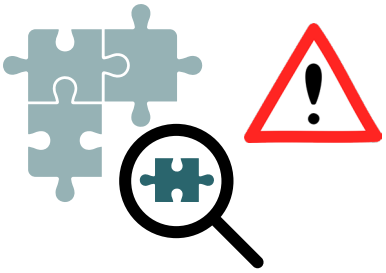
Patient safety in remote primary care encounters

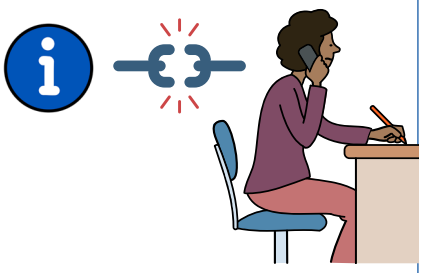
Findings from the Remote by Default 2 research study
Sub-study led by Rebecca Payne and Aileen Clarke

Consultations in general practice increasingly occur by telephone or video. These formats can be convenient but there are some downsides. In particular, it is not possible to do a full examination when the patient is not physically present. We examined the risks to patient safety in remote consultations.

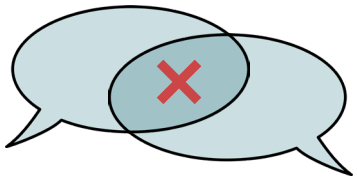
When we studied 12 general practices over 28 months, we didn't find any examples of patients coming to harm as a result of telephone or video encounters. This was mainly because staff were very aware of potential safety issues and tended to 'err on the side of caution'.



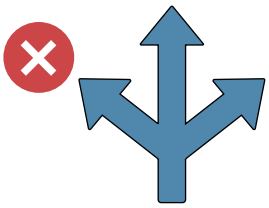
Using various national sources (e.g. complaints, closed medico-legal cases), we collected 95 examples of patients who had come to harm following a remote consultation. It's important to learn from these rare examples.



Safety incidents were sometimes caused by a busy staff member becoming distracted (e.g. a receptionist taking a call from a sick patient but forgetting to tell the doctor), especially when there was high workload and staff shortages.



Some incidents were linked to poor communication – such as the doctor not listening sufficiently closely, not asking enough probing questions, or jumping to conclusions about the likely diagnosis.



Sometimes, a patient was allocated to the 'wrong algorithm'. For example, a patient telephoned about 'throat pain' and was treated as a sore throat when the actual problem was a heart attack.

Some cases were difficult or impossible to assess safely by telephone. These included acute emergencies (e.g. possible appendicitis), very young patients, patients with complex medical or social needs, and patients unable to communicate fluently in English.

Learning summaries

Remote assessment in general practice is remarkably safe. With attention to staffing, training and appropriate channeling of patients to the right pathway, it could be made even safer.

For practice

- A well-staffed practice is a safe practice. Cover busy periods adequately and have contingency plans for staff absences.
- Train all staff to use the telephone to its full potential.
- Without visual cues like body language, it's even more important to listen closely and give patients time to tell their story and say what's troubling them.
- Identify potentially vulnerable patients (e.g. hard of hearing, elderly with limited English) and flag their record.
- Have protocols for problems that need in-person assessment, e.g. sick baby, acute chest / abdominal pain.
- Patient who haven't improved despite two previous phone consultations should be seen in person.

For policy

- Remote consultations and remote triage in UK general practice mostly occur by telephone.
- Not all patients or problems can be safely assessed by telephone.
- General practices must therefore be resourced to provide in-person assessment when needed.
- In-person appointments may be safety-critical for vulnerable populations, e.g. severe socio-economic disadvantage, complex needs, safeguarding.
- All practices should have protocols and training in place for which kinds of problem can be safely dealt with over the phone and which can't.
- However, because safety also depends on the judgement and initiative of front-line staff, safety should not be over-protocolised.

More information on this paper

Payne R, Clarke A, Swann N, et al. 'Patient safety in remote primary care encounters: multimethod qualitative study combining Safety I and Safety II analysis'. *BMJ Quality & Safety*. 2023 doi:10.1136/bmjqs-2023-016674

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