Title: Improving patient safety in Australian primary care

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Context: This improvement work will be included in Australian Primary Care Collaborative Program through Improvement Foundation of Australia.

Problem: Patient safety in primary care is emerging as focal issue worldwide. In Australia, there is no specific tool to measure or disseminate patient safety culture as in UK.

Assessment of problem and analysis of its causes:
A. Literature review
B. Conducting interviews with highly experienced surveyors from Australian General Practice Accreditation Limited (AGPAL) to identify what needs to be done to improve patient safety.
C. Assessing the utility of the patient safety culture tools in general practices

Intervention: We are developing Australian safety collaborative manual to improve patient safety in general practice. This manual includes aims, change ideas and measures to introduce:
A. A systematic approach to learn from significant events that affect patient safety
B. Robust systems for maintaining current medication and past medical history lists
C. Safe use of medicines that might be affected by or cause a deterioration of renal function
D. Regular review of prescribed medications in patients at risk of iatrogenic harm.

Study design: A cohort study will be used to measure the outcomes of participating practices in the safety collaboratives for 12months.

Strategy for change:
A. Develop a system for identifying significant events
B. Identify which events have the most impact by using a risk analysis matrix
C. Conduct “Significant Event and Root Cause Analysis” to identify areas where system of care can be changed
D. Complete and share Plan-Do-Study-Act cycle where changes are made
E. Develop system for continuous updating of past medical history as diagnoses evolve and new diagnoses are made
F. Develop system for continuous updating of currently taken medication
G. Develop a register of patients at risk of renal impairment and taking relevant medications [eg digoxin, regular NSAIDS/COX2]
H. Develop systems that ensure these patients are invited to attend for renal function at least annually
I. Develop a system to record the diagnosis of renal impairment/failure for patients with reduced eGFR
J. Develop a call/recall system for medication review in liaison with community pharmacist for patients considered at risk

Measurement of improvement:
I. Record of outcomes of SEA, root causes identified
II. Online submission of PDSA to state actions taken
III. Monthly report of PCS CAT 'clinical data self-assessment tool'
IV. Monthly data extraction tool to assess concordance of key medicines with predictable diagnoses.
V. Proportion of target patients who have had renal function monitoring in the last 15 months reported monthly
VI. Proportion of patients with eGFR<60 on two occasions who have renal impairment or failure recorded as an active diagnosis
VII. Develop a system to audit the proportion of eligible patients who have had a medication review in the last 12 months
**Lessons to be learnt:** This project will enable us to improve patient safety in Australia and to identify the gaps in the safety collaborative manual by national trial in APCC general practices. We would like present our work in Microsystem Festival to get a valuable feedback from the experts.

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**Conflict of interest:** None