

Dilemmas in Risk Management

Professor Aneez Esmail looks at three difficult situations and offers his advice.

'Much can go wrong in General Practice, so it is important to have a system to learn from your mistakes'.

The average practice has around four incidents that could lead to harm to patients each week.

Most of them will have very little consequence - a misfiled result or a missing discharge letter for instance – but too often they are ignored until something more serious happens, for example after a delayed diagnosis or even a misdiagnosis which may result in harm.

However, a practice wishing to improve patient safety should have good systems in place to record and learn from these incidents, and be proactive in identifying and mitigating risks that might emerge.

This article will look at common problems practices have in developing risk management systems and provides some advice on how to resolve them.

Problems getting started

'After a number of close-calls you agreed to make improving patient safety a priority a year ago, but nothing has changed. How can you establish a new system to manage risk?'

In order to improve patient safety, your practice must have a culture where staff are encouraged to evaluate risk, mistakes are acknowledged and there is a system to take action when things need to be put right.

This is not an easy task and it requires a good understanding of your practice's approach to risk management and a broad discussion about the 'safety culture' in your practice.

If you have decided to make patient safety a priority, then it is important to put someone in charge and agree a timetable of key activities and deadlines. Their first task should be to carry out an audit to assess your practices' safety culture.

The best tool for doing this is the Manchester Patient Safety Framework (MaPSaF) [1]. This tool was developed for general practice and will enable you to evaluate the overall commitment to patient safety in your practice.

The person in charge should watch the video on how to use MaPSaF **'Build a safety culture'** <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=61598> and then facilitate a discussion on safety culture in the practice using the tool. You will need to set aside about two hours as a practice team to do this, but it is a worthwhile exercise to stimulate discussion about the strengths, weaknesses and differences of the patient safety culture in your practice.

By carrying out this audit together, your practice team will have a shared understanding of where the main problems are; the barriers to improving things and also some of the strengths of the

practice. You should repeat this audit every two to three years (or sooner if you find that there are significant problems).

Lack of formal procedures

'We are a small practice and have rather an ad-hoc way of recording events that impact on patient safety. How can we formalise this process?'

So many things could go wrong in general practice that it can be difficult to know where to start, but starting a reporting system is essential to managing risk.

Agree that as a practice for a four-week period you will report on adverse events that take place within the practice. Give all staff the ability to anonymously report incidents that disrupt the delivery of best quality care in the practice.

Such an event may be small or large, administrative or clinical - anything that a practicing GP identifies as something to be avoided in the future. A good guide is if you conclude that the incident *'was something that should not happen in my practice, and I don't want it to happen again'*.

The simplest way to do this is to use a confidential web-based reporting tool with a link on every clinical computer. The NPSA's Incident Report Form [2] is one example, with a typical report taking only five minutes to complete and allows you to review all the incidents in your practice (**Practices are able to download their own data from the NPSA. At the end of the process it will ask if you want to save a local copy**).

The purpose of this is to systematically record what sort of errors take place, where and when they happen, who is affected by them and the potential and actual consequences. In a typical group practice of 5,000 patients, over a four-week period, you will expect to collect about 15 patient safety incidents.

At the end of the month, the person in charge should read the reports and present them to the practice. At this point you should not analyse the incidents, but get an agreement on which of them should be studied in more depth. Repeat this exercise at a different time each year and gradually build up a database of patient safety incidents.

Remember, this process is not a replacement for audits of significant events, which practices should conduct on an ad-hoc basis.

Too much information

'We are drowning in information, with a series of reports of significant events and our incident reporting system, but how can we learn from them?'

It is important to allow a practice to get to the heart of the problem and avoid any quick assumptions or individual blame for an incident, and there are various techniques to help do this.

Many incidents can be analysed through significant event audits and Professor Mike Pringle has given some excellent advice on this that I will not repeat [3]. However, for more serious outcomes (serious harm or death) often Root Cause Analysis is used.

Root Cause Analysis shows where systems need to be developed to prevent future harm, by identifying the chain of events and the contributory factors which caused the incident. It works best when the whole practice team is involved in agreeing to the investigation and learning lessons from it.

The practice should agree on an incident investigator who would need to be able to demonstrate competence, be objective and be independent. Ideally two or three people from different backgrounds should part of the investigating team (e.g. a GP, the practice manager a practice nurse/nurse practitioner).

The first stage will need to identify the chronology of the events, piecing together information from the records, interviewing staff, reviewing current policies and protocols. Most of this can be collected by the lead investigator.

Having collected the information, the investigator with the other members of the team will be able to develop a chronology of events. This is best written down as a flow chart showing a flow of events with some minimal descriptors.

Having gathered and mapped the information, the next stage is to analyse the underlying causes and lessons that can be learned. Many of the techniques used in this stage will be familiar – including brainstorming or brainwriting (where ideas are proposed anonymously on slips of paper and then read and transcribed by the investigator – useful if you want to avoid some individuals dominating the activity). The purpose of this stage is to generate as many ideas as possible to identify the cause of an incident and its possible solutions. It is best done as a whole practice team activity.

One of the most useful techniques in general practice is the ‘five whys’ technique. The key concept of the five whys technique is to keep posing the question ‘why?’ whenever a new cause has been identified. Typically by asking the question five times, the root causes of most problems can be identified. There is a simple template to record this on the NPSA website [4].

Having identified the root causes, it is important to consider what control measures can be implemented to prevent the incident happening again. You may have to revisit your protocols and checklists to see if they need to be modified or if new ones need to be developed.

For example, a very common area for safety incidents that cause significant harm are delays in diagnosis, which could be improved by systems that ensure that abnormal results are appropriately dealt with. It is important that any changes that are made are piloted and then reviewed – part of closing the loop.

Finally, ensure that you keep a record of what you have done. People leave and things get forgotten and having an organisational memory is a critical part of learning from things that go wrong.

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1. Manchester Patient Safety Framework (MaPSaF).
<http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59796>
2. National Patient Safety Agency. Incident Report Form.
<https://www.eforms.npsa.nhs.uk/gpreport/>
3. Dilemmas in significant event auditing, Pulse 2010.
<http://www.pulsetoday.co.uk/story.asp?sectioncode=24&storycode=4127376&c=4>
4. *Root Cause Analysis: Five whys tool* -<http://www.nrls.npsa.nhs.uk/resources/?entryid45=75605>

Questions:

1. **In an average general practice, how many patient safety incidents would you expect to occur each week?**

Never

10

4 ✓

Less than 2

30

2. **MaPSaF is a tool to**

Report patient safety incidents

Analyse patient safety incidents

Calculate the number of incidents that occur each week

Audit the safety culture of your practice ✓

Assess the patient safety climate of your organisation

3. **A reporting system will help you to**

Assess the safety culture of your practice

Classify all the serious clinical patient safety incidents in your practice

Keep a record of anything that should not have happened and which you don't want to happen again ✓

Keep a record of significant event audits

Identify who is to blame for things that go wrong

4. Root cause analysis is a mechanism for

Carrying out a significant event audit

Assessing the safety culture of your organisation

Identifying the person who is responsible for the patient safety incident

Working out the order in which things happen

Identifying systems that need to be developed to prevent future harm v

5. You should carry out a root cause analysis

On every patient safety incident

Only on significant events

On all incidents that involve a failure in diagnosis

On all incidents that involve a medication error

On patient safety incidents where you need to identify the chain of events, the contributory factors the lessons to be learnt v