

# European Patient Safety Conference 2017

Improving Safety for Everybody in  
General Practice and its Interfaces





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Each page in this Dublin ePDF contains bio/ abstract, link to PP slides, photo, and video if provided.

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# Welcome



Dear colleagues and friends,  
Fáilte go dtí Baile Átha Cliath

It gives me great pleasure to welcome you to the EQuIP European Patient Safety Conference in Dublin, by the sea in Dun Laoghaire, hosted by the Irish College of General Practitioners (ICGP).

EQuIP is the European Society for Quality and Safety, a network organisation within WONCA Region Europe. Having held an excellent first European Patient Safety in Primary Care conference in Prague in 2016, kindly hosted by the Czech College of General Practice, we decided to focus on Patient Safety for this second year running in order to develop further expertise in European General Practice in this emerging area of safety in primary care.



Safety is a societal goal, but it is a particular challenge for medicine given the range of presenting problems. General Practice has specific additional challenges due its role in providing longitudinal care from cradle to grave, managing multimorbidity in ageing populations, chronic condition and co-morbidity management and prompt access by patients to GPs for advice on symptoms within every body system within hours of symptom development, the complexity factor.

This conference will help to bring us up-to-date information and reports on improving patient safety in primary care, with examples from around Europe at the level of practices, organisations and national initiatives. As there is no single tool for managing safety in general practice, we need many. There is always room to improve the management of risks at work in the healthcare sector, to discuss and develop safer work practices in order to minimise clinical and organisational risks. Improving healthcare safety also requires that we promote healthy personal and professional health for health professionals, by involving individuals and professional organisations and health services.



EQuIP  
Conference on  
Patient Safety

22/23 April 2016

Prague ePDF #1 on Patient Safety

All these safety and risk management activities will of course require specific supports and resources, that as individuals we cannot fully provide, but together with our national colleges and societies of general practice we can bring more strength to begin this dialogue with health service planners, policy makers and other key stakeholders.

We hope you make new friendships and new professional alliances, as you experience shared learning and discussions in the tradition of EQuIP during this conference.

Go raibh maith agat

*Andrée Rochfort*

Dr Andrée Rochfort MICGP  
Conference Convener  
Co-Chair Scientific Committee  
Executive Board member EQuIP



# European Patient Safety Conference in the Media



## FAMILY DOCTORS NEED TO HEED THE WARNINGS OF STRESS AND BURNOUT ON PATIENT SAFETY IN GENERAL PRACTICE, CONFERENCE TOLD

Irish and European family doctors meeting at a major European conference on patient safety and general practice in Dublin this weekend (Fri 3rd & Sat 4th March) will highlight how doctors need to heed the warnings of stress and burnout and take action to care for themselves.

The impact of cutbacks and manpower shortages on family doctors will come under the spotlight at this weekend's wide-ranging EQuIP conference, which will address a wide range of topics on the theme of patient safety, including the impact of capacity and resources in general practice.

The Secretary of EQuIP, and conference organiser, Dr Andree Rochfort, said the conference is of huge importance to general practitioners in Ireland. Dr Rochfort is Director of Quality Improvement with the ICGP.

"Workload pressures and stress are a common part of many GP's lives, with the inability to find locums, and the complexity and unpredictability of their work", said Dr Rochfort. " This conference will have open discussions on balancing patients' expectations with their capacity to deliver, in a changing healthcare environment. Happy doctors means safer patients, and doctors need to heed the signs of burnout".

GP Dr Mark Rowe, who will give a workshop on physician well being, said some data would suggest that as many as 50% of GPs suffer from stress and burnout in their lives. "We are working in a dysfunctional system in the HSE, and the truth is that we cannot control a lot of the changes that are happening. So doctors have to put their focus on self-care", he said.

GP trainee Dr Anna McHugh will present a paper on the "OAK" project in Letterkenny Hospital which found ways of helping staff build resilience and overcome burnout.

Cork-based GP Dr Aoife Lyons surveyed how practices were using texting in their practices to communicate with their patients.

Full details of the conference proceedings can be found at [www.icgp.ie/equip](http://www.icgp.ie/equip)

Twitter hashtag for conference: #EQUIPDublin2017

Interviews available on request.  
Media queries: Aileen O'Meara, Communications Consultant, ICGP

087 2239830 [media@icgp.ie](mailto:media@icgp.ie) @ICGPnews



## On Social Media



Storify is a social network service that lets you create stories or timelines using social media such as Twitter, Facebook and Instagram.

In this case, the European Patient Safety Conference has been storified using the hashtag:

***#EQUIPDublin2017***

Please **click** on the photo to explore...

# Conference Gallery



The 2017 EQuIP European Patient Safety Conference took place on Friday 3rd and Saturday 4th March at the Royal Marine Hotel, Dun Laoghaire, Co. Dublin.

**Click** any of the photos to view gallery

# Scientific Committee



## **Isabelle Dupie,**

Co-Chair, General Practitioner, French EQuIP delegate, Chair of EQuIP's Patient Safety Working Group, Paris, France.

## **Andrée Rochfort,**

Co-Chair, General Practitioner, Secretary of EQuIP, Chair of EQuIP's Professional Health Working Group, Wexford, Ireland.

## **Bohumil Seifert,**

General Practitioner & Assoc. Professor  
Czech EQuIP delegate,  
Prague, Czech Republic.

## **Adrian Rohrbasser,**

General Practitioner, Swiss EQuIP delegate,  
Will, Switzerland.

## **Piet Vanden Bussche,**

General Practitioner, President of EQuIP,  
Berchem, Belgium.

## **Ynse de Boer,**

General Practitioner, Danish EQuIP delegate,  
Copenhagen, Denmark.

## **José-Miguel Bueno-Ortiz,**

General Practitioner, Spanish EQuIP delegate,  
Murcia, Spain.

## **María-Pilar Astier-Peña,**

General Practitioner, Org. Member of EQuIP,  
Saragossa, Spain.

## **Aneez Esmail,**

General Practitioner & Professor of General Practice,  
UK delegate of EQuIP,  
University of Manchester, UK.

## **Abstract Review Committee and Prize Judges**

Piet Vanden Bussche, Belgium.

Ynse de Boer, Denmark

Katrin Martinson, Estonia.

Le Vallikivi, Estonia.

Isabelle Dupie, France.

Andrée Rochfort, Ireland.

Laura Noonan, Ireland.

Louise Malone, Ireland.

Sheila Rochford, Ireland.

Sarah Maguire, Ireland.

Anna Stavdal, Norway.

Stefan Krnac, Slovakia.

José-Miguel Bueno-Ortiz, Spain.

María-Pilar Astier-Peña, Spain.



# Theme 1



## **Safer Healthcare:**

The unique context of safety in general practice and its interfaces



# KEYNOTE

## Safer Healthcare: Strategies for the real world



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### Presenter

*Charles Vincent (UK), M Phil PhD  
Professor of Psychology,  
University of Oxford.*

*Professor Clinical Safety Research,  
Imperial College, London.*

*Author of 'Patient Safety' BMJ Books, and of  
'Safer Healthcare – Safer Strategies for the Real  
World' with Prof René Amalberti*



### Bio

Charles Vincent trained as a Clinical Psychologist and worked in the British NHS for several years. Since 1985 he has carried out research on the causes of harm to patients, the consequences for patients and staff and methods of improving the safety of healthcare.

He established the Clinical Risk Unit at University College in 1995 where he was Professor of Psychology before moving to the Department of Surgery and Cancer at Imperial College in 2002. He is the editor of Clinical Risk Management (BMJ Publications, 2nd edition, 2001), author of Patient Safety (2nd edition 2010) and author of many papers on medical error, risk and patient safety.

From 1999 to 2003 he was a Commissioner on the UK Commission for Health Improvement and has advised on patient safety in many inquiries and committees including the recent Berwick Review. In 2007 he was appointed Director of the National Institute of Health Research Centre for Patient Safety & Service Quality at Imperial College Healthcare Trust.

He is a Fellow of the Academy of Social Sciences and was recently reappointed as a National Institute of Health Research Senior Investigator. In 2014 he has taken up a new post as Health Foundation professorial fellow in the Department of Psychology, University of Oxford where he continues his work on safety in healthcare and leads the Oxford Region NHS Patient Safety Collaborative.

With Rene Amalberti he has recently published 'Safer healthcare: strategies for the real world' Springer, Open Access (2016).



*The best session I attended was the keynote session with Prof. Charles Vincent. His perspective - even though he is more into hospital care - was a general talk on why and how to use a tool, and why it doesn't work in all contexts.*

*He encouraged every participant to reflect on this, which shows that anything is achievable as long as you know and are clearly aware of where you are going and how to reach your goal.*

(Dr André NGUYEN VAN NHIEU, Medecin generaliste)

# Which Framework for Patient Safety in General Practice?

# KEYNOTE



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## **Presenter**

*Dr. Jean Brami (France)  
GP in Paris*

*Author of 'Patient Safety in General Practice'  
with Prof René Amalberti*

## **Bio**

Jean Brami is a general practitioner, who lives and works in central Paris. He was formerly professor of general practice at University Paris Descartes and senior adviser at the HAS (High authority of Health), where he was in charge of patient safety in primary care.

He has written two books with René Amalberti on patient safety. In 2017, he published with colleagues the results of the first French study on patient's incidents in general practice, the ESPRIT study.



# Prescribing safely for patients in general practice

– case based CME small group learning methods (Quality Circles model)



**Download free presentation**

## Presenters

*Stephanie Dowling,  
Ken Harte,  
Tom English,  
Claire McNicholas,  
Laoise Byrne,  
Henry Finnegan,  
Ireland*



## Introduction / Aim

Introduction: Several reviews have examined the effectiveness of continuing medical education (CME). There is a consensus that CME interventions designed and run for groups from a single medical discipline, e.g. only general practitioners (GPs), are associated with better outcomes.

In Ireland, CME small group learning (SGL) for GPs is delivered by a national network of 37 tutors, each of whom coordinates SGL sessions for 2-5 groups of physicians locally. Twenty-four million consultations take place in Irish general practice each year. GP workload continues to rise due to an ageing population, chronic disease management and challenges arising from multi-morbidity.

There is an increase in the transfer of hospital related activity into general practice. ICGP membership data indicates a fifth of general practitioners are aged 60 or above with almost 33% aged over 55. The proportion of GPs working in rural practice has reduced from 31% to 21%; with 22% aged over 60 years.

Single-handed practices are more common in rural areas (26%) and less common in urban areas (15%) Out-of-hours cover, sick leave and holiday relief are essential for all GPs to practice in a safe manner; this is particularly so for those in single handed practices.

It has become increasingly difficult for GPs in rural areas to source locum cover. Patients and doctors experience loneliness and personal isolation in rural Ireland, with GPs frequently feeling professionally isolated.

## Method

Methodology: A national educational needs assessment of general practitioners throughout Ireland will be conducted. This will identify areas of need specific to those doctors working rurally. An educational module will be devised to address the identified needs. Rural CME-SGL groups who agree to participate will be randomly allocated to receive the teaching module. The primary outcome measure will be the capacity of CME-SGL to address the needs of rural GPs.

## Topic Description

How can we make general practice a safer, healthier and more effective place to work, within a changing healthcare system?

## Learning Objectives

1. Participants can learn about current ICGP (Irish college of General practice) small group learning (SGL) continuing medical education (CME) in Ireland (known also as quality circles)
2. Discuss specific areas of concern for doctors and patients in rural areas
3. Discuss how we ensure safety in health care delivery by small group education for general practitioners who are professionally isolated.

# Safety inequalities related to socio-economic status: How primary care may reduce them



**Download free presentation**

## Presenters

*Hector Falcoff, France*

*Piet Vanden Bussche, Belgium*

*Isabelle Dupie, France*



## Introduction / Aim

Aims of the workshop

- 1) Clarify the concepts : safety, safety inequalities related to socio-Economic status (SES), equity, equity of safety.
- 2) Identify socio-economic factors which jeopardize the safety of care at the patient, the doctor and the practice levels.
- 3) Understand how to provide safer care to every patient, whatever his/her socio-economic status.

## Method

- 1) Presentation of the concepts and mechanisms connected with safety inequalities related to SES.
- 2) Small groups of 5-6 participants will work on the detailed narrative of a low SES patient with poor outcomes related to a safety problem:
  - a. what could have been done, when, and by whom, to modify the outcomes;
  - b. what skills primary care providers, and particularly GPs, would have needed to act in this way;
  - c. what modifications of the practice organisation would have been necessary.
- 3) The groups will present a summary of their reflection.
- 4) The experts will propose a synthesis.

## Results

The participants will increase their motivation for

- 1) working on this topic ;
- 2) adapting care to specific social groups needs ;
- 4) including socio-economic factors when analyzing safety issues ;
- 5) implementing plan-do-check-act projects to improve equity of safety.

## Conclusions

Deprivation, isolation, low health literacy, poor communication skills, jeopardize patient safety through delayed access to care, delayed diagnosis, medication errors, inappropriate examinations and referrals. Primary care can contribute to reduce safety inequalities related to socio-economic status (SES), by applying quality improvement methods.

## Topic Description

The unique context of safety in general practice and its interfaces: Measuring and Monitoring Safety - Which Framework for Primary Care?

## Learning Objectives

1. Clarify the concepts : safety, safety inequalities related to socio-Economic status (SES), equity, equity of safety.
2. Identify socio-economic factors which jeopardize the safety of care at the patient, the doctor and the practice levels.
3. Understand how to provide safer care to every patient, whatever his/her socio-economic status.

# Social disparities in patient safety:

A systematic literature review

# PRESENTATIONS



**Download free presentation**

### Presenters

Sara Willems,  
Carlotta Piccardi,  
Lise Hanssens,  
Jens Detollenaere ,  
Belgium



### Introduction / Aim

Patient safety is the minimum prerequisite for a good quality of care and is generally seen as one of the most pressing healthcare challenges. For example, according to the European Commission, adverse drug events cause 197,000 deaths annually throughout Europe.

Patient safety should be equally achievable for all patients, based on individual need, and should not differ among different social groups. The goal of this review is as follows: (i) to synthesize existing literature in order to understand the state of evidence for social disparities in patient safety and (ii) to identify gaps in the existing body of knowledge in order to direct future research.

### Method

A systematic literature review of published academic literature is conducted. We search Pubmed, the Cochrane Library, and Web of Science back to 1 November 1999. Studies are eligible for inclusion if they were conducted in high-income countries and focused on social disparities in patients safety.

### Results

The majority of the included studies addressed ethnic and racial differences in patient safety. Although there are some mixed results, most of these studies show that ethnic minorities are more likely to be exposed to certain types of adverse events.

### Conclusions

Our findings suggest that there are social disparities in patient safety, especially for ethnic or racial subgroups. These differences may be interpreted as a shortcoming in the quality of healthcare, however, the minority of these included studies lacked a standardized approach to control for potential confounders (that are outside healthcare's control). Furthermore, little research studied the effect of other socioeconomic determinants on patient safety. Future research should address these gaps in the existing body of evidence.

### Topic Description

How can we make general practice a safer, healthier and more effective place to work, within a changing healthcare system?

### Learning Objectives

1. By attending this session participants will learn about the state of evidence in social disparities in patient safety.
2. By attending this session participants will learn about the gaps in the existing body of knowledge in social disparities in patient safety.

# Learning from Events in General Practice

# PRESENTATIONS



**Download free presentation**

## Presenter

*Suzanne Creed, UK*

An exploration of important issues and skills in relation to learning from patient safety incidents and will provide guidance on how to hold a significant event meeting

## Intended Learning Outcomes

Enhance understanding of patient safety and associated terminology

Appreciate the regulatory and professional obligations relating to reporting and learning

Develop skills in undertaking a systems based approach to significant event analysis

## Premise

Figures indicate that around 24 million GP consultations take place annually mostly for minor, self-limiting illnesses.

[Read more here](#)

However, there is still a significant requirement to manage complex chronic disease, diagnose serious illness, provide preventive care and assist patients with critical conditions. Research has suggested that around 1–2% of consultations in primary care are associated with an adverse event.

It is highly unfortunate, but currently inevitable, that a proportion of patients will routinely suffer some form of unintentional harm, mostly of low to moderate severity.

The cost of harm to patients, to those working in health care, and to productivity is significant.

Avoiding complacency and being constantly concerned about safety are core components in creating a positive safety culture. Such a culture means that people feel comfortable discussing errors, and leaders and front-line staff take shared responsibility for delivering safer care.

## Overview

Setting the scene

Why things go wrong

Incident reporting

Significant event analysis

Duty of candour

Setting the scene

## Background research on causation and prevention of medicolegal risk

The Medical Council states in Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 8TH Edition(2016):

“Open disclosure is supported within a culture of candour. You have a duty to promote and support this culture and to support colleagues whose actions are investigated following an adverse event. If you are responsible for conducting such investigations, you should make sure they are carried out quickly, recognising that this is a stressful time for all concerned.”

[Read more here](#)

The Nursing and Midwifery Board of Ireland states in Standards and Guidance, Principle 3 : quality of practice (2014):

“Safe, quality practice is promoted by nurses and midwives actively participating in incident reporting, adverse event reviews and open disclosure.”

[Read more here](#)



# PRESENTATIONS

## Safer surgery in primary care:

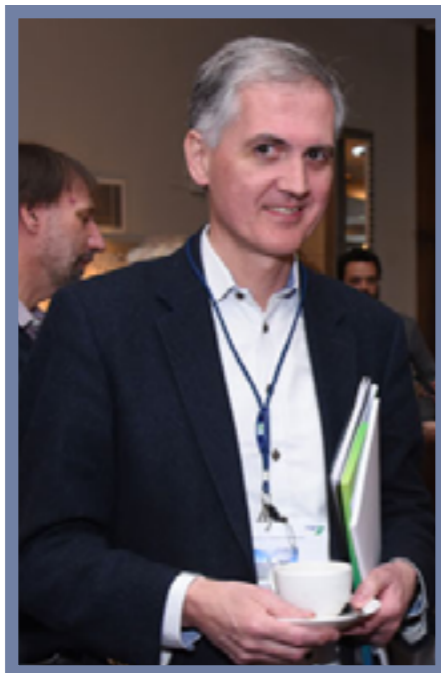
a new Irish tool for measuring and monitoring outcomes of surgical procedures in general practice



**Download free presentation**

### Presenter

*Niall Maguire, Ireland*



### Introduction / Aim

The safety of patients undergoing office based procedures can be enhanced by improved record keeping, decisional aids, the existence of a case registry and clinical audit.

We describe a novel, and to our knowledge, unique safety tool integrated in the medical records software of GPs that facilitates these four elements of a safe surgical service.

The report will describe aspects of operative safety in the low volume context of primary care and the introduction of a new checklist based surgical record.

The first results of using comparative data derived from this multi-site standardised registry to drive community based surgical audit, will also be presented.

### Method

In 2015, the Primary Care Surgical Association launched a case recording add-on for a major medical record system in Ireland. In tandem a data extraction tool was developed with our national primary care research network.

Automated algorithms provide for key performance indicators to be calculated and reported.

### Results

12 GPs reported 3031 cases to the system over a 17 month period from September 2015. The most common procedures were: cryosurgical ablations (24%) joint and peri-articular injections (19%), biopsies (14%) ellipse excisions (11%) curettage and/or cautery (9%) nail surgery (6%) excision of cysts (4%). 155 cases of non melanoma skin cancer were treated in six months.

Specific parameters relating to patient safety were complication rates (5%) and positive clinico-pathological correlation (74%). Three further measures with complex results were the adequacy of excision of cancers, the rate of unnecessary full thickness excisions and the proportion of cases with missing histology.

### Conclusions

The project demonstrates the adoption of a safety oriented record for planning, recording and follow-up of surgical cases in primary care. The standardised record has allowed automated data extraction and analysis. This is a powerful tool for surgical audit, a key element of safe surgical practice.

Difficulties were encountered with under-reporting by laboratories of quantitative disease margins for cancer cases, with the extraction analysis for monitoring inappropriate full thickness excisions and the recording of non-submission of pathology specimens. Refinements to the process will be targeted at these issues.

### Topic Description

The unique context of safety in general practice and its interfaces: Measuring and Monitoring Safety - Which Framework for Primary Care?

### Learning Objectives

1. Discover a method of data collection and automated analysis linked to the routine clinical record.
2. Appreciate the scope of office based procedures in Irish general practice.



# 'Take 5' initial outcomes from a regional exercise in improving care for individuals with complex comorbidities practice

# PRESENTATIONS



**Download free presentation**

## Presenters

*Brendan O'Shea,  
Philip Ahern,  
Garvan Browne,  
Brefni Reynolds,  
Kevin Moore,  
Muiris De Bhulbh,  
John O'Shea,*

*Ireland*



## Introduction

Fragmentation of healthcare is recognised as an important limiting factor in health outcomes, as well as a risk to patient safety. So also are lack of clarity regarding service delivery and failure of clinicians to clearly communicate regarding medical care and on limitations of the service provided. Finally, the challenge of providing rational care for individuals with complex comorbidities remains unsolved within most health systems.

## Aim

The primary aim of this project is to agree guidelines for the integrated care of individuals with complex comorbidities between primary and secondary care clinicians, identifying and addressing gaps in communication, which are usually normally implicit in routine service provision.

The secondary aim is to undertake an organised approach to disease coding in 5 agreed conditions in 7 general practices as part of the initiative, and measure increases following introduction of the guideline.

## Methods

The study setting includes Naas General Hospital, seven adjacent general practices, and The Kildare Faculty of the ICGP. The intervention is to introduce systematic coding for 5 agreed conditions, including Hypertension, Diabetes, COPD, CCF and Schizophrenia.

The initiative is branded 'Take 5,' and includes a set of integrated guidelines, together with a module on end of life planning, agreed by three specialist and three GP colleagues within the group.

The intervention includes communication by means of a project website, designed for use in both the public and professional domains.

[See more here](#)

## Results

Results include narrative of how the initiative was established, demonstration of the regional guideline through the project website, and data from first and second surveys of rates of coding for the 5 conditions in 7 practices (n = 2932).

## Conclusions

This study demonstrates how the regional space can be utilised by motivated clinicians, to communicate important messages into the regional health system, which address the need for clarity and truth in relation to service delivery for individuals with complex comorbidities.

It also demonstrates a pragmatic approach to the needs of individuals with complex comorbidities. It demonstrates how individual GPs Specialists and Clinics can align themselves around common clinical and ethical objectives. It justifies continuation of the project, with a view to collection of data on a wider variety of clinical outcome measures.



# 'Take 5' – Implementing Quality & Safety tools within general practice for use in those with chronic diseases



**Download free presentation**

## **Presenter**

*Mary Kearney,  
John Quinn,  
Andrina O'Brien,  
David Moore,  
John O'Shea*

*Ireland*



## **Introduction**

Effective care of ageing populations including individual patients with complex comorbidities is a global challenge. Historically, care has been provided on a predominantly single disease / hospital based model in most developed economies.

Concern regarding costs and sub optimal outcomes is resulting in a shift to care of patients with comorbidities, away from the secondary and into the primary care setting and the setting up of chronic disease management programs in general practice. In view of these factors, the practice decided to look at the prevalence of common chronic diseases using agreed codes

- 1) Hypertension,
- 2) Chronic Obstructive Pulmonary Disease,
- 3) Diabetes- non insulin dependent,
- 4) Heart Failure.

A fifth condition, Schizophrenia was chosen as an important mental health condition. Its care has been widely reported as been sub-optimal.

## **Method**

This audit was planned in conjunction with the Kildare Faculty of the Irish College of General Practitioners and Naas Hospital. It is generally accepted that the "5" lifestyle factors for multi-morbidity are:

- 1) alcohol intake
- 2) diet (fruit and vegetable consumption)
- 3) exercise
- 4) obesity
- 5) smoking

The project organisers advised us to record these lifestyle factors. In addition, it was decided that we would measure the following key parameters twice during the audit cycle.

- a) body mass index (BMI),
- b) influenza vaccination uptake,
- c) pneumonia vaccine uptake and
- d) check if routine blood tests had been performed

## **Results**

This audit gave the practice a definitive way to code patients with chronic diseases, practice staff rigorously documented lifestyle factors which are significant in multi-morbidity, training in brief interventions was undertaken.

## **Conclusions**

This practice team developed a safe and organised approach to caring for those with chronic diseases though using good practice policies and procedures, practice software use of the website [www.bettercareinkildare.com](http://www.bettercareinkildare.com)

## **Learning Objectives**

1. See a system that has worked in general practice for coding,
2. Gain an understanding of the usefulness of coding

# PRESENTATIONS

## Safe care for patients with chronic diseases - data from Electronic Medical Records helps to create safer structures



**Download free presentation**

### **Presenter**

*Eva Arvidsson, Sweden*

### **Introduction / aim**

Patient safety risks include patients with chronic disease(es) who don't come for regular check-ups. For those who come, it is not unusual that we fail to follow up on everything we should, especially for patients with many diseases and a lot of problems.

Having good structure, "orderliness", of the practice is a way to reduce these risks. We have made an improvement project aimed at creating such a structure in patients with COPD.

### **Method**

Information on all patients diagnosed with COPD anytime the last 5 years were collected from the EMR. We compiled data on drug prescriptions, tobacco use, visits to ED at the hospital due to exacerbation of COPD, multimorbidities, latest check-up etc.

### **Results**

Based on the collected data, we created a priority list to provide for visits to those in greatest need. A specially trained nurse see the patients, and in collaboration with a GP, offers smoking cessation, help to improve physical activity if needed, vaccinations, advice on drug use etc.

She also checks that the diagnosis is correctly based on spirometry results. We also created routines for newly diagnosed patients so that all GPs (including locums) know what to do, and that patients are registered with the nurse. We follow up the results with measurements. Still it is a way to go before the goal of all COPD patients have the best possible treatment is reached.

### **Conclusions**

Good structure is the fundament to reduce mistakes. We illustrate a practical way to create this structure, using COPD-patients as an example.

### **Topic Description**

How can we make general practice a safer, healthier and more effective place to work, within a changing healthcare system?

### **Learning Objectives**

- 1.** Learn about the relation between quality improvement and patient safety
- 2.** Be inspired by a method to create more structure to reduce the risk of mistakes
- 3.** Learn about teamwork in primary care

## A Risk matrix:

How to improve quality and safety in Community Health Centre Ljubljana



**Download free presentation**

### Presenter

*Tonka Susič, Slovenia*

### Introduction / aim

A Risk matrix: How to improve quality and safety in Health Centre Ljubljana Implementation of quality standards is not yet obvious in Slovenia therefore it depends on every institution how it will introduce them in praxis.

Since 2014, Health Centre Ljubljana with 1490 employees and 2.7 million patients' visits per year has systematically collected reports of accidents/defects/incidents. The aim was to set up Risk Matrix to minimise or remove risks.

### Method

On the basis of the reported adverse events by employees, results of external/internal supervisions, patients' complaints and accidentally checked medical records, risk consequences were determined. The Committee for quality (CQ) evaluated consequences using descriptors of severity levels published by the National Patient Safety Agency.

For the probability assessment of consequence occurrence, descriptors of frequency and probability descriptors were used. Risk matrix has assessed and characterized every risk as either low, moderate, high or extreme.

### Results

In 2014 and 2015, 323 reports of adverse events were collected. The Risk matrix defines 27 risks. "Adverse events associated with application of drugs/side-effects of drugs" is the only risk characterized as extreme. Reasons (lack of knowledge and expiration date of drugs), person responsible for avoiding risk (physicians, nurses) and measures for improving processes (internal guidelines and education) has been defined. As one of the outcomes, a whole series of vaccine was removed from market. Appropriate actions are undertaken for every individual risk out of 27.

### Conclusions

The Risk matrix, a careful examination of what could cause harm to people, enables precautions and prevents harm. A suitable risk management strategy depends on the individual institution. CQ defines priorities for remedial action and many improvements are implemented in praxis. Despite defining consequences as objectively as possible, it is inevitable that evaluation involves a degree of subjectivity. Reassessment of risks and its consequences is important.

### Topic Description

The unique context of safety in general practice and its interfaces: Measuring and Monitoring Safety - Which Framework for Primary Care?

### Learning Objectives

1. Get knowledge of use of Risk matrix in Health Centre Ljubljana
2. Get information on how to assist in praxis
3. Get insight into "plan-do-check-act" process

# Theme 2



**How can we make general practice a *safer, healthier* and *more effective* place to work, within a changing healthcare system?**



# KEYNOTE

## The limits of evidence may be found in the grey zones of uncertainty where science meets art' (James 1999)



**Download free presentation**

### **Presenter**

*Dr. Adrian Rohrbasser (Switzerland)*

*Head of Managed Care Santémed,  
General Practitioner in Switzerland  
& Member of EQuIP,  
Leader of EQuIP Working Group  
on Knowledge Translation*



### **Bio**

Adrian Rohrbasser, MSc in Evidence Based Health Care, is a general practitioner working for Santémed Health Care Centres, in Eastern Switzerland. He is passionate about teaching, learning and training, which he combines with his GP work. In summer he can be found away from his books and at the top of a ladder, painting his holiday home in Sweden or hiking and fishing in the mountains.

Adrian is a member of the quality committee of the Swiss Society of General Internal Medicine and of the European Society of Quality and Safety in Family Practice. In both, he heads working groups for quality circles, promoting knowledge translation and quality improvement in primary health care. This forms the topic of his research at the University of Oxford, Department of Continuing Education, where he is doing a DPhil in Evidence Based Health Care.

# KEYNOTE

## Keynote Address – Linking physician wellbeing to patient safety in primary care: When happy physicians equal safe patients



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### **Presenter**

*Dr. Efharis Panagopoulou (Greece)*

*Assistant professor of health psychology in the Medical School of Aristotle University, Greece*

### **Bio**

Efharis Panagopoulou, PhD is an Associate Professor of Health Psychology and Health Promotion in the Medical School of Aristotle University in Greece. After completing her doctoral thesis in Leiden University, The Netherlands, she joined the Medical School in 2002 with a European fellowship aimed at attracting research leaders from abroad.

From April -May 2012 she received a Fulbright scholarship to study the impact of information concealment on couples coping with cancer. To date, she has coordinated several international research projects in the field of stress, patient safety, and diagnostic decision making. Dr. Panagopoulou is the Principal Investigator of the OR-CAB project: "Organisational culture, professional burnout and quality of health care".

(7TH Research Framework, European Union). The project involves 10 partners from 9 European countries and the funding budget is 2.1 million Euros. She is also currently involved with the Institute of Population Sciences in the University of Manchester in several research projects on managing diagnostic uncertainty in primary care.

She is currently the coordinator of the Communication Skills Training Program for medical doctors, and the Personal and Professional Development program for members of the medical school. Her current research is focused on the role of cognitive and emotional processes on clinical practice and medical education.

# WORKSHOP

## Overdiagnosis and patient harm: How unsafe is striving for certainty?



**Download free presentation**

### Presenter

*Dr. Adrian Rohrbasser (Switzerland)*



### Introduction / Aim

Patients usually lack an obvious diagnosis at presentation. There may be uncertainties concerning evidence of underlying diseases. There may also be uncertainty about the patient's story and its meaning, or about what to do in a case with limited knowledge or skills. Additional uncertainty may arise when care is the result of the collaborative work of different providers where communication is lacking.

### Method

There are different conceptual approaches to uncertainty. Philosophically, there is conflict between our need for order and constancy and the reality of our limited existence in a chaotic world. This conflict leads to feelings of uncertainty and helplessness and it is this that doctors sense in severely ill patients. Psychologically, the feeling of uncertainty can be explained by difficulties in perception and interpretation of facts. Social sciences emphasize that the process of decision making is a rather long and irrational process when patients and doctors deal with symptoms and signs. Decisions are influenced by previous experiences and the advice of others.

### Results

In general practice, it is important to listen to the patient's story. Doctors understand patients' symptoms and signs better if they listen carefully to the narrative, paying attention to their own personal feelings. Patients present their symptoms not as a list but as a story describing how their illness affects them. This story is an ongoing, practical exercise where both narrator and listener build a relationship around symptoms and signs, leading to clinical decisions.

### Conclusions

The iterative process of decision making will differ depending on the level of uncertainty and on the level of agreement on the problem. It will vary between rational decision-making with a low level of uncertainty and a high level of agreement, and complex decision-making with a high level of uncertainty and a low level of agreement.

### Topic Description

How can we make general practice a safer, healthier and more effective place to work, within a changing healthcare system?

### Learning Objectives

1. Acknowledge clinical uncertainty
2. Become aware of different kinds of uncertainty
3. Have a model about how to tackle clinical uncertainty



# How European Health Systems and Professional Organisations support GPs with job burnout:

## Individual and organisational strategies to promote patient safety



**Download free presentation**

### Presenters

*Andrée Rochfort, Ireland*  
*Zlata Ozvacic Adzic, Croatia*  
*Claire Collins, Ireland*  
*Mehmet Ungan, Turkey*  
*Jean Karl Soler, Malta*



### Background and aim

Although there is growing interest about the potential impact of physician burnout on safety and quality of care, most research studies have focused on hospital-based settings. Job burnout in physicians has been linked to reduced productivity and negative clinical outcomes such as decreased empathy and compassion, increased medical errors and patient dissatisfaction. General practice has the additional factor of being a system of heterogeneous healthcare facilities dispersed throughout each country with limited capacity for in-house supports.

The aim of this workshop is to explore the initiatives performed by health systems and professional organizations of general practitioners (GPs) in Europe related to early identification and management of GP burnout.

### Method

A presentation will be given at the introductory part of the workshop, followed by small-group discussion on the impact of unmanaged job burnout on safety and quality of care, and the existing sources of support from health systems and GP professional organisations regarding early identification and management of GP burnout. This will be followed by a plenary discussion to develop possible solutions.

### Results

The expected results are various practices in identification and management of GP burnout from the participants' own countries. Participants will explore the concepts raised during the presentation and small – group interaction.

### Conclusions

In this interactive session the participants will discuss best practices regarding early identification and management of GP burnout in order to minimise the extent GP burnout could adversely affect quality and safety of patient care provided in the GP setting and in the interface of general practice with hospital services.

# Physician Wellbeing and Inner Happiness

## – Key paradigms for a Safer Patient Journey



### **Presenter**

*Mark Rowe, Ireland*

### **Introduction / Aim**

A Prescription for Inner Happiness; To Learn Why Self-Care Is Not Selfish Care. This workshop aims to highlight the importance of self-care by addressing the critical issue of physician wellbeing and burnout in the context of inner happiness, purpose and fulfilment.

### **Method**

Practical, Interactive , Engaging, Collaborative Exercises. Learning By Doing, Fun, Energising.

### **Results**

Deeper Understanding of 'The 40 % Solution' - The Potential for enhancing inner happiness that each of us can choose to control and significantly influence.

### **Conclusions**

Enhance Knowledge, Develop Skills and Challenge Attitudes to Enhance Inner Happiness, Support Physician Wellbeing and by extension provide a protective buffer against professional burnout.

### **Topic Description**

How can we make general practice a safer, healthier and more effective place to work, within a changing healthcare system?

### **Learning Objectives**

- 1.** Develop a deeper understanding of why inner happiness and fulfilment matters for their wellbeing.
- 2.** Learn some practical skills to boost inner happiness.
- 3.** Take home a different type of prescription - your very own prescription for happiness and wellbeing.

# Report on the Norwegian College of General Practice Position paper on Appropriate use of Healthcare Resources



**Download free presentation**

## **Presenter**

*Gunnar Olsen, Norway*



*Gunnar Olsen and Croatian EQuIP friends*

## **Overdiagnosis and related medical excess**

The Norwegian College of General Practise published in 2016 a Position Paper on this issue. Confidence in the medical profession depend on doctors safeguarding the fundamental ethical commitment not to harm.

However, some parts of medical practise are now expanding in the ways that do not harm. However, some parts of medical practice are now expanding in the ways that do not promote health, leading to unnecessary use of resources and, at worst, harm.

The Norwegian College of General Practise wishes to place overdiagnosis on the agenda among their wn mebers, other doctors, health authorities, media and the general population in order to stimulate public debate and contribute to a better use of health services.

The key messages of the College are:

- Overdiagnosis endangers patient and public health.
- Overdiagnosis is driven by the notion that physicians should always be able to detect or prevent serious disease at an early stage, by an excessive reliance of technology, individual prevention and by commercial interests.
- It is important that GPs contribute to reducing overdiagnosis, as GPs are both gatekeepers and coordinators for many health services.
- Physicians and authorities should acknowledge and support the view that even an excellent health care system cannot always detect diseases at an early stage.
- The aim of this presentation is to present the Position Paper and the attitude of the Norwegian College of General Practice to overdiagnosing.

## **Resouces**

[The Norwegian College Positon Paper on Apropriate use of Health Care Recources](#)

[Position Paper](#)

## Open disclosure about adverse incidents in general practice:

What's the effect of connecting them with possible discontent and complaints in future?



**Download free presentation**

### Presenter

*Stijn van den Broek, Netherlands*

Recently the Dutch Government revised and published the law about quality, complaints and disputes in healthcare. The aim was to lower the threshold for patients to participate in signalling adverse incidents and to express possible discontent.

Now all caregivers are required to discuss incidents with potential for harmful consequences with their patients as soon as possible. They must register this event in their medical files; they must note the measures that are taken and the names of involved colleagues in order to support patients in case they decide to submit a formal complaint.

In the Netherlands GP's use an internal practice-based procedure of reporting incidents: "blame free" and "not to detect dysfunctioning", "without personal impact on the reporter in the practice", "in order to learn (as care givers) within an organization". This new rule could have adverse effects on safety of the reporter as well as the patients because open disclosure may be connected with possible formal complaints.

In 2016 the Dutch Government declared that making a note of the full names of all colleagues involved in the incident in the medical file is obligatory. After that a group of Dutch experts in patient safety declared that this specific interpretation would be contradictory to a safe incident reporting procedure and suggests a separation of procedures for incident reporting and complaints in the interests of quality improvement and patient safety.

***The best session for me was the presentation about adverse incidents, since we are currently looking into how to avoid the conflict between incident reporting and having a complaint.***

(Dr László Róbert Kolozsvári, Hungarian EQuIP delegate)

Representatives of Dutch experts on patient safety and Dutch Government have discussed this interpretation and possible solutions. The Dutch College of GP's, the National Association of GP's and the Organization of Out-of-Hours GP's and chronic care services have adapted their guidance to the new law and contain a clear distinction between safe, trustful, open disclosure with patients about near misses and incidents while also supporting caregivers if patients present discontent or complaints about their care.

An incident reporting procedure for the patient medical record and a complaints procedure are desirable. In addition to these activities an internal practice anonymized incident registration will be maintained. Currently stakeholders agree with these developments, but more insight into the documentation in medical files is needed.

Although it will never be waterproof, this way of dealing with personal data of caregivers avoids undesirable conflict between incident reporting and complaints and keeps the current incident reporting procedure safe, open and effective to improve quality and patient safety.

# How to build resilience and overcome burn out

# PRESENTATIONS



**Download free presentation**

## Presenter

*Anna McHugh, Ireland*

## Introduction / Aim

Aging populations, increasing demands, lack of collegiality and healthcare systems under strain mean physician burn out is becoming a worrying epidemic that poses a real threat to quality care provision for patients. Staff engagement is the opposite to burn out.

Engaged, positive, mentally resilient staff have been proven to improve patient care, outcomes and personal job satisfaction.

Are there low key daily interventions which can boost staff engagement?

## Method

In Donegal an "OAK" – Occasional Act of Kindness - initiative was launched in the challenging winter months. Hospital Consultants, GP's and allied health professionals were invited to attend a lunch time session where complimentary refreshments were provided.

Colleagues were simply encouraged to sit for even 5 minutes and have a chat. Staff checked in, asked how colleagues were coping and took an interest in each others lives. The aim was to boost collegiality, over come bullying in the work place and to encourage occasional acts of kindness to one another when stressed. An online survey adapted from Wilmar Schaufeli's validated staff engagement tool was completed by participants.

## Results

- Staff engagement scale: Agree/Strongly Agree
- Boosts Collegiality and Strengthens relationships at work 97%
- Would make me more likely to take the initiative to help a colleague if they were struggling 90%
- Boosts my energy at work 80%
- Increases my mental resilience at work 83%
- Enhances my enthusiasm at work 90%
- Helps me persevere, even if things are not going well 87%
- Helps me to continue working even for long period of time 63%
- Helps to instill a sense of pride in the work place 84%
- Boosts overall morale at work 93%

## Conclusions

Low key daily interventions can be effective in promoting staff engagement and positively influencing patient care, as one participant fed back "Simple things make a big differences."

## Topic Description

How can we make general practice a safer, healthier and more effective place to work, within a changing healthcare system?

## Learning Objectives

1. Consider how they can be more engaged personally.
2. Consider what can simple things can be done in individual practices to promote a healthier work environment.
3. Encourage those involved in health systems design to incorporate staff engagement measures

# The Safe Use of Texting (SMS) in Irish General Practice

# PRESENTATIONS

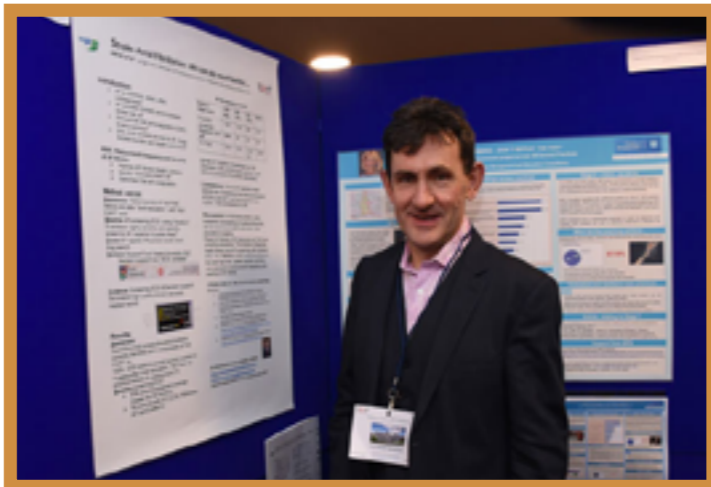


**Download free presentation**

## Presenters

Aoife Lyons,  
Dorothy Leahy,  
Matt Dahm,  
Diarmuid Quinlan,

Ireland



Diarmuid Quinlan

## Introduction / Aim

Texting has become more prevalent in General Practice as a tool used to communicate with patients, however, the Office of the Data Protection Commissioner suggests that texts should be limited to appointment reminders and general announcements only. The main objective of this study was to assess the extent of use, and the purpose of texting by General Practitioners (GPs) to communicate with patients.

## Method

A mixed methods study based in Cork City and County from November 2015 to 2016 that involved: A GP phone survey (n=389), a patient satisfaction survey (n=78) and a focus group with GPs (n=6).

## Results

### 1. Phone Survey:

Time saving was identified as the biggest advantage of texting amongst texters (80%) and non-texters (50%) alike, and potential breach of confidentiality was identified as the biggest disadvantage amongst both groups at 32% and 69% respectively. 53% of non-texters suggested that they would use texting if it was endorsed by the ICGP or their medical indemnifier.

### 2. Patient Satisfaction Survey:

Most patients (99%) were happy to receive texts from their GP.

### 3. Focus group:

Again the risks and benefits of texting were highlighted. Risks identified were: having incorrect patient phone numbers and potential breaches of confidentiality. The benefit unanimously identified was time saving via the use of GP software to facilitate fast delivery of text communication.

## Conclusions

In a busy practice setting, texting can assist in time management for GPs and provide patients with fast test results. However, GPs need further support if they are to communicate safely with patients through texting. Collaborative efforts are required from relevant policy makers to provide clear guidelines for GPs to protect patient confidentiality.

## Topic Description

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

## Learning Objectives

1. Identify his or herself as either a texter or a non-texter and question why that is.
2. Hear the current guidelines for GPs on the recommended use of texting in General Practice.
3. Learn how to implement a practice policy on the safe logging of patient identifiers and consent.

# Theme 3



## **Facilitating Safety:**

*Policy & Safety Culture,  
Staff & Patient Participation,  
Safer Transitional Care in the  
practice interfaces*



*Katthiana Aparicio (WHO) & Dorien Zwart*

# Patient, Family and Community Engagement: a global overview

# KEYNOTE



**Download free presentation**

## Presenter

*Ms. Katthyana Aparicio (Geneva)*

*Programme Officer, Patient Safety and Quality Improvement World Health Organization headquarters in Geneva, Switzerland*



## Bio

Katthyana has been working for WHO since 2006. She joined the former Patient Safety Programme in 2007 and played an important role in project management and evaluation of the Patient Safety Research Small Grants Programme.

From 2013 she has been working for the Patients for Patient Safety Programme (PFPS) and for the African Partnerships for Patient Safety. Katthyana has extensive experience on patient safety. Her role includes the management of multi-cultural projects with a focus on global networks management and institutional health partnerships implementation.

She liaises closely with members of Spanish and French speaking countries, she provides support to countries on capacity development for engagement of patients, families and communities. Katthyana has business administration and project management background.

She is fluent in English, French and Spanish. Katthyana holds two master degrees from the University of Geneva, one in Business Administration and the other in Information Systems and has completed formal training in Project Management.



# Grease in the Wheel of Improving Positive Patient Safety Culture in Practice

# KEYNOTE

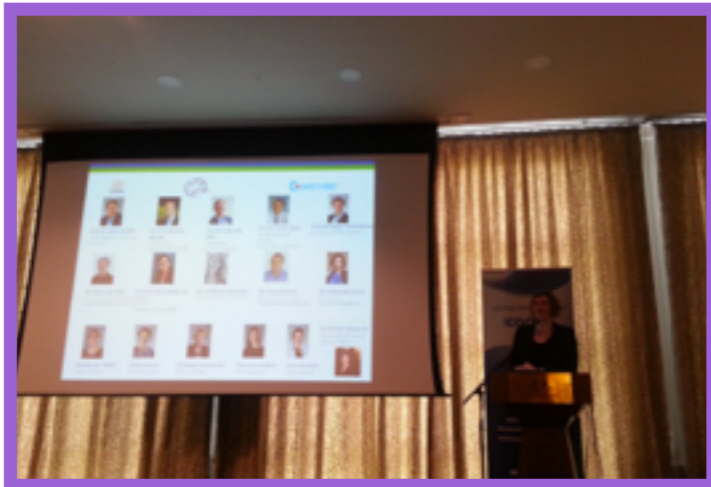


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## Presenter

*Dr. Dorien Zwart (Netherlands)*

*Associate Professor, Department of General Practice, Julius Center, University Medical Center, Utrecht, The Netherlands*



## Bio

Dorien Zwart, M.D., Ph.D., is a 2016-17 Dutch Harkness Fellow in Health Care Policy and Practice. She is currently an Associate Professor in the Department of General Practice in the Julius Center for Health Sciences and Primary Care at University Medical Center Utrecht. She also practices as a Family Physician at the Primary Health Care Center De Bilt.

Zwart primarily focuses on patient safety in general practice, and within this scope, is developing and supervising a research portfolio as part of healthcare innovation research in Julius Center of Health Science and Primary Care. This portfolio includes projects on the Transitional Incident Prevention Program (TIPP), which centers on safety in patient transitions between primary and secondary care, a trial on pharmacotherapy optimization through integration of a non-dispensing pharmacist in a primary care team (POINT) and a study aiming at analysis and improvement of telephonic triage of patients with complaints that are suspect for acute cardiovascular disease (Safety First).

Beside her research on patient safety, she co-supervises the academic medical education research within her department, where she is responsible for innovation and development for the master's program. Zwart received her medical degree from the University of Groningen, her medical specialty degree from the University Medical Center Utrecht and her doctorate from the Graduate school of Life Sciences at the University of Utrecht.

# Managing conflict and aggression in General Practice

# WORKSHOP



**Download free presentation**

**Presenter**  
*Suzanne Creed, UK*

The Managing Conflict and Aggression in General Practice workshop will assist practices in recognising and managing different aspects of conflict that they may encounter at work. It provides practical tools and tips that can be used to help resolve a difficult situation.

### Intended Learning Outcomes

- Appreciate the common causes of conflict
- Understand the importance of communication when dealing with potential conflict
- Understand how aggression escalates
- Understand human behaviour
- Understand the importance of confidentiality
- Identify methods for dealing with conflict situations.

### Premise

All staff working in general practice have a right to work in an environment that is free from harassment and threat. No-one should have to tolerate the threat of physical or verbal abuse. Unfortunately conflict and aggression towards staff in general practice does occur. This is primarily because the work involves contact with a wide range of people in circumstances that may be difficult. Patients and their relatives may be anxious and worried. Some patients may be predisposed towards violence.

### Overview

- Why is conflict a problem
- Identifying common risk factors contributing to conflict
- Human behaviour
- Practical tips to reduce the risks
- Summary.

### Background Research on causation and prevention of medicolegal risk

3,462 incidents of physical assaults were recorded by HSE between Jan 2012 and July 2016

[Link](#)

"Assaults by patients on medical staff cost €1.5 million a year" Irish Examiner 2014

[Link](#)

A survey carried out in 2010 of GP's working in the mid-west out-of-hours co-op found 47% had experienced intimidation or harassment by a patient in the OOH

51% had been verbally abused

10% had experienced violence or assault

[Link](#)



# PRESENTATIONS

## EQuIP Delegates' perceptions on the Medical Office Survey on Patient Safety Culture



**Download free presentation**

### Presenters

*Isabelle Dupie,  
André Nguyen Van Nhieu,  
France*



*Anna Stavdal (WONCA Europe president) & André Nguyen Van Nhieu*

### Introduction / Aim

Patient safety depends on a culture of trust, reporting, transparency and discipline. For health-care organisations, in every country, this requires major culture change. There are not yet strong evidences showing the link between developed safety culture and better patients' outcomes, but it appears to be a necessary foundation.

The Medical Office Survey on Patient Safety Culture (MOSPSC) is one of the tool designed to measure Patient Safety Culture in a medical office by assessing the opinions of staff at all levels - from physicians to receptionists. The aims of the study was to explore the opinions and perceptions of GPs from EQuIP network on the tool and on its feasibility in family medicine organisations. In addition, the study gives a picture of the diversity of those organisations among European countries

### Method

A web-based cross-sectional study to measure patient safety culture was conducted among the EQuIP delegates from November 29th, 2015 to February 16th, 2016. The MOSPSC was sent along with a feasibility questionnaire. A group interview was held during the EQuIP meeting in Prague April 2016 to complete the study with qualitative datas. 8 EQuIP delegates and one expert on patient safety were also interviewed individually. Descriptive statistics were done using R.Studio and qualitative datas were double-coded and are being analyzed.

### Results

The survey response rate for participants was 72.5% (29/40). 19 european countries participated. Results were displayed in 18 radial plots showing 10 dimensions of patient safety culture explored by the MOSPSC. A dimension was con-

sidered developed if there were 75 % or more positive responses. It was considered with potential for improvement if there were less than 50% positive answers.

Patient safety culture was perceived to be globally developed with the only exception of the dimension 'Work pressure and pace'. 73% of the participants rated Patient Safety in their office as good or very good. EQuIP delegates mostly found the MOSPSC easy to fill but only 50% thought it could help to understand patient safety. The MOSPSC has not been translated in most non-english-speaking european countries. Nearly half found it very interesting and 63% would like to be involved in a study using the MOSPSC. 65% of GPs work in a single speciality organisation. Only 23% of EQuIP delegates work in a multi-speciality primary care center.

### Conclusions

Equip delegates found the MOSPSC globally interesting and would like to be involved in a study exploring patient safety culture using this tool. The qualitative datas when analyzed will add relevant information on its best use in primary care

### Topic Description

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

### Learning Objectives

1. learn about a validated tool in primary care to measure patient safety culture / Medical office Survey on Patient Safety Culture
2. understand the concept of patient safety culture

# A systematic review of primary care safety climate survey instruments: their origins, psychometric properties, quality and usage



**Download free presentation**

## **Presenters**

*Ciara Curran,  
Sinead Lydon,  
Maureen Kelly,  
Andrew Murphy,  
Chloe Walsh,  
Paul O'Connor,  
Ireland*

## **Introduction / Aim**

Safety climate measurement is a frequently utilised method of proactive safety assessment in primary care. It is most frequently assessed using a questionnaire. However, in order to accurately assess safety climate, it is important that valid and reliable survey instruments are used. Currently, there is considerable variability in the quality of these surveys instruments and there is no consensus on which instrument is 'best' to use. We aimed to identify the origins, psychometric properties, quality and safety climate domains measured by survey instruments used to assess safety climate in primary care settings.

## **Method**

Systematic searches were conducted using Medline, Embase, CINAHL and PsycInfo in February 2016. English-language, peer-reviewed studies that reported the development and or use of a safety climate survey in a primary care setting. Two independent reviewers extracted data (survey characteristics, origins and psychometric properties) from studies and applied the Quality Assessment Tool for Studies with Diverse Designs (QATSDD) to assess methodological rigour. Safety climate domains within surveys, were deductively analysed and categorised into common health-care safety climate themes.

## **Results**

Twenty safety climate surveys were identified, of which fifteen had been adapted from two widely used US hospital-based surveys. Only two surveys were developed de novo for a primary care setting. The quantity and quality of psychometric testing varied considerably across the surveys. Management commitment to safety was the most frequently measured safety climate theme (87.5%). Workload was infrequently measured (25%), despite having been shown to increase the risk for medical errors and influence quality of care in primary care.

## **Conclusions**

Valid and reliable instruments, which are context-specific to the healthcare environment for intentional use, are essential in order to accurately assess safety climate. Key recommendations include further establishing the construct and criterion-related validity of existing instruments as opposed to developing additional surveys.

## **Topic Description**

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

## **Learning Objectives**

- 1.** Identify the primary care safety climate survey instruments available for use and their purpose within the practice
- 2.** Describe the psychometric properties of these survey instruments and the importance of using valid and reliable instruments and also describe the convergence of safety climate themes across these instruments
- 3.** Identify areas of future research to further develop the area of safety climate measurement in primary care.

# Safety Climate Measurement in Ireland – a comparison with England and Scotland

# PRESENTATIONS



**Download free presentation**

## Presenters

*Ciara Curran,  
Sinead Lydon,  
Maureen Kelly,  
Andrew Murphy,  
Ireland*



*Ciara Curran and Irish friends*

## Introduction

Safety climate measurement is a key component of patient safety toolkits in English and Scottish primary care. We aimed to measure safety climate in Irish primary care and compare the findings to published data from England and Scotland.

## Method

A cross-sectional, anonymous survey was administered to Irish general practices in West of Ireland. PC-SafeQuest Survey was utilized to measure safety climate scores. This survey consists of 30 items divided into five sub-scales (workload, communication, leadership, teamwork, and safety systems). Responses are provided on a seven-point Likert scale. The effect size of the difference between the Irish sample and English and Scottish samples was calculated for each sub-scale, and the overall safety climate score. Responses were also compared in the Irish sample based upon role.

## Results

The overall difference in safety climate scores between Irish and English samples demonstrated a medium effect size, indicating that the Irish respondents reported a more positive safety climate (means score safety climate score of 5.5 and 5.1 respectively,  $d= 0.4$ ).

Although there was little difference between the overall safety climate scores for the Irish and Scottish samples, the Scottish sample had a more positive attitude to workload as compared to the Irish sample (mean workload score of 5.0 and 4.3 respectively,  $d= 0.6$ ).

Within Ireland, workload had the lowest mean score (4.3) and leadership had the highest mean score of all factors (6.0). The only significant

difference based upon roles was for workload ( $p=0.002$ ). GP Principals had a significantly more negative perception of workload than administrative staff.

## Conclusions

The safety climate in Irish primary care is broadly comparable to Scotland. However, workload would appear to be an area that should be examined- particularly for more senior GPs. Negative perceptions of GP principals on workload may reflect 'burnout' or the pressure of recent financial cutbacks.

## Topic Description

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

## Learning Objectives

Report the results of the safety climate study conducted in West of Ireland in Irish primary care using the PC SafeQuest Survey and identify any positive / negative findings across the 5 subscales of workload/communication/ leadership/teamwork and safety systems.

Identify areas across these subscales where there may be differences between perceptions of safety climate based upon roles within the general practice surgery and generate discussion on why this may be.

Reflect on differences between Irish, Scottish and English safety climate based on similar published studies using the same instrument

# PRESENTATIONS

## The Safety Climate in Primary Care (Sap-C) Study: A randomised controlled feasibility study



**Download free presentation**

### Presenters

*Paul O'Connor, Ireland,  
Sinead Lydon, Ireland,  
Margaret Cupples, UK,  
Nigel Hart, UK,  
Andrew Murphy, Ireland,  
Ciara Curran, Ireland*

### Introduction / aim

Research on patient safety has focused primarily on secondary care and there is a dearth of knowledge relating to safety, and safety improvement strategies, in the context of primary care. This is problematic given the high rates of usage of primary care services and the myriad of opportunities for errors daily. Research supports this suggestion with studies reporting that there are between 5 and 80 patient safety incidents, or errors, made per 100,000 primary care consultations.

### Method

The SAP-C study is a feasibility study employing a randomised controlled design that is running in 10 general practices (five intervention practices, five control practices) in Ireland. The aim of this study is to evaluate the feasibility and effects of an intervention intended to improve patient safety in primary care. The intervention is derived from the Scottish Patient Safety Programme in Primary Care.

The nine-month intervention consists of: 1) the administration of a safety climate measure to all staff members at each intervention practice at three timepoints and the provision of feedback on safety scores to each practice, and 2) the completion of two patient chart audits using a specialised trigger tool intended to facilitate the detection of unidentified patient harm.

### Results

Initial data suggest that safety climate in Irish primary care settings is quite positive. A discrepancy in the reports of "managerial" (i.e. senior GPs) and "non-managerial" (i.e. assistant GPs, administrative staff) staff was noted however suggesting that managerial staff may overestimate the safety of their practices.

### Conclusions

This study is currently ongoing and will conclude in May 2017. It is anticipated that the study will provide useful data regarding the prevalence of undetected patient harm in Irish primary care, the safety climate of Irish general practices, and will contribute to an improved standard of care delivered by general practitioners.

### Topic Description

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

### Learning Objectives

1. Learn to define a patient safety incident and be able to describe the most common types of patient safety incidents that occur in general practice settings
2. Learn about the different methods of assessing patient safety in general practice settings
3. Come to understand some of the challenges associated with delivering a safety improvement intervention in the context of Irish general practice.

# Safety culture in Norwegian Primary Care

# PRESENTATIONS



**Download free presentation**

## Presenters

*Gunnar Bondevik,  
Dag Hofoss,  
Ellen Catharina Tvetter Deilkås,  
Norway*

## Introduction / aim

Title: "Safety culture in Norwegian primary care"  
Patient safety culture is how leader and staff interaction, attitudes, routines, awareness, and practices protect patients from adverse events. The Safety Attitudes Questionnaire (SAQ) is an instrument to measure safety attitudes amongst health care providers. The original SAQ version includes six patient safety factors: Teamwork climate, Safety climate, Job satisfaction, Perceptions of management, Working conditions, and Stress recognition.

The aim of this project is to develop tools for measuring safety culture by investigating psychometric properties of the SAQ – Ambulatory Version (AV) in the following seven services in Norwegian primary care: Out-of-hours, general practice, nursing homes, child health clinics & school health services, home care, mental health and municipal emergency units. We will also study variations in safety attitudes amongst the employees, variability between work units, and within unit homogeneity.

## Method

Project period 2012–2020. By 2016, we have completed studies in three of the primary care services: out-of-hours, general practice and nursing homes. Health care providers were invited to answer the Norwegian versions of the SAQ-AV, adapted to each of these services. Statistical analysis included confirmatory factor analysis and multiple linear regressions.

## Results

Of the 973 invited health care providers in the three services, 554 (57%) answered the questionnaire. Patient safety factor scores in general practice were higher than found in out-of-hours clinics and nursing homes. At the congress, we will present the psychometric properties of the SAQ-AV for these primary care services. We will also present variations in safety attitudes amongst health care providers in general practice, out-of-hours clinics and nursing homes.

## Conclusions

The Norwegian versions of the SAQ-AV may be useful tools for measuring several aspects of safety culture in the primary care setting. Safety culture assessment may help leaders to initiate targeted quality improvement interventions. Further research should investigate associations between safety culture and occurrence of adverse events in primary care.

## Topic Description

Facilitating Safety: Policy & Safety Culture, Education, Involving health system stakeholders in transitional care and practice interfaces.

## Learning Objectives

1. ...learn how the Safety Attitudes Questionnaire - Ambulatory Version (SAQ-AV) can be used to measure safety attitudes amongst health care providers in primary care.
2. ...learn about variations in safety attitudes amongst health care providers in different services of primary care.
3. ...learn how safety culture assessment may help leaders to initiate targeted quality improvement interventions.

# PRESENTATIONS

## Testing of the Slovenian version of the safety attitudes questionnaire – ambulatory version



**Download free presentation**

### Presenters

Zalika Klemenc – *Ketis, Slovenia,*  
Ellen Catharina Tvetter Deilkås, *Norway,*  
Dag Hofoss, *Norway,*  
Gunnar Bondevik, *Norway*

### Introduction / aim

Several tools have been developed to measure safety attitudes of health care providers. One of them is also the Safety Attitudes Questionnaire (SAQ) which is regarded as one of the most appropriate ones. In 2007, it was adapted to outpatient (primary health care) settings.

The aims of this study were to translate the English version of the SAQ-Ambulatory Version (SAQ-AV) to Slovenian language; to test its reliability; and to explore its factor structure.

### Method

This was a cross-sectional study that took place in Slovenian out-of-hours primary care clinics in March-May 2015 as a part of an international study entitled Patient Safety Culture in European Out-of-hours services.

We used the Slovenian version of the SAQ-AV. The link to the questionnaire was emailed to health care workers in the out-of-hours clinics. A total of 438 participants were invited. We used exploratory factor analysis to determine the factor structure.

### Results

Out of 438 invited participants, 250 answered the questionnaire (response rate 57.1%). Exploratory factor analysis put forward five factors:

- 1) Perceptions of management,
- 2) Job satisfaction,
- 3) Safety climate,
- 4) Teamwork climate, and
- 5) Communication.

Cronbach's alpha of the whole SAQ-AV was 0.922. Cronbach's alpha of the five factors ranged from 0.587 to 0.791.

### Conclusions

Our study showed that there might be other safety culture factors in out-of-hours care not recognised before. We therefore recommend larger studies aiming to identify an alternative factor structure.

### Topic Description

The unique context of safety in general practice and its interfaces: Measuring and Monitoring Safety - Which Framework for Primary Care?

### Learning Objectives

Recognise the importance of tools for measuring safety culture in primary care.



# PRESENTATIONS

## Transitional patient safety in the Netherlands: a qualitative study on patient participation



Slides are not to be shared due to unpublished research results.

### Presenters

Judith Poldevaart,  
Leida Reijnders,  
Antoinette De Bont,  
Niek De Wit,  
Dorien Zwart,

Netherlands



Dorien Zwart

### Background & aim

Patient participation has been recommended as an important way to improve patient safety. Despite numerous initiatives and developed tools to enhance patient participation, evidence of their effectiveness in improving patient safety is limited.

When a patient transfers between primary care and hospital the patient has an increased risk of experiencing a transitional incident. The objective of this study was to explore patient participation in transitional patient safety from a both patients' and health care providers' perspective.

### Method

Qualitative template analysis was used for a purposive sample of thirteen semi-structured interviews with patients who transitioned between general practice and hospital.

These findings were analyzed alongside data of focus group discussions with 98 healthcare providers, namely hospital staff of three hospitals and their referring general practitioners on the role of the patient in transitional patient safety.

### Results

Both patients and health care providers voice the lack of sufficient knowledge in patients of how health care providers handle the transition of care. Patients varied in the need to participate, from none to extensively. Those who want to participate expressed difficulty in how to actually participate. Health care providers confirmed the extensive differences between patients and elaborated on approaches tailored to individual patients. Health care providers expressed the need for a more shared responsibility for safety, whereas the majority of patients feel health care providers bear sole responsibility.

### Conclusions

The lack of both sufficient knowledge and insight of patients in the way health care providers handle the transition of care may impede patient participation to improve transitional patient safety. Improvement strategies should focus on the role of health care providers to engage the individual patient to participate, tailored to their needs and capacity. Interestingly, patients and health care providers seem to differ in their opinion on who is responsible for transitional patient safety.

### Topic Description

The unique context of safety in general practice and its interfaces: Measuring and Monitoring Safety - Which Framework for Primary Care?

### Learning Objectives

Recognise the importance of tools for measuring safety culture in primary care.

# PRESENTATIONS

## How differences between primary and hospital care shape transitional patient safety; a qualitative study



Slides are not to be shared due to unpublished research results.

### Presenters

Judith Poldevaart,  
Leida J. Reijnders,  
Antoinette A. de Bont,  
Marije A. van Melle,  
Niek J. de Wit,  
Dorien L.M. Zwart  
Netherlands

### Introduction

Transitions between primary care and hospital, such as discharge, referrals and medication continuity are identified as high-risk situations. Differences in culture between primary care and hospital could explain why interventions to improve handover does not improve patient safety. This study aims to understand the differences in culture between primary care and hospital in order to give direction to future interventions to improve transitional patient safety.

### Method

Twelve focus group discussions on perceived risks, reflection upon incidents, suggested solutions and experienced differences in understanding transitional patient safety were conducted with either general practitioners (7 focus groups), or hospital staff (5 focus groups) (n=98). Template analysis was used to analyse the data.

### Results

General practitioners and hospital staff reflected differently on patient safety incidents. While general practitioners reflected upon individual patients and specific incidents, hospital staff reflected upon frequent incidents and the necessity to follow procedures and guidelines. Respondents discussed how the working context varies substantially with respect to patient populations and organizational structures - which comes with a different perception of diseases and risks in transitions. Transitional patient safety is shaped by - what is called- the no man's land between general practice and hospital.

### Conclusions

General practitioners and hospital staff differ in their attitudes towards safety. These differences affect the collaboration and complicate the improvement of transitional patient safety. Hence, better understanding and awareness of the organisational differences and its effect on transitional care processes and patient safety is essential.



*I enjoyed Dorien Zwart's presentations a lot. We will try start to build up the culture of Patient Safety in Primary Health Care in Estonia step-by-step after this European event.*

(Dr Katrin Martinson, Estonian EQuIP delegate)

# Theme 4



## Implementing Patient Safety using Practical Safety Tools & Methods for General Practice, & Involving Patients and Staff.



*Prof. Walter Cullen and Dr. Paul Bowie with EQuIP friends*

# Risk Management and Safety Strategies for Patients and Healthcare Professionals in the Primary and Secondary Care Interface

– an Irish Perspective



**Download free presentation**

## **Presenter**

*Prof. Walter Cullen (Ireland)*

*Professor of Urban General Practice,  
School Of Medicine, UCD, Dublin*



## **Bio**

I am a GP in Dublin City and Professor of Urban General Practice at UCD School of Medicine (2014-date) and previously, was Foundation Professor of General Practice at the University of Limerick Graduate Entry Medical School (2009-14). I currently lead a multi-disciplinary research team that as well as colleagues at UCD involves formal collaborations with HSE, primary / secondary care, service user representatives and international experts. It has realised in excess of 150 peer reviewed publications and over €3m in grant income.

Our research interests include how we can enhance primary care - and its interface with secondary care, especially for patients with mental health and substance use problems. Since 1998, I have taught General Practice to students at UCD and previously worked as Foundation Professor of General Practice at UL and led the establishment of Academic General Practice Networks affiliated with both these Schools.

# Safety Tools and Methods for General Practice

## - A Scottish Perspective



**Download free presentation**

### **Presenter**

*Dr. Paul Bowie (Scotland)*

*Programme Director (Safety and Improvement)  
NHS Education for Scotland, Glasgow  
Hon Senior Lecturer, Institute of Health and  
Wellbeing, University of Glasgow*



### **Bio**

Paul Bowie PhD C.ErgHF MIEHF FRCPEd is a Chartered Ergonomist & Human Factors specialist, patient safety scientist and medical educator with NHS Education for Scotland based in Glasgow, Scotland, UK.

He has worked in the National Health Service in Scotland for over 20 years in a range of quality and safety advisory roles. He gained his doctorate in significant event analysis from the University of Glasgow in 2005 and has published over 80 papers on healthcare quality and safety issues in international peer-reviewed journals.

He is Associate Editor of BMC Family Practice and a PhD supervisor/examiner and Honorary Associate Professor in the Institute of Health and Wellbeing at the University of Glasgow. In 2011 he was elected Fellow of the Royal College of Physicians (Edinburgh) and is a Registered Member of the Chartered Institute of Ergonomics and Human Factors.

# Complaints Management in General Practice

– Good service, bad service, and lip service

# WORKSHOP



**Download free presentation**

## Presenter

*Mary Davin Power, Ireland*



## Introduction / Aim

This workshop is designed to support the concept of having a robust complaints policy in every practice, for the following reasons: 1. A Complaints Policy keeps the patient central to the practice and involves the patient in how the practice might develop 2. A good Complaints Process can highlight difficulties within the practice which GPs may not otherwise be aware of, and act as an 'early warning system' for potential safety issues. 3. A Complaints Policy inviting patients to complain within the practice may serve to provide the information, explanation or apology which the patient seeks, without the patient feeling they have no option but to make a medical council complaint or a medico-legal claim.

## Method

Powerpoint presentation and exchange of views from the floor of experiences in other practices both Irish and European. There are three issues for discussion regarding management of complaints:

1. To have a complaints policy in the practice – why it's a good idea
2. To have a good protocol of management of complaints involving all members of staff
3. To ensure that all complaints are managed according to the practice complaints policy.

## Results

GPs should have a deeper understanding of why it is good practice to have a robust complaints policy and how it is not 'just lip service' but can be used as an 'early warning system' in any practice regarding potential safety issues and can help avert greater difficulties at a later time for the GP.

## Conclusions

The aim of this workshop is that each attending GP who does not already have a complaints policy will explore the possibility and hopefully have a policy in place within six months of attending the workshop. Where they do already have a policy in place they should gain new insight and ideas regarding the implementation of the policy. It would be hoped that a more widespread use of a good complaints policy will ultimately result in fewer Medical Council Complaints and Medical Negligence claims when patient dissatisfaction is dealt with in an open and proactive manner. Ultimately it will alert the GP to any potential difficulties in the practice and help signpost possible patient safety issues.

## Topic Description

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

## Learning Objectives

1. Develop a robust complaints policy in the practice – and understand why it's a good idea
2. Have a good protocol of management of complaints involving all members of staff within the practice and ensure that all complaints are managed according to the practice complaints policy
3. Ultimately run a safer, smoother practice where patient comfort and satisfaction is prioritised.

# Management of Test Results for General Practice Staff

# WORKSHOP



**Download free presentation**

**Presenter**  
*Julie Price, UK*

A short workshop exploring important issues in relation to management of test results in General Practice.



## Intended Learning Outcomes

- Acquire a greater understanding why management of test results is important
- Appreciate risks and consequences associated with poor test results management
- Update knowledge of the principles of good test results management
- Identify any improvements needed within your current system, by carrying out risk assessments and process mapping
- Enhance skills to ensure your practice has safe well designed robust system for managing test results that can trap human error and reduce the likelihood of an adverse event

## Premise

Practices use the laboratory services on a daily basis, sending off specimens and receiving results, which are checked for abnormalities and actioned as necessary. Is the system you have at your practice robust, effective and safe? When was the last time a test result was lost or not conveyed to a patient? Can you be sure that there are no reports in the system that you have not seen or acted upon?

Like many risks in general practice the effective management of test results is threatened by both a lack of robust systems and human error. Well-designed test results systems can trap human errors and help reduce the likelihood of adverse events, thus preventing harm to patients.

## Overview

- The importance of good test results management
- Risks associated with test results in General Practice
- Risk assessment of the test result process

## Background research on causation and prevention of medicolegal risk

An MPS study found that approximately 60% of claims in general practice handled by MPS related to the failure to diagnose. Many of these can be attributed to system error, eg, an abnormal test result not acted on; a test result scanned into the wrong patient record, or an abnormal result not communicated to the patient.

Over the past 12 years MPS has conducted more than 1,500 Clinical Risk Self Assessments (CRSAs) in general practice. The data analysing from over 80 CRSAs conducted during 2016 reveals that 75% of practices had risks associated with their test results system.

# WORKSHOP

## De-prescribing as a patient safety tool in primary care



**Download free presentation**

### Presenters

*María-Pilar Astier Pena,  
Jose-Miguel Bueno-Ortiz,*

*Spain*



### Background:

Deprescribing (D) is a structured approach to drug discontinuation. The major aim of D is to purge the drug(s) considered unwanted in a given patient, especially in the Elderly patients (E) with multiple comorbidities or in those suffering from chronic disease.

Current guidelines have limited applicability to E with comorbid conditions, the efficacy and safety of many drugs is unknown or questionable and there is evidence that taking more than ten drugs simultaneously cause adverse events.

The differential diagnosis of any sign or symptom in the E should always include the question, "Could this be caused by a drug?". General Practitioners have the possibility to promote a safer use of medications in E.

### Aims:

1. Introduce the concept of Deprescribing and why it is important for patients and doctors.
2. Define the concepts of therapeutic cascades and Deprescribing ascents;
3. Provide an overview of the evidence to stop unnecessary or potentially harmful medications and point out specifically good examples of common drugs which would be appropriate to Deprescribing
4. Provide resources to help to tackle these issues with patients and, to empower to make Deprescribing a regular part of family practice.

### Methods:

Short theoretical introduction followed by work in small groups on frequent clinical situations.

### Results:

To share groups' proposals on Deprescribing and facilitate resources to build family practice's plan to promote Deprescribing among elderly patients in our practices.

### Conclusions:

This workshop can be used by primary care teams to promote a safer use of medications among Elderly patients.





# PRESENTATIONS

## A patient centered, safer and more efficient way for prescribing warfarin in primary care



**Download free presentation**

### Presenters

*Rita Fernholm,  
Jonas Hermansson,  
Sweden*

### Introduction / Aim

Boo primary care centre in Nacka, Sweden, manages approximately 240 patients on active warfarin treatment. A risk analysis showed that testing and prescribing involved 28 different steps and 9 parties, leading to a high risk of errors.

The aim of the study was to shorten and simplify the process flow for testing and prescribing warfarin in order to increase patient safety. The aim was also to evaluate if TTR (Time in Therapeutic Range) was affected by the intervention and to assess time expenditure and cost of the new process flow.

### Method

This study was based on the introduction of rapid analysis (point of care) for the process of testing and prescribing warfarin. This took place during 6 months. An evaluation of TTR, costs and adverse events was performed. An evaluation was also conducted in the form of surveys to patients and staff regarding satisfaction with the new process.

### Results

The process was shortened from 28 steps and 9 parties involved to 9 steps and 4 parties involved. The feedback time for patients was shortened from 1-3 days by mail to less than 10 minutes still at the primary care centre. TTR improved from 75 % to 81 % (not statistically significant). The incidence of adverse events was not affected.

The surveys showed that the overwhelming proportion of patients, doctors, assistant nurses and laboratory staff were pleased with the change and the patients would recommend others to monitor their treatment at Boo Primary Care Centre. There was a reduction in time expenditure for the staff. The running costs decreased from approximately 8,000 €/month to about 7,000 €/month.

### Conclusions

The introduction of the rapid analysis method enabled a completely different process flow with increased quality, reduced time expenditure for both patients and staff and reduced running costs. Patient involvement was higher than before and both patients and staff were satisfied with the changes.

The study may have implications on improved compliance to warfarin treatment, if so, it will increase patient safety. With shorter process there are fewer things that can go wrong and with direct communication the risk for misunderstanding is reduced.

### Topic Description

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

### Learning Objectives

1. Learn means to simplify care, making it safer together with the patients.
2. learn about safety in prescribing warfarin within primary care.

# PRESENTATIONS

## Could the collaboration between general practitioner and clinical pharmacist increase the safety and quality of care at primary health care level?



**Download free presentation**

### Presenters

*Erika Zelko,  
Mate Štuhec,*

*Slovenia*

### Introduction / Aim

In Slovenia, because of serious increase in drug consumption in last decade, there was a high interest of The Health Insurance Institute of Slovenia (Slovenian name: Zavod za zdravstveno zavarovanje Slovenije, ZZZS) to avoid serious polypharmacy in real clinical practice.

For this purpose, ZZZS financed a trial entitled: »pharmacist consultant«, where a specialist of clinical pharmacy was enrolled into the each medical primary team. The main aim of this paper is to present successful case in primary health settings (treatment-resistant depression), where an appropriate collaborative care model has been used.

### Method

Patients' data were obtained from their medical records and a pharmacotherapy review. Pharmacotherapy review included the following important parts: drug-drug interactions, possible adverse events, existing drug indications, possible inappropriate medication in elderly and final recommendations according to the patients' outcomes.

### Results

The positive effects of this antidepressant combination, suggested by PC to GP, has not been widely reported, but there have been reports of a combined treatment with bupropion and additional antidepressant improving symptoms of treatment-resistant MDD. This type of collaborative care model showed improvements in MDD and neuropathic pain.

### Conclusions

In this report, we identified a case with positive evidence of this antidepressant combination relieving the symptoms of treatment-resistant MDD and collaborative care model with PC in primary health care setting. This is another evidence that a good collaboration between health care providers increases the safety and quality of treatment of the patient.

### Topic Description

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

### Learning Objectives

1. Understand the importance of good communication between different health care providers
2. Understand the role of clinician pharmacist in primary health care team
3. They will learn a new tool for safety work at primary health care level with patients using more drugs or have a lower response to usual medication

# Methotrexate:

A novel approach to safer use of potentially toxic medication

# PRESENTATIONS



**Download free presentation**

## Presenter

*Diarmuid Quinlan, Ireland*



## Introduction & Aims

Ireland has 11,000 patients taking methotrexate, and four times more adverse incidents than UK.

[Link](#)

Audit of methotrexate in my GP practice revealed seriously inadequate monitoring, and non-compliance with national methotrexate prescribing recommendations.

Developed multi-practice, patient-centered, interdisciplinary, safety initiative for patients taking Methotrexate. We developed a patient held "ALERT" card. Existing IT resources harnessed, to enhance patient safety nationally.

## Method

Presentation to 168 GPs, 120 pharmacists, unanimously committed to safer methotrexate management.

Patients; Patients survey completed.

Secondary care; Wrote to all local Rheumatologists, dermatologists and oncologists who initiate Methotrexate. Highly supportive of this initiative.

General Practice IT; Engaged IT providers, who incorporated "safe prescribing templates" enhancing safe Methotrexate use nationally: using existing IT resources to enhance patient safety.

"Orion" pharmaceuticals enhanced methotrexate safety warning.

Patient "ALERT" card initiative is simple, low-cost patient education resource, available electronically, easily disseminated and printing.

## Results

GP Audit demonstrated:

- BNF recommended blood testing improved from 21% to 95% of patients.
- Excessive blood testing was curtailed, maintaining patient safety while reducing practice workload.
- Prescribing compliant with national guidelines improved from zero to 65%.
- Vaccination status improved from 63% to 85%.
- Documentation of immunosuppression in patient summary improved from Zero% to 94%.
- Use of "pop-up alerts" increased from 7% to 30%.
- ICGP Methotrexate audit template [available](#):
- 168 GPs and 120 pharmacists committed to change prescribing/dispensing behaviour.
- Hospital consultants supported "ALERT" card.
- Oncologist proposed cross-pollinating "ALERT" card to all chemotherapy medications.
- Patient surveyed; all reported "ALERT" enhanced their understanding of methotrexate : one commented "It explains everything".
- Clear focus on patient empowerment, multi-disciplinary collaboration, aligned with smart use of existing IT, produced exciting sustainable results, locally, regionally and nationally. Think local, act Global.

Future quality requirement?

Methotrexate resource allocation as in NHS: [Link](#)

# Quality improvement cycle to a safer medication renewal in a rural GP practice

# PRESENTATIONS



**Download free presentation**

## Presenters

*Diogo Tavares Silva,  
Paulo Louro da Silva,  
David Silvério Rodrigues,*

*Portugal*



## Introduction / Aim

Chronic medication management is a GP's important task, making them the gatekeepers for patient's safety, minimizing drug interactions, dosing errors and side effects. A high number of medication renewal requests was perceived in our recently established rural practice, many of them inappropriate regarding quantity, dosing, active substance or therapeutical schemes, particularly in the authors' patient file. Our primary aim was to reduce the absolute number of medication renewal requests. Secondary goals are to evaluate inappropriate medication renewal requests and total time spent by general practitioner with renewals.

## Method

A focus group was performed in March 2016. A multi-step complex intervention was established:

1. Population sensibilization through alert charts and leaflets in the waiting rooms.
2. Internal protocol for medication renewal circuit
3. Medication management appointments for complex cases; we defined two periods: pre-intervention from January to April 2016, post intervention from August to December 2016; absolute number of medication renewal requests per week in the whole practice and in one family doctor file; qualitative appraisal of inappropriate medication renewal requests per week in one family doctor file; average time spent by GP with renewals per week. Comparison of means by student's t-test.

## Results

In 2016 there were 5410 medication renewal requests in our practice; The mean requests per week in the pre- and post-intervention periods were respectively:

99.8/100.2 (ttest = -0.278 p>.05) in the whole unit;

22.3/19 (ttest = 1.04 p>.05) in the authors' file.

Qualitative appraisal of inappropriate requests revealed that the majority were due to quantity and therapeutical schemes problems. Average time spent with renewals was 156 minutes per week.

## Conclusions

The intervention was not effective in the whole unit; Most of the renewals classified as inappropriate were due to high quantity and inadequate therapeutical schemes; Family practices must develop structured and locally tailored plans to deal with medication renewals

## Topic Description

Implementing patient safety using Safety Tools & Methods for general practice and safer communications involving patients and the practice team

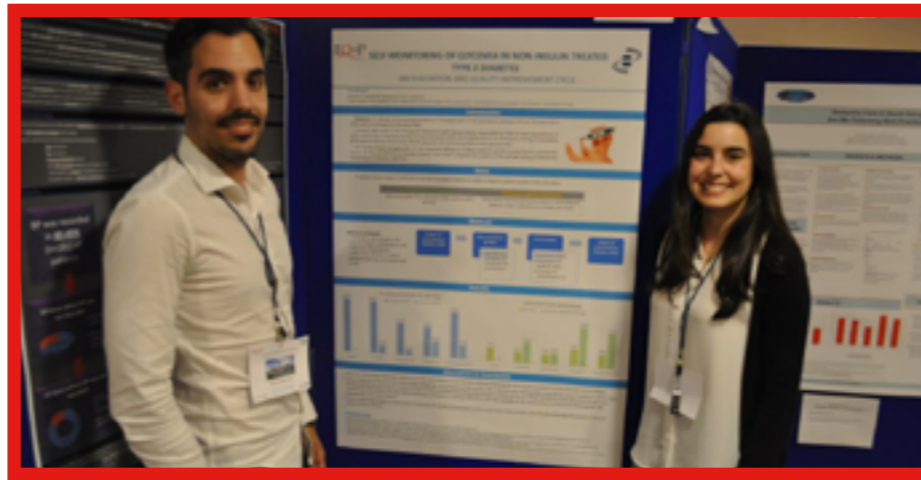
## Learning Objectives

1. Share their local experiences regarding patient care and safety
2. Gain knowledge from a wide variety of colleagues overseas, learning new approaches for common problems in the daily GP practice
3. Establish collaboration for future research projects.



## Posters

All titles are *clickable* links



### ***Developing a response plan to an unexpected serious adverse event in a health centre***

**By:** Maria Pilar Astier Pensa, Jose-Miguel Bueno-Ortiz, Spain

### ***An electronic intervention resulting in improved lithium monitoring***

**By:** Ciara Curran, Catherine O'Mahony, Ireland

### ***Stroke and Atrial fibrillation: We can do much better...***

**By:** Diarmuid Quinlan, Ireland

### ***Repeat Prescribing risk assessment across 48 GP practices in a NHS CCG***

**By:** Julie Price, UK

### ***Maintaining Patient Safety at a GP led Methadone Clinic - A Study of Psychotropic Use and Polypharmacy***

**By:** Niall Cronin, Patrick Halligan, Ireland

### ***Exploring the process of developing a Never Events list for general practice***

**By:** Diane Baylis, UK

### ***Medication changes made in the hospital and their documentation in the medical record of the general practitioner: a medical record review study***

**By:** Judith Poldevaart, Marije van Melle, Sanne Willemse, Niek de Wit, Dorien Zwart, Netherlands

### ***Physician – Pharmacist communication about potentially severe drug interactions***

**By:** Guido Schmiemann, Alexandra Pulst, Germany

### ***Abdominal Aortic Aneurysm: "Qui curat vincit" (He who cares, wins)***

**By:** Diarmuid Quinlan, Ireland

### ***Prescribing Safety Indicators, an example with Irish General Practice software***

**By:** Ealga Beary, Ireland

### ***Burnout in Irish General Practice (GP) Trainees in the Mid-Leinster Specialist Training Scheme***

**By:** Edwina O'Malley, Nick Fenlon, Ireland

### ***Significant Event Analysis in General Practice; A quality improvement project***

**By:** John Brennan, Ciara Kelly, Ireland

### ***Is general practice appropriately prescribing and providing adequate follow up for patients on Novel Oral Anticoagulants***

**By:** Orla Crowley, Ireland

### ***Assessment of blood pressure and cardiovascular risk factor monitoring in uncomplicated hypertensives in a Galway GP practice***

**By:** Maeve Byrne, Eugene O'Beirn, Ireland

### ***Self-monitoring of blood glucose in non-insulin treated type 2 diabetes - an evaluation and quality improvement cycle***

**By:** Vanessa Sa, Alexandra Mendonça, Diogo Tavares, Magda Coutinho, Pedro Barreira, Portugal

### ***Patient Safety: Top Tips for GP's in Training***

**By:** John Brennan, Ireland

### ***To determine if the care of Nursing Home residents with diagnosed dementia in Courthouse Road Medical Practice is in line with best practice***

**By:** Diarmuid Scully, Niamh Irving, Miriam Daly, Aisling Ní Shúilleabháin, Ireland

### ***Human Papilloma Virus (HPV) Vaccination amongst Men who have Sex with Men (MSM) in Ireland: GPs' awareness and vaccination rates***

**By:** Clare Daly, Ireland

### ***Infection Prevention and Control in General Practice***

**By:** Suzanne Creed, UK

### ***Medical Records for Primary Care Clinicians***

**By:** Julie Price, UK

### ***Safer Transitional Care***

**By:** Mary Gray, Geoff McCoombe, Ireland

### ***Safer Clinical Photography in General Practice***

**By:** Thomas Lynch, Isle of Man

### ***An audit of prescribing for elderly patients using the STOPP criteria***

**By:** Eilis Murphy, Declan Mathews, Ireland

### ***Diagnostic ultrasound in general practice in Ireland - A descriptive study***

**By:** Ciara McDonald, Lucia Gannon, Ireland

# Outcomes: Prize Winners



## Prize Winners

The prize winners for best poster, workshop, and oral presentation were:

- Dr John Brennan (Poster)
- Dr Stephanie Dowling (Workshop)
- Dr Ciara Curran (Oral Presentation)



Mr Fintan Foy CEO ICGP, Dr John Brennan & Dr Piet Vanden Bussche, EQUIP President

ISQua @ISQua

Congrats to our #ISQua QI Scholar in Resident Dr John Brennan whose poster was named European champion at #EQUIPDublin2017! @PeterLachman

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And she won the prize for best paper

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Ciara continues on with her second. I am up next ... @WorcaEurope @IrishCAPSS @pmycaretrials!

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# Outcomes: Dublin Declaration



## Dublin Declaration

European family doctors launch **The Dublin Declaration** on patient safety and demand adequate resources for general practice.

Please click here [for the Dublin Declaration](#).



The 2017 Dublin conference of general practitioners from 30 European countries has agreed a call for action to improve safety in healthcare for patients and to fight for adequate resources in general practice to deliver safer better healthcare across Europe.

The two-day EQuIP Conference on Patient Safety, hosted by the Irish College of General Practitioners, issued **The Dublin Declaration** calling on the 44 member organisations of Wonca Europe to highlight patient safety issues and to demand adequate resources in general practice to deliver better safer healthcare.

WONCA (World Organisation of National Colleges and Academies for Family Practice) is a global agency including over 80,000 GPs, and EQuIP is the WONCA Europe network organisation for quality and safety in primary healthcare.

Patient safety was the theme of the two-day conference held on 3rd and 4th March in Dun Laoghaire. Full details of the conference can be found at [www.icgp.ie/equip](http://www.icgp.ie/equip).

The Dublin Declaration, supported by the ICGP, EQuIP and WONCA, calls upon all Wonca Europe member organisations to:

1. **Acknowledge** the unique context of general practice within the greater health system
2. **Engage** with patients
3. **Encourage** collaboration between governments, policy-makers and other stakeholders for further development of safety initiatives to protect patients and health professionals from harm
4. **Fight** for adequate resources in general practice to deliver better safer healthcare
5. **Reaffirm** the commitment of WONCA Europe to support and advise decision makers in line with WHO Technical Series on Safer Primary Care
6. **Address** the lack of research and measurement of safety in primary care
7. **Emphasise** the importance of collaboration on integrating safety in medical education and training curricula and continuous professional development

The Conference included many studies from abroad, and in Ireland, where individual GPs, practices and departments of family practice took concrete actions to reduce patient risk and improve quality of care.

*"Safety is not an impersonal series of metrics in management,"* observed Anna Stavdal, President of WONCA, "it is an ethical choice of crucial importance every day for doctors and the people who come to them for personal care."

Dr Andrée Rochfort, Wexford, GP and Secretary of EQuIP, who was the Irish organiser of this international conference said: *"The Dublin Declaration puts patient safety and fighting for adequate resources for safer healthcare at the heart of the work of the 44 member organisations who were at the EQuIP conference. The Declaration is the cornerstone of the 2017 conference."*

She added: *"The Declaration shows that adequate resourcing of general practice is not just an issue for us here in Ireland but is of central importance across Europe."*

Twitter: #EQUIPDublin2017

## Outcomes: Take-Home Messages



- Primary Care is not a technology industry - we need our own ways to deal with Patient Safety (PS).
- We need to take the issue of PS seriously.
- This means prioritising it: Be prepared to get your hands dirty.
- Identify the leaders/leadership to make PS change happen.
- PS can be a positive thing - not only an additional work...we should enjoy it!
- We are moving from 'counting mistakes' to 'a culture of safety'.
- Take care of the most vulnerable patient groups.
- We have to listen to the story of the patient.
- Clients, not patients!
- Include PS and Team Work early in the medical education and postgraduate training.
- Use patient experiences as educational activities.
- Use CME to discuss PS and for sharing 'mistakes' with each other.
- Search for Team Solutions, together!
- Do you keep a weekly meeting to develop a PS intervention and implementing it?
- Doctors' Health is important and should never be a taboo.
- Never feel guilty for taking good care of yourself.
- Occasional Act of Kindness (OAK): Simple things can make a huge difference
  - - An obligatory coffee break can build resilience of health care workers.
- Feel free to open the Scottish toolbox to really facilitate PS.
- Structure the engagement between Primary and Secondary Health Care.
- Different healthcare systems will be in different places and phases on the journey towards PS. Coming together means that we do not have to start from nothing. We can start with the experiences of others. Coming together is already halfway there!