



# Health professionals are human too: Making mistakes in general practice

The underlying philosophy of “to err is human” is that everyone is capable of making an error. It is not a human failing but human nature. Academic qualifications, experience, judgement and knowledge do not exempt a person from being human. We can, however, take steps to minimise the impact that errors may have, and the frequency with which they occur.

Perhaps one of the most important aspects of minimising medical errors is questioning things that do not seem right. Practitioners should feel encouraged to question a colleague if an error is suspected, rather than feeling embarrassed or awkward in the face of authority or reputation. Questions from patients and their families about medical care, prescribing or dispensing should be welcomed rather than dismissed or discouraged.

## What is medical error?

Defining an error is a challenge as every event will be perceived and interpreted differently by each person involved. Often it is easy to disown an error or shift responsibility – “that was not my fault, it was a problem with the system” or “if my information system was up to date, I would not have prescribed the wrong medicine”. Errors usually have multiple causes with several people or systems involved in a cascading chain of events. The responsibility for error prevention is collective and collaborative rather than resting on the shoulders of an individual.

### Definition of error

Errors are events in your practice that made you conclude; “That was a threat to patient well-being and should not have happened. I do not want it to happen again.” Such an event potentially affects the quality of care you give your patients. Errors might be large or small, administrative or clinical, or actions taken or not taken. Errors might or might not have discernable effects. Errors are anything you identify as something wrong, to be avoided in the future. – Rosser et al, 2005<sup>1</sup>

## Medication errors

Medication errors are the most common type of medical error that occur in primary care. A medication error can be defined as; “failure of the treatment process that leads to, or has the potential to, harm the patient”.<sup>2</sup>

Medication errors may occur during the following processes:<sup>2</sup>

- Choosing the medicine and dose – prescribing faults (irrational, inappropriate, ineffective prescribing, under or over-prescribing)
- Writing the prescription – prescription errors, illegibility
- Dispensing the medicine – wrong drug, formulation or label

- Manufacture or preparation of the medicine – wrong strength, contaminants
- Administering or taking the medicine – wrong dose, drug, route, frequency or duration
- Monitoring – failure to alter a treatment when indicated, erroneous alteration

### Methods to minimise error

Most healthcare professionals are likely to have had some experience of medical errors, including near misses and errors that occur but are undetected. So what can be done in primary care to reduce medication errors and improve patient safety?

1. Review medication errors with practice colleagues and peers – discuss what went wrong (including near misses) and consider factors that could be put in place to prevent future events.
2. Introduce a culture of openness, no blame and collective responsibility – many error incidents are not single acts but result from a chain of events. GPs, pharmacists, practice nurses and other primary care practitioners all have a role and responsibility in selecting, delivering, receiving and administering medicines correctly.

3. Involve patients in their own safety – collective responsibility for error prevention extends to patients as well. Patients and their families should be informed about the medicines they are receiving and encouraged to act on their suspicions if they feel something is not right.
4. Be extra vigilant with high risk medicines and situations – some factors increase the risk of an error occurring. Patients who have been recently discharged from hospital are especially vulnerable to error due to factors such as confusion over medicine changes, poor information transfer and lack of follow-up. High-risk medicines such as warfarin and opioids, polypharmacy and prescribing to very old or very young people, may also warrant closer attention to prevent errors.
5. Report errors and patient safety incidents – decide individually or as a practice what method should be used.

### References

1. Rosser W, Dovey S, Bordman R, et al. Medical errors in primary care: results of an international study of family practice. *Can Fam Physician* 2005;51:386-7.
2. Aronson JK. Medication errors: what they are, how they happen, and how to avoid them. *QJM* 2009;102(8):513-21.

## The bpac<sup>nz</sup> Patient Safety Incident Reporting System

Designed for people working in primary care to report and review patient safety incidents.

The system is:

- Completely anonymous, no identifying information is collected or recorded
- Focused on systems or processes rather than individuals
- Independent and non-punitive

The primary purpose of the bpac<sup>nz</sup> Patient Safety Incident Reporting System is to improve safety by identifying the factors that commonly contribute to incidents in primary care, and sharing solutions to prevent these incidents from occurring again.

The online review facility includes the ability to comment on reports and view comments and observations made by peers on an incident. By submitting a report you are

making an important contribution to the safety of your patients and colleagues.

### How do I make a report?

Submit your report online on the bpac<sup>nz</sup> website:



[www.bpac.org.nz/safety](http://www.bpac.org.nz/safety)

# Patient safety incident reporting in general practice

**Associate Professor Susan Dovey**, Department of General Practice and Rural Health, Dunedin School of Medicine, University of Otago, reviews the bpac<sup>nz</sup> Patient Safety Incident Reporting System.

Until about ten years ago, it was an anathema to suggest that patients could be unsafe in the care of their health systems. That myth was blown out of the water in late 1999 when the US Institute of Medicine released its report *To Err is Human*,<sup>1</sup> horrifying many with the statistic that 98,000 Americans died unnecessarily every year because of what happened to them while they were in hospitals. The consequent flurry of public activity created many things, including systems for reporting unsafe incidents, which concentrated on hospitals as unsafe healthcare settings. A focus on patient safety as a leading healthcare issue spread rapidly throughout the Northern Hemisphere. Australia had its own patient safety revolution in the 1990s and was well positioned to advise emergent patient safety “experts” in Europe and the Americas. At the 55th World Health Assembly in 2002 the World Health Organisation (WHO) passed a resolution “recognising the need to promote patient safety as a fundamental principle of all health systems” and in 2004 WHO launched its Patient Safety programme. National reporting systems are now operational or planned throughout Europe but only the UK, Denmark and Ireland have health system-wide, comprehensive reporting.<sup>2</sup> Formal analyses to highlight learning points are part of the more mature patient safety incident reporting systems of only the US and Australia so far.

New Zealand, usually at the international forefront of healthcare reform, did not initially show leadership in this area. However we do now have a process for reporting “serious and sentinel” incidents in hospitals and a draft policy for managing patient safety incidents.<sup>3</sup> Confirmation of this policy was due in April 2010 but has not yet been announced. The policy proposes a system that closely mirrors patient safety incident reporting in Australia, incorporating features associated with superior systems, such as root cause analysis. It is intended to apply to all New Zealand health delivery organisations,

large or small, across the health sector. Unfortunately for the policy’s implementation in primary care, many of New Zealand’s general practices have limited experience in root cause analysis, less time to learn these skills and a lack of enthusiasm for engaging in the process of deciding whether an “incident” warrants a REB (Reportable Event Brief) or should be assigned a SAC (Severity Assessment Code) 1, 2, or 3.

Drawing on the international patient safety incident reporting research, bpac<sup>nz</sup> has designed a beautifully simple, yet sophisticated, primary care safety incident reporting system. It is not just for reports. It is for learning. It is completely anonymous, with web-based entries being moderated to ensure absolute anonymity before it is released to the public. It is also completely public: anyone can access it through the bpac<sup>nz</sup> website. Behind the scenes, the WHO international classification of patient safety incidents is applied to each report. Reports are made in plain English (or GP English!) without the need for any acronyms or jargon you would not use every day. Complicated reporting hierarchies are by-passed.

As of early July, 2010 25 reports had been made. Summaries of the main learning opportunities from these reports will regularly be published in *Best Practice Journal*. Both the reports themselves and the comments on the reports (which again can be made by anyone but are moderated by bpac<sup>nz</sup>) have learning points. For example, of the 16 current reports about incidents involving medicines, two are about warfarin brand mix-ups. The lesson comes succinctly from a commentator, who writes from experience with similar problems: “Our practice is to only prescribe 1 mg tablets if at all possible.” Table 1 summarises other reports. The bpac<sup>nz</sup> Patient Safety Incident Reporting System is an excellent resource for New Zealand primary care practitioners: it is for you, by you and about you. Its value will increase as you use it.

**Table 1:** A summary of bpac<sup>nz</sup> Patient Safety Incident reports, July 2010

Incident class	Type of problem	Learning points*
<b>Clinical process or procedure</b> (7 reports)	<p>Misdiagnosis of temporal arteritis</p> <p>Misdiagnosis of paroxysmal atrial fibrillation</p> <p>Documentation problems – eye checks for patient with diabetes, immunisations for patient with splenectomy</p> <p>Immunisation delivery problem</p> <p>Failure to deliver care indicated by positive lab test</p> <p>Referral lost in hospital system</p>	<p>Handover of patient information from GPs to and from other providers (hospitals, Healthline, labs, nurses, other GPs) is a high-risk situation: <b>a priority sort-out challenge.</b></p>
<b>Medications</b> (16 reports)	<p>Prescribed contraindicated drug:</p> <ul style="list-style-type: none"> <li>▪ Trimethoprim prescribed to pregnant woman</li> <li>▪ Drug interaction between sotalol and norfloxacin</li> <li>▪ Ocular steroids without fluorescein staining</li> </ul> <p>Prescribed wrong dose:</p> <ul style="list-style-type: none"> <li>▪ Levothyroxine prescribed at 1000x indicated dose: computer software not updated</li> <li>▪ Discharged on 80 mg daily PPI instead of 20 mg</li> <li>▪ Computer generated repeat prescription for 40 mg Lipitor instead of 10 mg</li> <li>▪ Computer generated PenG vials for injection instead of PenV capsules</li> <li>▪ Computer generated M-Enalapril instead of M-Eslon</li> </ul> <p>Dispensed wrong drug:</p> <ul style="list-style-type: none"> <li>▪ Adrenaline instead of vitamin B12</li> <li>▪ Atrovent inhaler dispensed instead of atrovent nasal spray</li> <li>▪ Inhibace 2.5 mg dispensed instead of Inhibace Plus</li> <li>▪ Dispensed wrong dose</li> <li>▪ 250 µg flixotide dispensed instead of 25 µg</li> <li>▪ 15 mg/5 mL midazolam dispensed instead of 5 mg/5 mL</li> <li>▪ Patient dispensed 3 mg warfarin when was instructed to take four pills (supposed to be four x 1 mg)</li> <li>▪ Warfarin 3 mg labelled as 1 mg</li> </ul> <p>Adverse reaction (no error):</p> <ul style="list-style-type: none"> <li>▪ Neutropenia with clozapine</li> </ul>	<p>Watch the computer – it doesn't always deliver what you intended</p> <p>Mistakes can slip in all along the prescribing pathway</p>
<b>Medical device and equipment</b> (2 reports)	<p>Patient slipped on pathway leading to the practice</p> <p>Patient tripped over poorly lit step</p>	<p>Scan your physical environment for potential hazards</p>

\* More personally applicable lessons will be found by reading and contributing to the reports

## References

1. Kohn L, Corrigan J, Donaldson M, eds. To err Is human: building a safer health system. Washington DC: National Academy Press; 1999.
2. Doupi D. National reporting systems for patient safety incidents. Helsinki: National Institute for Health and Welfare (THL);2009.
3. National Policy for the Management of Healthcare incidents. Working Draft. New Zealand Incident Management System: NQIP; 2008.