Submission to the Australian Commission on Safety and Quality in Health Care

Patient safety and quality improvement in primary care - Consultation paper

This submission was prepared by Andrea Hernan, Associate Research Fellow, Deakin Rural Health, Deakin University on 5 December 2017.

Thank you for providing the opportunity for primary care stakeholders and consumers to provide a response to the Patient safety and quality improvement in primary care - Consultation paper. This submission addresses some of the following areas the Commission has outlined in the guide to providing feedback.

Discussed below is research into the safety and quality issues in Australian primary care services, patient and consumer involvement in improving primary care safety, and strategies the Commission could adopt/facilitate to assist with preventing error in primary care.

Patients and consumers have shown that they have an important role to play when preventing errors and reducing harm. Their firsthand experience of care has been linked to a patient’s ability to provide detailed information about the processes, systems and structures that have led to the occurrence of an adverse event.1

Evidence suggests that patients have intimate and detailed knowledge and experience of their health care journey, have been able to identify a range of errors, and can adequately comment on when and why things have gone wrong.2 Patients can provide real-time information about patient safety that is a direct reflection of what is important to them regarding potential risks and how they can be prevented.3 6 Patients have also displayed insight into safety issues that professionals or others may not recognise,7 and reported safety incidents that may have gone undetected using other safety reporting methods.6 Research investigating the reliability of patients’ accounts has verified patients to be a trustworthy source of information. The information they provide has been used as part of wider patient safety learning systems and interventions.8-12

Although there are well-recognised benefits for involving patients to improve the safety of their care, there are still some unresolved contentions regarding the effectiveness of interventions,13 the roles and responsibilities of both patients and health professionals,14 and the kind of health care culture and organisational governance required for patient involvement in safety to occur successfully.7
Accordingly, research conducted with primary care patients in Australia has uncovered their perspectives of safety, how their views can be appropriately captured through the use of feedback tools, and how primary care staff can respond to patients’ safety concerns.

A series of studies conducted by myself and my colleagues with primary care patients has revealed that patients’ generally had an assumed sense of safety in the primary care setting. This perception was mitigated by feelings of trust and the doctor–patient relationship and limited patients’ risk awareness and ability to comment directly on potential safety issues. However, patients were able to identify various error-producing and latent conditions in the primary care setting which contribute to safety incidents. Using these patients’ views of safety, a patient involvement in safety tool was developed which could serve two purposes; 1) to engage patients as safety partners during their care and, 2) to provide feedback to primary care practices that can then be used to undertake safety improvement work. The tool is the Primary Care Patient Measure of Safety (PC PMOS) and has shown good reliability and validity with a large sample of primary care patients.

The PC PMOS is a 28 item questionnaire that captures patient feedback on 9 domains of contributing factors to safety including: access to care, communication, the external policy environment, information flow, organisation and care planning, patient related factors, the physical environment, referral systems, task performance and team factors. The data collected on the PC PMOS questionnaire could be used to develop, implement, and measure the effectiveness of specific safety prevention activities. Furthermore, data collected on the PC PMOS could compliment other patient safety intelligence data collected in primary care practice, such as staff incident reporting data and patient complaint data.

The feasibility of the PC PMOS as a tool to improve patient safety in primary care is currently being investigated by our research group with results expected in 2018-2019.

In the absence of any other available patient feedback on safety tools relevant for the Australian primary care context, the PC PMOS would be an appropriate tool for the Australian Commission on Safety and Quality in Health Care to promote and assist with implementation at a national level. Implementation could occur through systematic introduction of the PC PMOS into the National Safety and Quality Health Service (NSQHS) Standards and/or Indicators for primary care, and the National General Practice Accreditation Scheme (using the Royal Australian College of General Practitioners (RACGP) Standards for General Practice).
Specifically, the PC PMOS could become one of the RACGP approved questionnaires and be used to address the RACGP Standards for General Practice: Quality improvement Standard 1 and Quality improvement Standard 3 - Clinical risk management.19

Primary Health Networks are another avenue that the Commission could support the implementation of the PC PMOS. PHNs are in ideal position to promote the PC PMOS through their internal networks and assist with implementation at the practice level. As part of the feasibility study conducted by our research team, a practice manual and a training and education package will be developed to facilitate the introduction of the PC PMOS as a safety improvement approach. These resources could be available for PHNs to distribute and support their implementation.

Lastly, in collaboration with the Commission, national-level PC PMOS data could be collected by my research team to create the first national repository of patient feedback on safety in primary care. This kind of dataset would be invaluable in terms of learning about safety, generating national benchmarking opportunities for patient safety, and provides an opportunity for directing improvement initiatives by identifying weaknesses in the system that are leading to errors and harms occurring during clinical care delivery.

If you require further information about the research mentioned in this submission please feel free to contact me.

Yours sincerely,

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The views expressed in this response to the Patient safety and quality improvement in primary care - Consultation paper are those of the author and not necessarily those of Deakin University, primary health care organisations or primary care patients.
References: