad level practice improvements.

Research that reflects the whole sector

The majority of the research undertaken in this area has focussed on general practice, community pharmacy and medication safety. Primary health care is much broader than these services and many of those who responded suggested that research needs to be undertaken to determine the safety risks in other types of primary health care services, particularly in those likely to have a greater potential for harm.

> 'There is a need to broaden research to cover the community based health care sector.'
>
> ***Submission 35***

In addition, despite the fact that medication safety is one of the few areas where there is some evidence, some organisations called for further research on medication safety and in particular medication safety risks relevant to other primary health care services. Examples included prescribing by new prescribers (e.g. nurses and optometrists), prescribing for mental health conditions, post market evaluation of medicines, complementary medicine, and the impact and effectiveness of medications for children and risks associated with administering medicines in schools.

One organisation called for research to help understand more about the application of quality use of medicines in remote communities and Aboriginal Community Controlled Health Services.

Access to medications for Aboriginal and Torres Strait Islander peoples in remote areas has increased through the *National Health Act* Section 100 Scheme, however remote Aboriginal Community Controlled Health Services treat a high number of people on complex medication regimes and little is known about the use and effectiveness of medication regimes in this context.

Clear guidance on safe care and services

Those who provided responses also identified the need for clear and consistent resources including guidelines and standards designed specifically for the primary and community health environment. A key difficulty noted was identifying and accessing a clear, unambiguous, evidence-based guideline, protocol or standard for best practice care including for safety issues such as clinical handover, open disclosure, recognising and responding to clinical deterioration and infection control in primary health care settings.

Guidelines and standards for medication safety and security in non-office based practices, such as outreach clinics and schools, was also identified as an area of need. In addition, some respondents suggested research into best practice delivery of support services in primary health care, including organisational and administrative practices and processes was needed.

Changing roles and responsibilities

In recent years there has been a shift in roles and responsibilities within the primary health care sector. There have been a number of changes to the funding of tasks and services so that more professions are able to provide services such as prescribing and mental health treatment. However, those who provided a submission indicated that little is known of the impact that these changes in roles and responsibilities and many have called for further research on the impact of these changes on the safety and quality of care in the sector.

3. What are the key patient safety risks/considerations within primary health care?

There were many safety issues raised as key risks and concerns for patients within the primary health care sector. These risks ranged from high level, long standing national system-level issues to specific incidents which can be managed at a local level. A range of key themes emerged from the submissions (see page 5). Further information on these themes, as well as some examples of specific examples of risks identified in submissions can be found below.

Knowledge and understanding of the scope and extent of patient safety risks

Lack of awareness about risks to patient safety in primary health care in itself is a risk. Without the knowledge of the type, extent, impact and cause of patient safety risks in primary health care, it is hard for organisations to build the case to invest in patient safety initiatives and to effectively address the risks with systematic risk management processes.

Though there is widespread agreement that patient safety is a priority for all of health care, many of those who provided a submission suggested that investment is still needed in identifying and quantifying the types and burden of patient safety risks and incidents on the community, so that there is greater understanding of the baseline situation and the type of work that would assist to reduce those risks.

Scope, roles and responsibilities of the sector

Primary health care is a large, disparate sector, with a high proportion of standalone private facilities and providers. A number of respondents stated that the fragmented and complex nature of primary health care is an impediment to safe and high quality care. The number of services and professions within the sector, which in many cases provide similar types of care, can lead to a level of confusion for both health professionals and patients regarding the roles and responsibilities of different parties within the sector. This can lead to inappropriate treatment, duplication of services and can act as a deterrent to attendance.

There has been an incremental shift in responsibilities between professions over the years that has seen optometrists, nurses and other health professionals taking on new tasks such as limited prescribing. The complexity of these service arrangements and overlap of providers and services can make it difficult for patients to determine and navigate the most appropriate care pathway, potentially leading to poorer health outcomes.

Linked with this some respondents noted a lack of a readily identifiable point of responsibility for ensuring safety and quality both at the local level and across the primary health care system. Clarity around roles and responsibilities within primary health care should include consideration of responsibility for different aspects of safety, including clinical governance arrangements.

Communication and consumer education

The most commonly cited risks to patient safety identified in the submissions related to communication failures, either between the patient and the provider or between care providers. Some of the specific examples of communication risks identified include:

> '…deeper analysis reveals all complaints contain within them a component of communication failure.'
>
> ***Submission 56***

- limited health literacy of some patients, which can affect capacity to understand care and treatment requirements including medication regimens, and may result in poor compliance, treatment adherence and adverse events
- poor referral processes and transfer of information between health professionals and services, resulting in poor continuity, integration and follow up of care
- inadequate awareness and consideration of the patient's history and broader health needs, which can result in incomplete care planning and treatment
- poor implementation of activities to ensure cultural security, informed consent and appropriate levels of privacy and confidentiality, potentially providing a disincentive to continue care and treatment.

Consistent guidelines and standards for evidence-based care

Respondents identified that there are currently a range of competing guidelines and standards available to primary health care providers. These are often developed by different agencies, for different purposes using different methodologies. This may result in variable care for the same condition and consequently risks to patient safety.

> 'Generally confronting primary care physicians is the widespread availability of single disease clinical management guidelines in an environment of rising levels of multiple morbidity. General practitioners need guidelines on caring for people with multiple chronic illnesses so they can effectively treat them in combination…'
>
> ***Submission 30***

It was also noted that there is a trend towards the delivery of more complex and invasive care within the community, particularly within the home (e.g. home dialysis, therapeutic devices in situ). Respondents suggested that this type of care requires a more complex level of support than current guidelines and standards provide.

There was a call for fast tracking the development of guidelines for implementation of new technologies, such as online consultations. It was suggested that the implementation of these new technologies quite often outpaces the evidence of their effectiveness, as well as the development of relevant guidelines, processes and standards for their use and that this is a potential safety risk.

Finally, some respondents acknowledged that even when there is a single unambiguous guideline or standard there can be risks to patient safety when adoption of the guideline or standard is low.

Access to primary health care services

Access is a critical influence on safety and quality of care. Access issues such as provider availability, affordability of services and equity of services were noted in submissions as issues which can influence the likelihood of patients seeking care, the type of care that is delivered, the timeliness of the care and ultimately the safety of that care.

Access issues are generally faced by the most vulnerable groups such as Aboriginal and Torres Strait Islander peoples, the elderly, children, people from culturally and linguistically diverse backgrounds, people with disabilities and those in rural and remote areas.

For example, one patient safety risk raised in a number of submissions was the high proportion of casual and short term practitioners and difficulty engaging health professionals in rural and remote areas. This issue can result in poor continuity of provider and treatment plans, lack of holistic patient-centred care and can act as a disincentive for patients to attend a service. This issue also

contributes to organisational challenges such as maintaining clear governance and safety systems.

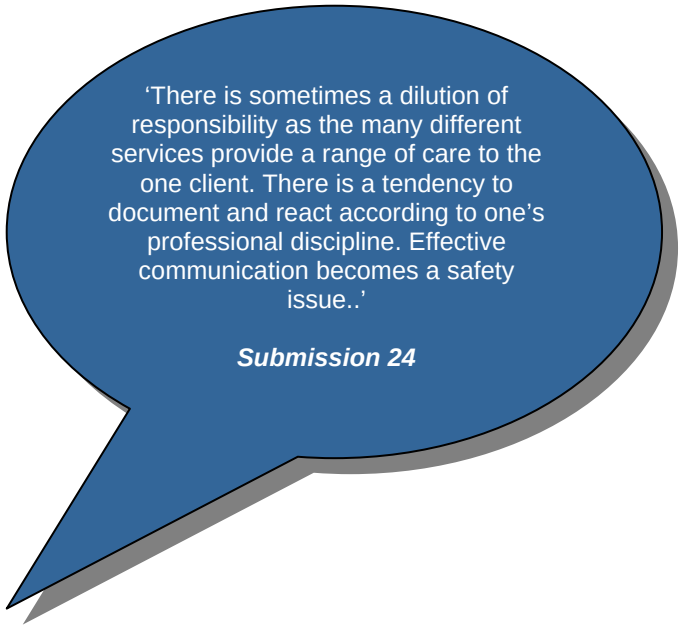
Respondents also noted that recent changes to co-payments and changing service delivery structures in primary health care are increasing the already significant barriers to vulnerable populations accessing care, providing a greater risk to safety and potential for greater disparity in health outcomes.

Integration and coordination of care

Lack of integration and coordination of care is an issue closely linked with communication. Integration and coordination is necessary to ensure that patients are directed through the correct care pathway, attend the most appropriate providers in the most appropriate timeframe and that their treatment considers all of their relevant aspects of their health and wellbeing.

A clear theme throughout the submissions was that integration and coordination within primary health care, and between acute, aged and primary health care, is lacking. Care pathways are not clear, clinical handover is inadequate and accountability and responsibility for care leadership is poorly managed.

One respondent stated that, despite wide acknowledgement that multidisciplinary care is effective for patients with chronic conditions, within primary health care there is poor implementation of this type of care. A number of responses to the paper suggested that current systems of support and funding for multidisciplinary care favour a limited number of disciplines and do not encourage genuine collaboration within the sector.



Many respondents acknowledged that the interface between acute care, aged care and primary health care is a key area of risk. There is little collaboration between the sectors about the patient's journey and there are few follow up systems for patients being seen across multiple providers.

Examples of some of the specific issues raised

A number of highly specific examples of safety issues relevant to primary health care were identified in the submissions including:

- preventable needle stick injury (Submission 8)
- unidentified pressure ulcer within the community (Submission 9)
- undiagnosed malnutrition within the community (Submission 10)
- increasing use of opiod analgesics (Submission 16)
- reliability of prescribing and dispensing software packages in identifying clinically important medicine interactions (Submission 16)
- issues with look-alike, sound-alike medicines (Submission 16)
- isolation and remoteness of some patients, services and providers (Submission 32)
- unlicensed care workers practicing outside scope without appropriate qualifications, education, registration, knowledge or skills (Submission 36)
- impact of unnecessary diagnostic testing (Submission 62)

- safety and efficacy of office based surgery including increasing use of sedation and anaesthesia (Submission 62)
- poor infection control and antimicrobial stewardship (Submission 65).

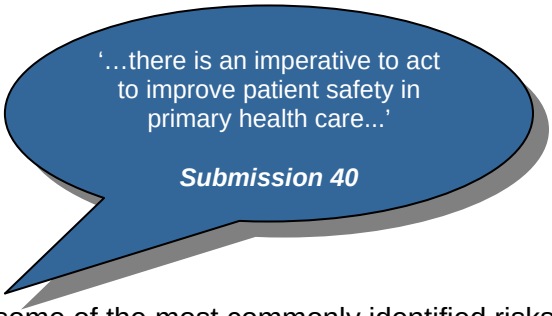
Further information on specific risks identified throughout submissions, including information on the potential consequences of these risks can be found at Appendix B.

Some respondents also provided case studies to demonstrate the types of risks to patient safety that occur within a variety of primary health care settings and services. These case studies show the breadth of the sector and emphasise the need for clarity in defining primary health care and patient safety in this context. A sample of these case studies can be found at Appendix C.

4. What solutions could be put in place to address these risks?

A range of options and activities were suggested throughout the submissions. Some of these had a very specific focus on addressing issues relevant to particular professions or organisation types, for example, raising the profile of speech pathologists in the diagnosis and assessment of consumers with a mental health condition, or instigating systematic nutrition screening in primary health care.

Other suggestions focused on very broad system-level change and included proposals such as realigning government funding streams and implementing greater coordination and consistency in licensing and registration requirements across the sector.



Grouped below are some of the most common system and organisational level recommendations for solutions which could be put in place to address some of the most commonly identified risks to patient safety.

Opportunities to improve systems and processes

Core to a number of submissions was the desire to gain clarification and agreement around the roles and responsibilities of different parties within primary health care. Many saw this clarification as including investigation and analysis of parallel licensing and registration requirements to ensure that there is parity amongst providers delivering equivalent services.

Respondents also suggested undertaking research to crystallise understanding of the extent and severity of patient safety risks in primary health care, including providing input and conducting research into infrastructure and systems of care in primary health care. One submission suggested undertaking a national review of consumer perspectives and experiences of patient safety in primary health care.

Following on from this, a series of activities were also proposed to generally improve systems and processes in primary health care including:

- Developing a systematic and coordinated identification, reporting and monitoring system for patient safety incidents in primary health care, which includes patient experience as a data source. It was suggested that any activity in this area should include support for infrastructure and resources required to implement this at the local level. In parallel to this one respondent also suggested creating safety indicators for primary health care.
- Developing clinical practice guidelines and standards that reflect the needs of primary health care services and provide unambiguous evidence-based approach to primary health care. It was suggested that existing standards (e.g. *Royal Australian College of General Practitioners Standards for General Practice*), research and laws could be utilised as a basis for formulating these in collaboration with professions, and that the implementation of the guidelines and standards could be could monitored and linked to pay for performance schemes.
- Clarifying and refining e-health systems, processes and protocols to support better transfer of information, as well as providing support for local implementation of these systems. This was seen as a means of addressing some of the communication failures consistently identified as a risk to patient safety.

- Agreeing on coordinated systems and processes to ensure standardised information is transferred between providers at referrals, and at admission and discharge from hospital. One stakeholder suggested that at a minimum it should be mandatory that an accurate and comprehensive list of medicines and the reasons they were prescribed should be routinely provided to the practice on patient discharge. Another recommended there should be binding standards in relation to quality and timeliness of discharge summaries.
- Improving systems for safe use of medicines. For example, one respondent recommended phase IV studies of Pharmaceutical Benefit Scheme approved medications and greater research into complementary/alternative medicines and interaction with other treatments. Other suggestions included improving systems through the application of quality use of medicines principles in medicines labelling, real time reporting of supply of schedule 8 medicines and consideration of a quality framework for implementation of the *National Health Act Section* 100 Scheme in rural and remote Aboriginal and Torres Strait Islander communities.
- Coordinating a national approach to improving health literacy, including facilitating access to, and understanding of, relevant health information for consumers in appropriate formats. It was suggested that checklists could be developed for consumers highlighting patient safety risks, use of interpreters could be mandated and that a cultural competency framework could be developed and implemented for use across the sector.
- Improving availability of scientific literature, by embedding literature, guidelines and other critical resources into electronic systems.

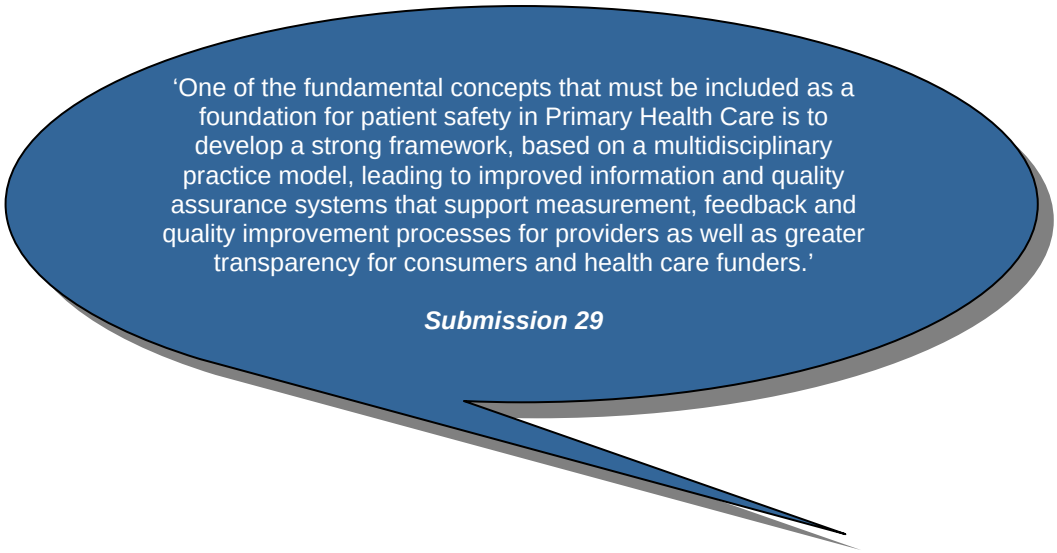
It was suggested that the majority of these activities would benefit from national level support and/or coordination.

Opportunities to improve organisational capacity to prevent and address patient safety risks

There were also a range of suggestions which focussed on developing and improving the capacity to identify, manage and respond to patient safety risks at the organisational level including:

- developing consistent and robust clinical governance, risk management and quality improvement strategies at an organisational level
- embedding cultural safety and security into organisational systems, processes, education and training
- coordinating and collaborating on the development of leadership, teamwork and organisational culture within primary health care, including facilitating this through appropriate education and training
- encouraging the development of learning organisation models including reflective practices and responsive services
- supporting the ongoing development of healthcare professional's capabilities including undertaking non-clinical work such as research, continuing education and health promotion/prevention activities.
- putting in place processes and systems to develop patient expertise in safety, to involve patient groups and to regularly inform the community about actual and potential patient safety incidents and adverse events
- ensuring processes are in place for consumers to access information on the redress available when harm occurs.

Overall, there was a repeated call for dedicated resources both at a national and local level to be allocated to activities that support patient safety improvements.



5. Where is action urgently needed to address patient safety in primary health care?

Building a primary health care community

Many of those who provided a submission suggested that there needs to be development of a clear and shared understanding of the roles and responsibilities of different parties within the sector. In addition, it was suggested that work could be undertaken at a national level to strengthen the collaboration and sense of community within primary health care. This would contribute to the sector's capacity to work effectively and act as a basis for strengthening the integration and coordination of care.

Building the capacity to identify and manage risk

Stakeholders are calling for the development and implementation of a method of accurately identifying the occurrence of patient safety incidents and identifying factors contributing to them. This could then feed into the development of more robust structures, processes and systems to support quality and risk management at the local level.

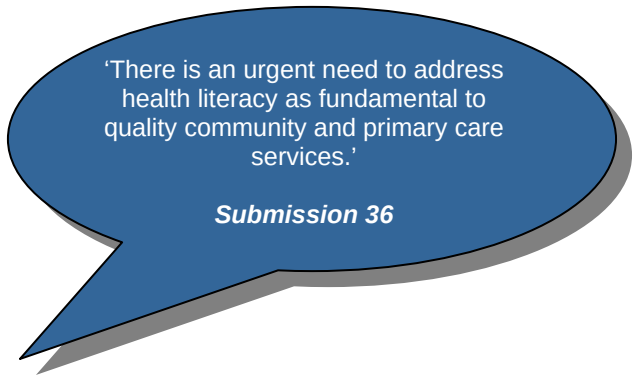
As part of this, it was considered that there needs to be a greater understanding and involvement of all primary health care staff in risk identification and management processes. Organisations need to develop the skills and credentials of staff responsible for managing quality and risk in primary health care organisations, across a range of professions.

At a regional, state and national level it was suggested that primary health care would benefit from improved coordination of existing quality improvement and patient safety activities in primary health care.

Improving communication and consumer education

Improving communication is key to increasing the safety and quality of primary health care. One submission suggested the development of communication pathways for providers across the sector and whole of health continuum. In addition, many submissions suggested that the implementation of strategies to mitigate clinical risks related to communication issues, such as discharge summaries and processes for clinical handover, were urgent and important issues.

A majority of submissions also noted health literacy as a critical safety factor which requires urgent attention, this was seen as an area potentially amenable to influence and an important opportunity to improve the safety of care for vulnerable people.



System-level issues

Many system issues were raised as requiring urgent attention, examples included the complex nature of the primary health care sector and services, and the potential for reform of funding mechanisms as incentives for improved safety and access to services. These types of issues influence the safety and quality of care, but are also critical influences on the effectiveness and efficiency of care. Any work to address these types of issues would need to be developed in consultation with health reform activity in this area.

6. What work is currently being done to examine or improve patient safety in primary health care?

Examples of work at the local level

Submissions provided examples of a range of activities that are currently being undertaken by different primary health care organisations that contribute to the safety of their services including:

- developing corporate and clinical governance structures
- establishing risk reference task groups
- undertaking root cause analysis and alternative review investigations
- reporting and monitoring through the Advanced Incident Management System
- undertaking corporate and clinical audits
- participating in accreditation processes
- completing Clinical Practice Improvement projects and training
- utilising patient satisfaction and/or experience surveys
- facilitating consumer participation in policy and program development.

However, feedback suggested that this level of review, investigation, reflection and development is not undertaken systematically or comprehensively across the sector. It appears that this work tends to occur where there is an interest, a clear safety culture and safety champions. Culture was seen as a critical factor influenced by traditional professional practices, affiliations, compulsory requirements, staff capacity and skills, and management and administrative priorities.

Examples of work at the regional, state and national level

A number of submissions provided examples of additional work being undertaken at the regional, state and national level with a focus on improving safety in primary health care including:

- the Victorian Healthcare Association's program on *Managing Clinical Risk in Primary Health Care*, which is part of the broader *Risk Management Frameworks and Clinical Risk Management Systems* project (Submission 17).
- the Victorian Department of Health's *Limited Adverse Occurrence Screening* (LAOS) programs in partnership with health services which are now being used in small rural services by general practitioners (Submission 17).
- the Federation of Ethnic Communities' Council of Australia and the National Prescribing Service's *Multicultural Quality Use of Medicines* program (Submission 19).
- Family Planning NSW's guidelines aimed at streamlining access to primary care services by people with a disability (Submission 23).
- the Victorian School Nurse's *School Nursing Professional Practice Standards* (Submission 31).
- the Australian Council on Healthcare Standard's *Evaluation and Quality Improvement Program (EQuIP)*, *Quality Divisions of Network* program, linkage documents, resource tools and *Risk Management and Quality Improvement Handbook* (Submission 32).
- the Royal Australian College of General Practitioners standards, guidelines, research and education programs and clinical audit tools (Submission 33).

- CRANAplus's education and training for remote health professionals and co-production of the *Central Australian Remote Practitioners Guidelines* (Submission 43).
- a range of medicines review programs under the Fifth Community Pharmacy Agreement including *Home Medicines Review*, *Medicines Use Review* and *Residential Medication Management Review*, and the *Clinical Interventions by Pharmacists* programs (Submission 50).
- the NSW Rural Doctors Network's telemedicine trials in remote NSW (Submission 49).
- the Australian General Practice Network's supporting quality use of medicines programs, education and training for primary health care professionals in safety and developing and implementing local e-health solutions, including for referrals and discharge summaries (Submission 51).
- the National Prescribing Service's studies related to patient safety in primary health care, online prescribing modules, *Good Medicines Better Health* project, *Medicines Line* phone services for consumers, educational visits, case studies, clinical audits, pharmaceutical decision support tools and interactive workshops (Submission 53).
- the Department of Health and Ageing's *Diagnostic Imaging Accreditation Scheme* and *Diagnostic Imaging Quality Program* (Submission 62) and new *National Standards for Mental Health Services* (Submission 63).
- the e-Health reform and work of the National e-Health Transition Authority (Submission 62).
- the Commission's new *National Safety and Quality Health Service Standards* and *Australian Framework for Safety and Quality in Healthcare*.

'Rural health service providers are very aware of the need to balance safety and quality of care with the patient choice, social and family needs including the risks and costs associated with travel on country roads to access services not available locally'

Submission 35

7. What patient safety in primary health care work would benefit from national coordination?

It was suggested that a national framework should be developed to guide primary health care service providers in activities to improve patient safety. Many respondents thought this should include defining the boundaries, roles and responsibilities within the primary health care sector; others suggested that there may also be a need to define a primary health care patient and an episode of care.

Some of those who provided submissions called for a nationally consistent system for reporting patient safety incidents or near misses in primary health care, including defining clinical indicators and coordinating development of a measurement framework which could be used for benchmarking. In particular, one respondent suggested the development of a centralised register for adverse medication events which could be used to monitor and analyse common factors and trends. These all were seen as activities which could be led at a national level.

Stakeholders wanted greater transparency and availability of information, including information coordination at a national level, in order to improve practices. Yet there were concerns that the historic culture of blame and fear of liability would be an impediment to action in this area. Respondents noted that the development of any reporting and measurement systems should focus on a goal of system or practice improvement rather than for use as a means of penalising individual practitioners or professions.

There were also calls for national action to ensure adequate resources are allocated to patient safety in primary care research, evaluation and reporting including a database to bring together results of patient safety research and other learning's and experience.

One stakeholder suggested that a national organisation should be established that would focus on research and data relevant to patient safety in primary health care. It was envisaged this organisation would coordinate the implementation of a national research agenda and data collection system to identify gaps in knowledge and coordinate activity to develop relevant clinical guidelines suited to guide practice in all primary health care settings.

It was widely acknowledged that improvement, coordination and streamlining of guidelines and standards were work that would benefit from national leadership and coordination. It was suggested that this should extend beyond clinical practice and include standards for clinical governance, accountability and medical software.

The issue of unlicensed care workers was also seen as an area requiring national action. A number of respondents saw this segment of the primary health care workforce as posing a risk to patient safety and saw opportunities for improving the level of qualification and the regulation of these types of care workers, for example in community aged care.

It was identified that some strategies to improve communication, such as health literacy initiatives would benefit from national coordination. A national approach in this area was seen as a means of ensuring coordinated and consistent health messages.

The vast majority of stakeholders acknowledged the role of e-health in improving aspects of patient safety in primary health care and that this was an area that would be largely led at a national level. However, e-health initiatives should be implemented in concert with more traditionally delivered safety improvement programs and strategies and policies in order to ensure maximum benefit. Some noted e-health should not be relied upon solely to improve communication within primary health care.

8. What role could different primary health care organisations take to improve patient safety in primary health care?

In response to this question submissions tended to refer to broad roles that organisations could take and reflected three different areas: supporting development of patient safety culture at the local level, facilitating collaboration and supporting national consistency and coordination for patient safety.

Support development of patient safety culture at the local level

It was suggested that primary healthcare organisations could support a patient safety culture at the service level by identifying patient safety champions, resourcing and supporting staff to undertake training in patient risk assessment and management, as well as ongoing continuing professional development, credentialling, providing appropriate levels of mentoring and supervision and generally taking action to build and maintain a satisfied and sustainable workforce.

It was suggested that primary healthcare organisations would also benefit from ensuring appropriate clinical governance mechanisms including risk management strategies are in place, and that there are systems and processes for ensuring evidence-based guidelines and standards are adopted.

Facilitating collaboration

Respondents suggested that organisations at all levels should be involved in developing partnerships between different services, including between government and non-government organisations, general practices, pharmacies, allied health services and other primary health care services, so that information sharing and greater coordination of services could be facilitated.

It was also suggested that primary healthcare organisations would have a role in fostering greater consumer involvement in services at a local and regional level, including using consumers in organisational planning and quality improvement processes through committees or structured consultation.

Those that responded noted that work needs to be undertaken by the whole sector, but also by organisations responsible for managing professional development, competencies and undergraduate training. These organisations should be encouraged to find ways to develop the skills and culture of health professionals in primary health care so that there is a stronger desire to proactively manage risks to patient safety in a collaborative manner.

Support national consistency and coordination

All relevant organisations should be involved in any development of nationally consistent systems for reporting safety incidents including the development of performance indicators, as well as any development of appropriate, effective and efficient guidelines and standards for the sector.

> ‘Monitoring and reporting systems should be well developed both nationally and locally.’
>
> ***Submission 9***

Tools should be developed at a national level that can be adapted and implemented at a local level to ensure consistent but flexible implementation of reporting systems, standards and guidelines across the thousands of small businesses in primary health care.

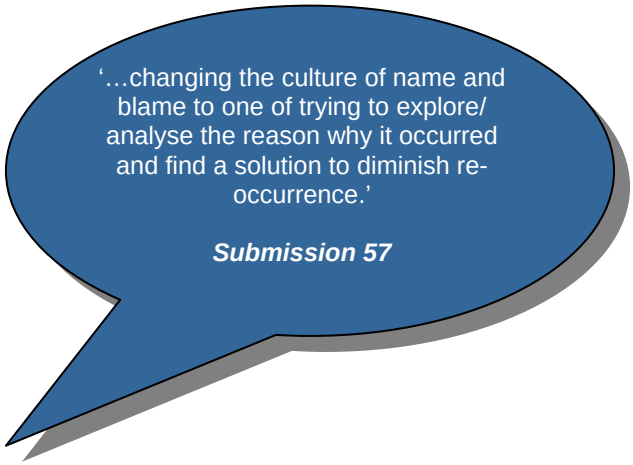
Additional considerations

Many stakeholders suggested that the already stretched resources within primary health care would need considerable support in order to implement any improvements to current service delivery models. It was viewed that staff need time and management support to dedicate the appropriate amount of investment in improving patient safety within primary health care services.

9. What would be the key challenges to implementing this kind of work in the primary healthcare sector? How could these challenges be addressed?

Culture/professional boundaries

A number of submissions acknowledged the role that culture plays in the process of identifying, acknowledging and responding to risks to patient safety in primary health care. Culture is influenced by the leaders of the organisation and, for patient safety risks to be minimised, those leaders need to be supportive of, and demonstrate investment in, a patient safety culture.



Linked with this is the issue of traditional professional roles, expectations and boundaries. The current reform process is challenging a number of these boundaries and there needs to be consideration of how to bring differing professions within primary health care to a shared understanding of the changing roles and responsibilities within the sector. In addition, as professions work more closely together, there needs to be a shared understanding of language and terminology used across the sector.

Fragmentation, coordination and complexity within primary health care

It is widely acknowledged that the Australian primary healthcare sector is a fragmented system, where there is limited service cohesion and a multitude of professions and providers offering services that are largely siloed. There are many different professional standards, guidelines, accreditation systems, registration and legislative requirements applicable to different segments of the sector, and in some cases these are not consistent.

Many primary healthcare organisations are private businesses while other services may be funded by state or federal governments. There are a high proportion of solo practitioners and practice accreditation is voluntary for general practices and community pharmacies. As a consequence many respondents noted that the drivers for change for individual organisations are different.

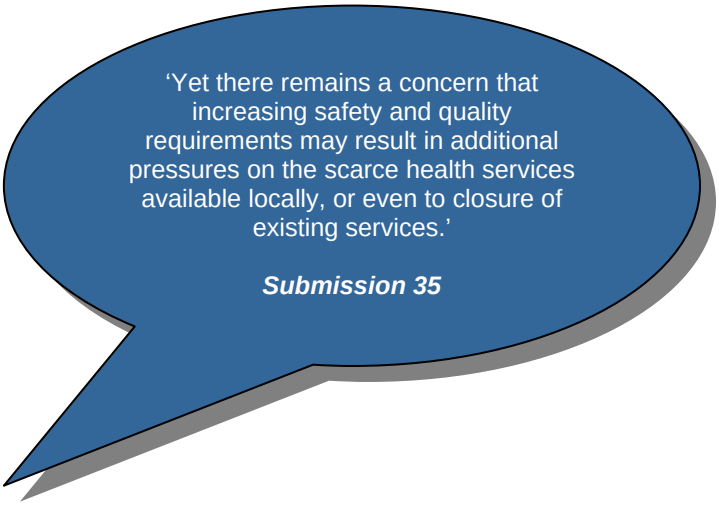
Consequently, attempting to change practices or apply standards to the sector as a whole would be complex and require considerable stakeholder engagement and consultation at both the national and local level. It also may not be possible to implement changes consistently within the sector until there is greater cohesion within primary health care and consideration of incentives or disincentives for delivering safer care.

Local implementation issues

Those who provided a response noted a number of challenges to implementing changes to improve safety of care at the local level. A central concern was the potential additional burden on services and staff that imposing these changes would likely entail.

Primary health care providers and services in many areas are stretched to capacity, there is little discretionary funding for activities and staff have limited time and in some cases expertise to undertake the type of review, reflection and systematic improvements which may be required.

Finding ways of genuinely engaging consumers at the service level was seen as key challenge for primary health care organisations, particularly raising health literacy of patients and gaining genuine patient and consumer participation in service improvement processes.



e-Health barriers

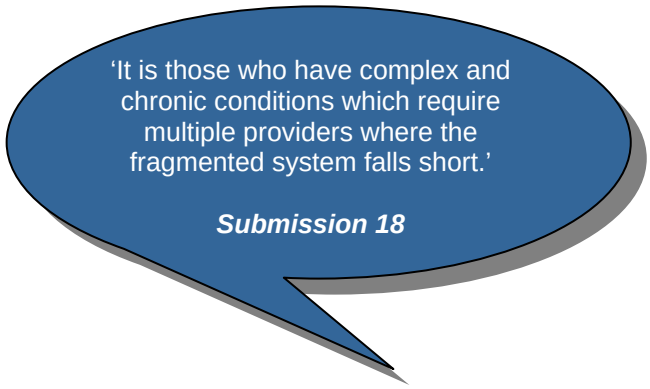
The vast majority of respondents saw the implementation of e-health initiatives as providing opportunities to improve communication, information flow, education and patient participation in their care. However, some respondents raised a number of potential barriers to implementation of effective e-health programs including lack of computers, significant double entry requirements in community nursing, the prevailing and traditional use of paper based records, limited access to internet, lack of connectivity and no mobile computer access in the field.

10. Are there specific patient populations that should be a particular focus when improving patient safety in primary health care? What are some of the unique challenges for these populations?

A range of groups were identified as potentially being at greater risk of safety incidents and harm than the general population. These groups are vulnerable in a range of ways and include:

- people from culturally and linguistically diverse backgrounds
- Aboriginal and Torres Strait Islander peoples
- people living in rural and remote areas
- people with a permanent or temporary injury or disability
- children including babies and young people
- refugees
- people from a low socioeconomic background including those with limited literacy, education, income and resources
- people with multiple conditions including those seeing multiple health providers and under multiple medication regimens
- people with a chronic condition (which may be either mental or physical)
- elderly people including those within community based residential facilities and living unassisted within the community
- people who are at risk of hospitalisation, or those preparing to enter or leave hospital.

Effort needs to be taken to ensure that services, programs and policies identify and address particularly vulnerable groups but also consider the broader implications of their vulnerability. For example, a patient with diabetes should be provided with information and education about diet and lifestyle changes that can improve their health along with their treatment. However, for those diabetic patients with low socioeconomic status and low health literacy living in a remote area, their vulnerability may pose challenges to their capacity to implement those lifestyle changes (e.g. access to fresh produce).



Part 3: Discussion

In this report we have summarised the responses to the discussion paper, including information on the types of safety risks which are seen as likely to occur within primary health care and the types of research, systems and processes that were suggested to help mitigate those risks.

There was agreement from respondents that, although we cannot yet accurately quantify the burden of unnecessary harm which is occurring, some harm must occur in primary healthcare. Stakeholders agree that that there is value in undertaking work in this area to better understand and address the risks to patient safety.

It was apparent from the variety of respondents' professions, affiliations, locations, service types, qualifications and skills that patient safety risks vary considerably and can be influenced by the context and environment in which care is delivered. There is value in and support for work to be undertaken at a national level to improve patient safety in primary health care, however, this type of work needs to have capacity for local adaptation to ensure that it is appropriate and relevant to local services and consumers and accounts for these contextual and environmental variables.

Key themes

The issues identified during the consultation process reflected four key themes. These themes align with key themes and priorities of other national initiatives such as the National Primary Health Care Strategy and primary health care reform activities under the National Health and Hospitals Agreement. Appendix D provides more information on these themes.

When developing its work program the Commission will be looking in detail at these key themes to help identify areas which are amenable to influence and within the Commissions remit. Directions the Commission may look at for each of the themes may include:

- **Theme 1: Lack of knowledge and understanding of the scope and extent of patient safety risks in primary health care.** This may include raising awareness of patient safety in primary health care, fostering research on patient safety in primary health care, raising awareness of the need for and value of risk management processes and developing capacity to identify and manage risk, developing patient safety indicators for primary health care and the development and adoption of local, regional and/or national systems for patient safety reporting.
- **Theme 2: Confusion about the scope, roles and responsibilities of the sector.** This may include fostering a greater sense of cohesion and collaboration within the sector, raising awareness of the roles and responsibilities within primary health care, supporting work to identify and address any inconsistencies in different qualification, licensing and registration requirements for equivalent professional practices.
- **Theme 3: Need for improved communication and consumer education.** This may include developing activities and strategies to improve consumer health literacy, developing or improving handover and communication processes within primary health care, work on e-health initiatives to improve record accuracy and availability, and clarifying practices around referrals and clinical pathways.
- **Theme 4: Limited accessibility of consistent guidance and standards for evidence-based care.** This may include reviewing and adapting existing guidelines and standards, developing new guidelines and standards, providing leadership on the most appropriate

and relevant guidelines and standards, and ensuring awareness of and equitable accessibility to guidelines and standards.

The Commission will look also at ways it can contribute, for example through work under national health reform, to addressing concerns associated with the system-level issues of access and integration and coordination of care. This may include developing communication tools and strategies, raising awareness and promoting use of multidisciplinary, collaborative and coordinated care models.

Opportunities and synergies

There are intersections between the work the Commission has undertaken for the acute care sector and the type of issues that challenge patient safety in primary health care. The Commission's work on the *Australian Charter for Healthcare Rights*, the *Australian Safety and Quality Framework*, the *National Safety and Quality Health Service Standards*, clinical handover, medication safety and healthcare associated infection present us with a number of opportunities to build on.

In addition, under the national health reform arrangements, the Commission will take on a greater role in the development safety and quality standards, guidelines and indicators and will work with clinicians, professional bodies and consumers to lead the drive toward practical health system improvements. There is clearly scope and a need for the Commission to undertake work specifically for the primary health care sector to address some of the concerns raised throughout the consultation process, particularly regarding clinical communication, collaboration and guidelines and standards.

It is also clear that many of the changes under health reform will affect the system-level issues raised during this consultation. The funding of new primary health care services, implementation of e-health initiatives and the establishment of bodies such as Medicare Locals, Lead Clinicians Groups and Local Hospital Networks aims to provide greater support and linkages between healthcare organisations, services and providers and facilitate improved communication. The Commission will contribute to addressing these system-level issues through its role in the health reform process and as a national leader in health care safety and quality.

The Commission is also undertaking developmental work to foster patient-centred approaches to health care including a focus on strengthening consumer engagement, communication and health literacy, which were key issues raised during this consultation process. As this program progresses there may be opportunity to develop products designed specifically for the primary health care sector.

Next steps

Over the coming months the Commission will be developing a program of work to support improvements to patient safety in primary health care. This program will take into consideration the risks, issues, opportunities and needs identified throughout this report, as well as looking at opportunities to build on the Commission's existing programs and aligning with other national reforms and primary health care programs.

The Commission's patient safety in primary health care program will reflect the Commission's role in working in partnership with organisations and individuals to improve the safety and quality of health care in Australia and to improve health outcomes for patients and consumers.

Appendix A:
List of Submissions

No	Respondent
1	Mr Ronald Humphreys
2	Centre for Healthcare Related Infection Surveillance and Prevention, Queensland Health
3	Australian General Practice Accreditation Limited
4	Associate Professor Laurie Grealisch, Faculty of Health, University of Canberra
5	Ms Diane Innes, The Good Shepherd Home
6	Greater Green Triangle University Department of Rural Health
7	Australian Rural Health Education Network
8	Medical Technology Association of Australia
9	Hunter New England Area Health
10	Dietitians Association of Australia
11	Department of General Practice, University of Melbourne
12	SA Council for Safety and Quality in Health Care
13	Combined Universities Centre for Rural Health
14	Australian Podiatry Association of South Australia
15	Ms Jenny Macmillan, Australian Institute for Primary Care and Ageing
16	National Medicines Policy Committee
17	Victorian Healthcare Association and Victorian Managed Insurance Authority
18	School of Nursing and Midwifery, Flinders University
19	Federation of Ethnic Communities' Councils of Australia
20	Health and Community Services Complaints Commission
21	Quality Improvement Council
22	The College of Nursing
23	Family Planning NSW
24	Centre for Remote Health
25	Speech Pathology Australia
26	Australian Nursing Federation
27	Australasian College of Podiatric Surgeons
28	Congress of Aboriginal and Torres Strait Islander Nurses
29	Australian Medical Association
30	General Practice NSW
31	Victorian School of Nursing
32	Australian Council on Healthcare Standards
33	Royal Australian College of General Practitioners
34	Heart Foundation
35	National Rural Health Alliance
36	Royal College of Nursing Australia
37	Australian Nursing Federation (Victoria Branch)
38	Royal Australasian College of Physicians
39	Aboriginal Medical Service Alliance Northern Territory
40	Consumers Health Forum
41	Australian Physiotherapy Association
42	Australian Psychological Society
43	CRANAplus

No	Respondent
44	Dr Elizabeth Barrett
45	SA Health
46	Council of Deans of Nursing and Midwifery
47	Victorian Managed Insurance Authority
48	Australian Institute of Health and Welfare
49	Royal District Nursing Service
50	Pharmaceutical Society of Australia
51	Australian General Practice Network
52	Statewide and Mental Health Services, Department of Health and Human Services Tasmania
53	National Prescribing Service
54	Queensland Health
55	NSW Therapeutic Advisory Group
56	Health Services Commissioner Victoria
57	Australian Practice Nurses Association
58	Ms Cheryl Hamill
59	Australian Indigenous Doctors Association
60	Victorian Quality Council
61	Queensland GP Alliance
62	Department of Health and Ageing
63	National Mental Health Consumer and Carer Forum
64	National Health and Medical Research Council
65	NSW Health
66	Medibank Health Solutions

Appendix B:
Further Detail on Key Risks to Patient Safety

There were a great variety of risks and risk factors identified throughout the submissions. Evidence on the prevalence of the risks identified is limited, however, the fact that these issues were repeatedly raised by diverse stakeholders indicates that these may be issues of concern to the sector.

When grouping the risks and risk factors identified we have modelled our categories on the taxonomy used in the *Measurement of Threats to Patient Safety in Australian General Practice* study (the TAPS study)[10] described in the discussion paper. The TAPS study errors were groups as either errors related to processes, or errors related to the knowledge and skills of health professionals. Similarly we have categorised risks as either:

- *process based issues:* this refers to issues that rise from the implementation or application of local level processes
- *education, training, knowledge or skills based issues:* which arise from training, education, qualification or the application of knowledge
- *systems based issues:* including health system structural issues that cause or compound safety risks for the individual or community.

The table below provides a summary of the key risks and risk factors that were identified through the consultation.

Category	Risk factor	Potential consequences
Process based risks	**Confusion between medicines that look or sound alike**	1) Risk of incorrect use of medication potentially resulting in adverse event or impact on effectiveness of medication.
	Use of complementary medicine	1) Possible medication interaction, adverse event or impact on effectiveness of medication.
	Increasing use of multiple medications	1) Can lead to medication interaction, adverse event or impact on effectiveness of medication.
	Increasing self medication	1) Potential medication interaction, adverse event or impact on effectiveness of medication.
	Use of non office-based primary care and care that is delivered in facilities not specifically designed for health services	1) Possible risk of adverse events due to service delivery at non-clinical community facility (eg. schools, public halls, outside, fly in/fly out services) including increasing use of home based care such as hospital in the home models (eg. chemotherapy in the home) and home visiting services.

Category	Risk factor	Potential consequences
Process based risks (cont.)	**Poor admission and discharge communication**	1) Poor awareness of pre-admission, admitted and post-discharge treatment can lead to failure to comply with ongoing/follow up treatment and can lead to complications resulting in readmission.
	Poor referral communication	1) Potential for delay in diagnosis and/or treatment may lead to greater complications.
	Poor communication between provider and patient (including failure to use interpreters and ensure cultural safety/sensitivity)	1) Can lead to misunderstanding of conditions, deter follow up attendance and lead to compliance issues. 2) May result in failure to identify safety incidents. 3) Possibly lead to failure to identify opportunities for system and process improvements.
	Uncoordinated and disjointed of care including lack of identified care 'team' and lack of identified clinical lead	1) Can lead to delay in accessing some services or accessing inappropriate services. 2) Patients may see different professionals in parallel which can lead to incompatible treatment. 3) Follow up quality reliant on local practice procedures/protocols which are variable and may not be consistent between services. 4) Potential to result in treatment for a series of individual conditions rather than holistic care.
	Variable accuracy and accessibility of documentation and records	1) Some records are handwritten which can lead to transcription errors, loss of records etc which effects on care delivery. 2) All software systems are not comparable and compatible and not all may be equally reliable in identifying clinically important medication interactions which can lead to medication errors. 3) Some nurses in general practice do not have access to records, even when performing care (or can not update records), which can lead to treatment errors or medication errors. 4) Lack of organised follow up procedures (e.g. post tests or post treatment) can lead to delayed diagnosis and/or treatment.
	Variable access to evidence and guidance on use of new technologies	1) Limited guidance may lead to inconsistent application of the technology and can increase errors and incidents. 2) Technological advances raise expectations about better outcomes and accessibility, when there may not be strong evidence (e.g. limited evidence on improved outcomes using robot surgery).

Category	Risk factor	Potential consequences
Process based risks (cont.)	**Inconsistent, non-systematised infection control systems**	1) Limited data collection can lead to poor awareness of extent of safety issue. 2) May result in increased risk of infection and/or incident. 3) Limited available guidance on infection control processes in the home or remote/outreach settings can lead to risk of infection in this setting.
	Poor implementation of clinical practice guidelines	1) Can lead to adverse or unrealised outcomes (e.g. use of opiod analgesics and poor compliance with cardiovascular disease risk assessment guidance).
	Competing guidelines and standards	1) There is no national gold standard guideline so decision on best practice care is variable which can increase risk of poor management of condition.
	Lack of guidelines that address multiple chronic conditions	1) Clinicians are provided with single condition guidelines; however, many patients experience multiple conditions which need to be treated in parallel. Without appropriate guidelines there is a risk that multiple conditions treated in isolation may produce adverse events.
	Lack of coordinated guidance on safety considerations for care outside the office practice setting	1) Application of office based protocols and guidelines in non-office based settings may be inappropriate and may not address the types of unique issues raised (e.g. community setting, at schools and other non-health based settings).
	Poor responsiveness to consumer needs and concerns (including involving patients in governance and design and delivery of care)	1) Potentially leads to lack of identification and prevention of safety issues and concerns. 2) May result in lack of engagement with the community.
Risks associated with education, training, knowledge and skills	**Limited consumer health literacy**	1) Influences potential treatment noncompliance, medication error other complication. 2) Can limit likelihood of participation and involvement in development and improvement of care systems. 3) May result in accessing and use of unreliable health care information from the internet to inform care decisions.

Category	Risk factor	Potential consequences
Risks associated with education, training, knowledge and skills (cont.)	**Health care providers practicing outside traditional scope without appropriate qualifications, education, registration, knowledge or skills**	1) In some cases health care providers/workers are being expected to undertake work outside their scope and training, which can lead to errors. 2) There is variance in expectations and training/educational/qualification and registration requirements for different professions for undertaking similar tasks (e.g. general practitioner requirements in order to prescribe compared with nurse practitioners) which may lead to variable implementation of the same care. 3) Different models of care, expectations of team, team composition and services provided in settings that are influenced by staffing shortages (e.g. rural and remote areas) can deliver variable care. 4) Changes to traditional practices (e.g. pathology) potentially raise the risk of unnecessary testing.
	Perception of poor cultural safety, security and privacy	1) May deter care attendance and compliance with care, particularly for Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically backgrounds. 2) Small communities and local health professionals could raise privacy issues, and fear of risk of personal health information being communicated with the community (often seen as a disincentive to seek care).
	Traditional professional boundaries, perceptions and concepts of primary health care	1) Can lead to confusion regarding roles and responsibilities which can result in consumers accessing incorrect or inappropriate services. 2) History within primary health care of not reporting risks, events and incidents, linked with fear of litigation can prevent reporting and addressing risks to patient safety. 3) Current reporting arrangements may be a deterrent as some are based on individual accountability for shared service delivery.
System issues	**National policy and program developers have limited knowledge of safety risks at the national level**	1) Impaired capacity to develop evidence-based interventions that target needs, and potential for ineffective or harm causing policies to be developed. 2) Limited capacity to provide appropriate support to organisations to help them identify and address safety issues may result in errors and incidents. 3) Development of inappropriate national strategies to address patient safety risks.

Category	Risk factor	Potential consequences
System issues (cont.)	**Inequity of funding support for professions/services to participate in multidisciplinary care**	1) May be a disincentive for providers to undertake multidisciplinary collaborative care. 2) Could prevent some patients from accessing some types of services (e.g. not all relevant health professionals may have access to Medicare Benefit Scheme rebates for care).
	Difficulty in accessing health services and providers in rural and remote Australia (including for remote Aboriginal and Torres Strait Islander communities)	1) Can be a disincentive to attend and maintain care regimes. 2) May raise privacy and confidentiality concerns due to close, small communities. 3) Potential for delayed diagnosis and treatment. 4) Consumer can be faced with the decision on whether to access any available care, delayed care or no care.
	Difficulty staffing health care positions in rural and remote Australia (including issues with short term contractors and high turnover)	1) Potential to lead to loss of confidence in care team. 2) May be a disincentive to attend and comply with health regimes (e.g. conflicting messages and lack of trust). 3) Possibly resulting in difficulty maintaining good governance and safety and quality programs. 4) Can lead to poorer access to appropriately qualified professionals and the resultant tension between any care versus no care.
	Increasing co-payments for consumers	1) May be a disincentive, particularly for vulnerable and disadvantaged groups, to access care. 2) Promotes rationalisation of care by consumers.
	Increasingly complex procedures being undertaken in primary health care (e.g. chemotherapy at home, home dialysis, minor surgical procedures in clinical rooms)	1) Potential for errors in procedures when the patient is responsible for complex care e.g. central line hygiene or administration of oral chemotherapy. 2) Possible errors due to the limited frequency with which some procedures may be practiced by some providers.
	Large disparate sector, with high proportion of standalone private facilities and providers	1) May result in limited cohesion, coordination and consistency of care within sector. 2) Potential for vast differences in quality, safety and outcomes across the sector.

Category	Risk factor	Potential consequences
System issues (cont.)	**Limited clinical governance and systems for continuous quality improvement**	1) Potential for poor systems and capacity to identify patient safety incidents. 2) Can result in poor systems and capacity to respond to and learn from patient safety incidents. 3) May lead to poor monitoring, reporting of patient safety incidents to community and consumers.
	Increased complexity in navigating the primary health care service system and proliferation of services with similar functions	1) Overwhelming array of providers and provider types combined with limited understanding of roles and responsibilities within sector can lead to inappropriate choice of provider, treatment and/or poor coordination of care.

Appendix C:
Case Studies

The following are case studies provided by respondents. Please note that these are directly taken from submissions and unedited.

Case Study 1 (Submission 21)

"Mr N, an intellectually disabled man in his mid 20s was attending a day program run by a large outer suburban community health service. The program was designed to help with his move out of institutional care into community living including the use of health services, and most activities operated from a local scout hall. The community health base for this program, has enabled this group of people with otherwise poor access to health services, to have their health needs addressed.

There are some 80 staff based in the community health service involved in supporting intellectually disabled adults in the region. Some three staff were involved in a particular activity on the day the incident occurred.

Two program participants became involved in a fight and while staff grappled with them, Mr N left the hall, ran down the street and onto a busy road. One of the staff ran after him but was not able to catch him. Mr N was struck by a car and was taken to hospital with a fractured leg.

Following the incident the agency conducted a review of risks in the program, and decided to move the activities to a more secure hall."

Case Study 2 (Submission 21)

"Ms R, a woman in her 30s had been attending a financial counselling service in a community health service for several years.. The counselling sessions were held in a small office overlooking a car park.

Ms R had never shown signs of emotional disturbance however on one occasion she arrived in an agitated state and throughout the interview with the counsellor became more distressed. The counsellor tried unsuccessfully to calm Ms R, however her agitation continued to build. The counsellor excused herself from the interview and sought help from a specialist psychiatric worker along the corridor. While she was out of the room, Ms R punched a glass window, severing the tendons in her wrist. She was bleeding profusely as the financial counsellor and the psychiatric worker attempted to assist her.

During that encounter, the two workers became smeared with the Ms R's blood, creating a risk of blood-born infection. Medical staff then arrived and donning gloves, proceeded to apply first aid then arrange to get Ms R to hospital.

The incident led to a review of procedures and the installation of distress devices."

Case Study 3 (Submission 21)

"Identical 6 month old female twins, A and B, were brought by their parents to the Immunisation Clinic for their immunisations. Although English was not the first language of either parent, interpreters were not required as the mother spoke good English and did not appear to have difficulties understanding.

The Immunisation Clinic was operated by a local council run on a monthly basis from a local Baptist church. It was staffed by child and family health nurses who have undertaken specific external training in immunisation and who are also required to maintain their accreditation annually through participation in update training. On the day of the incident it was staffed by 3 fully qualified and accredited child and family health nurses.

6 month immunisation for the twins comprised Prevanar (Pneumococcal vaccine) and Infanrix hexa (Diphtheria, Tetanus, Pertussis, Haemophilus influenza type B [Hib], Hepatitis B and Polio vaccines). Two doses of each vaccine were drawn up by two immunisation accredited child and family health nurses for administration to the twins. It was intended that each nurse would administer a different vaccine to each of the twins. Instead, both nurses accidentally picked up the same vaccine. Two doses of Prevanar were therefore administered to the first twin, A.

The error was realised by nursing staff immediately after the vaccines had been administered. Both parents were advised at this point of the error in administration. The regional Public Health Unit was consulted for advice and the mother was offered the opportunity to speak with the Public Health Unit directly, which she accepted.

Following advice from the Public Health Unit, the infants' mother then gave consent for the second vaccination of Infanrix hexa to be administered to twin A, and also gave consent for the other twin, B, to receive both vaccinations, all of which were done.

Twin A later suffered a fever and rash however the Public Health Unit advised that they were more likely to have arisen from a viral infection than as an effect of a Prevanar overdose.

The incident was subject to a Clinical Risk and Review process and a range of recommendations were made for changes to procedures including that one nurse should assume responsibility for each child throughout immunisation episodes, and that the service should ensure clear communication with parents about post immunisation care of injection sites."

Case Study 4 (Submission 21)

"Mr L, a 28 year old Aboriginal man attended an Aboriginal Health Service with chest pain and breathing difficulties. Mr L was married with three children. His first point of contact at the service was an aboriginal health worker who referred him immediately for examination by a general practitioner.

He was interviewed and examined by the general practitioner who discussed with Mr L the risk factors for ischaemic heart disease. He was then given an appointment card to return the next week for a cholesterol test and two weeks later an appointment with a cardiac specialist.

Mr L did not attend for the cholesterol test nor the specialist appointment but visited the service on subsequent occasions later in the year for treatment of boils and later, a dog bite. Approximately nine months after the first attendance he visited the service with pain under his right shoulder which had started three months earlier at the end of the football season. He was given a sample pack of a nonsteroidal anti-inflammatory drug. One and a half hours after this visit, the service received a telephone call from the local hospital advising that Mr L had collapsed on his way home

from visiting the service and had been taken to hospital by ambulance. He was unable to be resuscitated. His death was reported to the coroner. An autopsy revealed that the cause of death was coronary atherosclerosis. There was evidence of myocardial fibrosis, which was consistent with longstanding coronary artery disease.

Mr L's family later sued the service for damages over Mr L's death. At the hearing, the practice management and administrative procedures which existed at the service at the time of the first attendance were scrutinised in great detail. Evidence was led that the specialist clinic had been cancelled. During the course of the investigation into the patient's death it became apparent that the wrong patient's medical record had been produced to the clinic on the date of the specialist appointment. There was a note made on that date in another medical record which bore the same name as Mr L. There was nothing on the file to indicate that there were two patients with the same name. Usually, in this situation, the front cover of both files would be marked 'Note: two files with the same name'.

The system in place at the service when a person failed to attend the clinic was to follow up the patient either by telephone or by facsimile, and notify the patient of the need to attend the next specialist clinic. This did not happen in this case because the wrong file had been produced at the clinic. Ultimately, the judge found that it was a 'serious administrative error to extract the wrong file at the specialist clinic...'

With regard to the cholesterol test, the practice at the service was that if a patient failed to attend for this type of test, they would be offered the test at their next visit to the service. A new computer system was installed later which would pick up nonattendance and flag the nonattendance for the next practitioner. However, at the time when the test was booked, the paper based medical record system relied upon the next practitioner picking up the fact that there had been a nonattendance. This system appeared to have failed because, on the three subsequent occasions that the patient had attended the service, when he was seen by other GPs and health practitioners, the patient did not undergo a cholesterol test. Nor was there any indication that the initial GP's notes had been read and followed up by any of the other GPs or health workers.

In the court case, the initial GP was found not to be culpable as he was able to give a good account of his examination of Mr L and his warnings to him about the risks of coronary artery disease. On the other hand the service was found to have been negligent for a series of administrative problems which resulted in the patient not being followed up. The service did not have an adequate system to follow up patients who had been referred for further investigations and treatment. There was also an inadequate system for identifying files in which the practice had more than one patient with the same name."

(This case has been summarised from a report written by Dr Sara Bird in the Australian Family Physician Vol. 38, No. 5, May 2009, from a legal case. This case was reported in a medical journal and subsequent steps to improve the service's procedures were not reported.)

.Appendix D:
National Themes and Priorities for Primary Health Care

National Health and Hospitals Reform

Focus 1: Improving our hospitals
Focus 2: Better access to GP and Primary Health Care services
Focus 3: Training more doctors, nurses and allied health professionals
Focus 4: Supporting aged care
Focus 5: Investing in prevention
Focus 6: Helping those with mental illness

National Primary Health Care Strategy

Key Priority Area 1: Improving access and reducing inequity
Key Priority Area 2: Better management of chronic conditions
Key Priority Area 3: Increasing the focus on prevention
Key Priority Area 4: Improving quality, safety, performance and accountability

Patient Safety in Primary Health Care
Key Themes from Consultation

Theme 1: Lack of knowledge and understanding of the scope and extent of patient safety risks in primary health care
Theme 2: Confusion about the scope, roles and responsibilities of the primary health care sector
Theme 3: Need for improved communication and consumer education
Theme 4: Limited accessibility of consistent guidance and standards for evidence-based care in primary health care
System-level issues

- **A**ccess to primary health care services
- **I**ntegration and coordination of health care

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