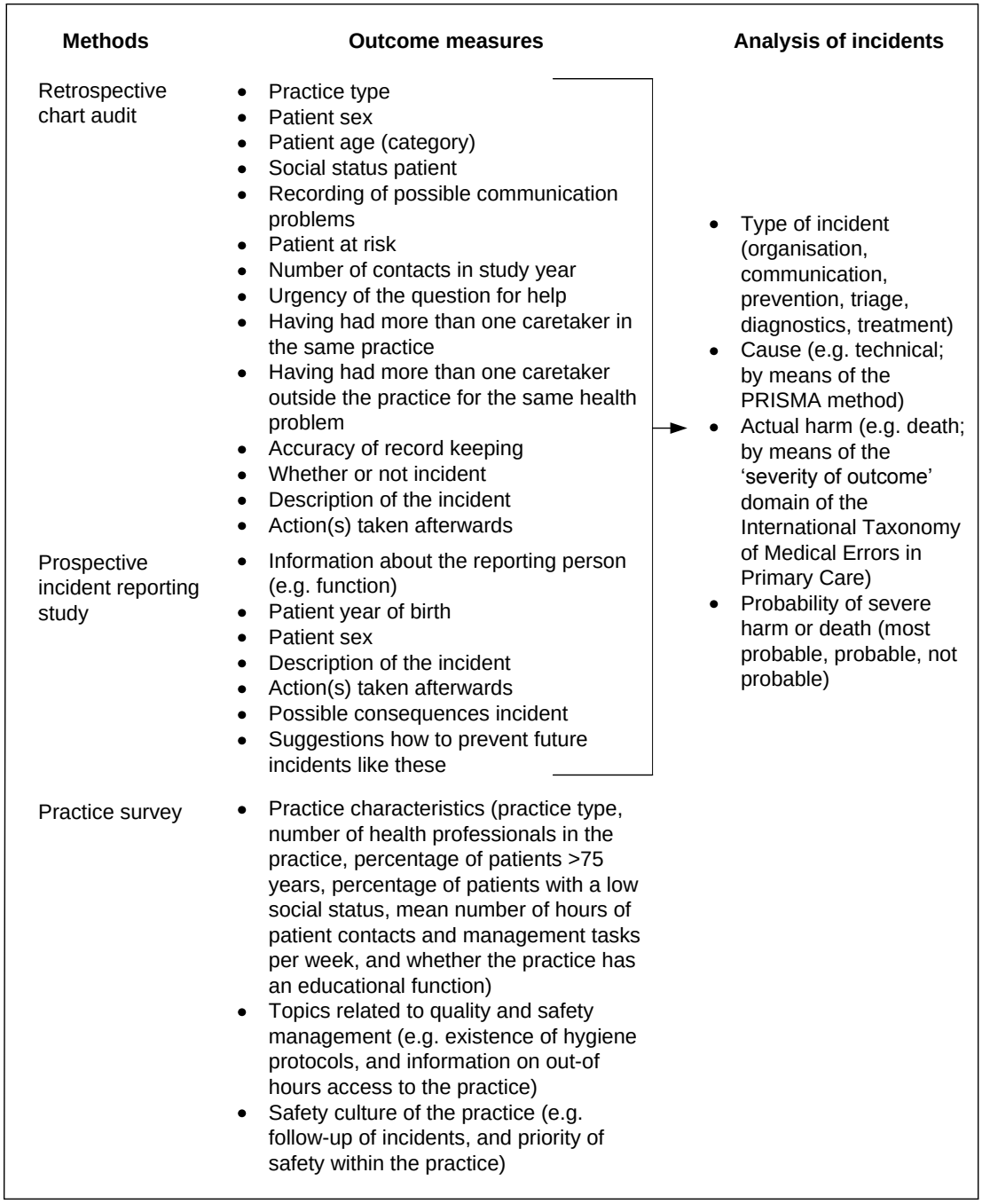
Methods
Outcome measures
Analysis of incidents
Retrospective chart audit
Practice type
Patient sex
Patient age (category)
Social status patient
Recording of possible communication problems
Patient at risk
Number of contacts in study year
Urgency of the question for help
Having had more than one caretaker in the same practice
Having had more than one caretaker outside the practice for the same health problem
Accuracy of record keeping
Whether or not incident
Description of the incident
Action(s) taken afterwards
Prospective incident reporting study
Information about the reporting person (e.g. function)
Patient year of birth
Patient sex
Description of the incident
Action(s) taken afterwards
Possible consequences incident
Suggestions how to prevent future incidents like these
Practice survey
Practice characteristics (practice type, number of health professionals in the practice, percentage of patients >75 years, percentage of patients with a low social status, mean number of hours of patient contacts and management tasks per week, and whether the practice has an educational function)
Topics related to quality and safety management (e.g. existence of hygiene protocols, and information on out-of hours access to the practice)
Safety culture of the practice (e.g. follow-up of incidents, and priority of safety within the practice)
Type of incident (organisation, communication, prevention, triage, diagnostics, treatment)
Cause (e.g. technical; by means of the PRISMA method)
Actual harm (e.g. death; by means of the 'severity of outcome' domain of the International Taxonomy of Medical Errors in Primary Care)
Probability of severe harm or death (most probable, probable, not probable)