GENERAL PRACTICE: LOW RISK, OR NOT ENOUGH DATA?

As a GP, I believe in the adage that there can be no quality without safety. But compared to, let's say, a hospital intensive care unit, or an operating theatre, general practice often feels like a 'low-risk' environment. Tripping over a pram in the waiting area, or being handed the wrong prescription, may be upsetting (and could lead to a complaint), but these are less likely to result in serious harm than an incorrect intravenous drug dosage or wrong-site surgery. However, there are a number of reasons why we should not be complacent. First, general practice exists in a high volume, high turnover setting with multiple complex tasks occurring in parallel, so even if problems are of a low impact, their absolute number may be considerable in a setting conducting more than 300 million consultations a year.¹ Secondly, we know relatively little about the epidemiology of error in general practice: a situation described by some as a 'data desert'.² Previous Care Quality Commission work has identified frequent patient safety risks from medicines reconciliation post-hospital discharge,³ and Avery's work on medication errors has firm data from general practice.⁴

Thirdly, delayed diagnosis has had recent attention, which may have both safety and quality issues in its causal pathway;⁵ and communication errors, both around results and interpersonal dimensions, have also been highlighted as a common area for problems in general practice⁶ — but a comprehensive epidemiology and systems analysis in this setting has not entered the literature. Finally, methods commonly recommended for enhancing safety in healthcare settings have been less tested in general practice and primary care settings, than in secondary care.

NEW INSIGHTS INTO ENHANCING PATIENT SAFETY CULTURE IN PRIMARY CARE

This month's *BJGP* brings together several articles evaluating recommended approaches to enhancing patient safety: risk recognition and personalised care,⁷ incident reporting,^{8,9} and routine use of checklists.¹⁰ Verbakel and colleagues⁸ and Milligan *et al*⁹ also explicitly refer to the importance of the organisational safety culture, the former using a validated tool

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(the 'MaPSaF')¹¹ which can be applied by practices as a measure of their own safety culture and its dimensions. Waller *et al*'s⁷ article links safety awareness with quality improvement, and shows encouraging data from patients whose perception of their GPs' care in an Australian setting was very positive. However, their article also highlights the public's perception that poor access to service impairs quality, and that it is harder to achieve high-quality ratings in more deprived areas.⁷ In situations where workforce capacity and resources in general practice are stretched,¹² this is a timely reminder that both quality and safety are likely to be dependent on systems and infrastructure investment as well as individuals' efforts.

Efforts to improve care and learn from problems are also likely to be dependent on high levels of individual and team motivation, a degree of autonomy and choice, and trust in the use of data. The enthusiasts who developed and piloted Bowie and colleagues' checklist¹⁰ can be contrasted with the nursing home staff who, in Milligan *et al*'s words,⁹ under-reported medication errors because they would then be 'perceived to be negative in terms of external perceptions of the quality of care being delivered ...'.

Verbakel⁸ showed increased reporting of safety issues when primary care teams were prompted by a survey raising the issue, and a much stronger response when practice staff voluntarily undertook

an educational workshop. The latter appears to have included design features known to maximise educational impact and application of learning,¹³ and greatly increased reporting activity, although the sample was small and the actual detail of behavioural alterations at practice level are sadly not reported. Reporting is only a proxy for change, and cannot be relied on for actual safety improvements.¹⁴ However, this professionally-adopted approach contrasts with the apparent fear of transparency in Milligan *et al*'s⁹ forthcoming *Debate & Analysis* article, though full details of the latter research are not yet reported and the imputation about staff culture is not substantiated.

So, what might be the take-home messages from these four attempts to address aspects of patient safety in general practice? First, an international perspective adds value, and shows common features of modern general practice in different health systems. Then, positive benefits for practice may result from systematic routinised and practice-owned safety checks,³ and also from educational approaches to identifying and learning from lapses and errors. The mechanism of creating externally-driven requirements to report safety issues appears to work less well, so ownership of an initiative trumps mandating; and the setting of nursing home care seems to have different challenges and organisational dynamics from general practice. But we can conclude little from any of these studies

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about the extent of safety lapses, the actual harms which result, or the human factors behind safer systems and culture of general practice; nor is a systems approach taken in any of the studies. Patterson *et al*'s¹⁵ competency study pointed out the extent of multitasking in general practice, querying this as a potential risk factor. Much is made of the role of technology in making GPs more systematic in diagnosis, or in assessing potential risks, but this is not yet widely used in practice, where protocol-driven care has lost professional sympathy, and shortage of time means that working through additional templates may be skipped in the face of a busy clinic. So, more research is needed, but with a broader scope and a professionally-driven design (as used in Waller⁷ and Verbakel⁸).

GPs in England may find a resource for work on safety through their local Academic Health Sciences Networks and Collaborations for Leadership in Applied Health Research and Care (CLAHRCs). In East Anglia for example, both have a patient safety workstream, and although to date these have been dominated largely by projects based in secondary care, there is potential for funding to be drawn down for GP-based projects. The pressures on general practice should not be a barrier to research and the dissemination of good practice, and those in possession of research funding should note the need for more work in this setting.

Finally, the design of research needs to overcome the barriers that it seeks to identify — the Milligan⁹ report begs more questions than it answers, and we look forward to understanding why the staff felt reluctant to use the project as a learning opportunity.

The articles made me wonder what it takes to share mistakes openly. I hypothesise that first the health professional must recognise an error or lapse: then, they must trust the person or system they share that knowledge with. Performing such an enquiry with a positive purpose — to improve care, or to benefit from feedback — is likely to produce a different motivation from being

monitored or inspected. Risk to reputation is a powerful force against disclosure. And a heavy workload or reflective space is likely to reduce engagement with a positive safety culture; simply because of lack of time to undertake reviews, significant event analyses, systems checks, and active learning. Patient safety is a priority: the organisation and system needs to support it.

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