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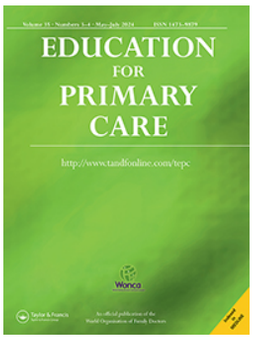

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Teaching patient safety in remote consulting

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ABSTRACT

A significant proportion of primary care consultations now happen remotely. Although the vast majority occur safely, a recent study highlighted areas of risk which may be compounded by the limited training many GPs have received in remote consulting. To provide safe remote services, consideration needs to be given to adapting practice workflow to optimise remote care. Patients less suitable for remote consulting, either due to disease, extremes of age, disability or for social reasons should be identified and prioritised for face-to-face encounters. Training supports both the development of individual communication skills for remote care, and effective team working. Practice-based group learning events can be used to share experiences, identify resources, and consider the risks in remote care and how they can be mitigated. The paper presents some fictionalised cases, illustrating where patients came to harm, as a result of a remote consultation, and where harm was averted due to actions taken by practice teams. These can be used to support critical thinking and discussion within practice development meetings and tutorials with trainee GPs and other practice staff. Using the paper as a basis for reflection, teaching and action can facilitate the delivery of safer remote care.

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Introduction

The way general practice is currently delivered is significantly different from the world in which many of today's Trainers trained. Although a shift towards remote consulting started in the 1990s, it remained a gradual change in most in-hours General Practice settings until the COVID-19 pandemic [1]. The vast majority of remote consultations are by telephone, but asynchronous consultations, where a patient submits a message to the practice, which is dealt with at a separate time, are becoming increasingly commonplace. The most recent NHS England figures show that, in February 2024, 26% of the consultations were done using telephone, and 4% were online or video [2]. This leading article draws heavily on the author's paper in BMJ Quality and Safety [5] in combination with other relevant published literature in order to present some key aspects that should be considered when providing training for remote consulting.

General practice is a speciality focused on holistic care, managing complexity, uncertainty and risk, and providing continuity of care to patients across their life course. GP training reflects this with a significant emphasis on the development of consultation and communication skills. The GP consultation is a much examined and theorised specimen with many scholars offering tools and models to aid GP registrars. These mostly support face to face consulting however, with very few models available to help support remote consultations. A significant proportion of GPs will have had no training in any form of remote consultation. An even smaller proportion will be trained in how to deliver safe and effective primary care using asynchronous or video consultations. The new Simulated Consultation Assessment forming part of the licensing examinations for the Membership of the RCGP is conducted using video, but literature relating to the SCA implies that the marking is agnostic of the video modality [3,4].

Remote consultations require a different approach and skillset to face to face consultations. The processes that need to sit behind remote consultations also differ from those required to provide in-person care. Payne et al.' s paper on safety in remote consultations [5] offers practical pointers for implementing safe and effective remote consulting into practices and can be used for teaching GP trainees and practice staff.

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Patient safety in remote primary care encounters

The paper, published in BMJ Quality and Safety, was the first to combine two different types of safety data [5]. Traditionally, the safety literature focuses on Safety I incidents where a significant event is reviewed and lessons identified often leading to tightening of policies and procedures. This study combined the findings of various Safety I data sources with Safety II methodology, using ethnography and qualitative methods to examine why things do not go wrong and how staff adapt processes to avoid safety incidents.

The paper details the step practices took to keep remote care safe. Strategies such as supporting trainees and junior team members, knowing who the vulnerable patients were and adapting access pathways to meet their need, erring on the side of caution and 'breaking the rules' when it was needed all played a part. On the rare occasions safety incidents did arise, thematic analysis of incident reports and interview transcripts revealed five themes: a challenging organisational and system context, poor communication compounded by remote modalities, limited clinical information, remote modality placing additional burdens on patients and carers; and inadequate training [5].

A key point made by the paper is that risks can build when a (wrong) remotely made diagnosis is given the same credence as a diagnosis made in person. Errors can be compounded as subsequent consultations build on the previous assumptions.

Remote consulting does not work for all patients at all times. Some clinical conditions are inherently riskier when assessed remotely. These can include acute chest or abdominal pain, breathing difficulties, new psychosis and a history which is vague or doesn't make sense. Any condition which isn't resolving, or which is not following the expected trajectory should be reassessed in person. Escalating parental concern should never be ignored, and an acute condition in a patient with pre-existing complex illness may be harder to assess remotely.

Patients benefitting most from a face-to-face encounter include those at the extremes of age, those with whom communication is challenging by virtue of language non-concordance, deafness or learning disability and those unable to interact effectively either with key technologies or with wider health systems [5–7]. Special consideration should be given to care home residents – remote consultation may be appropriate when it can be supported by observations and input from care home staff, but can carry risks with these high-need patients if inadequate information is gained remotely.

Everyone involved delivering remote care should be aware of these key risks and communicating them to registrars is vital.

Developing safer practices within the practice

Two of the themes related to system and practice processes supporting remote consulting: a 'challenging organisational and system context', and 'remote modality placing additional burden on patients and carers'.

The research highlights that practices using remote modalities need to ensure that practice processes and workflows have been adapted for this method of care delivery. In particular, processes are needed to prevent patients and information getting 'lost in the system'. The patient still in the waiting room at the end of morning surgery acts as a visible reminder to staff, the patient who hasn't received an expected ring-back is invisible. Staff taking and making calls need to be protected from distractions. Where the patient's unique needs do not fit within standardised protocols and pathways, staff need permission to adapt processes in order to provide safe and individualised care. Converting a remote consultation to a face-to-face encounter where inadequate clinical information has been gleaned remotely needs to be enabled and championed. This must be facilitated at the system level, with slots available to book patients into following a remote encounter.

When developing GPs, we are not just developing clinicians, but the practice leaders of the future. Addressing the organisational factors that can enhance or detract from safety is as vital as teaching the communication skills required.

Developing the safe and effective remote GP

The themes of 'poor communication compounded by remote modalities' and 'limited clinical information' are linked by the final theme, 'inadequate training'. The remote consultation is not the same as an in person one; non-verbal communication (NVC) is missing and not fully replaced even when using video [7]. Different skills are required in order to complete the tasks of the consultation. Without these skills the GP is left struggling to establish rapport with the patient and risks missing vital stages of the consultation such as the psychosocial aspects, the patient's health understanding and their agenda [6,7]. This leads to poor communication and limited, more transactional consultations.

The literature suggests, and most GPs will have experienced, that it is more difficult to establish rapport without NVC cues [6–8]. Traditionally, a patient waiting for a face-to-face appointment will have rehearsed

an opening gambit. A call invading their daily life means that they are less prepared to tell their story and so do not own the first part of the consultation as would normally be expected. Patients may also be more distracted during remote consultations, or be censoring their speech because of their environment. A GP working remotely needs to acknowledge this and adapt their own part in the consultation in order to overcome these obstacles.

One tool often taught in GP training is using the 'golden minute' at the start of the consultation. Many GP trainees have been challenged by their trainers to not speak in this minute and let the patient give the history. This commonplace tactic may be less effective when consulting remotely; is it a golden minute or has the call dropped, is the GP still listening, has the sound been lost from the video? The loss of the patient controlling the first part of the consultation inherently changes the dynamic and risks the GP being drawn into closed questions too early and missing aspects of the history.

One significant finding of the patient safety paper, which aligns with the literature elsewhere, is that safety netting is not done well during remote consultations. Arguably it is more important remotely because of the limited clinical information available and the higher risk of misunderstanding. The paper suggests that diagnoses and management plans are considered provisional and to be altered when new information is found. A safety net here is critical, but practice processes need to be in place to allow both the GP and the patient to enact the safety net. A patient should not be told to ring back for a face-to-face appointment if there are no appointment slots available, and they are diverted elsewhere.

Training can help overcome the barriers to effective consulting inherent in remote modalities, but there is little available, and many GPs rely simply on gaining experience through doing consultations. In a training environment, the Consultation Observation Tool can be used to help trainees develop remote consulting skills, and video/recordings of remote consultations should be part of all trainees' development. A recent article published by InnovAiT offers an infographic and various tips on how to learn how to do video consultations effectively [7]. For established GPs, recording their remote consultations and reviewing them later is hugely beneficial process, especially if they can reflect on the ease of establishing rapport and the effectiveness of the consultation in comparison with face-to-face ones. For practice teams, a paper by the same authors provides a set of draft competencies for training in the remote delivery of primary care [9].

Recommendations for practice

The paper highlights various challenges with remote consulting but specifically provides opportunities for practice learning. The fictionalised cases illustrating how some patients came to harm as a result of remote consulting, and in others, where the actions taken by practice staff avoided harm (found in Table 1 of the paper) can be discussed in education sessions and the learning drawn out. Secondly, the organisational elements needed to deliver safe care could form the basis for a practice training session, where current pathways are examined and risks identified and addressed.

Conclusion

This study on patient safety in remote consultations provides practical pointers for implementing safe and effective remote consulting into practices and for teaching GP trainees and colleagues. It contains resources which can support the training of practitioners in effective communication, clinical assessment, and safety netting within a remote context. These can be used to support both GPs and wider practice teams to provide safer care within the current landscape of General Practice.

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