Meredith A B Makeham
BMed(Hons), MPH(Hons), PhD, FRACGP, is Clinical Lecturer, Discipline of General Practice, The University of Sydney, New South Wales.
meredith@gp.med.usyd.edu.au

Chris Cooper
MBBS, MPH, MRCGP, is Lecturer, Discipline of General Practice, The University of Sydney, New South Wales.

Michael R Kidd
MBBS, MD, FRACGP, is Professor and Head, Discipline of General Practice, The University of Sydney, New South Wales.

Lessons from the TAPS study

Message handling and appointment systems

The Threats to Australian Patient Safety (TAPS) Study collected 648 anonymous reports about threats to patient safety from a representative random sample of Australian general practitioners. These contained any events the GPs felt should not have happened, and would not want to happen again, regardless of who was at fault or the outcome of the event. This series of articles presents clinical lessons resulting from the TAPS study.

Clinical lesson

The reception staff members of a general practice are the first point of communication with patients. Staff should be educated about urgent presentations that require immediate medical attention. The practice also needs a clear system for handling messages and ensuring that all requests are acted upon.

Case study

The parents of a boy aged 7 years called the reporting general practitioner's practice for some advice about a problem that they were having with their child. The receptionist noted in the 'message book' at the front desk that at 10.30 am the child was experiencing pain in the scrotum. In this practice, any messages are generally read at various intervals during the day, and on this occasion it was a further 2 hours before the GP saw the note. An instruction was relayed to the parents to bring the child straight in, however they did not arrive until 2.00 pm. At this point the patient was seen straight away and referred to hospital for urgent urological assessment. A torsion of the appendage of the testicle was found at operation later that afternoon.

Comment

This case study illustrates the importance of educating reception staff about urgent requests and presentations, and the need for a system where urgent messages are passed on to the GP without delay. It highlights the importance of clear communication with anyone requiring urgent assessment. In this case there may have been further miscommunication from GP to receptionist and then to the parents regarding the need for the patient to present immediately once the doctor became aware of the message and the potential urgency of the patient's condition.

The TAPS study collected error reports from a representative group of Australian general practitioners[1] and found that 70% of reported errors were due to process problems in the delivery of care as opposed to deficiencies in the knowledge and skills of health professionals.[2]

Practice and health care system errors accounted for over 30% of all 'process' events identified in the study. Around 14% of these were related to message handling and appointment systems in the practice[2] and resulted in problems ranging from inconvenience to patients and GPs through to urgent enquiries being missed with the potential for serious harm, as in the case study presented.

A United Kingdom general practice based study of reported errors found that around 7% were due to problems with 'appointments', however its different type of classification system meant that 'message' errors were not included here and it is unclear what further proportion of mistakes were message handling difficulties.[3]

Earlier Australian error research found that 'poor communication between patients and health professionals', and 'administrative inadequacies' contributed to over 30% of reported incidents from GPs. The results are difficult to compare to TAPS due to the use of different methodology and classification systems.[4]

TAPS GPs often expressed concern about patient expectations, reflected in problems that then arose in relation to message handling. Consideration of the guidelines given to reception staff about how to respond to requests for 'phone consultations', how to recognise urgent medical problems, and the need for a system to relay these messages to the GP, could help minimise some of the feelings expressed about being overworked or unable to adequately respond to all messages received.

An electronic system or intranet that sends messages directly to the GP's desktop allows a record of all messages to be kept on the practice computer system. Only one report of message handling errors involved the use of such a system, and this was a problem when a GP forgot to complete a task rather than not being alerted to an urgent problem.

Message handling and appointment system errors reported in the TAPS study

- GPs forgetting to act on a message they were given, often during a consultation with another patient.
- Administrative delays in a message reaching the GP regarding a patient needing urgent medical advice or attention.
- Verbal messages to administrative staff regarding patient medical management being inaccurately relayed to patients or not passed on at all.
- Messages written on paper slips for the GP (without copies) being misplaced.
- Appointment mistakes, with patients booked in to see the incorrect GP in a group practice.
- Delays in attending to patients waiting for appointments due to a breakdown in the practice's system for alerting the GP to their presence.

Lessons in preventing message and appointment errors

- Educate reception staff on recognising urgent medical presenting complaints
- Avoid responding to messages from patients with medical management plans that need to be relayed verbally by reception staff
- Keep a written record of tasks to be completed each day and messages received and responded to, preferably on an electronic system
- Avoid message systems based on slips of paper left on desks or in trays with no copies
- Establish boundaries around responding to phone requests and ensure that these are clearly understood by reception staff

Conflict of interest: none declared.

Acknowledgment

The TAPS study was funded by a NHMRC PHC project grant. Meredith Makeham was a NHMRC scholar and received additional support under the Researcher Development Program, PHC RED Strategy, funded by the Commonwealth Department of Health and Ageing.

References

1. Makeham MA, Kidd MR, Saltman DC, et al. The Threats to Australian Patient Safety (TAPS) study: incidence of reported errors in general practice. Med J Aust 2006;185:95–8.
2. Makeham MA, Stromer S, Bridges-Webb C, et al. Patient safety events reported in General Practice: A taxonomy. Qual Saf Health Care 2008;17:53–7.
3. Rubin G, George A, Chinn DJ, Richardson C. Errors in general practice: development of an error classification and pilot study of a method for detecting errors. Qual Saf Health Care 2003;12:443–7.
4. Bhasale AL, Miller GC, Reid SE, Britt HC. Analysing potential harm in Australian general practice: an incident-monitoring study. Med J Aust 1998;169:73–6.

AFP CORRESPONDENCE afp@racgp.org.au