

SAFE: Prevent diagnostic harm by safety-netting in clinical consultations

Co-design and implementation of safety-netting strategies

Background: Serious preventable harm in primary and emergency care is often related to diagnostic error. Communicating safety-netting advice in the consultation is a promising approach for improving patient safety. The aim of this project is to co-design and implement safety-netting strategies in 30 primary care practices, 3 out-of-hour services, and 2 emergency departments in Sweden.

Methods

Co-design of intervention components

1 45 min web course for clinicians



2 Safety-netting checklists

- ☐ **S**EE diagnostic uncertainty
- ☐ **A**NTICIPATE course of events
- ☐ **F**LAG for symptoms
- ☐ **E**NGAGE in understanding

3 Documentation template

2 new searchable **key terms** added to electronic health record template

- **Expected course of events**
- **Contact healthcare if**

Expected outcomes

Shared situational awareness

Knowledge and understanding

Feeling of safety & security

Satisfaction with care / job satisfaction

Documentation quality in EHR

Diagnostic accuracy



Mitigated consequences of diagnostic error

Fewer visits to wrong level of care

Challenges: Safety-netting targets the behaviors of clinicians and their organizations, as well as clinician-patient collaboration and subsequent patient behaviors. Outcomes are difficult to evaluate. We aim to use CFIR and Kirkpatrick's evaluation model to guide longitudinal data collection and analysis.



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