



ACTION POINTS

Compiled by Tim Albert

The purpose of this page is to encourage dissemination of the findings in *QSHC*, particularly to managers. Please feel free to photocopy this page and pass it on.

Q: How would patients like to give feedback to their healthcare provider?

The authors analysed questionnaires from nearly 2000 adults registered with GPs in Grampian, northern Scotland. They asked them to choose whether they would prefer to give feedback via patient representatives, a telephone comments line, or a feedback website. They also outlined three scenarios and asked them to choose from a number of different ways of giving feedback about them. More than four out of five respondents favoured the idea of patient representatives, and these were the most widely preferred actions for two out of the three scenarios. Participants justified their choice mainly on the basis of ease of use, the perception that they would be listened to, and the likelihood that something would be done. A substantial minority, however, felt that their concerns would not be listened to, however they were expressed; as one commented: "No one listens". The authors conclude that any new attempts to improve responsiveness "must clearly demonstrate their effectiveness in order to regain and retain public confidence".

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Appoint patient representatives—and then listen to what they have to say.

"There is no doubt that the 'new NHS' is struggling to be user responsive; only by thoughtful improvements to the methodology and approach used in primary care will it be possible to rectify the situation".

Commentary by S Pickard, page 403

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Q: To what extent do our healthcare institutions really value the safety of their patients?

This study was carried out at the Johns Hopkins Hospital in Baltimore, USA. The authors received completed "safety climate" questionnaires from 395 clinicians, nurses, pharmacists and ICU staff, and 23 "strategic leadership" surveys from members of the senior management and patient safety committees. Staff felt that their supervisors were more committed to patient safety than senior managers, and doctors gave a lower score than nurses for climate of safety. Members of the senior management committee were more positive about safety than those on the patient safety committee, although both groups gave a low score to strategic planning. The authors argue that a more strategic approach to patient safety is needed. They also report that they have made a number of changes since the survey, such as a safety mission statement, a non-punitive error reporting policy, safety tips for patients and their relatives, and a patient safety intranet site. They conclude: "We look forward to collaboration and comments as we work to transform our efforts to improve patient safety from rhetoric to reality".

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Senior managers should have a strategic plan to improve patient safety.

Q: Is there a way of improving the reporting of errors in general practice?

In this study researchers developed a classification of errors in general practice which they incorporated into an anonymous self-report form. There were six categories: prescriptions, communication, appointments, equipment, clinical care, and "other" errors. They used the form to collect information on errors made in 10 English general practices over a two week period in June 2002. A total of 940 errors were recorded: 42% related to prescriptions, although only 6% of these were medication errors; 30% were communication errors and only 3% were clinical errors. The overall error rate was about 7 per 100 appointments. Most of those using the form (68%) said they found it acceptable and only 8% found it threatening. The authors conclude: "The method is acceptable and can be used to identify practice specific problems that require action. It can also highlight common areas for concern which the primary care trust can consider and act upon, disseminating the information and supporting lessons learned through a 'no blame culture'."

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We now have a usable way of analysing errors in general practice.

Q: How robust are case record review forms?

Case record reviews have proved very useful in the drive towards patient safety, but the standard clinical review form was developed in the early 1970s and has a number of disadvantages. It depends on the quality of patient records, has low to moderate reliability, and can be time consuming and expensive. Members of the clinical safety research unit in a London hospital have been developing a new clinical review form. They have divided it into five sections, each with a defined purpose and a modular structure. They asked hospital based teams in eight countries to review the new form, and most of the feedback was positive. The authors write: "We consider that the positive nature of the present findings suggests that this modified form should be considered for use in future case record reviews". They also state that the training of reviewers remains of vital importance.

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We may be on the way to having a new form for case record reviews.