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Incident (significant event) Management in Primary care

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Overview

- Introduction to incidents in Primary Care
- Internal incidents
- Externally reported incidents
- Third party incidents
- Serious Incident or not an Serious incident
- Tea break
- From P's to Tom Jones
- Writing up your findings

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Introduction

Complexity – NHSE / CCG / CQC / HSE (RIDDOR – Reporting of injuries, diseases and dangerous occurrences) /NRLS

Poster on Clinical Pathways

http://midnottspathways.nhs.uk/

http://www.rcgp.org.uk/clinical-and-research/toolkits/patient-safety.aspx

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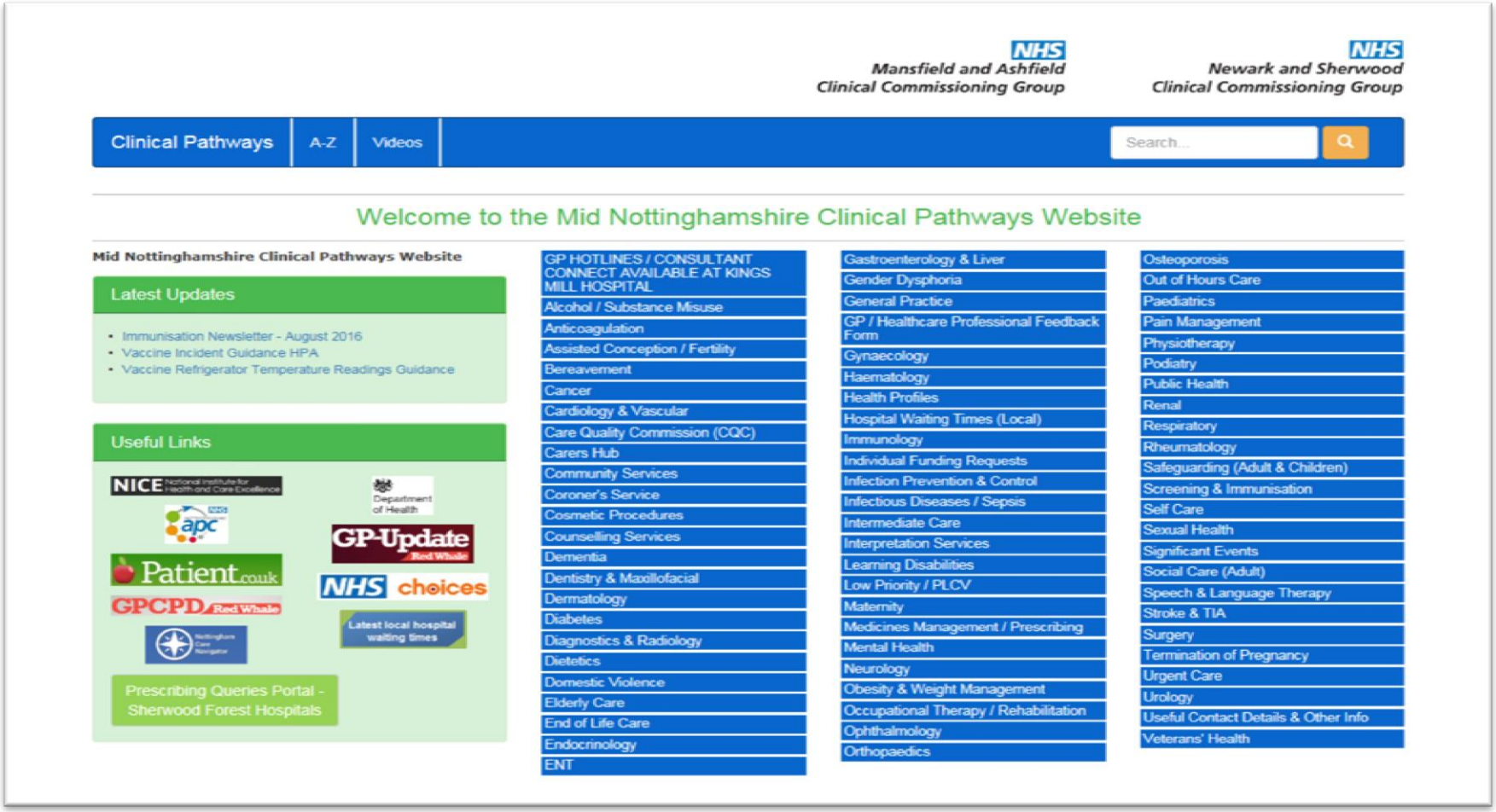

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Internal incidents – managed internally

Internal reporting system (policy)

SEA – full cycle (see mythbusters)

CQC ‘Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However; the practice did not undertake a detailed documented analysis of significant events to detect themes and trends and prevent recurrence.’

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Tips

- Analyse the good as well as concerns
- Analyse in a systematic way to ascertain what can be learnt and indicate changes for improvement
- Team based
- Revalidation – not just doctors!
- NRLS reporting

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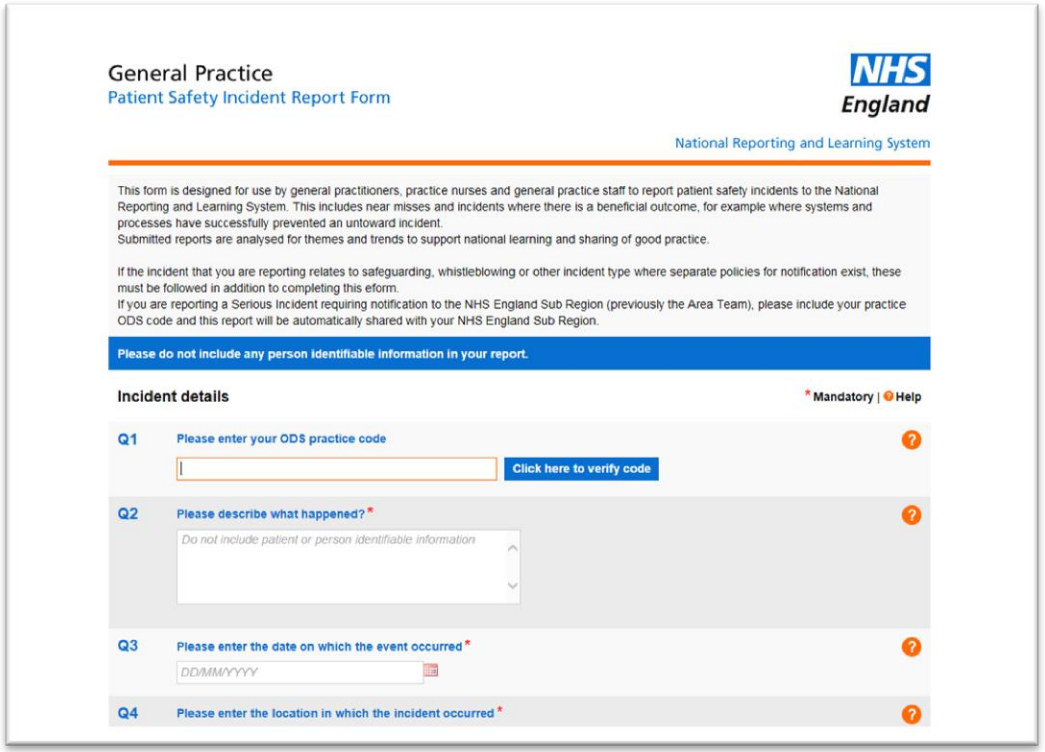
NRLS

National
Reporting
Learning
System

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



General Practice
Patient Safety Incident Report Form

NHS England
National Reporting and Learning System

This form is designed for use by general practitioners, practice nurses and general practice staff to report patient safety incidents to the National Reporting and Learning System. This includes near misses and incidents where there is a beneficial outcome, for example where systems and processes have successfully prevented an untoward incident.
Submitted reports are analysed for themes and trends to support national learning and sharing of good practice.

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 this eform.
If you are reporting a Serious Incident requiring notification to the NHS England Sub Region (previously the Area Team), please include your practice ODS code and this report will be automatically shared with your NHS England Sub Region.

Please do not include any person identifiable information in your report.

Incident details

* Mandatory | Help

Q1 Please enter your ODS practice code

Click here to verify code

Q2 Please describe what happened? *

Do not include patient or person identifiable information

Q3 Please enter the date on which the event occurred *

DD/MM/YYYY

Q4 Please enter the location in which the incident occurred *

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Externally reported Incidents

CQC – Notifications
Medications / CD's
Information Governance
Professional Registration
HSE
Infection Control
Notifiable Diseases
Screening /Immunisation

Serious Incidents

SI Framework
Never Event Framework
SI Notification form
Investigation

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Third Part Incidents

Concerns about other providers? – acute / community / care homes

Provider to provider UNLESS an SI then tell us as well.

Burden of investigation

Patient experience teams

	SFHFT Contacts
SFHFT Patient Safety Incident or Concern	elaine.smith62@nhs.net Tel. 01623 622515 ext. 6305
SFHFT Prescribing or Medication query (Prescribing Queries Portal http://nww.nottstpct.nhs.uk/formulary/queryportal.htm)	sfh-tr.prescribingqueries@nhs.net
SFHFT Appointment or Pathway query	Central.SupportTeam@sfh-tr.nhs.uk
SFHFT Patient Experience Team	pet@sfh-tr.nhs.uk KMH: Tel. 01623 672222 Newark: Tel. 01636 685692

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Supporting others in investigations

- When there is a Serious Incident it is important that the investigator has access to all relevant information
- Information Sharing agreements in place with other providers
- Sharing information is necessary where there is a serious incident

(Serious Incident Framework 2015/ Never Event Framework)

Disclosure Exemptions under the Data Protection Act & Confidentiality: NHS Code of Practice

In certain circumstances personal information may be disclosed, however it is vital that staff make an assessment of the need to disclose the information and document that the information has been released to whom for what reason. Further guidance is available from the Information Governance Team and the Confidentiality: NHS Code of Practice.

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The Serious Incident Framework

'Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified'.

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Reporting Serious Incidents

- Reported on STEIS (Strategic Executive Information System)
- CCG reports on your behalf
- You must report within 48hours of identifying an incident

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A Word about Never Events

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SI or Not SI

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Question 1

Alex is 48 he has had a tough year with a recent divorce and loss of his job.

Three months ago he went to see his GP because he felt things were getting on top of him and he was feeling desperate. The GP begins to treat Alex with some medication asking Alex to return in a couple of weeks so he can review how he is getting on. Alex makes an appointment to come back but he does not attend, the practice does not make contact with Alex.

Three days later the practice is informed by the police that Alex had been found dead as a result of suicide.

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YES

This is a serious incident because Alex's death was unexpected. Alex was in receipt of care from his GP for mental health issues. Therefore the practice must review the death to see if there was anything that could have been done differently.

- Had the GP asked Alex if he was thinking of harming himself?
- Were there missed opportunities to refer Alex into support services?
- Should the practice have followed Alex up more proactively?

In cases like this the practice is also likely to be asked for information by the coroner.

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Question 2

Primary Care Support England (PCSE) sends a batch of 25 patient records to your practice. The records include electronic copies of letters and communications about treatment the patients have received.

Practice staff realise that the records sent to them do not relate to any of the practices patients

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YES

The first step with any IG incident is to use the IG toolkit to support you in deciding if the incident needs to be reported externally. This incident is a SI but not for your practice, you may still be the ones to raise it firstly with PCSE, then the CCG but also the ICO.

This actually happened last year when some work was outsourced to a private company.

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Question 3

As part of the retinopathy screening programme diabetic patients attend high street optometrists for initial testing. Two patients from your practice attends a routine screening appointment and it is found that a further follow up in secondary care is required. The optometrist writes to the GP practice asking for an onward referral into secondary care. The practice files the letters away without arranging the appointments.

The incident comes to light when the ophthalmologist is contacted by a patient saying they had not heard anything from the hospital.

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YES

This is a serious incident.

Although a small number of patients was affected it was part of a national screening programme. The SI framework requires incidents relating to national programmes like this to be reported as SI's

This incident actually happened locally and was investigated by the CCG and NHS England

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Question 4

Mabel is 86 years old and she comes in to the surgery to get her annual flu vaccination.

When her name is called she gets up from her chair and begins to walk to the nurses room. As she does so she begins to feel dizzy and falls onto the floor.

Surgery staff give Mabel some help and Mabel is eventually able to get up, she has a small bruise on her leg but no other injury

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No

- This is not an SI because Mabel did not suffer any harm as a result of the incident. It would have been different if Mabel had sustained a serious injury such as a broken hip of significant head injury. Then it would have been an SI
- **The practice would still need to ensure this is reported as an internal incident and make sure that an review is undertaken to ensure there were no factors that might have contributed to her falling such as a trip hazard**

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Question 5

- John is 56 years old and has numerous health problems which have resulted in him needing to use a wheelchair all the time. He is married and he and his wife manage at home although sometimes it is a bit of a struggle for John to get in and out of his chair. As a result he tends to spend most of his time sat in his wheelchair.
- John does not like to complain but does attend the surgery regularly for check ups for his high blood pressure and asthma. One day John becomes unwell and is admitted to hospital, he is found to have a deep pressure ulcer to his bottom

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YES but it's a grey area

- Grade 3 and 4 pressure ulcers are considered to be significant harms to patients.
- They all must be reviewed by the organisation responsible for the patients care at the time they acquired the pressure ulcer. In this case this is the GP practice
- The practice would be asked to consider if there was more that could have been done to help prevent the pressure ulcer from developing in the first place

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Question 6

Alice is 84 years old and lives in a residential home . She has dementia and is incontinent of urine. From time to time she becomes aggressive this is often associated with a urine infection.

Over the past 6 weeks Alice has been treated 4 times by her GP for a suspected urine infection, she has been given 4 courses of antibiotics.

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Two days after starting her fourth course she begins to suffer from severe diarrhoea and abdominal pain. She becomes dehydrated and is admitted to the local hospital as an emergency. A sample is taken in ED and C.difficile is identified and treatment started, unfortunately Alice is so unwell that she passes away, the cause of death is recorded as C.difficile

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YES

- If a death is caused by C.difficile then it is automatically a SI and is reportable on STEIS and to the Health Protection Agency. (14 day time frame)
- The same is true for any case of MRSA blood stream infection
- The good news is the investigation is led by either the CCG (infection control team) or sometimes by secondary care.
- The practice MUST support the investigation and agree to implement any actions that are agreed at the end of the investigation.

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Question 7

- Jane has several moles, one mole is causing her discomfort and is bleeding.
- The GP runs a minor ops service and agrees to remove Jane's troublesome mole
- The GP removes the wrong mole during the procedure and Jane makes a complaint

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YES

- This is actually a NEVER EVENT
- Wrong Site Surgery
- It is reportable as an SI but will be recorded as a NEVER EVENT

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Examples in Primary Care

Unexpected death possibly related to a patient safety incident
Suspected suicide
Grade 3 and above pressure ulcer
Safeguarding incident
Allegation of abuse (victim or perpetrator) where it could have been avoided or happened during provision of NHSE care e.g.. restraint
Delayed diagnosis/treatment or failure to diagnose/treat
Medication errors /Controlled drugs
Medical device incident
Cold chain incidents
Vaccination/immunisation/screening incidents
Confidentiality breaches
Business continuity
Information governance – e.g.. 'Stolen' PID

'the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response '

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- Where to Start!!!
- First thing to remember is we are here to help
- CCG reports on STEIS on your behalf
- Take a systematic approach
- Use the tools and templates

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Steps to take

1. Report the incident internally
2. Scope the incident – what do you think happened and could it be an SI? (write a summary SI1 form)
3. Make sure any immediate actions to preserve safety are taken
4. Contact the CCG Quality Team
5. Get your Folder started
6. Hypotheses think of all the ways this might have happened and write them down
7. Begin tabular timeline
8. The five P's
9. Analysis
10. Write up findings

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Organisation

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The incident

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The 5 P's

- Plan
- People
- Paper
- Parts
- Place

- Simple chronology
- Timeframe for investigation
- Who and what?
- Electronic and paper records and documents, policies, SOP's
- Any equipment?
- Where did it happen? Take a look, take pictures if helpful

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Event Number	Date	Time	Description of event	Who was involved	Details	Any missing information?	Things that have gone to plan	Care Delivery Problems (Things that haven't gone to plan)
1.	2.9.16	17.30	Fridge data logger checked	Nurse GB	Data logger shows temp was 5.5^0 Statement GB ' I checked the data logger at the end of my clinic'	No	Checked within policy	
2.		19.30	Clinic room cleaned	Cleaner JF	Cleaning schedules showed floor in treatment room A was vacuumed. Statement JF 'I removed a plug so I could use the socket for the vacuum cleaner. I cannot remember putting the plug back in' Cleaning company email 'we have no record that the cleaner was trained or orientated to this site'	~~Training records / staff orientation~~		**Cleaner did not know she had unplugged the fridge**
3.	5.9.16	08.00	Flu clinic commenced	Nurse AR	Statement AR ' The waiting room was packed. I quickly started vaccinating patients to clear the back log. When nurse GB came in she pointed out that the fridge light was not on and the fridge was unplugged…….			

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WHY

WHY

WHY

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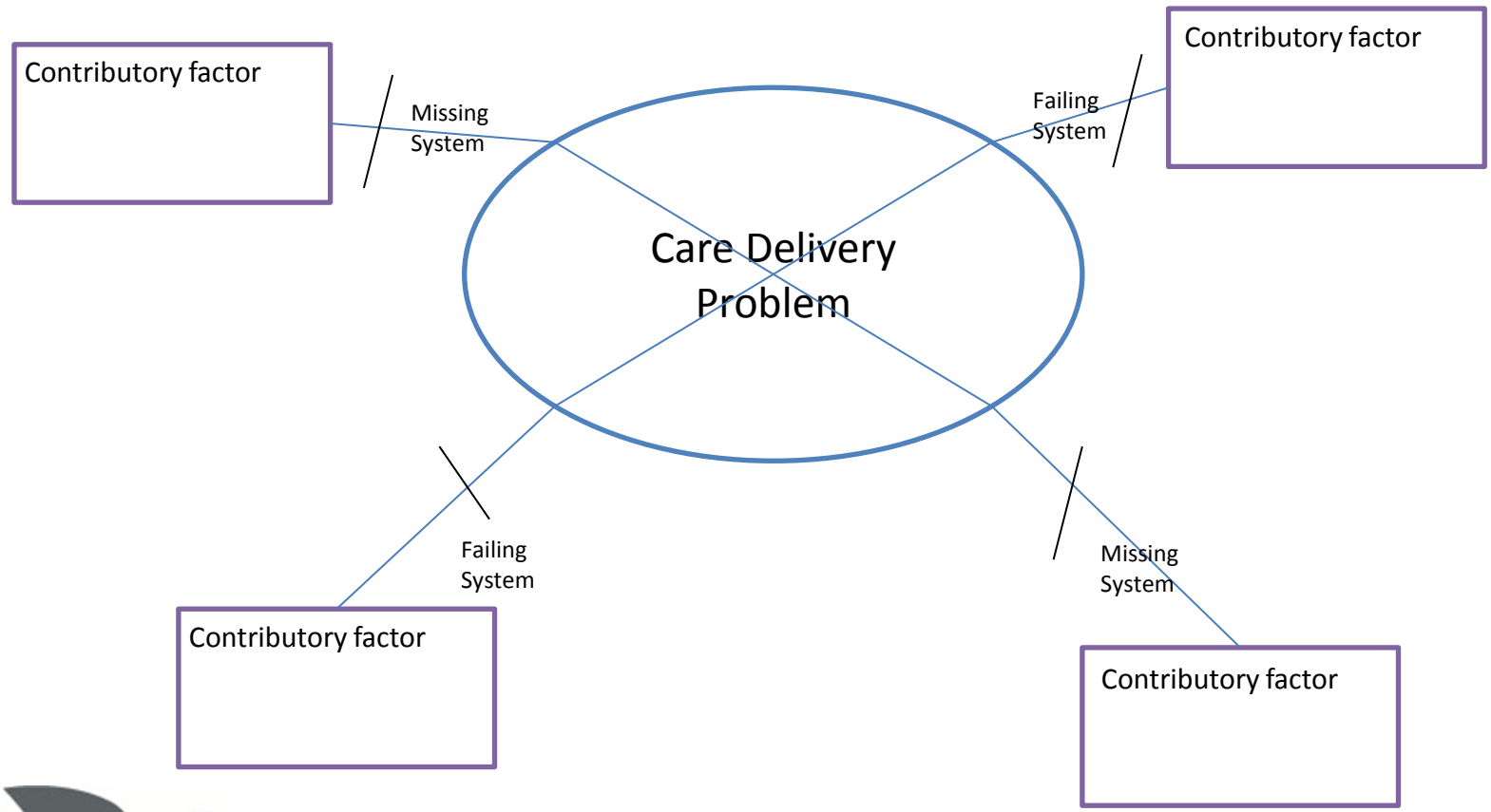

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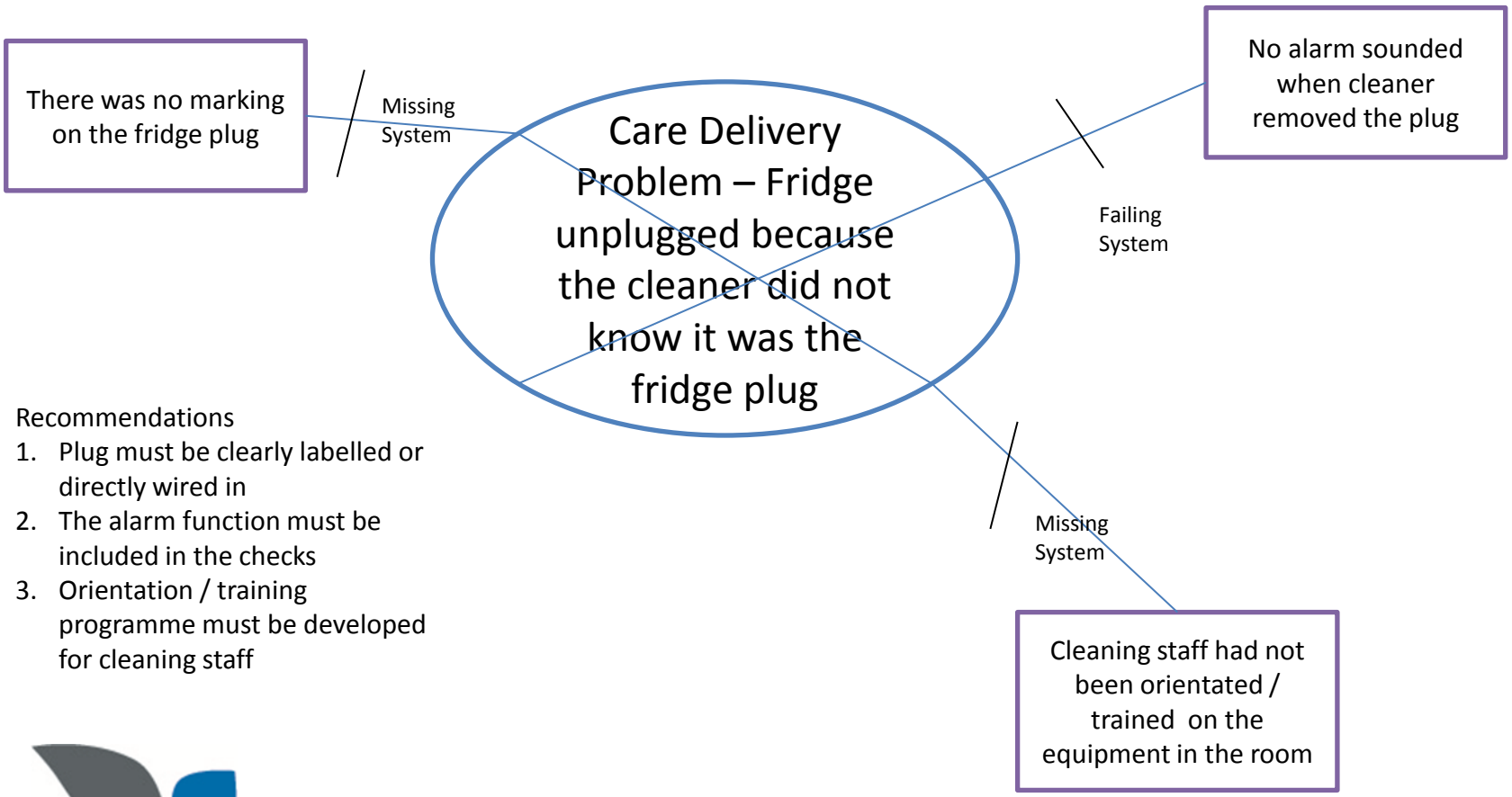

Recommendations

1. Plug must be clearly labelled or directly wired in
2. The alarm function must be included in the checks
3. Orientation / training programme must be developed for cleaning staff

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Presenting Your Findings

RCA report

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Action plan

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What happens next:

- Submit to CCG
- Review Panel
- Closure on STEIS
- Share learning

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