Learning to be safer – Part 1

How and why to report incidents in primary care

Is this an incident?

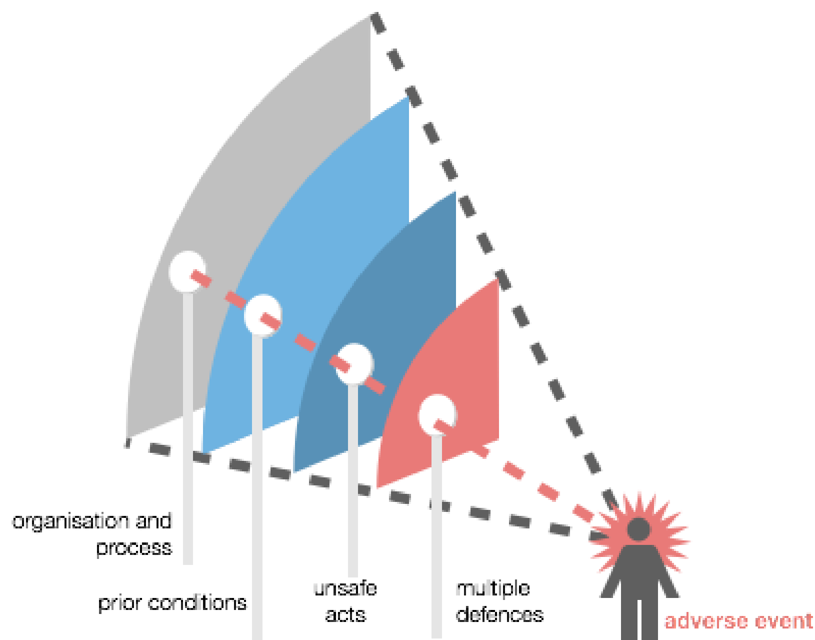
James Reason defines "**Error** [is when] a planned sequence of mental or physical activities fails to achieve its intended outcome" Not all errors lead to **harm**, and not all harm is due to error.

Every year, there are 360 million consultations in primary care in England. Medical error in primary care is believed to occur at a rate of between 5-80 times per 100,000 consultations. Prescribing and prescription errors occur in up to 11% of all prescriptions, mainly related to dosage. A quarter of patients experience an adverse event within four weeks of starting a medicine, of which 11% are considered preventable.

A **patient safety incident** or adverse event is defined as "any unintended or unexpected occurrence that could have or did lead to harm." (National Patient Safety Agency)

A **significant incident** is defined as "an occurrence thought by anyone in the team to be significant in the care of patients or the conduct of the practice."

James Reason's Swiss Cheese model explains that although many layers of defence lie between hazards and accidents, there are flaws in each layer that, if aligned, can allow the adverse event to occur.



North Bristol NHS
NHS Trust
NHS Bristol
Clinical Commissioning Group
NHS England
West of England Academic Health Science Network
Published: November 2016

Types of incidents:

- Access, admission, transfer, discharge (including missing patient)
- Adverse media coverage or public concern about the organisation or the wider NHS
- Bogus health workers
- Clinical assessment (including diagnosis, scans, tests, assessments)
- Consent, communication, confidentiality
- Death on GP premises
- Delayed diagnosis
- Disruptive, aggressive behaviour (including patient-to-patient, verbal and physical behaviour)
- Documentation (including electronic & paper records, identification and drug charts)
- Environment and infrastructure
- Implementation of care and ongoing monitoring / review
- Infection control incident
- Infrastructure (including staffing, facilities, environment)
- Medical device / equipment
- Medication
- Other
- Patient abuse (by staff/ third party)
- Patient accident
- Pressure ulcer grade 3 or 4
- Safeguarding issues (including child abuse, child death, and safeguarding vulnerable adult)
- Self-harming behaviour (including suicides)
- Surgical error (including wrong site surgery)
- Treatment, procedure
- Unexpected death

What is the level of actual harm?

Between October 2014 and September 2015 of incident reports made in England, the vast majority of incidents (95%) results in no harm or low harm.

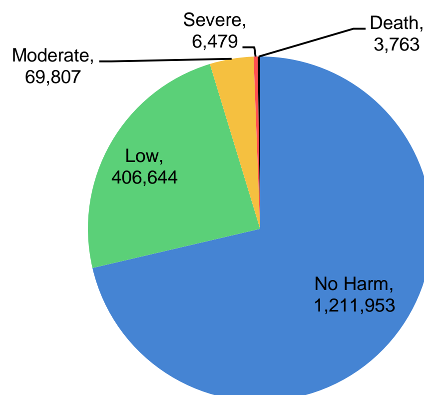
None – No harm / No harm (harm prevented)

Low – Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons

Moderate – Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons.

Severe – Any unexpected or unintended incident which caused permanent or long term harm, to one or more persons.

Death – Any unexpected or unintended incident which caused the death of one or more persons. *



* Incidents reported as level of harm "death" include suicides.

A **good catch** or **near miss** is a positive incident where staff member's actions showed great initiative in preventing an incident from progressing, or safety net systems in place worked.

Is this a serious incident or a never event?

A **serious incident** usually involves an adverse outcome, e.g. unexpected or avoidable injury or death, an allegation of abuse or where healthcare did not take appropriate safeguarding action, or an incident which threatens an organisation's ability to continue to deliver an acceptable quality of healthcare services. Serious Incidents need to be reported on STEIS (STrategic Executive Information System) in line with the NHS England Serious Incident Framework (SIF). **Never events** are classed as serious incidents.

On an annual basis across the NHS there are around 30,000 serious incident investigations and 300 never events. In comparison there are 1,781,640 incidents reported through the NRLS.

Serious Incidents may require an organisation to notify other relevant bodies, and in some cases investigation may need to be carried out by an independent investigator. In some cases this may involve liaising with a Serious Case Review or Safeguarding Adult Review process. For more information see https://www.england.nhs.uk/patientsafety/serious-incident/

Why should I report patient safety incidents?

All patient safety incidents should be reported to the NRLS. Incidents with an actual (not potential) level of harm with death or severe reported to NRLS are likely to meet the definition of a Serious Incident, and therefore reported to STEIS as well. However there are some incidents which despite having a lower of actual harm may fit the criteria for a Serious Incident. If in doubt please discuss with your local Commissioning Safety Team.

Reporting incidents to the NRLS helps protect patients from avoidable harm by increasing opportunities for the NHS to learn when things go wrong. The patient safety team at NHS Improvement use incident reports submitted to NRLS to identify key themes and trends and take action at a national level to prevent similar incidents from occurring, often through Patient Safety Alerts via the Central Alerting System (CAS). https://www.cas.dh.gov.uk/Home.aspx These alerts are cascaded to general practice via your local NHS England sub-region.

Incident reporting is also important at a local level as it supports the whole practice team to learn about the root cause of an incident and what can done locally to keep patients safe from avoidable harm. It forms an important part of your safety surveillance system.

By reporting a patient safety incident to the NRLS you can gain **Continuing Professional Development** (CPD) credits. After you submit a patient safety incident report to the NRLS using the e-form you will be sent a CPD / Serious Event Analysis (SEA) template via bounce back email. You can use this template for team based learning and also personal learning for CPD, Appraisal and Revalidation.

The templates can also be used as evidence for Care Quality Commission (CQC) inspections.

How do I report a patient safety incident to the NRLS?

The NRLS have developed a GP e-form designed to make it quick and easy to report incidents to the NRLS.

https://report.nrls.nhs.uk/GP_eForm

This includes near misses and incidents where there is a beneficial outcome, for example where systems and processes have successfully prevented an untoward incident.

A desktop icon has been developed to make it quicker and easier to access the GP e-form. See http://www.england.nhs.uk/ourwork/patientsafety/general-practice/ for instructions.

If the incident that you are reporting relates to safeguarding, whistleblowing or other incident type where separate policies for notification exist, these must be followed in addition to completing the eform.

When reporting using the e-form, practices can choose to include their practice code. Including this data will enable the NRLS to share information with local NHS England sub regions and, if the practice opts to, their CCG.

However, a practice can also choose not to include their practice code and report to the NRLS entirely anonymously. NHS England will still analyse the information for themes and trends to generate national learning. The purpose of reporting is to learn from incidents to prevent similar events occurring, therefore, person identifiable information is not required (this includes both patients and staff). Some frequently asked questions and myths: [1]

Do I need to register in order to report patient safety incidents?	No, you do not need to register.
Is the ODS code the code for the GP practice?	Yes, it is for the practice, not individual GPs.
Can I view incident forms I have previously submitted?	Not currently. You are given the option of saving or printing the form for your own records after pressing the submit button.
What feedback do we get/ where can I view a report of all incidents I have reported?	Reports are used to provide national learning, which is fed back in different forms, for example national alerts, and quarterly data summaries. At present organisational level data is only reported on incidents reported via NHS trusts. These reports are published every six months.
The myth: **Only patient safety incidents of a clinical nature should be reported**	The reality: **All categories of patient safety incidents should be reported.** Learning from administrative processes such as documentation (including records / identification), access, administration, transfer and discharge is equally important.
The myth: **Only GPs can report to NRLS using the new general practice specific eform**	The reality: **GPs, practice nurses, practice managers and all practice staff are able to report to NRLS using this form.**
The myth: **Only incidents that have resulted in actual harm to a patient should be reported**	The reality: **All levels of harm including "no harm" events where harm has been prevented should be reported.** These are excellent sources of learning about the barriers and defences the practice has in place that have worked, or the actions taken to prevent an incident from causing harm to a patient.
The myth: **Reports will be used for performance review of individuals and to apportion blame**	The reality: **Anonymised aggregated data is used for analysis of trends and themes and all person identifiable information is removed, this includes the names of staff members.** When a patient safety incident occurs the crucial issue is not "who is to blame for the incident?" but "how and why did it occur". One of the most important questions to consider is "what is this telling us about the systems in which we work". The purpose of reporting is to learn from incidents to prevent similar incidents occurring, so person-identifiable information is not required (this includes both patients and staff), and certainly not to apportion blame to any individuals.
The myth: **High levels of reporting will make the practice "look bad"**	The reality: **High reporting is a sign of an open and fair safety culture.** An increase in reporting of patient safety incidents is a sign that an open and fair culture exists where staff learn from things that go wrong. Organisations with a culture of high reporting are more likely to have developed proactive reporting and learning to ensure the services they provide are safe.

[1] Adapted from http://www.cqc.org.uk/content/nigels-surgery-24-reporting-patient-safety-incidents-national-reporting-and-learning-system