safety IN PRACTICE

...for Primary Care

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AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Waitematā District Health Board

Best Care for Everyone

What you'll hear today...

- What is the problem?
- What is Safety in Practice?
- Our methodology
- Measurement
- Outcomes
- Challenges & lessons learned
- Sustainable future

WHAT IS THE PROBLEM?

28%

Of patients harmed from medicines in hospital

29%

Of medication related harms occur in the community

67%

Of admissions due to adverse events from medicines are considered preventable

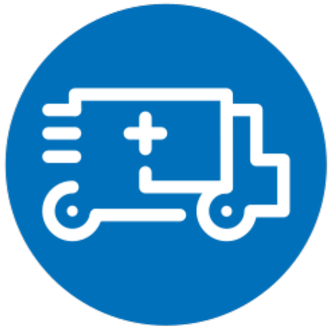
Rob G, Loe E, Maharaj A et al NZMJ 2017; Howard RL, Avery AJ, Howard PD et al, QualSafHealtcare BMJ 2003; Davis P, Lay-Yee R, Briant R. Ministry of Health, New Zealand. Occasional Paper. Adverse events in New Zealand public hospitals: principal findings from a national survey. 2001. ISBN 0-478-26268-X www.health.govt.nz/system/files/documents/publications/adverseevents.pdf (Accessed 07-05-19); Howard RL Avery AJ, Howard PD, Partridge M. Investigation into the reasons for preventable drug related admissions to a medical admissions unit: observational study. Quality and Safety in Health Care. 2003;12(4):280–5. http://qualitysafety.bmj.com/content/qhc/12/4/280.full.pdf (Accessed 07-05-19)

WHAT IS SAFETY IN PRACTICE?

- A Quality improvement (QI) programme for primary care
- Focused on reducing preventable patient harm
- Utilises the Institute of Healthcare Improvement (IHI) Model for Improvement
- Created with patients at the centre - 'every patient every time'

36 General Practice Clinics

66 Community Pharmacies

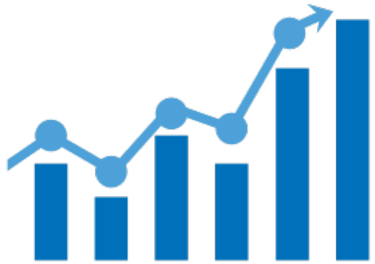


1 Urgent Care Clinic

INTERVENTION

Attend inter-professional learning sessions to learn QI methodology and share ideas

Teams choose a focus area and submit monthly audit data

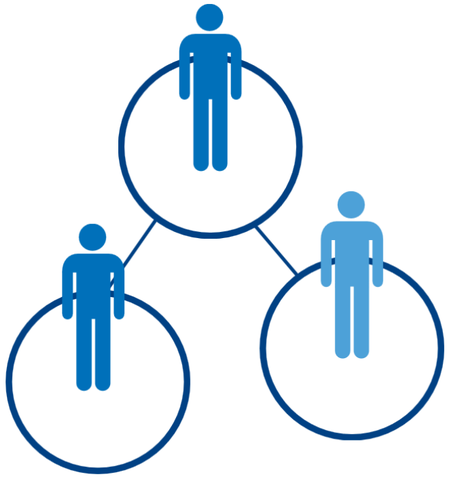


Conduct PDSA cycles to implement change ideas

Teams are supported by on-site visits from a clincal lead and improvement advisor

Safety culture tools help teams to improve their organisational culture

COMPLICATED BY ISSUES



Primary care teams are geographically isolated.

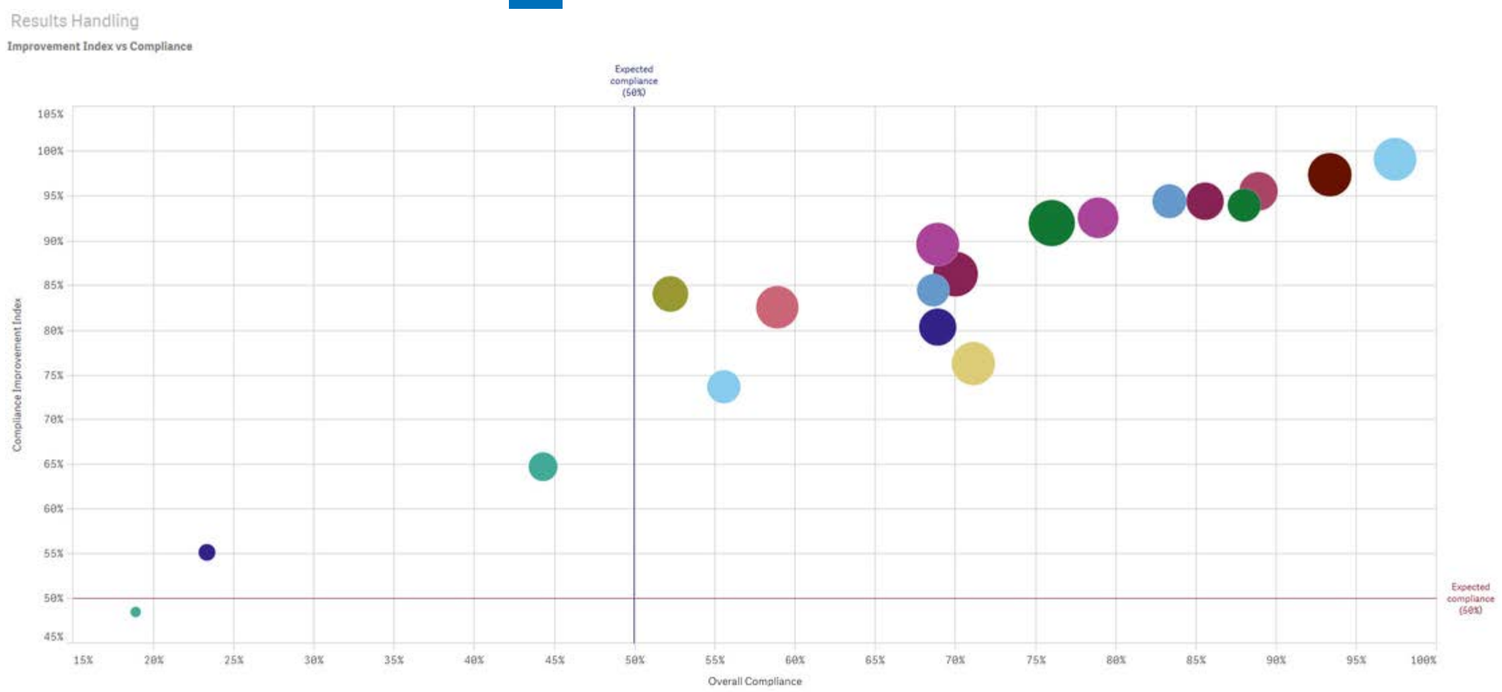
There are limited opportunities for primary care teams to collaborate and learn together

HOW DID WE MEASURE CHANGE?

- Monthly audits of 10 random patients to provide data and facilitate Plan-Do-Study-Act (PDSA) cycles to implement changes.
  - Reliable best practice (process measure)
  - Patient understanding (outcome measures)
- Patients are central in the auditing process through the use of outcome measures
- A pilot is being initiated on equity

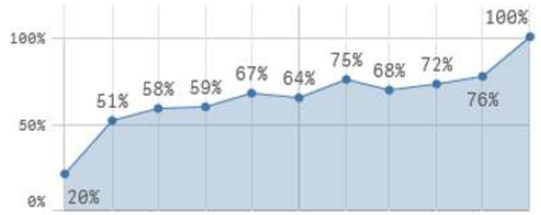
ENHANCED DATA VISUALISATION

- Qlik enables targeted intervention and support
- Teams are on average demonstrating 40-60% improvements



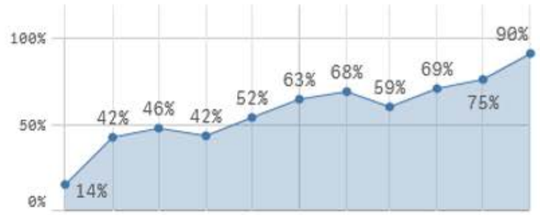
WARFARIN RUN CHARTS -

1. Is there evidence the patient was informed...

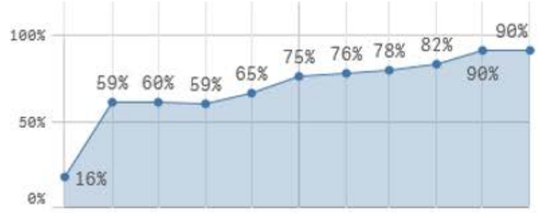


2. Is there evidence the patient was informed...

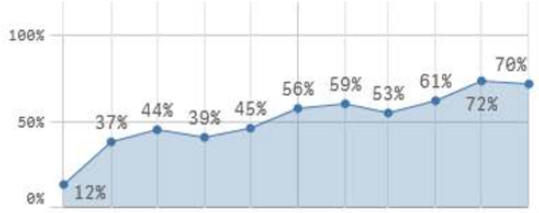
3. Is there evidence the patient was informed...



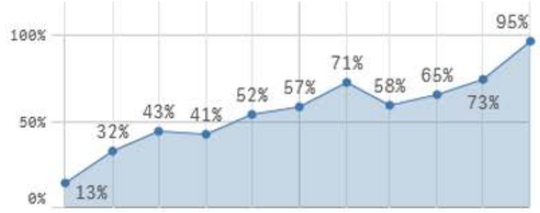
4. If yes, is there evidence they were informed...



5. Is there evidence the patient was informed...



6. Is there evidence the patient was offered wr...



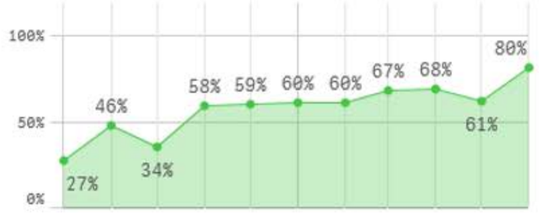
7.Was the patient able to correctly describe (d...

8. Was the patient able to describe what to do i...

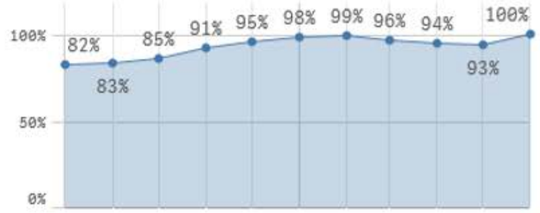
9. Was the patient able to identify a possible si...

Process Compliance

Outcome Compliance



10. Was the patient able to identify who to ask...



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Feedback Speaks

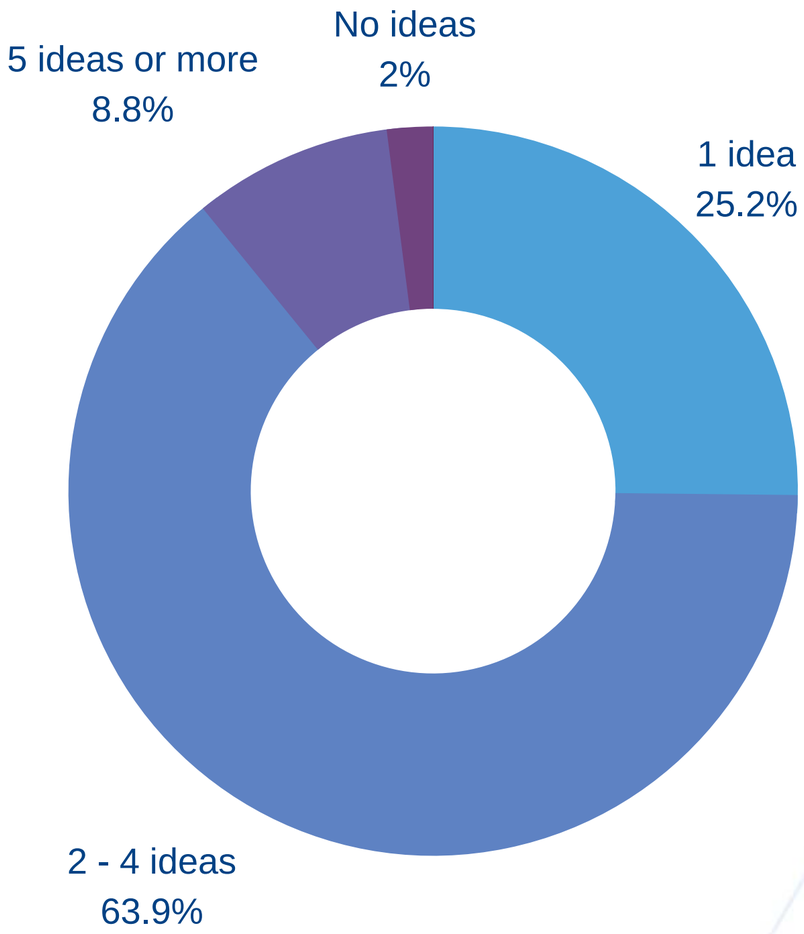
Most valuable part of the learning sessions...

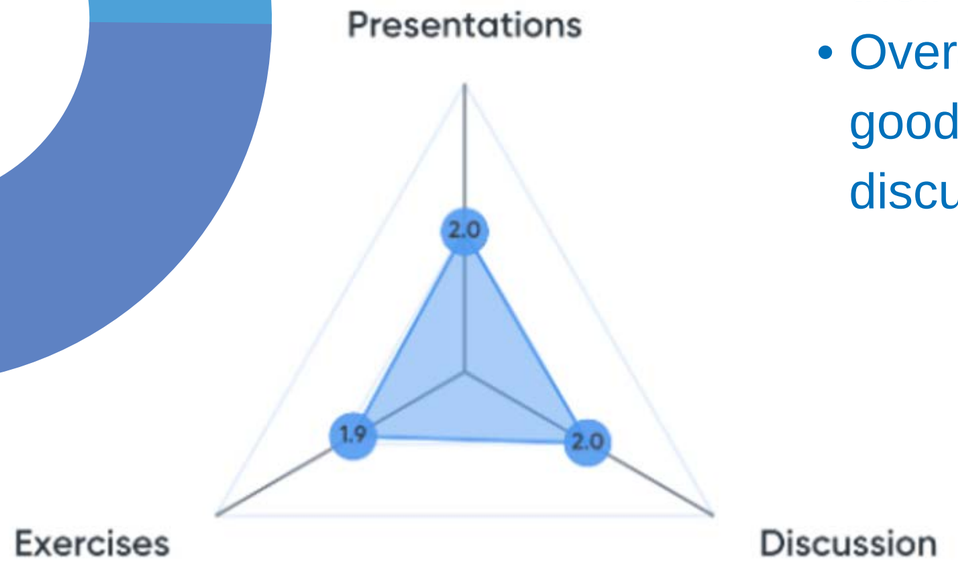
- "Discussing with other groups and listening to their ideas and seeing how they approach the same challenges"
- "Joint discussions between GP & Pharmacy; gaining different perspectives"
- "Discussion time between pharmacy and general practice, hearing how safety in practice has worked elsewhere"

Participants Found Value In...

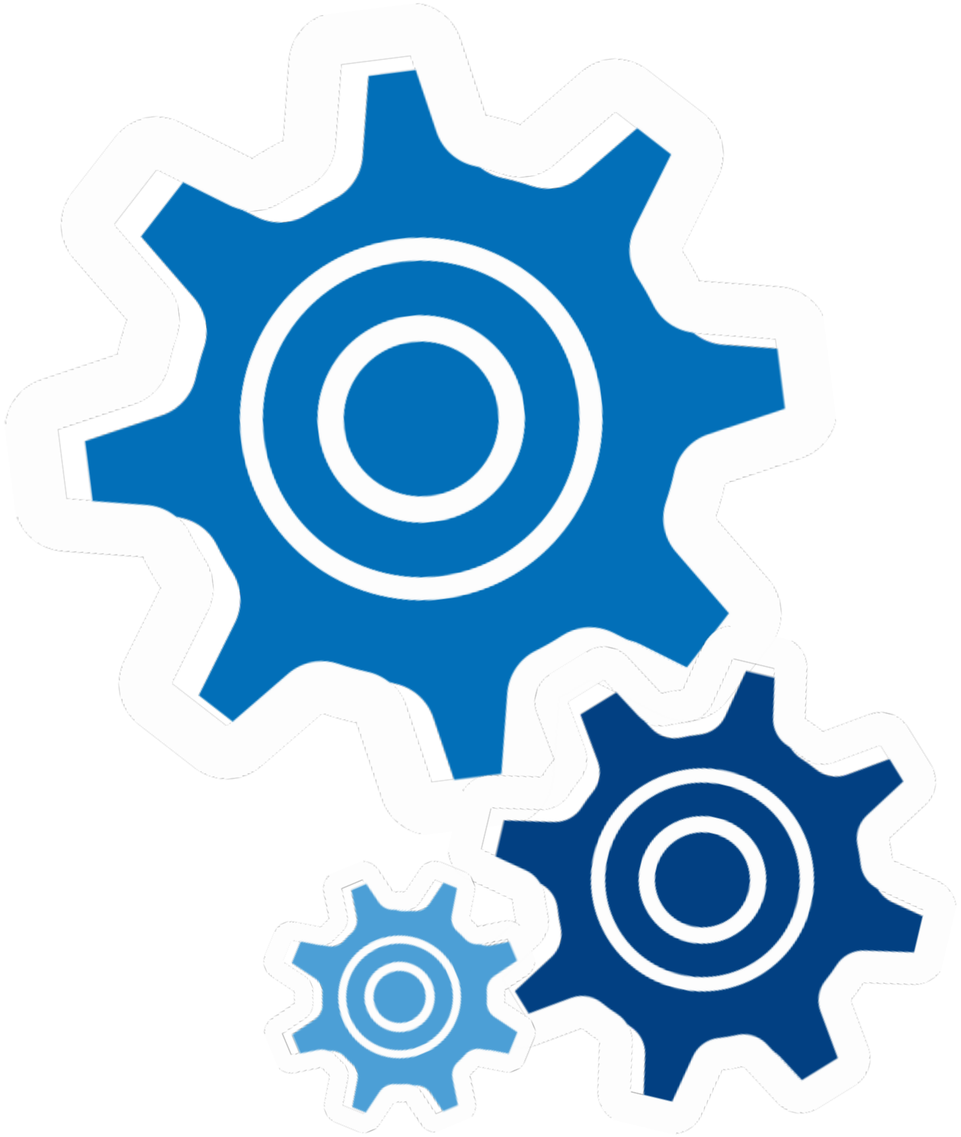
- "Learning about the PDSA cycle"
- "Change management tips & change models"
- "Facilitation skills and engaging teams for change"
- "Learning about brainstorming and anti-solutions"
- "Having dedicated time to reflect on progress without interruptions "

Feedback Speaks





- 98% of participants leave learning sessions with at least one new idea (n = 149) to implement within their team
- Overall participants feel there is a good balance of presentations, discussions and exercises.



Challenges & Lessons Learned

- Maintaining engagement
- Sustaining change
- Highly resource intensive
- Program expansion requires automation & streamlining
- Virtual platforms are needed for sustainability
- Accreditation & alumni network

Take Home Messages

- First do no harm
- QI enables system level changes to become business as usual
- There is always room for improvement
- It's **not** rocket science

QUESTIONS?

THANK YOU FOR LISTENING

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