General practice management toolkit: Managing quality

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Note

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Contents

Acknowledgements i
Introduction v
1. Practice culture 1
  1.1 Trust 2
2. Quality assurance and practice accreditation 3
3. Systems and processes 4
  3.1 Systems 4
  3.2 Processes 4
  3.2 Process improvement 5
4. Waste 7
5. Continuous quality improvement 9
  5.1 Patients as customers 9
6. Managing risk 11
  6.1 Establish the context 12
  6.2 Identify risks 13
  6.3 Analyse risks 14
  6.4 Treat risks 15
  6.5 Communication and monitoring risk 16
  6.6 Human factors in risk management 19
7. Patient safety 20
References 21
Resources 22
Appendix: Terms and definitions as described by the Australian Council for Safety and Quality in Health Care 23
Activities 24
  Activity 1. Practice survey on patient safety 24
  Activity 2. Improving patient safety – using a chain-of-events timeline 31
Introduction

The organisational culture of a practice shapes the way it responds to issues of quality and bears a predictive relationship with safety. Practices that cultivate a just and fair culture, centred on safety, openness and honesty, demonstrate an increased capacity for improvements in quality of care.

Origins of quality management

Quality management draws heavily from its origins in industrial production. Western Electric Hawthorne’s giant manufacturing plant in Chicago employed around 40,000 people in the early 1930s. The plant conducted studies into improving productivity, looking at the effects of working conditions (eg. lighting, working hours, rest breaks) on employee performance. One of these studies contributed to the description of the ‘Hawthorne effect’ and gave rise to the study of organisational behaviour.1

The ‘quality movement’ had a key development period in the post-war reconstruction of Japan (1946–56). Three of the most substantial contributors to modern quality management, Walter Shewhart, W. Edwards Deming and Joseph Juran, all worked at the Hawthorne plant in the 1920s and early ‘30s. Their focus at the time was on manufacturing and the reduction in variation of product quality.

The plan, do, study, act (PDSA) cycle (also known as the Shewhart cycle) that is so familiar today was promoted by Deming in Japan in the 1950s. The statistical control chart used in ‘six sigma’ method is another of Shewhart’s contributions that is still used today.2

Juran was a contemporary of Deming who contributed to post-war development in Japan. Juran developed ideas such as a project-by-project approach to quality improvement, Pareto analysis (ie. 80/20 rule) and the need for widespread training in quality.3

Quality management in healthcare

Physician and health services researcher Avedis Donabedian used a production framework to divide quality in healthcare into structure (how care is organised), process (what was done) and outcomes (what happened to the patient).4 This model has been widely referenced since the 1960s. Donald Berwick and the Institute for Healthcare Improvement in the United States (www.ihi.org) have been championing change and innovation in healthcare since the 1990s, using quality approaches learned from the industrial sector.

The RACGP Framework for quality in general practice (Figure 1) was published in 2007. It recognises clinical risk management and continuous quality improvement in the domain of professionalism, as well as accreditation in the domain of competence.

Quality management involves quality assurance (measuring performance), quality improvement and quality planning. While measurements of outcomes is part of quality assurance, so too is the management of safety and risk. Risk management is a significant part of medical practice management. Business risks need to be addressed in addition to clinical risks. This module focuses on quality management from a business, rather than clinical, perspective, although there is significant overlap. Clinical governance is addressed in General practice management toolkit: Clinical governance (Module 12).
Figure 1. Framework for improving quality in general practice


Learning outcomes

- Recognise the impact of practice culture on quality improvement.
- Discuss customer value for patients of a medical practice.
- Apply continuous quality improvement tools in process improvement.
- Understand techniques for improving patient safety, such as root cause and near miss analysis.
- Identify and analyse practice risks using risk management framework.
- Recognise and distinguish system and human error.
- Develop strategies to support doctors’ health and wellbeing.
1. Practice culture

Organisational culture is a key determinant of quality. Edgar Schein described organisational culture as,

‘the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaption and internal integration and that have worked well enough to be considered valid, and therefore taught to new members as the correct way to perceive, think, feel in relation to those problems’.5

Schein described three levels of organisational culture (Figure 2).

![Figure 2. Three levels of organisational culture](image-url)

Over time, practices develop an accepted paradigm for the ‘way we do things here’. Quality improvements can fail when there is a failure to understand the practice culture and take steps to change the basic underlying assumptions. For example, many practices operate with clinicians effectively working in isolation from their practice colleagues, linked only by a shared administration and facility.

The organisational culture profile, developed by Charles O’Reilly, Jennifer Chatman and David Caldwell, addressed seven dimensions of culture, which have been validated.6 By asking staff to sort and order value statements listed on cards, a profile can be developed to describe the organisation’s culture. The values are:

- outcome orientation
- people orientation
- stability
- attention to detail
- innovation
- risk taking
- aggressiveness
- team orientation.

The medical culture has traditionally been either extremely critical of mistakes or reluctant to identify colleagues whose work patterns increase risk to patients. The research work of Maxfield and others, Silence Kills: The Seven Crucial Conversations for Healthcare, highlights the impact of organisation culture on patient safety.7 This work revealed that healthcare workers found it difficult to speak up when there was an obvious problem due to a lack of ability, a belief that it was not their job or a lack of confidence that it would result in change.

Limited time and fear of retaliation were also listed as obstacles to confronting others’ behaviour. The survey found less than 10% of physicians would confront a colleague over recurring mistakes, breaking rules or incompetence.7
Case study: Establishing a practice culture

Dr White wanted a practice where she felt confident in asking for help, and to be supported by her fellow GPs and practice staff. She started to be more explicit about her interest in improving the care her practice provided and mentioned small uncertainties and lapses in the ways things happened. In her individual discussions, she supported staff when they asked questions and encouraged their critical appraisal of ways to improve care.

The positive aspect of such an approach is that notable improvements are achieved within the practice when people become willing and able to address issues relating to patient safety.

Confronting others over their behaviour is undoubtedly difficult, yet the Maxfield study found around 10% of people are prepared to do it. A practice culture that is supportive to colleagues and focused on patient safety is best able to address such issues when they arise.

One of the important principles of Silence Kills: The Seven Crucial Conversations for Healthcare is: make it safe. People want to hear the truth if it’s delivered safely. What they don’t want is brutal honesty.

When starting a conversation the other person may find confronting, it is important to allay fears they will likely have about the information. You need to convey to the other person that you value them and their contribution. In order to overcome defensiveness you need to ensure they understand you are concerned about their interests, as well as the safety of the patients or others. (If you do not share concerns for their interests you are probably part of the problem.)

The ‘seven crucial conversations’ focus on:

- broken rules
- lack of support
- mistakes
- incompetence
- poor teamwork
- disrespect
- micromanagement.

1.1 Trust

Trust is empowering. Personal experience and personality will cause us to be more or less trusting. Working with people you trust leads to better information sharing. As a professional and leader in the practice, you have the ability to develop and shape the culture of openness and trust.

Trust is not gained automatically. It requires time to develop. It is also a fragile element and can be readily damaged. Trust is an outcome, over time, of:

- displaying integrity as a result of moral character rather than external rules
- consistency of actions
- staying true to your word
- being fair in making decisions and taking the time to explain the reasons for decisions
- genuinely caring for colleagues, co-workers and patients
- being open with information while respecting confidences when required
- competency in your work
- loyalty, such as showing support for associates during difficult situations.

There may be times where trust is lost as a result of our actions or inactions. To regain trust we must acknowledge and apologise for the breach of trust. It then takes time to re-establish trust, possibly months or years, and in some cases it may not be possible to undo the damage.
2. Quality assurance and practice accreditation

Quality management requires a verification process, referred to as quality assurance. Australian general practice uses the RACGP Standards for general practice (4th edition) as the reference document for third-party assessors to gauge quality and accredit practices. Australian General Practice Accreditation Limited (AGPAL) and GPA Accreditation plus are currently recognised for this purpose. The assessment team must include a GP.

Practices that meet the standards receive accreditation for a 3-year period. The purpose is to promote continuous improvement and safety in healthcare. Medicare Australia uses accreditation as a prerequisite for access to grants, such as the Practice Incentives Program (PIP).

Close to 90% of Australian general practices were accredited in 2012. While about two-fifths obtain accreditation in order to access government grants, the majority of practices see it as part of quality improvement and as recognition of their standards.5

The Australian Commission on Safety and Quality in Health Care’s (ACSQHC) Measurement for Improvement Toolkit is available online (www.safetyandquality.gov.au) and covers three main areas: organisational capacity, patient safety incidents and clinical performance (Table 1).

<table>
<thead>
<tr>
<th>Table 1. Areas covered by ACSQHC’s Measurement for Improvement Toolkit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational capacity</td>
</tr>
<tr>
<td>Clinical governance</td>
</tr>
<tr>
<td>Leadership</td>
</tr>
<tr>
<td>Safety culture</td>
</tr>
<tr>
<td>Communication and teamwork</td>
</tr>
<tr>
<td>Consumer and community involvement</td>
</tr>
<tr>
<td>Professional competence</td>
</tr>
<tr>
<td>Ongoing education</td>
</tr>
<tr>
<td>Information management</td>
</tr>
<tr>
<td>Patient safety incidents</td>
</tr>
<tr>
<td>Identification</td>
</tr>
<tr>
<td>Analysis and investigation</td>
</tr>
<tr>
<td>Management</td>
</tr>
<tr>
<td>Feedback and learning</td>
</tr>
<tr>
<td>Clinical performance</td>
</tr>
<tr>
<td>How performance measurement is defined</td>
</tr>
<tr>
<td>How clinical performance is measured</td>
</tr>
<tr>
<td>Characteristics of performance measurement</td>
</tr>
<tr>
<td>The advantages and disadvantages of clinical performance</td>
</tr>
</tbody>
</table>
3. Systems and processes

3.1 Systems

Our understanding of biological systems provides a useful basis to explore organisational systems. Peter Senge re-introduced the term ‘systems thinking’ into contemporary management discussions. He describes systems thinking as:

- seeing interrelationships rather than linear cause–effect chains
- seeing processes of change rather than snapshots.

Russell Ackoff was a proponent of systems thinking in the 1960s. He recognised that in order to understand a system you need to consider the interactions, not just the parts. Ackoff, who had a background in social research, said we should regard a corporation as a social system or community rather than a biological system. He described synthetic thinking as a way of thinking about and designing a system based on its functions as a whole. Analysis breaks the system down into its parts to increase knowledge of how it works. According to Ackoff, systems thinking incorporates both synthetic thinking and analysis. He said: ‘A social system floats in a sea of purposes at multiple levels with some purposes incompatible within and between levels; and its management must concern itself with all of these.’

Apply systems thinking when you encounter a situation in the practice that is complex or appears to be a ‘mess’. Introducing systems thinking into management is an essential part of improvement activities.

3.1 Processes

Processes are a sequence of actions using resources (time, materials, knowledge, energy) leading to an output. Mapping a process using a flow chart helps in understanding the steps involved and where improvements can be made.

SIPOC model

The supplier, inputs, process, output, customer (SIPOC) model, or ‘customer supplier’ model, is a management tool for analysing and redesigning business processes (see Figure 3). Mapping a process helps to make opportunities to improve more visible. When designing or improving a process, it is best read from right to left. If there is variation in the output, the cause is to be found ‘up stream’ in the SIP part of the diagram.

![Figure 3. The SIPOC model](image-url)
Benchmarking

Benchmarking is the process of measuring your performance in comparison to other medical practices. It is an effective way to inform business improvement activities. Benchmarking against business performance or clinical measures allows a practice to address areas of sub-optimal effectiveness or efficiency.

The PCS Clinical Audit Tool (CAT) can enable practices to produce reports on whole-population health measures. It works with some of the major clinical software programs in Australia. Benchmarking becomes an important tool for clinical improvements when combined with the Australian Primary Care Collaboratives (APCC).

Visit www.clinicalaudit.com.au for more information regarding CAT.

3.2 Process improvement

PDSA cycle

Shewhart developed the plan, do, study, act (PDSA) cycle to assist with improvement activities in industrial production (Figure 4). It is a simple repetitious four-step approach:

- Plan a change aimed at improvement.
- Do implement the plan.
- Study or check the results of the plan.
- Act on the results (ie. make any necessary adaptations or improvements) then repeat the steps or embed the changes into the process.

The APCC has adopted the PDSA cycle as a key improvement tool.

See RACGP Putting prevention into practice (green book) for more information about the PDSA cycle.

![Figure 4. The PDSA cycle](image)
Where do you start with improvement activities?

Start by identifying an improvement opportunity. The acronym FOCUS describes a set of steps that can lead to a useful PDSA cycle:

- **F** – find a process improvement opportunity.
- **O** – organise a team that understands the process.
- **C** – clarify the current knowledge about the process.
- **U** – uncover the root cause for variation or poor outcomes.
- **S** – start the PDSA cycle.

Suggested improvement activities include:

- collect meaningful data
- identify root causes of problems
- develop appropriate solutions (to the root causes)
- plan and make changes
- identify customer (patient) needs and concerns
- study the use of time
- localise recurring problems
- improve a process.
4. Waste

Improvement can be achieved by reducing or eliminating waste. The concept of ‘lean thinking’, used in manufacturing, is now being used in many other areas, including healthcare. It is a quality management approach that involves defining value from the customers’ perspective, mapping processes to define which steps are required to create value (value stream mapping) and then eliminating waste.

Lean thinking defines ‘7 wastes’:

- excess capacity or production
- excess stock
- excess waiting or transport
- movement
- unnecessary steps or processes
- complexity
- bureaucracy.

Excess waiting is an important waste in general practice. Waiting for a patient is a waste of a doctor’s time and waiting for the doctor is a waste of the patient’s time. Getting the appropriate balance is important. Where many patients are waiting simultaneously, there is a need for larger waiting areas and parking spaces.

The number of steps in a process not only potentially creates waste (complexity and unnecessary steps), but also reduces the reliability of the process.

Examples

An example from Institute for Healthcare Improvement shows how reducing the number of steps might improve reliability.

Let’s assume we have a hypothetical process comprised of six steps, each with the following reliability rating.

<table>
<thead>
<tr>
<th>Step</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>99%</td>
</tr>
<tr>
<td>Step 2</td>
<td>95%</td>
</tr>
<tr>
<td>Step 3</td>
<td>99%</td>
</tr>
<tr>
<td>Step 4</td>
<td>98%</td>
</tr>
<tr>
<td>Step 5</td>
<td>90%</td>
</tr>
<tr>
<td>Step 6</td>
<td>95%</td>
</tr>
</tbody>
</table>

This six-step process has a 78% probability of success \(0.99 \times 0.95 \times 0.99 \times 0.98 \times 0.90 \times 0.95\). Stated another way, the process fails (is defective) 22% of the time.
We could make the system better by eliminating unnecessary steps. If we determine Step 5 can be eliminated, the new process would look like this:

<table>
<thead>
<tr>
<th>Step</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>99%</td>
</tr>
<tr>
<td>Step 2</td>
<td>95%</td>
</tr>
<tr>
<td>Step 3</td>
<td>99%</td>
</tr>
<tr>
<td>Step 4</td>
<td>98%</td>
</tr>
<tr>
<td>Step 6</td>
<td>95%</td>
</tr>
</tbody>
</table>

The process now has an 87% probability of success (0.99 x 0.95 x 0.99 x 0.98 x 0.95), much improved from the original 78%.

Below is an example of eliminating waste in a general practice.

Monitoring anticoagulation using international normalised ratio (INR):

- Patient attends pathology collection centre for blood collection.
- Nurse takes blood and sends to main laboratory for INR test via courier.
- Result is faxed to GP’s clinic.
- GP checks result and patients notes and records new order.
- Patient telephones for result, receptionist checks new order and advises patient.

Transferring the task of handling the result and recording the new order is one way of eliminating waste in the general practice. However, this reduces the reliability of the process because other factors, such as medication changes, the patient having confused the last instruction or having an illness may need to be considered.

An alternative is to reduce the number of steps by providing point-of-care testing for measurement of INR by the practice nurse, as well as a review by the doctor immediately afterwards, in order to determine subsequent dosing and testing interval. The need for INR monitoring can be eliminated all together by using the novel oral anticoagulants when appropriate.

Practice costs can be of two types: ‘hard’ costs that consume an actual resource (eg. time, money), and ‘opportunity’ costs that divert resources away from one activity to another, thereby losing the gains that could have been made from the activity. Opportunity costs are often an unrecognised expense.
5. Continuous quality improvement

Quality is difficult to define. The Australian Business Excellence Framework (BEF) is an integrated leadership and management system that aims to create an environment for continuous improvement within organisations. The BEF features innovation, quality and improvement as key areas of organisational capability. The eight principles of business excellence are internationally recognised and used as the basis for good management. They include the following elements:

- To improve the outcome, improve the system and its associated processes.
- Continual improvement and innovation depend on continual learning.
- All people work in a system; outcomes are improved when people work on the system.
- Effective use of facts, data and knowledge leads to improved decisions.
- All systems and processes exhibit variability, which impacts on predictability and performance.\(^\text{15}\)

Quality management principles (as per Standards Australia ISO 9004):

- customer-focused organisation
- leadership
- involvement of people
- process approach
- system approach to management
- continual improvement
- factual approach to decision making
- mutually beneficial supplier relationship.\(^\text{16}\)

5.1 Patients as customers

Most GPs feel more comfortable with the term ‘patient’, rather than ‘client’, ‘consumer’ or ‘customer’, in the medical setting. The latter terms have strong associations with commercial relationships. Whatever terminology is used, patients will be satisfied to a greater or lesser extent depending on their perception of service value.

This can be understood as an equation in which:

\[ \text{Value} \quad \text{equals} \quad \text{Benefits} \quad \text{minus} \quad \text{Sacrifices} \]

The below equation proposed by Kotler is another way of determining perceived customer value:

Customer benefit = \( f(v, b, r, -c, -t) \)

In this equation, ‘\( v \)’ is market value; ‘\( b \)’ is brand value; ‘\( r \)’ is relationship value; ‘\( c \)’ is cost paid; ‘\( t \)’ is time expended.

Using this formula in the context of a medical practice, we note that it recognises the benefit is greater than the financial cost to the patient. In the case of a general practice:

- Market value – represents the perception of the value of GP services in the community.
- Brand value – some medical practices have a higher perceived value as a result of reputation, practice facilities, range of medical and other health providers.
- Relationship – patients generally have a preference for seeing the same doctor, but will offset this
against other factors such as convenience and cost (eg. patients often have a preferred GP for complex problems and a bulk-billing GP for perceived ‘simple’ issues).

- Time – patients will evaluate the time expended to attend a GP: they may be willing to take time off work, travel and wait longer for complex problems, while a quick visit to a bulk-billing GP may be preferred for simpler issues.

Ten dimensions of service quality

1. Reliability involves consistency of performance and dependability.
2. Responsiveness concerns the willingness of employees to provide service in a timely way.
3. Competence means possessing the required skills and knowledge to perform the service.
4. Access involves the approachability and ease of contact. It includes convenience of location and hours or operation, waiting times and telephone access.
5. Courtesy refers to politeness, respect, consideration and friendliness of contact personnel.
6. Communication means keeping customers informed in language they can understand. It involves listening, explaining about the service and costs.
7. Credibility involves trustworthiness and looking after the customer’s interests.
8. Security is the freedom from danger, risk or doubt and includes protection of privacy.
9. Understanding involves making the effort to understand the customer’s specific needs and giving individualised attention.
10. Tangibles include the physical environment of the service, as well as the appearance of the staff and other customers and any service support materials received.
6. Managing risk

Risk is defined as:
- anything that threatens your ability to meet your objective
- the probability of a negative consequence.17

In addressing risk management, it is important to recognise the drivers that have increased its relevance to your practice. Potential drivers include:

- Healthcare consumers are more active in demanding higher levels of safety.
- Government is responding to consumer demands by increasing regulations.
- Litigation is becoming more frequent where there are failures to deliver care in accordance with expectations.
- Financial pressures allow a smaller margin for error in running a business.
- Providers other than GPs are offering primary healthcare services.

Embedding risk management as an element of all practice activities is a critical function of practice management.

Taking a proactive approach to risk management is essential for good management. Failing to address risk in the practice is negligent. A risk management strategy requires a systematic process of identifying, analysing, evaluating and treating risks (Figure 5).

**Figure 5. Risk management overview**

AS/NZS ISO 31000:2009 figure (modified) Reproduced with permission from SAI Global Ltd under Licence 1410-c067.
6.1 Establish the context

The activities of medical defence organisations (MDOs) have provided doctors with increased exposure to approaches to reducing clinical risks. Practices also have insurance to protect against financial loss in event of fire or public liability. The issues of risk extend across the full breadth of activities conducted in the practice. Professional reputation is of great importance to a medical practice and is contingent on the effective management of all other practice risks. A professional reputation takes a long time to develop but can be severely damaged overnight.

The context in risk management is used to define the relationship of the practice objectives to the external and internal operating environment. The scope of the risks to be assessed needs to be identified at the outset to ensure the process remains manageable given the time and resources available. The process may begin by scanning the full range of risks, or focus on an already identified area of risk.

Documentation of the process should be sufficient to allow each step to build on the previous work and allow subsequent review processes to occur. Using the various areas listed above, a SWOT (strengths, weaknesses, opportunities, threats) analysis can be used to define the context of the risk assessment to be carried out. A PEST (political, environmental, societal, technological) analysis helps expand the areas of risk.

Consider the following areas in your practice and the risks to which you are exposed:

- people
- property and equipment
- information
- finance
- legal
- environment
- reputation
- competition and service demand
- political.

For example, the practice needs to be aware of the updates to privacy regulations when transferring health information.

The process of establishing context also needs to identify and communicate with the various stakeholders.

Developing a risk matrix assists in the process of analysing risks. A standard approach is to use a combination of the consequence and likelihood of an event to define the level of risk.

Consequence defines the impact the event would have on one of the objectives of the practice. A common approach is to use a qualitative descriptor from insignificant to catastrophic. The likelihood defines the probability of the event occurring and may be described in a quantitative or qualitative manner (Table 2).
Table 2. Examples of defining consequences, likelihood and risk

<table>
<thead>
<tr>
<th>Consequence</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insignificant</td>
<td>No patient harm; financial loss less than $1000</td>
</tr>
<tr>
<td>Minor</td>
<td>Minor and brief patient harm; financial loss less than $10,000</td>
</tr>
<tr>
<td>Moderate</td>
<td>Patient has significant but brief adverse effect; financial loss up to $100,000</td>
</tr>
<tr>
<td>Major</td>
<td>Patient has significant sustained adverse effect; financial loss up to $1 million</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>Patient severely affected and may die; financial loss more than $1 million</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>Some cases reported in literature</td>
</tr>
<tr>
<td>Low</td>
<td>Some cases reported each year</td>
</tr>
<tr>
<td>Moderate</td>
<td>Could occur at least once in your career</td>
</tr>
<tr>
<td>High</td>
<td>Will occur several times during your career</td>
</tr>
<tr>
<td>Almost certain</td>
<td>Occurs at least once per year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Risk can be managed by routine procedures</td>
</tr>
<tr>
<td>Medium</td>
<td>Requires specific risk reduction strategy</td>
</tr>
<tr>
<td>High</td>
<td>Action required immediately to avert major harm</td>
</tr>
<tr>
<td>Extreme</td>
<td>Activity must be ceased to avoid almost certain catastrophe</td>
</tr>
</tbody>
</table>

6.2 Identify risks

Developing a risk register is useful in using a systematic approach to risk management. Once you have agreed on the process and scope of the risk management activity, it is helpful to schedule a series of meetings to work through the required stages. Further information may be sought and disseminated between meetings.

Risk identification suggestions:

- audits
- walk through of the process
- flow charts
- focus groups
- complaints
- near miss analysis
- incident reports
- clinical indicators
- interviews
- expert experience (eg. MDO).
Risk identification

<table>
<thead>
<tr>
<th>SOURCE OF RISK</th>
<th>RISK EVENT</th>
<th>IMPACT OF RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>How can it happen?</td>
<td>What can happen?</td>
<td>What is the consequence?</td>
</tr>
</tbody>
</table>

Case study: Identifying risk

Dr White, a practice principal, saw a new patient, Jeff, 57, for the first time late one afternoon. Jeff’s appointment was fit in to a busy schedule at his request, as he said he was ‘pressed for time’.

He and Dr White discussed the reason he had made the appointment: urinary frequency and dysuria for the past 24 hours.

Dr White quickly assessed Jeff, performed a urinalysis and settled on a provisional diagnosis of a urinary tract infection. They agreed Jeff would return for a longer consultation the following afternoon, when a detailed history could be taken and the presenting problem would be more fully explored.

As he was leaving, Jeff asked if there was any treatment he could take until the results were back, as he was finding the symptoms quite distressing.

Dr White gave him a sample of an antibiotic as a short-term measure. As both she and Jeff were in a hurry, Dr White didn’t enter it into her clinical software, as she normally would with prescription drugs.

The sample contained trimethoprim and sulphamethoxazole. Jeff was highly allergic to sulphur. Once he got home, Jeff read the label and decided not to take the medication because he was concerned about the sulphur component. He returned to the practice the next morning and discussed the issue with Dr White, who was disturbed by how easily Jeff could have been harmed.

6.3 Analyse risks

Using the risk matrix and rating for likelihood and consequence, risks can be assessed in relation to their impact or severity – the level of risk.

In many situations, safeguards will already be in place to either avoid or minimise a hazard.

ALARP principle

Achieving a low risk usually comes at a cost. The ALARP principle refers to ‘as low as reasonably practical’. The carrot diagram is used to represent level of risk and risk tolerance – the thick end of the carrot represent a large risk (Figure 6). The concept is readily observed in the diagram and risks fall into one of three regions:

- Risk that is unacceptable except in extreme situations.
- Risks that are tolerable provided it can be demonstrated they have been reduced to as low as reasonably practical (ALARP).
- Risks that are well accepted without any special measures.
6.4 Treat risks

After identifying and analysing risks, the next step is to manage the risks determined to be unacceptable or that can be lowered at a reasonable cost. The following options are available:

- avoid
- reduce
- transfer
- retain.

Avoidance of a risk can occur by not providing certain services, such as procedural obstetrics or methadone programs.

The reduction of a risk is achieved by decreasing the likelihood of an event or by reducing the consequence. For example, needle-stick injuries can be reduced by not recapping needles or using retractable needles.

Risk can be transferred away from the practice to another party. For example, referring patients who require more complicated treatments or procedures, such as excision of melanomas, appendectomies and fractures requiring manipulation under anaesthetic, to surgeons with more expertise.

After assessing a risk, however, it may be considered necessary to retain the risk if there is no practical alternative. For example, use of a chaperone for gynaecological examinations in general practice is infrequent despite potential the risk of a professional misconduct allegation.

While the idea of treating the numerous risks that may be present in your practice can be daunting, it should never prevent your practice from implementing safeguards. These do not have to be instigated straight away. A more useful approach is to use an ‘ease/impact’ analysis that identifies what is easy/hard to do and what has little/high impact (Table 3).
### Table 3. Example of a completed analysis (using the above case study of Jeff and his allergic reaction)

<table>
<thead>
<tr>
<th>Easy to do – has little impact</th>
<th>Easy to do – has high impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place notice in waiting room reminding patients to report allergies</td>
<td>Have receptionist hand a pre-appointment questionnaire to all new patients and train to book all new patients with a double appointment</td>
</tr>
<tr>
<td>Hard to do – has little impact</td>
<td>Hard to do – has high impact</td>
</tr>
<tr>
<td>Lobby government for specific Medicare item numbers for practice nurse’s pre-appointment interviews</td>
<td>Have practice nurse interview all new patients and fill out health summary before they see GP</td>
</tr>
</tbody>
</table>

### 6.5 Communication and monitoring risk

Promoting and supporting an open and trusting workplace is a key requirement for successful risk management. If people are fearful of criticism or lack confidence that their concerns will be taken seriously, they are unlikely to speak up about errors or near miss events.

It is essential to have processes to monitor and review the risk reduction strategies you have implemented. Time pressures, lack of understanding and complacency can cause initiatives to fail, so implement your action plans and regularly check whether the risks are being reduced.

#### Top 10 medico-legal risks for GPs

The Medical Defence Association of Victoria analysed its records during 2005–06 to develop the areas of most medico-legal risk to GPs:

1. Poor record keeping.
2. No documentation of the consent process.
3. Altering of records when something has gone wrong.
4. Failure to follow-up referrals.
5. Failure to follow-up test results.
6. Failure to check the history when writing scripts.
7. Giving a diagnosis and treatment over the phone.
8. Insufficient time/care given to establishing a sound doctor–patient relationship.
9. Rushing consultations.
10. Failure to say anything if something has gone wrong.

#### Root cause analysis

Root cause analysis (RCA) is a method that can be used to identify contributing causes to high risk/high impact adverse events (Table 4). RCA is used to ‘drill down’ into serious events (and near misses) to find out what happened, why it happened and what can be done to prevent it from happening again.

The focus in RCA is on systems and processes, not individuals.

There are three phases in an RCA: investigation (how did the event occur?), analysis (why did the event occur?) and decision (what have we learned and what needs to be done?).
Table 4. Three phases of RCA

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Analysis</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Confirm and describe the incident</td>
<td>• Identify critical events</td>
<td>• Identify solutions and assess for effectiveness</td>
</tr>
<tr>
<td>• Map a timeline for the incident (event and causal factor chart)</td>
<td>• Analyse critical events</td>
<td>• Develop recommendations</td>
</tr>
<tr>
<td></td>
<td>• Identify root causes</td>
<td>• Write a risk reduction action plan</td>
</tr>
<tr>
<td></td>
<td>• Support analysis of root causes with evidence</td>
<td></td>
</tr>
</tbody>
</table>

RCA tools

Cause and effect diagram

The cause and effect, or ‘fish bone’, diagram is constructed by placing the effect on the right-hand side and developing a causal link to a number of factors from the left (Figure 7).

![Figure 7. Cause and effect diagram](image)

Hazard, barrier, target analysis

An adverse effect can result from the absence or failure of a protective measure. Systems are usually designed to be safe in a range of situations. Prescribing software may alert the user to adverse effects in the presence of particular medical conditions. This alert system acts as a barrier. Identifying the target, the barrier (if any) and the hazard in an adverse event can assist in the analysis of how the incident occurred and how it can be avoided (Figure 8).
Change analysis

Change analysis involves specifying how a situation that resulted in an adverse event is different from similar situations where no adverse events occur (Figure 9). The process involves specifying the deviation (e.g., patient received incorrect dose of medication) and how the conditions in which this event occurred were different from those in which it did not occur.

What happened this time?

Compare to usual conditions
Analyse differences
Assess impact

What should have happened?

Case study: Treating risk

After thoroughly discussing the events with other staff, Dr White and her practice team decided to look at what caused omissions of important information. The failure to record allergies presented as a problem that required attention.

GPs felt they needed to record a number of important pieces of information at the first appointment, but were faced with work pressure. Everyone agreed a new patient-information form would help reduce this pressure.

They further agreed it was important to encourage patient knowledge of allergic reactions and allergies must be recorded during the first appointment.
6.6 Human factors in risk management

Human error is unfortunately a major cause for adverse outcomes in the healthcare sector. This is also observed in other industries, particularly those that require complex decisions and technology. James Reason used a ‘Swiss cheese’ model to show how highly technical systems often have many layers of defences, barriers and safeguards to protect against hazards (Figure 10). Holes in the defensive layers arise from active failures and latent conditions.

Active failures result from people performing an unsafe act: slips, lapses, mistakes and procedural violations.

Latent conditions are a result of system problems because of decisions made by management, technology designers, policy makers and others not directly involved in the action. The effect of latent conditions may not be evident for years, but can result in time pressure, fatigue, inexperience or lack of appropriate equipment. The current workforce shortage is an example of this.

Figure 10. Swiss cheese model
7. Patient safety

The RACGP Standards for general practices (4th edition) recognises the relationship between quality and safety with criteria addressing continuous improvement and clinical risk management.

‘Healthcare needs to recognise that safety concerns are real, that the system is prone to error and failure, and that we need to work to reduce the risk in areas that are inherently risky. We need to redesign and simplify many aspects of healthcare. Management of the system needs to change dramatically to allow clinicians and nurses at the frontline to influence management decisions effectively. Otherwise we will fail to engage their active support in improving safety and quality. Management has a necessary focus on improving efficiency, but this alone will not improve safety and quality. Management must also fund, support and encourage redesign of systems, monitor activity reports, feed their results back into the systems, and encourage and reward safety improvements.’

Medical mishaps are inevitable in healthcare. However, careful assessment of adverse events can lead to reductions in risk and improve standards in medical practice. Fear of litigation, embarrassment or criticism have been barriers to the self-reporting of errors. A change in culture is required to see these events as being opportunities to learn and improve. Different types of mishaps provide different learning opportunities. For example:

- Errors can prompt/trigger an evaluation of procedures to prevent these and other more serious events.
- Near-misses, or events that almost (but do not) cause no harm, provide a useful way to identify safety issues before patient harm occurs.
- Adverse events, both anticipated and unanticipated, can stimulate critical thinking about evidence and standards.

**Box 1. Ten steps to improving patient safety**

<table>
<thead>
<tr>
<th>Phase 1. Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Foster a just and open culture so people have confidence to examine how to improve.</td>
</tr>
<tr>
<td>2. Identify a near miss where error(s) may have caused patient safety issues.</td>
</tr>
<tr>
<td>3. Tell someone about the incident so they can help with the improvement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase 2. Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Prioritise whether the incident will be systematically analysed.</td>
</tr>
<tr>
<td>5. Analyse causes both direct and root causes so the sources of error can be addressed.</td>
</tr>
<tr>
<td>6. Identify potential safeguards that mitigate likelihood or reduce the impact of error(s).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase 3. Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Implement safeguards to reduce the likelihood of recurrence of the error(s).</td>
</tr>
<tr>
<td>8. Review the impact of the corrective actions.</td>
</tr>
<tr>
<td>9. Share insights and information about the events, the causes and the improvements with a broader audience.</td>
</tr>
<tr>
<td>10. Maintain vigilance about the potential for error in order to ensure a safe environment is fostered.</td>
</tr>
</tbody>
</table>

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References

Resources

Further reading


Websites

- Australian Council for Safety and Quality in Health Care
  www.safetyandquality.org
- Institute for Healthcare Improvement
  www.ihi.org
- Quality Improvement Council
  www.qic.org.au
- The silent treatment: Why safety tools and checklists aren’t enough to save lives
  www.silenttreatmentstudy.com
- Australian Primary Care Collaboratives
  www.apcc.org.au
Appendix: Terms and definitions as described by the Australian Council for Safety and Quality in Health Care

**Adverse event:** an incident in which harm resulted to a person receiving healthcare.

**Adverse reaction:** an adverse event where the correct process was followed for the context in which the event occurred, but unexpected and unpreventable harm resulted. For example, an adverse drug reaction will be said to have occurred when a patient suffered unexpected and unpreventable harm even though the right drug was used for the correct indication in the right dose given by the right route. Adverse reactions can also result from some diagnostic tests, therapeutic interventions or devices.

**Error:** unintentionally being wrong in conduct or judgement. Errors may occur by doing the wrong thing (commission) or by failing to do the right thing (omission).

**Event:** something that happens to or with a person.

**Harm:** includes disease, injury, suffering, disability and death.

**Healthcare incident:** an event or circumstance during healthcare that could have, or did, result in unintended or unnecessary harm to a person, and/or a complaint, loss or damage.

**Healthcare outcome:** the health status of an individual, group of people or population that is wholly or partially attributable to an action, agent or circumstance.

**Incident:** an event or circumstance that could have resulted, or did result, in unintended or unnecessary harm to a person, and/or a complaint, loss or damage.

**Near miss:** an incident that did not cause harm.

**Quality of healthcare (degree of):** the extent to which a healthcare service or product produces a desired outcome or outcomes.

**Risk:** the chance of something happening that will have a negative impact. Measured in terms of consequences and likelihood.

**Risk management:** designing and implementing a program of activities to identify and avoid or minimise risks to patients, employees, visitors and the institution; to minimise financial losses (including legal liability) that might consequentially arise; and to transfer risk to others through payment of premiums (insurance).

**Root cause analysis:** a systematic process whereby the factors that contributed to an incident are identified.

**Safety:** freedom from hazard.

**Side effect:** an effect, other than that intended, produced by an agent (see also ‘adverse reaction’).
Activities

Activity 1. Practice survey on patient safety


Survey instructions

Think about the way things are done in your practice and provide your opinions on issues that affect the overall safety and quality of the care provided to patients.

The term ‘provider’ refers to doctors, nurses or other health professionals who diagnose and treat patients, and prescribe medications. The term ‘staff’ refers to all others who work in the practice.

If a question does not apply to you or you don’t know the answer, check ‘Does not apply or don’t know’.

If you work in more than one location in your practice, only answer in relation to the location where you received this survey. Do not answer about the entire practice.

Section A: List of patient safety and quality issues

The following items describe potential events in medical practices that affect patient safety and quality of care.

| How often did the following events occur in your practice over the past 12 months? |
|-------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Access to care                | Daily          | Weekly         | Monthly        | Several times in the past 12 months | Once or twice in the past 12 months | Not in the past 12 months | Does not apply or don't know |
| 1. A patient was unable to get an appointment for an acute/serious problem within 48 hours | 1              | 2              | 3              | 4              | 5              | 6              | 7              |
| Patient identification        |                |                |                |                |                |                |                |
| 2. The wrong medical record was used for a patient | 1              | 2              | 3              | 4              | 5              | 6              | 7              |
| Medical records               |                |                |                |                |                |                |                |
| 3. A patient’s medical record was not available when needed | 1              | 2              | 3              | 4              | 5              | 6              | 7              |
| 4. Medical information was filed, scanned, or entered into the wrong patient’s medical record | 1              | 2              | 3              | 4              | 5              | 6              | 7              |
| Medical equipment             |                |                |                |                |                |                |                |
| 5. Medical equipment was not working properly or was in need of repair or replacement | 1              | 2              | 3              | 4              | 5              | 6              | 9              |
### How often did the following events occur in your practice over the past 12 months?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Several times in the past 12 months</th>
<th>Once or twice in the past 12 months</th>
<th>Not in the past 12 months</th>
<th>Does not apply or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. A pharmacy contacted our practice to clarify or correct a prescription</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>7. A patient’s medication list was not updated during his or her visit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

### Diagnostics and tests

<table>
<thead>
<tr>
<th>Event</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Several times in the past 12 months</th>
<th>Once or twice in the past 12 months</th>
<th>Not in the past 12 months</th>
<th>Does not apply or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. The results from a lab or imaging test were not available when needed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>9. A critical abnormal result from a lab or imaging test was not followed up within one business day</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

### Section B: Information exchange with other settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Several times in the past 12 months</th>
<th>Once or twice in the past 12 months</th>
<th>Not in the past 12 months</th>
<th>Does not apply or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outside labs/imaging centres?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>2. Other medical practices/external physicians?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>3. Pharmacies?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>4. Hospitals?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>5. Other? (specify):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>
### Section C: Working in your medical practice

<table>
<thead>
<tr>
<th>To what extent do you agree or disagree with the following statements about the practice?</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Does not apply or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Others help out when someone gets very busy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>2. There is a good working relationship between staff and providers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>3. We often feel rushed when taking care of patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>4. Staff are trained when new processes are put into place</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>5. We treat each other with respect</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>6. We have too many patients for the number of providers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>7. Staff receive adequate on-the-job training</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>8. It is more disorganised than it should be</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>9. It has quality procedures for checking that work was done correctly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>10. Staff are asked to perform tasks they haven’t been trained to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>11. It has enough staff to handle its patient load</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>12. It has problems with workflow</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>13. It emphasises teamwork in taking care of patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>14. It has too many patients to be able to handle everything effectively</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>15. Staff follow standardised processes to get tasks done</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>
### Section D: Communication and follow-up

How often do the following events occur in your medical practice?

<table>
<thead>
<tr>
<th>Event</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
<th>Does not apply or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providers are open to staff ideas about how to improve processes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>2. Staff are encouraged to express alternative viewpoints</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>3. It reminds patients when they need to schedule an appointment for preventive or routine care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>4. Staff are afraid to ask questions when something does not seem right</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>5. It documents how well chronic care patients follow their treatment plans</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>6. It follows up when we do not receive an expected report from an external provider</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>7. Staff feel their mistakes are held against them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>8. Providers and staff talk openly about practice problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>9. It follows up with patients who need monitoring</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>10. It is difficult to voice disagreement in this practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>11. Staff discuss ways to prevent errors from being repeated</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>12. Staff are willing to report mistakes they observe</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>
Section E: Owner/managing partner/leadership support

A. Are you an owner, managing partner, or in a leadership position with responsibility for making financial decisions for your medical practice?

<table>
<thead>
<tr>
<th>To what extent do you agree or disagree with the following statements about the owners/managing partners/leaders of your medical practice?</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Does not apply or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. They aren’t investing enough resources to improve the quality of care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>2. They overlook patient care mistakes that happen repeatedly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>3. They place a high priority on improving patient care processes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>4. They often make decisions based on what is best for the practice rather than what is best for patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

Section F: Your medical practice

<table>
<thead>
<tr>
<th>To what extent do you agree or disagree with the following statements about the practice?</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Does not apply or don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When there is a problem, we see if we need to change the way we do things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>2. Our practice processes are good at preventing mistakes that could affect patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>3. Mistakes happen more than they should</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>
4. It is just by chance that we don’t make more mistakes that affect our patients

5. It is good at changing office processes to make sure the same problems don’t happen again

6. Getting more work done is more important than quality of care

7. We check to see if changes made to improve the patient care process have worked

<table>
<thead>
<tr>
<th>Section G: Overall ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How would you rate your medical practice on each of the following areas of healthcare quality?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>a. Patient-centred</td>
</tr>
<tr>
<td>b. Effective</td>
</tr>
<tr>
<td>c. Timely</td>
</tr>
<tr>
<td>d. Efficient</td>
</tr>
<tr>
<td>e. Equitable</td>
</tr>
</tbody>
</table>
Overall rating on patient safety

2. How would you rate the systems and clinical processes your medical practice has in place to prevent, catch and correct problems that have the potential to affect patients?

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Section H: Background questions

1. How long have you worked in this medical practice?
   - a. Less than 2 months
   - b. Between 2 months and 1 year
   - c. Between 1 and 3 years
   - d. Between 3 years and 6 years
   - e. Between 6 years and 11 years
   - f. 11 years or more

2. How many hours per week do you typically work in this medical practice?
   - a. 1–4
   - b. 5–16
   - c. 17–24
   - d. 25–32
   - e. 33–40
   - f. 41 or more

3. What is your position in this practice? Check one category that best applies to your job.
   - a. GP
   - b. Practice nurse, nurse practitioner, psychologist, mental health nurse or other health provider
   - c. Management: practice manager, office manager, business manager, nurse manager
   - d. Administrative or clerical staff: receptionist, medical records, accounts or billing, other administrative or clerical staff position

Section I: Your comments

Please feel free to write any comments you may have about patient safety or quality of care in your medical practice.

Thank you for completing this survey.
### Activity 2. Improving patient safety – using a chain-of-events timeline

Using the template below, examine an instance in which an event has occurred regarding patient safety.

<table>
<thead>
<tr>
<th>Step 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Working from right to left, write down the event that occurred in your practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Write down what you would have liked to happen at each point</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Write down what safeguards can be put in place to ensure what you want to happen does happen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Healthy Profession.
Healthy Australia.

RACGP