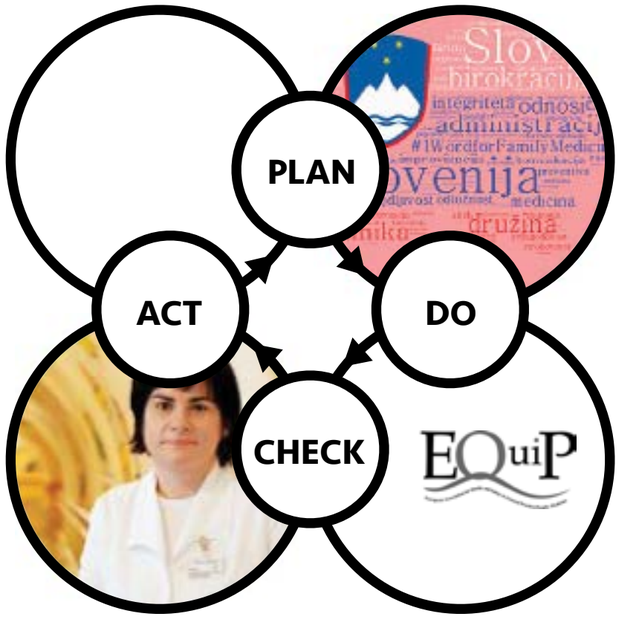
EQuiP

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

Teaching Quality **and** Safety **for Family Doctors**

- Schemes, Projects, Cases, and Your Stories...

CASE: Slovenia



TEACHING QUALITY TO FAMILY MEDICINE TRAINEES

By Zalika Klemenc-Ketis,
EQuiP delegate from Slovenia

Background

Quality and Safety in Family Medicine is being taught to family medicine trainees in a form of a module which lasts for two days (16 teaching hours). It involves lectures, small group work, discussion, and a final assignment (a project).

The module takes place during the first six months of a 4-year speciality training. The project assignment takes place during the whole four years of training.

In this abstract, the project assignment will be described in details.

Aims

The aim of the project assignment is to perform a quality improvement project based on PDCA method.

Methods

The main method used for this project is a PDCA cycle:

- Trainees have to identify a quality problem within their practice.
- They have to perform a root cause analysis.
- They have to determine quality indicators and quality standards.
- They have to assess the current situation regarding the chosen problem.
- They develop interventions to improve the situation or solve the quality problem and implement them in their practice.
- They have to assess the situation again and evaluate the success of the interventions.
- They have to write a short report which gets assessed by the teacher.

Results

At the end of the training, the students are able to:

- Identify quality problems and challenges in their own practice.
- Plan a PDCA cycle.
- Develop and implement interventions.
- Evaluate the success.

Conclusions

This quality improvement project enables trainees to actively improve the quality of their practice.

Links

Mateja Bulc, Igor Švab, Danica Rotar Pavlič & Marko Kolšek (2006) Specialist training of Slovene family physicians, European Journal of General Practice, 12:3, 128-132. **Link to article**.

Family Medicine Around The World: The Besrour Papers

The scope of family medicine and the nature of family medicine training vary considerably worldwide. Lack of capacity, lack of understanding of the discipline's role, and variability of standards and recognition can represent challenges. New technologies, collaborations, changes in pedagogy, variable methods of training, and system-wide support might represent opportunities for advancement of the discipline and of population health.

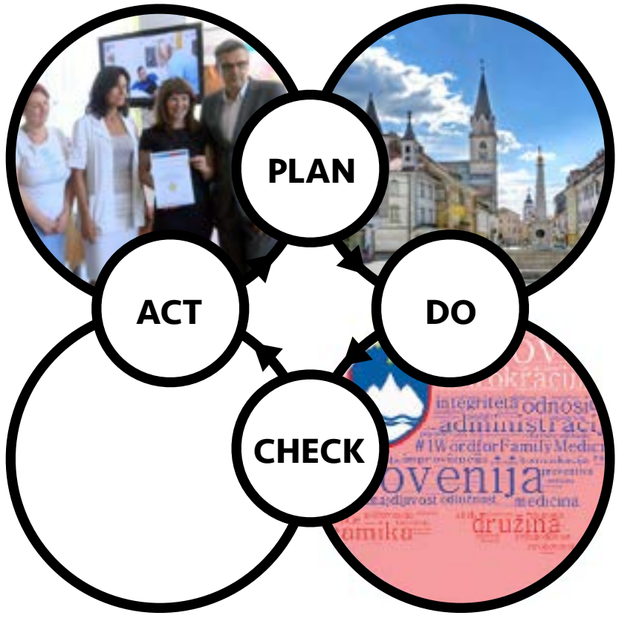
We might ask whether regions or countries can learn from the experience of their peers or whether the development of family medicine is inevitably one of trial and error, with training and end products tailored to fit the needs of each context.

Understanding these issues is important, as the Besrour Centre and its partners are engaging in exciting new collaborations to promote our discipline globally.

Source: Arya, N., Gibson, C., Ponka, D., Haq, C., Hansel, S., Dahlman, B., & Rouleau, K. (2017). Family medicine around the world: overview by region: The Besrour Papers: a series on the state of family medicine in the world. Canadian Family Physician, 63(6), 436–441.

Link to article

MY STORY:
Slovenia



ISSUING INSTRUCTIONS TO PATIENTS ON SICK LEAVE

By Katja Drole, GP trainee from Slovenia

Background

Most family medicine clinics in Slovenia do not issue patients on sick leave with written instructions for behaviour during their absence from work. When reviewing a random sample of 30 charts of patients at our health centre, who were on sick leave in April 2016, I determined that none of them were recorded as having been issued instructions.

Employers increasingly monitor their employees. If a patient is monitored during sick leave, they can claim they did not know they were not allowed to do something. Article 233 of the Rules on Compulsory Health Insurance states that personal physicians must define absence from work with the start and end dates, as well as that they must issue the patient with instructions on behaviour during the absence from work (lifestyle regime, strict bed rest, rest, walks ...).

Aims

The aim of the Quality Improvement project task was to introduce issuing instructions for behaviour during sick leave at our health centre.

Methods

We used a sample from the Kranj Health Centre with three different regimes – strict rest (I), rest with permitted short walks (II) and permitted longer walks (III). All three regimes are defined in more detail. All three doctors and both nurses who work at the health centre agreed to introducing the change. We agreed that the doctor would enter the regime number in the chart, with the nurse then issuing the instructions to the patient. In special cases, individual instructions may be issued to patients as well.

QUALITY MEASURE
Percentage of patients on sick leave, issued with written instructions.

QUALITY INDICATOR
Patients receive written instructions.

QUALITY STANDARD
At least 90% of all patients receive written instructions for behaviour during sick leave.

Results

In July 2017, I again reviewed a random sample of 30 charts of patients at our health centre who are currently on sick leave. Of these, 20 (66%) contained entered sick leave regime numbers, while 10 did not.

Conclusions

The aim of the task and the quality standard (90%) were not fulfilled. All of us in the team believe that in light of the increased pressure from employers, issuing instructions is necessary, and we will continue to strive to do so.

In this regard, I consider my project task a success, as it emphasised an issue that no had addressed up to now. Currently, we are only two thirds of the way towards implementation, but as we all believe that this needs to be improved, I have no doubt it indeed will be.

The Best Thing

I work in a private health centre and our director is very proactive and open to new ideas and improvements. We have a great team in a practice setting, which puts emphasis on quality improvement. Also, we (= the doctors) got a lot of help from our dedicated nurses, who kept reminding us to issue a sick leave regime, if we forgot about it. For another project, I would try to motivate and encounter the entire team, so that we collectively embrace the processes of change and work together on achieving the common goals.

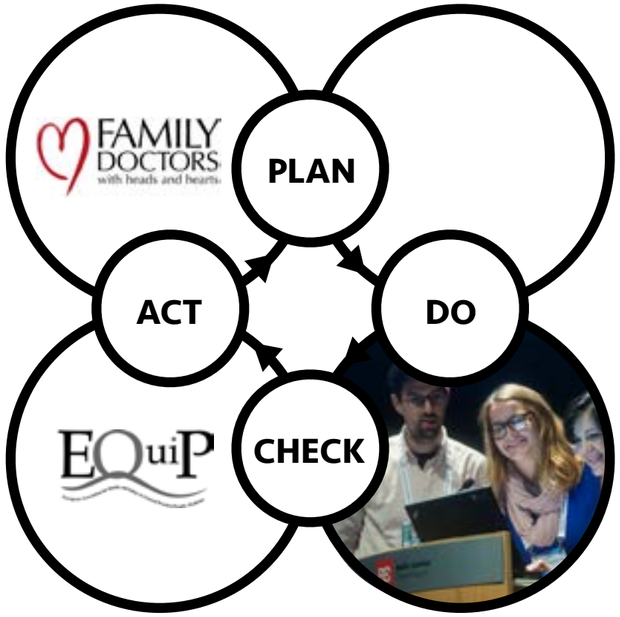
On the contrary, some of my young doctor colleagues had problems with their practice management not accepting new ideas. That put an effective stop to any quality improvement initiative.

We might ask whether regions or countries can learn from the experience of their peers or whether the development of family medicine is inevitably one of trial and error, with training and end products tailored to fit the needs of each context.

To Be Improved...

We did not reach the goal, even though everyone worked hard to make it. It is difficult to reach the goal quickly and efficiently, so for the next project I will reconsider if the suggested goal is maybe a bridge too far. The main problem in this current case was patients on sick leave for more than a year not getting a written regime in the beginning of the sick leave. This will be changed from now on.

LEARNINGS: Europe



Workshop Learnings: "Quality Improvement 2.0"

- Results from a Wonca Europe 2016 Conference

By Ulrik Bak Kirk,
EQuiP Manager

Conclusion

If EQuiP and Family Medicine ChangeMakers (FMCM) should suggest an Ideal European Medical Curricula on Quality Improvement in Family Medicine/General Practice.

Doctors in GP Specialist Training learn about how to implement guidelines and how to work in a team, but no one is taught how to make leadership of doctors a motor for quality improvement and how to use a PDCA strategy for quality projects.

Furthermore, awareness about patient safety is slowly rising, but it will become more and more important in the near future.

Background

The article **Teaching quality improvement in family medicine** (2012) concluded that only a small bank of international literature on the topic of implementing improvement methods in primary care exists - and little is currently known about teaching QI in this setting.

This highlights the urgent need for an international consensus on learning outcomes for QI in the medical curricula of undergraduate, specialty training and continuous professional development for family doctors and other specialists.

The Ideal Quality Improvement Programme Framework

We asked the participants (on basis of the 10 elements from the EQuiP Quality Framework) to rate and design the ideal QI programme in GP Specialist Training. This was their priorities:

1. To implement guidelines
2. To work in a team
3. To work in a patient-centred manner
4. To use electronic medical records to support quality
5. To make leadership of doctors a motor for quality improvement
6. To use a PDCA strategy for quality projects
7. To deal with critical incidents/medical errors
8. To manage information
9. To work with the practice population
10. To measure practice performance/competence

Quality Improvement Schemes

	Denmark	Ukraine	Serbia	Portugal	Kosovo	Romania	France
Dealing with critical incidents/medical errors	◢					◢	■
To implement guidelines	■	■	■	■	■	■	■
To work in a patient-centred	■			■		◢	■
To work in a team	■	■	■	■	■	■	■
Measuring practice performance/ competence		◢					■
To use electronic medical records to support quality	■		●	●	●	●	●
To manage information	■	◢	◢				■
To work with the practice population	■		◢		◢		■
How to make leadership of doctors a motor for quality improvement	◢	◢			◢	◢	◢
Using a PDCA strategy for quality projects	◢	◢				◢	

■ We **have** been trained in this

● We **have** an electronic medical system **available**, but it is not necessarily used for QI.

◢ We **want to** be trained in this

No symbol: We **have not** been trained in this

CASE: France

French EQuiP Summer Schools 2013-2015

By Dr. André NGUYEN VAN NHIEU,
Academic GP Montreuil, Paris Diderot, France

Background

The European Society for Quality and Safety in Family Medicine (EQuiP) has since 2008 developed Summer Schools as a method for teaching research in quality improvement (QI) in primary care to support the training of healthcare providers.

The Société Française de la Thérapeutique du Généraliste (SFTG) has organised French-speaking EQuiP-inspired Summer Schools on Quality Improvement for the last three consecutive years - where many projects were born from participants with diverse backgrounds (GPs, pharmacists, nurses).

Aims

1. Raise the awareness about the French Summer Schools.
2. Promote the importance of diverse backgrounds participants in enriching the exchanges.
3. Understand how Summer Schools can help in achieving a Quality Improvement project.
4. Display breathtaking Quality Improvements Projects (QIP) from the Summer Schools.

Methods

Three 4-days Summer Schools took place in a charming place near Paris during the summer.

The summer Schools are held in French language and are not restricted to GPs. Experts on quality are invited for interactive plenary sessions and to facilitate workshops «à la carte» in small groups.

Workshops on individual QIP are gathered per topic to allow exchanges and sharing ideas including self working time. The French participants are financially supported by the national organism for continuing medical education.

Results

From 2013 to 2015, there were approximately 16 participants per Summer School: A total of 49 participants, mostly GPs or GP trainees and nurses, pharmacists, healthcare managers) and 7 European Quality Experts invited.

Participants were from Belgium, Switzerland and France. In total, the Summer Schools dealt with 24 QIP within patient safety, therapeutical education and chronic diseases, set up of a healthcare centre, social inequities reduction etc.

Conclusions

The SFTG Summer Schools are a relevant work-catalysing QI tool in primary care.

Read the printed poster presented at the Wonca Europe Conference in June 2016 in Copenhagen.

Summer School Testimonial

For our project on primary care organisation to begin, setting a specific place and date in our compelling lives emerged as an obvious need. The EQuiP French Summer School provided by the SFTG (Société Française de la Thérapeutique du Généraliste) provided the perfect time and place to start-up.

After three days of workshops and dedicated teamwork reflexion, the team project ended up well known and resource-persons were identified to support us. Finally, we emerged with our roadmap ready to use!

One year later, the project QUALICO-PC France applied for funding for the psychometric validation of the project questionnaires and research protocol. Also, we applied PREPS (research program on the performance of the health system) for € 250.000, involving 4 research units, 350 GP offices and 3500 patients.

Dr. Aymeric Henriot (Grenoble)
Academic GP

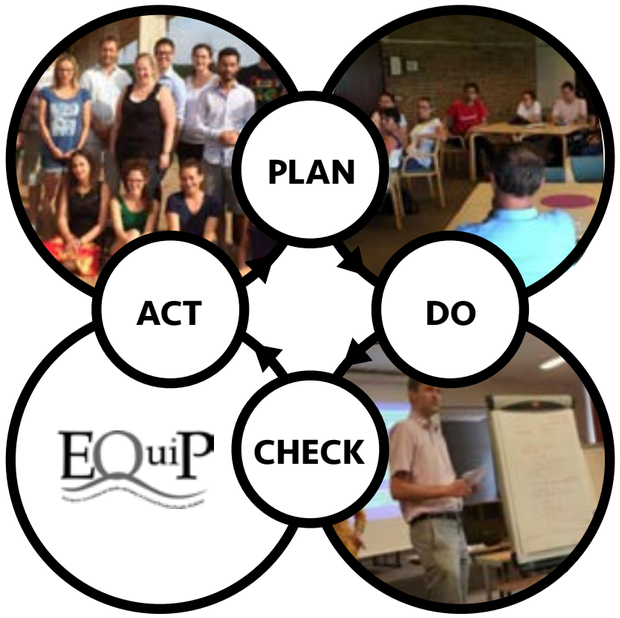
Summer School Testimonial

Safety in the elderly people is an important issue we decided to work on locally. Our aim was to improve continuity of care for the elderly between ambulatory and hospital care in a systemic perspective.

We attended the French EQuiP Summer Schools twice. Meeting other healthcare providers of various organisations and of different disciplines, the input of the experts in Quality Improvement, allowed to enrich our project and develop the design of our study.

Sophie Dubois (Paris, France)
Pharmacist & Primary Care Coordinator

CASE:
Europe



English EQuiP Summer Schools 2008 - 2016

By Zalika Klemenc-Ketis,
EQuiP delegate from Slovenia

Background

Summer Schools are a traditional method for teaching research in quality improvement in primary care settings organised by the European Society for Quality and Safety in Family Practice (EQuiP).

The initiative started in 2008, as there was an interest in many countries for summer courses in English. The new tradition of summer courses, organised in different countries and on different locations, as to ensure people to have an easy access, started off successfully in Tuusula, Finland in 2009. It continued in Ghent, Belgium in 2011, Berlin, Germany in 2013 and Middelfart, Denmark in 2014.

From 2013-2015, the EQuiP Summer Schools have also been conducted in French in partnership between EQuiP, the "Société Française de la Théra-peutique du Généraliste" (SFTG) and the "Fédération Française des Maisons et Pôles de santé" (FFMPS).

Aims

EQuiP wants to support and catalyse the training of researchers, trainees and family physicians/general practitioners by organising international summer courses. Summer Schools aim to bring knowledge about quality improvement (QI), initiate or improve a quality improvement project and share innovative ideas with other participants on QI in primary care.

EQuiP Summer School 2013, Germany (8 min.)

Methods

Summer Schools are organised in a four-day course, including a social program to support networking. The program alternates lectures, small group work, case studies, individual work and workshops. European experts on QI and research are engaged as teachers and participants from different background contribute to rich exchanges.

Results

The participants have to develop and present a personal plan/project of research in QI in primary care and perspectives. The participants have built a solid European network that ensures multiple feedbacks on their own project when needed.

Conclusions

The EQuiP Summer Schools offer a great opportunity to learn about research in QI, to exchange ideas and to get targeted feedback from very experienced researchers in the field.

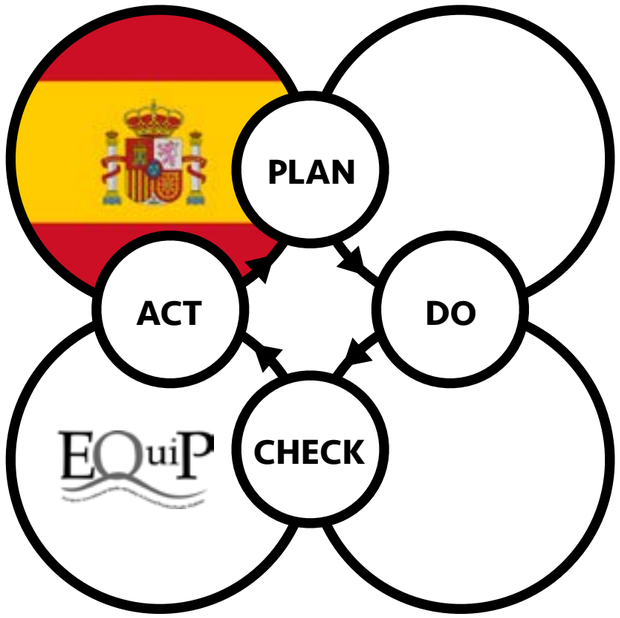
Read the printed poster presented at the Wonca Europe Conference in June 2016 in Copenhagen.

EQuiP Summer School 2014, Denmark (5 min.)

Summer School Testimonial

I gained a lot from the course content and the intense exchange with the teachers but I particularly loved getting to know so many passionate researchers with various backgrounds and diverse interests.
- Jasmin Knopp

CASE: Spain



Teaching Quality and Safety for Family Doctors in Spain

By José Miguel Bueno Ortiz & Maria Pilar Astier Peña,
EQuiP delegates from Spain

World Health Organization (WHO) defines the quality of health care as ensuring that each patient receives the most adequate diagnostic and therapeutic services to achieve optimal health care, taking into account all factors and knowledge of the patient and the medical service, and thus achieve the best result with the minimum risk of iatrogenic effects and maximum patient satisfaction with the process.

The Institute Of Medicine (IOM), in EEUU, states that the quality of health services is measured by the extent to which health services for individuals and populations increase the likelihood of achieving optimal health outcomes comparable to the current knowledge of professionals.
These definitions have in common the consideration that the quality of care is a multidimensional concept. Usually the dimensions attributed to quality have been: effectiveness, efficiency, user satisfaction, accessibility, adequacy and professional competence.

The Patient Safety (PS) was a dimension later incorporated by the IOM itself, as it appears in the report "Crossing the Quality Chasm: A New Health System for the 21st Century" and which shows that the quality of care of patients is altered when Adverse Events (AE) happen, and mainly if they are preventable. Many studies revealed their magnitude, their serious impact and high frequency, as well as the preventability of a considerable percentage of them. This is why PS has taken a leading role in managing the quality of health services, and WHO and other organizations explicitly link PS with the quality of health care and recommend the greatest possible attention to be given to this aspect of health care.

Nowadays, quality health care is unthinkable without taking into account the attribute or dimension of PS. It becomes a transversal dimension of the rest of quality dimensions, being even the fact that the rest of them are constructed on it, as reflected in the report "To err is human, Building a safer health system", which measures for the first time the transcendence of a global form and the impact of PS problems in the health system. Ultimately, it is a question of improving the quality of health care through the incorporation of PS interventions and strategies on the first line of healthcare systems.

Primary Care (PC) is the first point of contact between patients and the healthcare system. An error at this level can lead to a succession of unnecessary tests and treatments that could harm the patient. Despite of having less harmful AE in PC than in hospitals, the large numbers of patients we visit every day increase the likelihood of suffer AEs for primary care professionals each year. The rate of primary care visits/contacts in Spain is the highest in Europe with an average of 9.5 per person in a year (Organisation for Economic Co-operation and Development (OECD) mean 6.8).

Despite the regional differences we have in our country, the basic primary care structure is quite similar. The way we deliver primary healthcare in the national health system it is mainly organize through a similar basic structure in all regions. Each regional healthcare system is organized into Health Areas of 250,000-300,000, which refers to an administrative district that brings together a functional and organizational group of health centres and primary care professionals.

A Health Area:
- Is served by a single general hospital and its policlinic
- Had its own primary care and its own secondary care director with management autonomy
- Has several HCs and at least one tertiary referral hospital:
  - A HC is a clinic staffed by a group composed of family physician, paediatricians, nurses, nursing assistants and administrative staff.
  - Some HC also offer midwifery, physiotherapy and dental services.
  - HCs are owned by the regional health authority, which supplies a health centre for each geographical district.

Citizens living in a district register as patients with a general practitioner. Patients contact the HC for an appointment, whether scheduled or urgent, or for a referral to specialists. There is a gatekeeping system in place. Family physicians may care for patients in the HCs, "at patients' home" or nursing homes and refer them to a more specialized level if needed.

According to the principle of continuing care, health centres also includes evening emergency attention in urban areas which have a near hospital and 24hs shifts in rural ones. As my HC which offer 24 hours services and referral hospitals or specialists are 40 to 120 kms.

Primary Care Professionals working in a HC are normally employed with the status of civil servants, although they share a population management contract linked to economic incentives with regional health authorities. The Regional Health Service pays the salaries of all staff, provides the supplies and maintenance for the HC and The Regional Clinical Electronic Records Software and Regional Electronic Prescriptions' System. Prescriptions are under patients' copayment.

Each HC has a multidisciplinary management team consisting of a physician, a nurse and an administrative officer. This team organizes the healthcare activities. These professionals are known as "coordinators".

Since the nineties all regional healthcare systems introduced quality indicators for primary care team. Those quality indicators were related to clinical goals (blood pressure control or other diseases' indicators), to appropriate prescriptions, patients satisfaction surveys and improvement plans deployed in the health district.

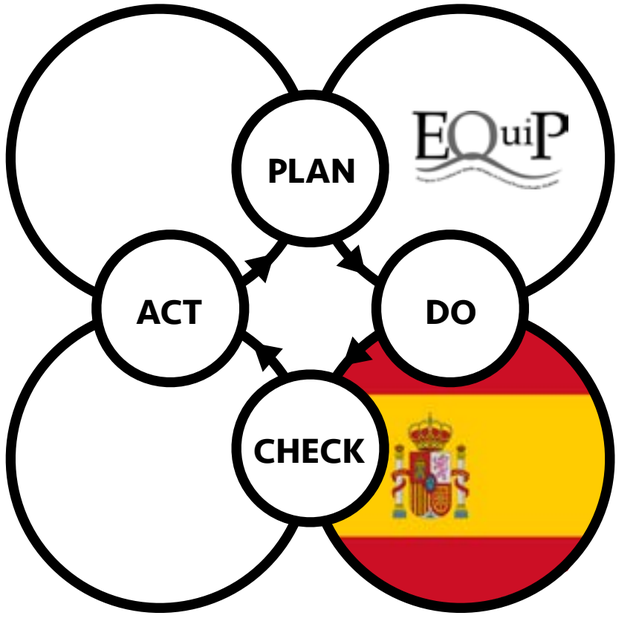
Quality Management Systems in Primary Care have evolved and some regions have introduced ISO 9001 to assess health centres quality systems as in Galicia, Basque Country, Aragon. Meanwhile others regions are working to develop own regional quality certifications for health centres and primary care professionals as Andalucia and Catalonia.

So nowadays in primary care in Spain quality and safety are clearly the way we manage health centres with good health outcomes. Once we have analysed the present situation, it has not appeared by chance, but it is the result of training in quality and safety to the primary care professionals.

Both national ministry and regional services have invested lots of resources on training first on healthcare quality and later on patient safety. Scientific societies as SEMFYC (Spanish Society for Family and Community Medicine) and SECA (Spanish Society for Healthcare Quality) have contributed to the global training.

The strategy to spread on practice quality and patient safety have been structured through "The Seven steps to patient safety in Primary Care" as suggested by NPSA (National Patient Safety Agency):

CASE: Spain



Teaching Quality and Safety for Family Doctors in Spain

By José Miguel Bueno Ortiz & Maria Pilar Astier Peña,
EQuiP delegates from Spain

7 Steps Towards A Safer Practice of Quality

- Step 1: Build a safety culture
  To promote readings on PS and Q in Spanish
  To make safety culture surveys
- Step 2: Lead and support your practice team
- Step 3: Integrate your risk management activity
- Step 4: Promote reporting
  Through a national platform with an anonimated system lead by the Health Ministry.
- Step 5: Involve and communicate with patients and the public
- Step 6: Learn and share safety lessons: Promoting teaching tools to family doctors in training:
  HFMA (Healthcare Failure and Modal Analysis)
  Ishikawa Diagram in Cause Root Analysis
- Step 7: Implement solutions to prevent harm

Relevant Free Training Programs for Healthcare Professionals

1. **Webpage** of National Health Ministry

2. **Webpage** of Patient Safety Group of SEMFYC

3. **Webpage** for the National Patient Safety Incidents Reporting System

4. Webpage of Regional Healthcare Systems
   ASTURIAS
   ANDALUCIA

5. **Spanish Society for Healthcare Quality** (SECA):

6. Others activities with medical students in medical schools and with family doctors trainees:
   - Learning to use patient safety tools: root cause analysis of severe adverse events
   - Learning to report a patient safety incident through the platform of National Patient Safety Incidents Reporting System
   - Reducing diagnostic errors: learning and improving clinical reasoning
   - Developing quality indicators to measure improvement activities in health centres