Improving our practice reliability

Quality improvement and patient safety

Francine Lemire MD CM CCFP FCFP CAE, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER

Dear Colleagues,

We know that incidents that compromise patient safety (PS) commonly occur in health care institutions as well as in community care. A number of studies in the hospital sector, including the Canadian Adverse Events Study by Baker and colleagues in 2004, suggest that unsafe care leads to an incidence of adverse events among hospitalized patients of 7% to 15% in high-income countries.[1,2] Less is known about incidents in primary and community-based care. A recent systematic review suggests a median of 2 to 3 incidents for every 100 consultations or records reviewed in primary care.[3] Approximately 6% of these incidents might be associated with severe harm, as suggested by Rosser and colleagues in 2005.[4] Delayed or missed diagnoses and prescribing errors are more often associated with severe harm.[3]

Quality improvement (QI) experts accept the 6 dimensions of quality put forward by the Institute of Medicine in 2002: safety, timeliness, efficiency, effectiveness, equity, and patient-centredness.[5] The CFPC welcomes the additional focus on QI and PS in the 2015 CanMEDS enabling competencies and hopes to reflect this in the 2017 CanMEDS–Family Medicine framework. The importance of this is also reflected in the CFPC's Patient's Medical Home document: "Goal 9: A Patient's Medical Home will carry out ongoing evaluation of the effectiveness of its services as part of its commitment to continuous quality improvement."[6]

The engagement of family practice in QI and PS presents both challenges and opportunities. There might be a temptation to apply processes and tools that have been used in the hospital sector to family practice. While much can be learned from health care institutions, it is essential that specific QI and PS initiatives be developed and evaluated in primary care and family practice. Context is important. Estabrooks and colleagues identified 10 variables that affect outcomes of QI initiatives: leadership, culture, evaluation, social capital, resources, formal interactions (eg, team meetings), informal interactions (eg, hallway conversations), and the time, staff, and space necessary to do this work well.[7] There are many pressures facing family physicians right now. There might be scepticism in our profession around QI and PS as another form of accountability imposed on us by others. However, I believe we ignore this at our peril and that attention to QI and PS offers a tremendous opportunity for leadership in our discipline and, most important, for improving the care we provide to our patients. It is hard to argue with that!

Here are some questions for us to ponder.

- Several departments of family medicine are now incorporating curricula in QI and PS. How can we embrace this nationwide in teaching and community practices? How do we best support faculty development in QI and PS?
- How do we engage practitioners in embracing QI—not as something that is part of their accountability (ie, an "add on"), but rather as an area for leadership, an opportunity for team development, and an opening rich in potential for practice improvement if deployed appropriately?
- How do we foster the development of a culture oriented toward PS in family medicine, where practitioners are free of medicolegal fears in talking about PS incidents, near-misses, and lessons learned, and where practices emerge from such discussions with a plan to engage in PS in primary care?

Part of owning our discipline involves injecting new knowledge about our health care system. Engaging, in a meaningful way, in QI and PS is an element of this. Let's seize this opportunity. How can we do this better? I welcome your feedback.

Cet article se trouve aussi en français à la **page 527.**

Acknowledgment

I thank **Drs John Maxted** and **Phil Ellison** for their assistance with this column.

References

1. Baker GR, Norton PG, Flintoft V, Blais R, Brown A, Cox J, et al. The Canadian Adverse Events Study: the incidence of adverse events among hospitalized patients in Canada. *CMAJ* 2004;170(11):1679-86.
2. Jha A, Godlee F, Abasi K. Delivery on the promise of universal health care. *BMJ* 2016;353:i2216.
3. Panesar SS, deSilva D, Carson-Stevens A, Cresswell KM, Salvilla SA, Slight SP, et al. How safe is primary care? A systematic review. *BMJ Qual Saf* 2015 Dec 29. Epub ahead of print.
4. Rosser W, Dovey S, Bordman R, White D, Crighton E, Drummond N. Medical errors in primary care. Results of an international study of family practice. *Can Fam Physician* 2005;51:386-7. Available from: **www.cfp.ca/content/51/3/386.long**. Accessed 2016 May 9.
5. Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the quality chasm. A new health system for the 21st century*. Washington, DC: National Academy Press; 2002.
6. College of Family Physicians of Canada. *The Patient's Medical Home*. Mississauga, ON: College of Family Physicians of Canada; 2015. Available from: **http://patientsmedicalhome.ca**. Accessed 2016 May 9.
7. Estabrooks CA, Squires JE, Cummings GG, Birdsell JM, Norton PG. Development and assessment of the Alberta Context Tool. *BMC Health Serv Res* 2009;9:234.