




Patient safety incidents

Patient safety is the most fundamental aspect of quality practice. The RACGP defines patient safety as reducing the risk of unnecessary harm to an acceptable minimum level. Ensuring patient safety requires high level communication skills, clinical knowledge and skills, clinical reasoning, professionalism, organisational skills, and practice systems. Both the ACRRM and RACGP highlight the requirement for supervisors and training practices to have processes in place to prevent, identify and manage patient safety incidents. Monitoring of registrar competence to ensure patient safety is therefore a critical aspect of effective clinical supervision.

<p>TEACHING AND LEARNING AREAS</p> 	<ul style="list-style-type: none"> • Definition of patient safety incidents, near misses, adverse events etc. • Frequency of patient safety incidents in general practice • Common causes of patient safety incidents • Impact on patients and practitioners • Formal analysis of patient safety incidents as a learning opportunity and quality improvement mechanism • Clinical strategies to minimise error and patient safety incidents – see GPSA teaching plan on Reducing diagnostic error • System approaches e.g. recalls and reminders • Critical incident reporting 				
<p>PRE- SESSION ACTIVITIES</p>	<ul style="list-style-type: none"> • Read the 2008 AFP article Lessons from the TAPS study – reducing the risk of patient harm 				
<p>TEACHING TIPS AND TRAPS</p> 	<ul style="list-style-type: none"> • Discuss patient safety processes at orientation to the practice • Foster a culture of blame-free support and open disclosure of error/near misses • Identify registrar learning needs early and review these regularly • Use a call for help list to identify high-risk scenarios • Undertake regular formative assessment activities to monitor competence e.g. direct observation • Analysis of a patient safety incident can be a powerful learning opportunity for registrars but needs to be conducted in a supportive, structured and blame-free manner • Involve the MDO early if a patient safety incident occurs • Consider regular patient safety incident meetings in the practice 				
<p>RESOURCES</p> 	<table border="1"> <tbody> <tr> <td data-bbox="323 1736 434 1910">Read</td> <td data-bbox="434 1736 1493 1910"> <ul style="list-style-type: none"> • RACGP Clinical risk management in general practice resource • NHS Education for Scotland. Significant Event Analysis: Guidance for Primary Care Teams • Panesar S et al How safe is primary care? A systematic review. BMJ Qual Saf. 2016. </td> </tr> <tr> <td data-bbox="323 1910 434 1975">Watch</td> <td data-bbox="434 1910 1493 1975"> <ul style="list-style-type: none"> • RACGP podcast Threats to patient safety </td> </tr> </tbody> </table>	Read	<ul style="list-style-type: none"> • RACGP Clinical risk management in general practice resource • NHS Education for Scotland. Significant Event Analysis: Guidance for Primary Care Teams • Panesar S et al How safe is primary care? A systematic review. BMJ Qual Saf. 2016. 	Watch	<ul style="list-style-type: none"> • RACGP podcast Threats to patient safety
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<p>FOLLOW UP & EXTENSION ACTIVITIES</p>	<ul style="list-style-type: none"> • Undertake the RACGP glearning activity on Clinical Risk Management 				