Exploring opportunities to improve patient safety when GPs work in or alongside emergency departments: realist synthesis and evaluation

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There is a lack of evidence for potential patient safety risks when GPs work in or alongside emergency departments
Method: what works, for whom, how and in what circumstances?

- We used realist methodology to understand how and why patient safety incidents occurred when GPs worked in or alongside emergency departments and how safe care was perceived to be delivered.
- Data sources: literature review; national patient safety incident reports and Coroners’ reports; local ‘datix’ reports, observations and staff interviews at a purposive sample of 13 selected hospitals sites.

Results

Few national incident reports were identified:
9 Coroners’ reports (9/1347, 2013-2018)
217 NRLS reports (217/13074550, 2005-2015, see figure)

These were largely due to:
- inadequate streaming processes;
- errors in GP clinical decision-making and inadequate skillset; and
- inadequate referral pathways and communication between services.

Clinical directors from 11 of the 13 hospital sites had no patient safety concerns and 2 integrated sites perceived that experienced GPs within the team improved overall patient safety in the department.
Driver diagram to show priority areas to focus improvement interventions to improve the safety of care delivery when GPs work in or alongside emergency departments

Aim

Outcome

Primary Drivers

Mechanisms

Secondary drivers

Contexts

Potential measures

To improve

the safety of

patient care

when GPs

work in or

alongside

emergency

departments

To ensure

appropriate

patients are

streamed to the

GP

Local guidance on which patients are appropriate for the GP service

An experienced nurse assessment, including basic observations and use of early warning scores

Standard triage target times for both services

Well defined GP role and expectation considering GP experience, skillset and local patient demand

Clear governance processes

GP education and learning including metacognition principles and cognitive forcing strategies

Strong clinical (ED and GP) leadership to promote a culture of inter-professional learning

GPs as permanent staff members

Face-to-face communication (informal and meetings)

Clear emergency or specialist referral pathways

Standardised computer systems for emergency and primary care services including discharge summaries and investigation follow up processes

• Re-attendance at ED within 7 days
  • Number of streamed patients sent back to ED
  • Patient feedback
  • Patient safety incident reports
  • Audit grades of streaming nurses
  • Audit staffing levels (sickness/unfilled shifts)
  • Audit recording of basic observations
  • Audit use of early warning scores (NEWS)
  • Audit triage times

• Mortality rates
  • Re-attendance at ED within 7 days
  • Clinical feedback systems (e.g. X ray)
  • Patient feedback
  • Patient safety incident reports
  • Auditing clinical documentation
  • Audit use of protocols for high risk conditions
  • Audit induction and appraisal processes
  • Compliance with mandatory staff training

• GP(s) appointed in leadership role
  • GP representation at management meetings
  • Inter-professional educational activities
  • Frequency of GP/ED briefings/debriefings
  • Delivery of feedback from incidents/complaints
  • Formal staff patient safety assessment tool
  • Audit patients lost in the system
  • Audit timely electronic discharge summary
  • Case management for frequent attenders
  • Audit investigations requested before patient streamed to GP
  • Audit action of urine and swab results