EQuiP

European Association for Quality and Safety in General Practice/Family Medicine

(C) Kristyna Kozouskova

EQuIP
Conference on Patient Safety

22/23 *April 2016*

Dear colleagues and friends,

PP slides (Welcome to the Czech Republic, 2MB)

Let me to invite you: Family physicians and other professionals involved in primary care with quality and safety, on behalf of the International Organizing Committee, to the EQuiP Conference on **Patient Safety** from April 22-23 in Prague.

European Society for Quality and Safety in Family Practice (EQuiP), a network organization within WONCA Region Europe, chose this emerging topic in order to provide primary care physicians with up-to-date information on methods and processes used to improve quality and patient safety in primary care around Europe and to share international experience with safety initiatives on practice, regional or national level.

The conference will address both participants with none or limited experience with patient safety as well as experts in the field. Some of them, Dr. Maria Pilar Astier-Pena from Spain, prof. Aneez Esmael from UK or Dr. David Marx from the Czech Republic will provide key note lectures on safety awareness, research on safety and safety sustainability.

The discussion-based format of the conference will encourage audience participation through interactive workshops and practice-based studies.

The additional value of this meeting is an opportunity to visit again beautiful, affordable and visitor friendly Prague, and to meet colleagues and get knowledge in a historical venue, a palace built in the 17th century, located in the middle of old Prague, where the conference will take place.

Look for more information on the website of the conference:
www.equip2016.cz

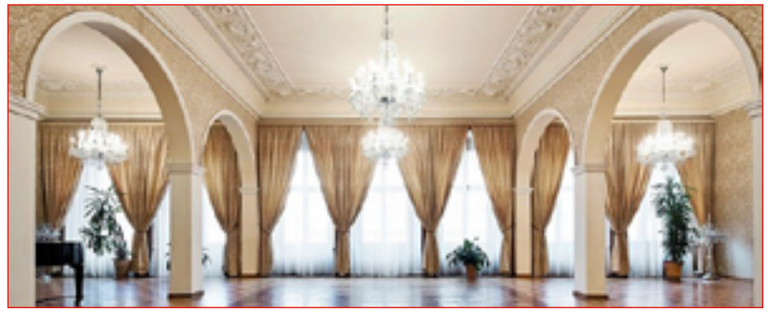
Bohumil Seifert

Conference Venue : Kaiserstein Palace

Malostranské náměstí 23/37,110 00 Praha 1

Discover the discreet charm of this Baroque work of art in Prague's Lesser Quarter. Originally built in 1654, it is now protected as a historical landmark by UNESCO. The palace has had many famous guests over the years, such as opera diva Emmy Destinn, or the scientist Joachim Barrande.

Kaiserstein Palace has a variety of halls and function rooms available to meet all social event requirements in a refined style.



Organising Committee

1 **Bohumil Seifert, Chair**
General practitioner and assoc. professor, head of the Department of General Practice, First Faculty of Medicine Charles University in Prague, Czech Republic

2 **Adrian Rohrbasser**
General Practitioner, Switzerland EQuiP delegate, Will, Switzerland

3 **Piet Vanden Bussche**
General practitioner, president of EQuiP, Berchem, Belgium

4 **Jan Kovar**
General practitioner, Czech EquiP delegate, Volyne, Czech Republic

5 **Isabelle Dupie**
General Practitioner, French EQuiP delegate, Paris, France

6 **Ynse de Boer**
General practitioner, Danish EQuiP delegate, Copenhagen, Denmark

7 **Jose Miguel Bueno Ortiz**
General Practitioner, SEMFYC delegate in EQuiP, Murcia, Spain

8 **Dijana Ramic**
General Practitioner, Croatian EQuiP delegate, Krapina, Croatia

Fatal mistakes

Source: Sarah Kliff on March 15, 2016

Follow this **link**:

Doctors and nurses make thousands of deadly errors every year. They are reprimanded. Do they also deserve support?

Kim Hiatt had worked as a nurse for 24 years when she made her first medical error: She gave a frail infant 10 times the recommended dosage of a medication. The baby died five days later.

Hiatt's mistake was an unnecessary tragedy. But what happened next was an unnecessary tragedy, too: Seven months after the error, Hiatt killed herself.

"She fell apart," her mother, Sharon Crum, says. "I suppose it would be the same thing you felt, if you felt at fault for a child's death."

This is a story about Hiatt, the mistake she made, how she struggled with that tragedy, and how the institutions that had previously supported her ultimately shut her out.

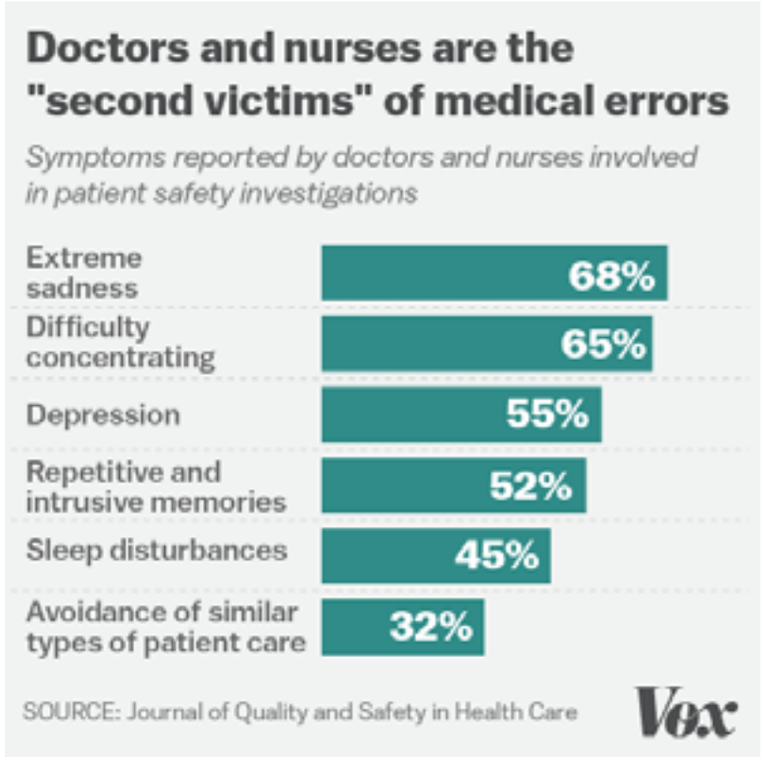
It is also a story about an open secret in American medicine. Medical errors kill more people each year than plane crashes, terrorist attacks, and drug overdoses combined. And there's collateral damage that often goes unnoticed: Every day, our healers quietly live with those they have wounded or even killed. Their ghosts creep into exam rooms, their cries haunt dreams, and seeing new patients can reopen old wounds.

"Every practicing physician has either made an error that harmed a patient or certainly been involved in the care of a patient who has been harmed," says Albert Wu, who directs the Johns Hopkins Center for Health Services and Outcome Research.

A new line of research that Wu began in the 1990s has found that many health care providers experience anguish, turmoil, and emotional trauma in the wake of a serious medical error. The providers are, in Wu's view, "second victims" of the mistake.

Just like their patients, these providers struggle to make sense of how an effort to heal turned into serious harm. One 2009 study found that two-thirds of providers reported "extreme sadness" and "difficulty concentrating" in the wake of harming a patient. More than half experienced depression; one-third said they avoided caring for similar patients afterward, for fear of making a similar mistake. Some consider suicide — and a smaller fraction, like Hiatt, take their own lives.

Nurses and doctors rarely discuss mistakes with their colleagues. Bringing attention to a mistake feels like highlighting one's own incompetence. Clinicians know that their peers have somehow managed to survive these events and turn up to work each day. So they try to do the same.

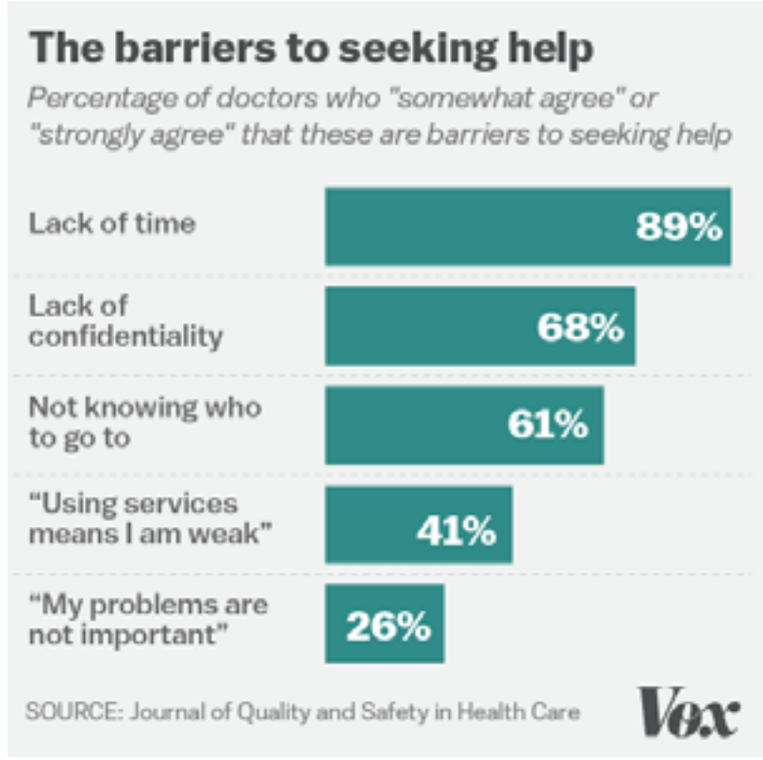


"The best word I can use to describe that day, and really the first couple of days, is isolated," says Rick van Pelt, an anesthesiologist at Brigham and Women's Hospital in Boston who nearly killed a patient during a routine surgery in 1999. "There was no way to communicate effectively to my wife what had happened. What do you say when you almost killed a patient? I was a horror show."

It's easy to write off these providers' anguish as insignificant next to that of the patients and families they've harmed. They made a horrible, harmful mistake. Maybe they should feel bad! But clinicians don't exist in a vacuum. In the wake of an error, they have to keep seeing patients and performing surgeries. If they don't regain confidence in their skills, other patients could suffer.

And as any clinician will tell you, even the best doctors make mistakes — if we are going to have a medical system, then we are going to have medical errors. So it's important not only to learn how to prevent all the errors we can, but also to support clinicians when they inevitably do make mistakes.

About a dozen hospitals nationwide — out of 4,000 total — have begun to set up anonymous hotlines where clinicians can call and talk to a peer about their emotional traumas. The idea is to give them a safe space, isolated from the malpractice system or even their own name, to talk openly about their grief. It's a small step toward a shift in medicine, away from a culture that sees mistakes as unspeakable and toward one that recognizes that America's health care providers —people like Hiatt — have suffered tremendously.



Online recources

Learning from International Networks about Errors and Understanding Safety in Primary Care:

LINNEAUS Euro-PC

Patient safety implications of general practice workload (RCGP)

British Journal ofGeneralPractice, April 2014 (Editorials)

Monitoring patient safety in general practice: the increasing role of GPs

Programme & PP Slides

Friday 22 April

9:00-09:30 Welcome and Opening Session
- PP slides (Welcome, 5MB)

09:30-10:30 Keynote: David Marx:
Patient Safety Sustainability - Ever Climbing, Never Rest!
- PP slides (Marx, 3MB)

10:30-11:00 Coffee and Tea

11:00-12:30 Workshops & Oral Presentations

Workshops
What is Patients safety in Primary Care?
(Ynse de Boer, Denmark)
- PP Slides (de Boer, 2MB)

EQuiP's Patient Safety Culture Survey
(Isabelle Dupie, France)
- PP slides (Dupie and Van Nhieu, 2MB)

Oral Presentations (Chair: Jan Kovar)
Don't assume that your patient is straight
(Janecke Thesen and Gunnar F Olsen, Norway)
- PP slides (Thesen and Olsen, 1MB)

Inappropriate medication in nursing home residents – How to improve medication safety?
(Guido Schmiemann, Germany)
- PP slides (Schmiemann, 2MB)

How do healthcare professionals assess patient safety culture in family medicine in Croatia?
(Orlic Neretljak, Croatia)
- PP slides (Neretljak, 1MB)

Quality improvement in antibiotic prescription in uncomplicated Lower Urinary Tract Infections
(Cátia Barão, Portugal)
- PP slides (Barão, 1MB)

Patient safety for patients with chronic diseases
(Eva Arvidsson, Sweden)
- PP slides (Arvidsson, 1MB)

12:30-14:00 Lunch

14:00-15:00 Keynote: Maria Pilar Astier-Pena:
Are Spanish Healthcare professionals aware of patient safety? Building a safer primary care.
- PP slides (Atier-Pena, 33MB, big and slow download)

15:00-16:30 Workshops & Oral Presentations

Workshops
The aftermath of adverse events (AE) in primary care: Interventions to reduce its impact on healthcare teams
(Maria Pilar Astier-Pena, Spain)
- PP slides (Atier-Pena, 21MB, big and slow download)

Assessment by GPs of a GPs capacity to deliver healthcare which is safe for them and their patients
(Andree Rochfort, Ireland and Zlata Ožvačić Adžić, Croatia)
- PP slides (Rochfort and Adžić, 1MB)

Oral Presentations (Chair: Dijana Ramić Severinac)
To report or not to report: That is the question! Using the theory of planned behavior to explain healthcare professionals' use of CIRS in primary care
(Anna Bauer, Germany)
- PP slides (Bauer, 1MB)

Feeling safe in primary care: preliminary findings from a longitudinal, ethnographic study (MAXIMUM) of older people with multimorbidity
(Rebecca Hays, United Kingdom)
- PP slides (Hays, 1MB)

The German Critical Incident Reporting System for Primary Care: 12 years of content and perspectives
(Martin Beyer, Germany)
- PP slides (Beyer, 2MB)

PRisM study: Assessment of a multifaceted program on teamwork and risk management in primary care
(Marc Chaneliere, France)
- PP slides (Chaneliere, 1MB)

Strengthening capacities to improve quality and patient safety in primary care. Experience from the Czech Republic
(Bohumil Seifert, Czech Republic)
- PP slides (Seifert, 1MB)

Patient safety in primary care in Hungary
(László Róbert Kolozsvári, Hungary)
- PP slides (Kolozsvari, 3MB)

16:30-17:00 Coffee and Tea

17:00-18:00 Panel Discussion: *How to engage our colleagues (doctors and staff)?*

- Conference Dinner -

Saturday 23 April

09:00-10:30 Keynote: Aneez Ismail:
Patient Safety in Primary Care in the past, now, and in the future
- PP slides (Esmail, 1MB)

10:00-11:30 Workshops & Oral Presentations

Workshops
How to deal with unintended events?
(Piet vanden Bussche, Belgium)
- PP slides (Vanden Bussche, 6MB)

How to measure patient safety?
(Aneez Ismail, United Kingdom & Ynse de Boer, Denmark)
- Please consult Ismail's PP slides above

11:30-12:00 Coffee and Tea

12:00-13:00 *Concluding remarks: Where to go next with patient safety for primary care?*
(Piet vanden Bussche, Belgium & Job Metsemakers, the Netherlands, Isabelle Dupie, France & Ynse de Boer, Denmark)

Conference Abstract Book and Programme Overview

Link to **Conference Abstract Book**

Video recordings

David Marx (Czech Republic):
- Patient Safety Sustainability - Ever Climbing, Never Rest!

Rebecca Hays (the UK):
- Feeling safe in primary care: preliminary findings from a longitudinal, ethnographic study (MAXIMUM) of older people with multimorbidity

Anna Bauer (Germany):
- To report or not to report: That is the question! Using the theory of planned behavior to explain healthcare professionals' use of CIRS in primary care

Bohumil Seifert (Czech Republic):
- Strengthening capacities to improve quality and patient safety in primary care. Experience from the Czech Republic

Martin Beyer (Germany):
- The German Critical Incident Reporting System for Primary Care: 12 years of content and perspectives

Marc Chaneliere (France):
PRisM study: Assessment of a multifaceted program on teamwork and risk management in primary care

László Róbert Kolozsvári (Hungary):
- Patient safety in primary care in Hungary

Patient Safety videos and slides from NHS Brighton and Hove Clinical Commissioning Group Quality Conference
- Source:

In November 2015, the CCG held a Patient Safety Conference which focussed on how we learn from incidents , and on the empowerment of front-line clinical teams to improve quality and patient safety. All the videos from our 'Quality Streets Ahead' patient safety conference are now available to view and share on the CCG's YouTube channel.

You can find a **two-minute summary film of the event here**.

Full-length films of presentations are linked below, and the **papers that accompanied the presentation can be found here**.

Supporting People To Get The Most From Their Medicines
(Speakers: Cleo Butterworth, Medicines Optimisation Lead, and Kath Howes, Lead Pharmacist, NHS Lewisham CCG)

Re (think) Patient Safety (Dr Suzette Woodward, National Campaign Director for the Sign Up To Safety Campaign)
- Video:

Enhancing Patient Safety In General Practice (Dr Martyn Diaper, Head of Primary Care Patient Safety, NHS England).
- Video:

Safeguarding Symposium delivered by our Director of Clinical Quality and Patient Safety, Soline Jerram.
- Video:

Culture Symposium delivered by the KSS Patient Safety Collaborative
- Video:

***Maria Pilar Astier-Pena** (Spain)*
She is a full time GP in Centro Salud de Caspe (Servicio Aragonés de Salud), a rural Health Centre in the North of Spain since 2010. Chair of the Spanish Society of Family and Community Medicine (SEMFYC) Patient Safety Working Group since 2012 (link to Twitter), which organizes the Annual Conference on Patient Safety in Primary Care and member of the National Board of the Spanish Society for Quality in HealthCare (SECA) since 2008, currently serving as Honoray Secretary.

She belongs to the Second Victim and Third Victim Research Group (link to Facebook and link to Twitter) who is currently working to develop tools to train and support second and third victims in the healthcare system.

She will present the first Spanish national survey on patient safety culture in primary care: Are Spanish healthcare professionals aware of patient safety in primary care? (The European Journal of Public Health 2015). Results may reflect on-going efforts to build a strong safety culture in primary care in Spain as in other European countries. 4,344 Primary Care professionals completed questionnaire showing significant variation in perception between certain dimensions among professionals over 55 years, with managerial responsibilities, women, nurses, administrative staff who had better PSSI scores than professionals with more than 1500 patients and working for more than 11 years at the same Heath Centre. This has potential safety implications and may have to be aligned for a positive and strong safety culture to be built and maintained.

***Aneez Esmail** (United Kingdom)*
He is Professor of General Practice at the University of Manchester and Director of the NIHR Greater Manchester Patient Safety Translational Research Centre.

As a health services researcher he has published work in several areas of public health (prevention of cot deaths, epidemiology of solvent abuse, preventing paediatric admissions, the evaluation of telemedicine and patient safety).

He is recognised internationally for his research on discrimination in the medical profession. Within the UK his work has resulted in significant changes in recruitment, selection, monitoring and assessment of the medical profession. This work was recognised internationally with the award of a Harkness Fellowship and Visiting Professorship at Harvard University in 1997.

He will discuss fundamental questions such as: Has patient care been safe in the past? Are our clinical systems and processes reliable and are we responding and improving? Is care safe today and will it be safe in the future? Can we collaborate to improve safety in a primary care system in Europe that is so heterogeneous that it can challenge many of our precepts about what works and what can be done?

Also, he will run a workshop about the measurement and monitoring safety from the perspective of primary care. This will build on the ground breaking work of Charles Vincent and how we can use this framework in primary care.

Read more here.

***David Marx** (Czech Republic)*
Since the early nineties, he has been actively participating in the health-care system reform of the Czech Republic. He is at present advising the Czech Ministry of Health on issues concerning health care quality and safety. He is also a member of the Charles University Faculty (Prague) - Vice-Dean on the Third Medical Faculty.

He will discuss: Patient Safety Sustainability - Ever Climbing, Never Rest! Although health care industry has been for long time known as a highly risky one, the introduction of risk-reduction tools into everyday clinical practice has been much slower that in other areas. Systematic quality improvement and patient safety measures started in the Czech Republic in 1998, but it took over 10 years to launch nationwide tools to improve patient safety.

In 2009 the country has introduced national patient safety goals and launched action plan for patient safety. The presentation describes most frequent implementation obstacles observed in applying sustainable patient safety programs and examples of successful practice.

Read more here.

Short report of the panel discussion

Q: Is patient safety an issue that we need to address in general practice/family medicine?

A: *It is an issue! It is important to reflect on it and to work on it in general practice!*

Panel members
Zlata Ozvacic Adzic(*Croatia*)
Maria Pilar (*Spain*)
Jochen Genischen (*Germany*)
Isabelle Dupie (*France*)
Job Metsemakers (*the Netherlands and Wonca Europe president*)
Aneez Ismael (*the UK*)

Moderator
Piet vanden Bussche (*Belgium*).

How many of us in the audience believe our colleagues are addressing patient safety in their daily practice in an evidence based, continuous and active way? (By raising hands about 5% of participants in the audience were convinced of this), what do we need to address to improve PS in PC? What structures do we need to put in place in general practice to address this?

Education and Training
Teaching is an important way to start introducing these concepts. Using patients and doctors who could testify of their personal experiences about this are very powerful, ,patients who have had unsafe experiences and doctors who have experienced a complaint or an error; and let us not forget to use CME CPD to deepen GPs awareness of the subject.

Measuring Patient Safety
It will be important to gather and assess all the instruments that are available for assessing patient safety (PS) in primary care (PC). There is not 1 instrument that covers all aspects of PS in PC; we need a range of instruments to measure safety in the practice.

Dealing with Uncertainty while Practicing in General Practice
In general practice, patient demand is such that a new patient is seen and their problems are dealt with on average every 6-10 minutes, every day. One of the very unique properties of safety in primary care is working in / dealing with uncertainty, as patients in PC are cared for in a process of longitudinal care which is difficult to relate directly to specific outcomes at a point in time.

This makes it different from hospital care and therefor it is essential to look at patient safety in a different way in terms of general practice as it is not appropriate to simply copy what is done in the hospital setting. The agenda for research and action on PS in PC has often been inspired by/driven by (the priorities) of hospital care.

Research in Patient Safety in Primary Care
For future research we can identify some very specific topics for PC:
- Healthcare is general practice is complex. Patient safety incidents and adverse events are inevitable in every healthcare setting. There is no healthcare facility which is incident free. Can we identify high risk groups and orientate our energy and resources towards these?

- If we practice with an emphasis on PS how do we prevent over-diagnosis?

- We need additional research on medication errors in PC, it is a different prescribing environment, and we need to assess the role of IT and clinical decision support system.

- Teamwork and quality management systems are different in PC.

- How to identify and handle doctors who do not do a good job?

- How to deal with the impact of adverse events on the health professional?

- Define other methods to research PS. Now we often do it retrospectively and an RCT is not the right technique to do it prospectively, it is ethically not correct in this context.

- It is often difficult to prove a specific intervention works to improve patient outcomes, and we often see that only a comprehensive holistic systems wide approach is effective to change things and to improve patient outcomes. The patient needs to be at the centre of this, as part of the practice team and this will keep mutual trust and help in the management of patient safety incident.

Patient Care in the Interface between General Practice and other Care
What about clinical handover and the problems with patient going to and coming back from secondary care? PC is not separate from the rest of the health system and we know a lot of errors occur in these moments the patient is in the interface between systems of care.

Regulations and Legal Aspects of Reporting and Investigating Safety Incidents
What about regulations and a legal framework? That could be a powerful way to realize change. Do we need regulation to change things or is regulation something that endangers quality because it is often (perceived as) extra burden and administration and endangers real quality improvement. Maybe professional bodies (our colleges and societies who are responsible for education and training GPs and CPD) are an alternative way to try to reach GP's and start a process of change.

But we have to identify medicolegal and defensive medical practices which for the moment make it impossible to work on PS in a constructive way. One area that requires change is to ensure that notification of adverse events can happen in a blame-free context and that the information is used to make the care better, not to punish or have the health professional risk going to court.

Conclusion
The doctor-patient relationship in general practice is the key to improving quality and safety of care. Improving communication in the doctor-patient relationship will help to reconcile the different perspectives of the doctor and the patient on patient safety issues. Also the interface between primary and secondary care is an area that deserves attention in order to reduce harm to patients.

We need to address the issues of high risk patient groups and in particular the negative consequences of over-diagnosis and under-diagnosis in patients. We should ask if we need to re-write research methods for assessing and developing the patient safety culture.

We are at the beginning of a structured approach to patient safety in primary care and in this early phase we need to ask what do people think and feel about it, the views of patients and doctors. Then we can go forward.

Report by
Piet vanden Bussche & Andree Rochfort
April 2016

Conference Photo Gallery

Link to **Conference Photo Gallery**

Take Home Messages

Second and Third Victim Research Group, 2015

Recommendations for providing an appropriate response when patients experience an adverse event with support for health-care's second and third victims

- The care of GP's is safe (compared with other health providers).

- In about 2% of situations safety problems occur. In 0.7% these problems become harmfull for patients, but in most situations harm is limited and often it can be repaired. Nevertheless, it is important to think and foster patient safety in primary care. Patient safety is part of global quality management and can be the opening door to introduce quality in general pracitce.

- Untill now, the research about safety in PC was driven by the way hospitals and secondary care handled the theme. We need an theoretical framework, because genreal practice is a totally different context, e.g. growing multimorbitdity, the individual doctor-patient relationship, the continuity of the care etc.

- One of the most striking differences is that GPs are experts in working in uncertainty. Just enhancing certainty in the way the hospital does, does not work in PC and would enlarge problems. How do we manage safety, living in this uncertainty? It is more about minimizing danger than about guarantee of safety in primary care.

- Another interesting point coming out of the research in PC is that there is a inversed relationship between the number of patients a doctors sees and the safety (s)he provides.

- We have already a broad set of tools to promote safety in primary care and we will need to use all of these in a comprehensive and feasible way to ensure safety in general practice. Some of these tools are similar to secondary care, e.g. incident reporting and analysis, but we do not need to do it the same way as in the hospitals. A month collecting CI in the practive every three years might be as informative as doing a continous registration.

- Health care workers in a team where an error occurred have a high risk to become (second) victim. They need support, and strategies to do so are available. Young doctors and trainees' are extremely vulnerable, and strategies should be developped to ensure that they can learn in a safe environment.

- It is important to realize that safety and Quality in priamry care are delivered within a team and that support and implementation happens within the team and the practice in which they work.

- We have to think about patient participation in realising safe care and in teaching safety both in the university and in CPD.

- Burn out or 'job intoxication' may be an important cause of unsafety. What do we do with doctors, who do not perform as might be expected?