Meredith A B Makeham
BMed(Hons), MPH(Hons), PhD, FRACGP, is Senior Lecturer in General Practice, School of Public Health and Community Medicine, University of New South Wales. m.makeham@unsw.edu.au

Deborah C Saltman AM
MBBS, MD, FRACGP, FAFPHM, is Head, Institute of Postgraduate Medicine, Brighton and Sussex Medical School, Brighton, United Kingdom.

Michael R Kidd
MBBS, MD, FRACGP, is Professor and Head, Discipline of General Practice, University of Sydney, New South Wales.

Lessons from the TAPS study

Recall and reminder systems

The Threats to Australian Patient Safety (TAPS) study collected 648 anonymous reports about threats to patient safety from a representative random sample of Australian general practitioners. These contained any events the GPs felt should not have happened and would not want to happen again, regardless of who was at fault or the outcome of the event. This series of articles presents clinical lessons resulting from the TAPS study.

Clinical lesson

Let your computer help you help your patients. The recall and reminder system within your computerised medical records can be used to improve the quality of care you provide and avoid serious patient safety errors.

Case study

A man, 56 years of age, presented to his GP for a 'check up'. The GP organised some pathology investigations including a prostate specific antigen (PSA) test, which was found to be abnormal. The GP reviewed results in the patient's paper file from 2 years earlier and noticed that the patient's PSA had also been abnormal at that time. The GP had noted at that time that follow up was required but had not acted upon this. The patient recall and reminder function had not been utilised in the practice's computer system. The patient was subsequently found to have carcinoma of the prostate, with a prognosis possibly worsened by the 2 year delay in diagnosis. The GP felt that these types of problems were compounded by the use of both paper and computer records in the practice.

Comment

General practices need to ensure that systems are in place so that follow up of patients with abnormal test results is never overlooked. Practice utilisation of computerised recall and reminder systems could assist in preventing such errors.

■ **The Threats to Australian Patient Safety (TAPS) study established the incidence of errors reported by general practitioners[1] and developed a simple classification to describe these errors.[2] Approximately 21% were related to systems errors in general practice and other health care settings, and around 23% of these related to recall and reminder systems.[2] These types of errors were not related to a deficiency in the knowledge or skills of health professionals, but to problems in the processes used to ensure the delivery of optimal and safe health care.**

Earlier research on incident reporting in general practice has cited examples of recall and reminder system failures, such as the failure to recall a patient with abnormal test results,[3] or the failure to ensure a follow up examination of a patient with a previously noted abnormality.[4] Over the past decade most Australian GPs have started to use computerised medical records[5] with inbuilt recall and reminder systems. A recent study of Australian GPs showed that while 90% were using computers for clinical purposes, only 20% were using all of the available clinical functions in their electronic medical record system.[6]

Types of recall and reminder errors

The major types of recall and reminder errors that arose from the TAPS study were:
- failing to use an available computer system in the practice when seeing patients and checking their results
- forgetting to add recalls and reminders to a patient's electronic record when they are seen on a home visit or in an aged care facility
- incompletely using computer recall and reminder systems, with some types used routinely (eg. Pap tests), but others not used in any standard way
- having a recall or reminder on a patient's computer file, but failing to attend to it during a subsequent consultation or failing to have a routine in the practice for reviewing them periodically
- using the computer to check results and choosing the option 'needs further discussion', then failing to check this actually takes place

- presuming the recall or reminder is a colleague's task, especially in a multi-doctor practice with patients who are shared by several GPs, or when a GP and specialist colleague presume a recall will be done by the other; or a GP assuming that a nursing home should get in touch if an abnormal result is received
- presuming the recall or reminder is solely the patient's responsibility – expecting that a patient will telephone for results but not following up if they do not; or copying pathology results to patients at their home address, expecting them to contact you if they see something abnormal
- forgetting to remove recalls or reminders when a task has been attended, inconveniencing patients recalled for a completed task, and cluttering the recall system in the practice which could discourage its future use.

Lessons for preventing recall and reminder errors

- Learn to use your computer recall and reminder system to its full potential and, whenever possible, avoid mixing paper based and electronic systems. Seek assistance from your software vendor and/or your local division of general practice

- Entering recalls for patients who have visits outside the practice could be carried out onsite using mobile devices that are then synchronised with the records on your practice computer system

- Institute a periodic review of your patient recalls and reminders, involving your practice team, with clear guidelines around roles and responsibilities

- Don't rely on patients or colleagues at other locations to be solely responsible for recalls and reminders

Conflict of interest: none declared.

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AFP CORRESPONDENCE afp@racgp.org.au