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Managing clinical risks

Tips from the toolkit 9

Patient safety is of prime importance. Medical practice has inherent risks that need to be identified and reduced or avoided. Developing and implementing risk management processes is a necessary part of professional practice and is part of The Royal Australian College of General Practitioners' Standards for general practices. This article is based on The Royal Australian College of General Practitioners' 'General practice management toolkit'.

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Risk is the chance of something happening that will have an impact on objectives. It is measured in terms of consequences and likelihood.[1] Medical indemnity organisations (MDOs) and professional colleges are active in promoting systematic approaches in risk management. It is important that general practitioners are familiar with these approaches and incorporate them as part of routine practice and clinical management. A risk management process diagram is shown in *Figure 1*.

Practical steps

Clinical risk takes many forms in general practice. Risk includes events such as an incorrect or a delay in diagnosis, medication errors and infection.

There is a frequent overlap between clinical management and practice management. Practice managers and GPs can contribute to risk reduction by developing a whole of practice approach.

To be systematic, there are a number of approaches a practice can use. Many practices have monthly meetings, and including risk management as a permanent agenda item is an appropriate inclusion. Incidents and complaints can be collated and reviewed. Because risk is of such importance to a medical practice, scheduling a periodic risk management meeting can allow a practice to be more effective in controlling this area of practice.

Methods that can be used to identify risks include:

- a physical inspection or audit – many of the MDOs have audits that can be applied to general practice. Undertaking accreditation with Australian General Practice Accreditation Limited (AGPAL) or General Practice Accreditation (GPA) reduces risk as it formalises your systems and provides an external 'set of eyes' as to whether you meet The Royal Australian College of General Practitioners (RACGP) *Standards for general practices*. It is worth recognising that these are minimum standards and practices should aspire to set even higher standards than those listed by the RACGP
- reviewing reports by MDOs on high risk areas is helpful in directing attention to critical areas. Risk management workshops and case studies are available to improve knowledge and skills in this area
- patient journey assessment – flowcharting the patient's journey with your practice and determining the critical steps needed can identify potential pitfalls from the booking process through to subsequent recall and follow up.

Other approaches include brainstorming, scenario analysis, sentinel event and adverse outcome analysis, patient feedback, incident reports and clinical indicators.

Example: minimising the risk of delay in a diagnosis of cancer

Cancer is a progressive condition where early diagnosis can dramatically improve the outcome. In primary care we need to systematise the care

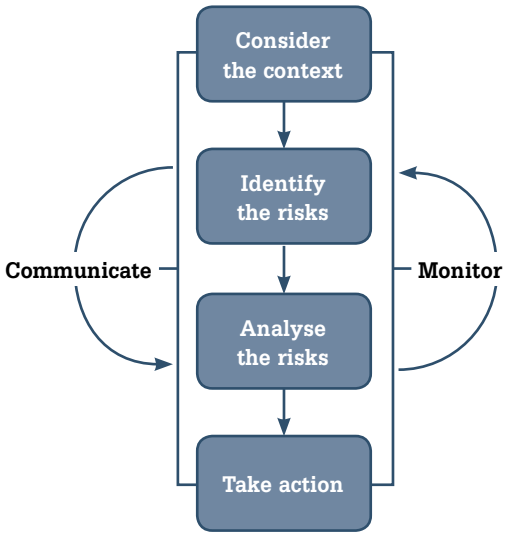

Figure 1. Risk management process [1]

process so that risks for patients are reduced. Practice managers are not able to improve clinical acumen but they can assist with practice processes. This may involve reviewing the practice approach to high risk clinical problems where a delay in diagnosis could lead to harm. Flagging review appointments means the receptionist can alert the GP if a review appointment is cancelled and not rescheduled within a predetermined time interval. Recall systems can be used for patients that need a diagnostic review. Patients often forget instructions to return for a review and a practice based system to recall patients adds to the safety of the clinical process.

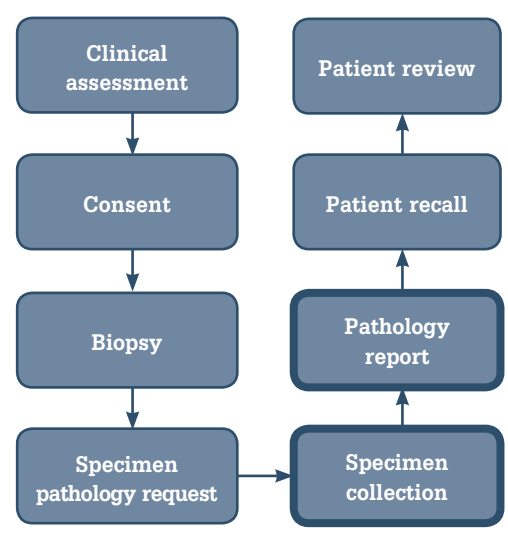

Figure 2. Process for biopsy of suspicious skin lesions

Melanoma

Australia has a high incidence of skin cancers including melanoma. General practitioners in full time practice are expected to see 1–2 patients per year with a new melanoma, and possibly examine thousands of skin lesions that are benign. In a 1996–2006 study by Avant[2] of 412 melanoma cases where the diagnosis was missed or delayed, 54% of missed or delayed diagnoses involved a GP. Significantly, these were situations where the patient had requested an opinion on the skin lesion. In two-thirds of these patients, there was a failure to recognise the lesion as melanoma. It is expected that GPs are more at risk of missing a melanoma because they see a large volume of patients with multiple conditions and the skin lesion may not be the primary presentation. However, because of this, we need to use approaches to minimise the risks.

The conclusions from the Avant analysis were:

- a history of change in a lesion should not be ignored
- clinically suspicious lesions that are not excised should be red flagged to ensure they are reviewed on a regular basis
- excised lesions are sent to a pathologist with a request form including adequate and clear details describing the lesion, the history of the patient and any previous biopsy
- doctors must have adequate recall and follow up systems to track pathology specimens and the results.

Undertaking a process review

An illustration of a process review is used here by breaking down the process of the excision of a suspicious skin lesion into a set of tasks. In the example in *Figure 2*, specimen collection and the handling of the pathology report are highlighted as areas of potential risk.

Wherever possible aim for simplicity and avoid duplication. Using a single pathology provider for reporting of histology specimens is a logical step. Apart from reducing the number of couriers transporting histology specimens, a relationship with the reporting pathologist can be developed which helps improve the diagnostic process. A log should be kept to confirm all specimens collected from the practice, and this can also be used to confirm a report has been received, thereby completing the cycle. Another use for the log is to match sterilising cycles of instruments to the procedures performed.

e-health systems receive downloaded pathology results that are checked by the referring doctor and an action created. The implementation of this action is usually delegated to administrative staff or a practice nurse. Back up processes need to be in place if any of these steps fail, eg. a download is unsuccessful, the doctor or staff member is on leave, or the patient fails to attend for review.

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