Welcome & Introductions

- Dr Rosa Canalese – GP Synergy
- Dr Tony Saltis – Valley to Coast
- Dr Gerard Ingham – Beyond medical education
- Dr Simon Morgan – Valley to Coast
- Dr Lawrie McArthur – Adelaide to Outback
Gully Group Productions
“To err is human”

Managing critical incidents in a teaching practice setting
Outcomes of the session

GP supervisors will be able to;

- Implement practice based teaching focusing on responding to medical errors.
- Debrief a critical incident with a GP registrar in a manner that provides support for the GP Registrar and facilitates learning from critical incidents.
- Reflect on, and consider improvements in their own practice based systems for managing critical incidents that may impact on patient safety & the provision of quality clinical care.
Outcomes of the session

Medical educators will be able to;

- Understand the key elements of the workshop delivery and implementation of the learning activities.

- Deliver a similar workshop for the GP supervisors in their RTP.
What is medical error?

“An error is an event in your practice that makes you conclude; “that was a threat to patient wellbeing and should not happen. I don’t want it to happen again”

Makeham M. TAPS study. MJA 185(2).2006
What is medical error?

Errors May;
- Be large or small
- Be clinical or administrative
- Be actions taken or not taken
- Or may not have discernible effects

Makeham M. TAPS study. MJA 185(2).2006
Scope of the problem in Australian Primary health care

The TAPS study – reported patient safety incidents

Incidents per patient seen per year was 0.24% (or 1 for every 417 patients seen)

Australian Commission on Safety and Quality in Healthcare. Patient Safety in Primary care Discussion Paper. 2010
Errors related to practice and health care systems, 21.30%
Investigation errors, 12.40%
Medication errors, 20.40%
Errors in managing patient care, 18.70%
Errors in diagnosis, 11.80%
Communication & Process errors, 12.90%
Treatment errors (non-medication), 2.50%

Source: Makeham M. TAPS study. MJA 185(2).2006
A time to reflect

- Recall a time when you have made an error in clinical practice.

- How did you feel?
Discussion – video scenario

• How would you approach this situation?
• What are the different issues for GP Registrars?
• What are the key issues to consider?
• Practice talking to the GP Registrar

http://youtu.be/qgghIId1Mwc
Consider the following areas.

- The patient
- The doctors – GP Registrar & Supervisor
- The systems & the practice
- Self care issues & strategies
Planning in practice teaching.

- Discuss how you would develop and deliver in practice teaching based on critical incidents of mistakes & errors.