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Patient safety in primary care, GPs can come aboard!

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Patient safety is now a major dimension of Quality in Primary Care as well as in Hospitals. General Practitioners can develop their Safety culture and deliver safer care by getting used with reporting and analysing adverse events. Clarifying the safety concepts and models and experience their handling seems a good start.

Learning goals:

- 1) Clarify some définitions: incident, error, adverse event, contributing factors, preventing barriers
- 2) Experiment reporting Adverse Events
- 3) Get more familiar with the cheese swiss model of James reason

Method:

- Presentation: «Patient safety, what are we talking about?»
- Short stroll (walk) Participants are invited to recall an adverse event occurred in their own practice.
- The participants are split into groups of 2 or 3 depending on the number of participants. Each participant tells his/her story. The other 2 participants listen. After discussion, participant writes on a post-it note:
 - What was the adverse event, what was the risk for the patient in the story?
 - What were active and/or latent errors?
 - What could be a preventive barrier?

Report: large group Each group choose one of the 3 story and explain the case in large groupe.

The group try to represent the case with the swiss cheese model: What is the arrow? What are the holes? What are the cheese slices?

Conclusion: The EQuIP project on patient safety – Dublin 2017 Expected impact on the participants:

- Discover that it is not so difficult to tell and discuss adverse event stories
- Motivate to enter in a current practice of sharing and analysing
- Engage into positive safety culture