Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
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*Family Medicine-Primary Care Program*

# *Safety Learning Summary Systems Review*

## Category:

### Summary - What happened?

An adult patient attended the same Primary Care Clinic (PCC) where care had been received for many years. Unable to see the usual primary care provider (PCP #1), an appointment was made with an alternate provider (PCP #2) at the same PCC. At the time of the clinic visit the patient appeared generally healthy. Arrangements were made for a non-urgent specialist consult based on the presenting symptom as an urgent follow-up was not indicated at that time. A week later a phone call was received at the clinic requesting an appointment with PCP #1 due to concern over increased symptoms. Unable to accommodate the request and after a subsequent phone conversation an appointment was made with PCP # 3 in a weeks' time.

Over the following month, the patient was seen in the clinic 4 times and had one Emergency Department visit. The patient's condition was deteriorating with worsening symptoms and onset of new symptoms. It was thought that the patient's undertreated chronic medical condition was the cause of worsening symptoms. Treatment was directed at this source.

The patient and family were becoming increasingly concerned over the patient's condition and were not satisfied with the direction of care. These concerns were escalated by letters, phone calls and impromptu clinic visits. The patient/family was not satisfied with the responses to their concerns.

At the final visit to the clinic the patient was able to see PCP #1. The patient's condition had deteriorated to the point of requiring hospital admission. There was continued thought that the patient deterioration was related to the underlying chronic medical condition. The patient was admitted to hospital where a diagnosis was made of a rare terminal illness. The patient died approximately a month later while in hospital.

**What were the review findings?**

- The Primary Care Clinic (PCC) was implementing the use of the Electronic Medical Record (EMR). Due to this implementation, the Primary Care Provider's (PCP) available appointments were significantly reduced.

- Change management strategies were implemented in anticipation of the EMR roll out. However, the impact of the EMR roll out was underestimated. The implementation of the EMR was delayed by several months which reduced the effectiveness of some strategies. This was realized early in the implementation and attempts were made to minimize the negative impact of the implementation.

- The PCP #1 had reduced their EFT however panel size adjustments were not made in a timely way to reflect an equitable panel size which further compounded patient wait times. This in combination with the EMR roll out necessitated some patients seeing different providers resulting in decreased continuity of care.

- At the time of this event and during the implementation of EMR PCC management was in transition.

- There were informal processes for team collaboration which included care conferences within the clinic team. Due to the demands of human resources required by the process changes these were not broadly utilized.

- The processes for determining a need for case collaboration and utilizing care conferences are variable and non-descript.

- Family had been attempting to advocate for the patient and expressed concern as the patient's condition deteriorated. This was done via letters, phone calls and in person visits. They were dissatisfied with the response.

- At the initial appointments with new care providers it was not evident to providers that family/patient was dissatisfied.

- Family was not aware of how to escalate concerns to management at the time of the event.

- There is no standardized process or communication for how patients/family might elevate unresolved concerns within the WRHA Primary Care Clinics.

- The patient historically and at the time of this event was hesitant to accept traditional treatments for a chronic medical condition.

- The care providers believed that symptoms could have been related to the exacerbation of the chronic condition and lack of recommended treatment for same.

- The relationship between the patient's persistent and new symptoms and his final diagnosis only became clear with hindsight.

**Identified areas for system improvement**.

Interprofessional Collaboration and Patient Engagement

- Opportunity for clearly defined or communicated avenue for patient/family/staff navigation when there is a disparity of direction or dissatisfaction that is not easily resolved by usual processes.
- Opportunity to promote visible management personnel in patient care area. (Since this event a manager has been designated for this area and the manager's office has been relocated to a more visible location within the clinic setting).
- Opportunity for a defined consistent escalation process to identify when a formal interprofessional collaborative team conference would be utilized.
- Opportunity for current team collaboration processes to consistently include patient and family. Strongly suggest patient/family be included/considered/consulted in collaboration processes inclusive of formal interprofessional team conferences focusing on their care.
- Opportunity to maximize interprofessional collaborative practice to support strategies and approaches for patients who are hesitant to accept traditional medical treatments or second opinions.

Change Management

- Opportunity to improve anticipatory change management strategies. Significant concurrent changes were occurring within the clinic at the time of this event. Management was in transition. Delays in the EMR roll out impacted the effectiveness of planning strategies.
- Opportunity to improve processes related to panel size adjustments. Ensuring PCP's who reduce their EFT have timely panel size adjustments to reflect an equitable panel size to support reducing patient wait times.
- Opportunity for a clearly defined or consistent process for permanently transitioning patients to other providers within the WRHA Primary Care Clinics.

**Actionable Recommended Changes (DRAFT)**

1) **Aligned with Team Competencies for Collaborative Care: #2 Role Clarification**

All clinics to post signage with staff names & roles clearly identified (would need to be developed). Signage to be located near registration/check in area. Similar to Fee for Service Walk in clinic's with names & roles clearly identified. Office door to the Managers office needs to have signage indicating Primary Care Clinic Manager.

**2) Quality of the Patient / Family experience**

Raise patient awareness when there is disparity of direction or dissatisfaction that is not easily resolved by the usual processes what can they do? If after you speak to a Clinician and the patient/family have any further questions concerns. **Any member of the team** is able to offer and make available patient/family case conference. We are able to offer involving anyone from our team. We will work together to find ways to support improving our communication.

**How:**

2.1) Insert into clinic brochures that are provided to patients to raise patient/ family awareness. Explore if other options?

2.2) Incorporate as a part of orientation for all roles.

2.3) Need to develop internal team process that patient / family conference is available and it be explored/ offered to the patient/family and documented as to the outcome of that offer.

**3) Aligned with WRHA endorsed Team Competencies for Collaborative Care: #1 Person Centered Care**

3.1 At a minimum case conferencing to be held at the clinic site at least once a month and to strongly work at having the patient and family included/considered /consulted with any collaboration processes inclusive of formal interprofessional team conferences focusing on their care. Case Conferencing is not limited to monthly and could be done at any time.

**How:**

Be deliberate in having any member of the team to bring forward a case to support interprofessional practice and shared learning opportunities. Would also support teaching as have opportunities for interprofessional practice learners.

**4) Change Management**

4.1) Having an Electronic Medical Record will provide us with the opportunity to improve processes related to panel size adjustments. Ensuring PCP's who reduce their EFT have timely panel size adjustments to reflect an equitable panel size to support reducing patient wait times.

4.2) Opportunity for a clearly defined or consistent process for permanently transitioning patients to other providers within the WRHA Primary Care Clinics.