NHS
Surrey Heartlands

MEDICINES MANAGEMENT GUIDE TO PRESCRIBING

Section 9 – General Practice Patient Safety Event Reporting

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9 GENERAL PRACTICE PATIENT SAFETY EVENT REPORTING

9.1 GMC GUIDANCE

Reporting adverse drug reactions medical device incidents and other patient safety incidents - GMC (gmc-uk.org) states that doctors should

- Check that all serious patient safety events are reported to the relevant national body, especially if such patient safety events are not automatically reported through clinical governance arrangements where you work.

- Where appropriate, also report relevant adverse drug reactions and patient safety events to the patient's general practitioner, the pharmacy that supplied the medicine, the local controlled drugs accountable officer and the medicine manufacturer.

9.2 RATIONALE FOR PATIENT SAFETY EVENT REPORTING

Recording patient safety events, both positive and negative, indicates a positive safety culture. Positive safety cultures encourage staff to be open and honest when things go wrong. Recording patient safety events can proactively improve safety.

By improving reporting GPs can build the foundations for driving improvement in the safety of care received by patients.

Reports of harm or near misses to the LFPSE service provide NHSE/I with important insight of patient safety events from across the country. This enables risks to be identified and appropriate action to be taken to prevent patient safety events – such as the cascading of patient safety alerts, developing learning resources and holding workshops for NHS staff. The information gained will therefore be used to build a safer NHS and protect patients from avoidable harm.

Learning from one patient safety event can be shared and may benefit lots of other patients locally too - once a report has been made it will be reviewed by the Surrey Heartlands Medicines Safety Team, in conjunction with the practice team involved, and then learning, when appropriate, disseminated to the rest of Primary Care in Surrey in an anonymised way.

9.3 WHAT SHOULD BE REPORTED?

All patient safety events (clinical and non-clinical) should be reported where a patient was harmed or could have been harmed. This includes near misses and patient safety events where positive action prevented an incident from occurring.

Some examples of patient safety events that should be reported include:

- Patients without necessary safety monitoring e.g., INRs on warfarin
- Incorrect repeat medicine lists e.g., not updated following a hospital admission
- Prescribed medicines that are incompatible with a documented allergy status
- Wrong drug chosen from drop down list and prescription produced
- Incorrect administration of a medicines e.g. vaccines
- Dispensing error that patient highlights to GP

9.4 REPORTING A PATIENT SAFETY EVENT TO THE LFPSE SERVICE

General practice staff can quickly and easily report patient safety events to the NHS England » Learn from patient safety events (LFPSE) service - the national patient safety event database.

The LFPSE e-form was developed in consultation with general practice staff and can be completed in a matter of minutes, with many questions requiring quick and simple answers.

Primary care information can be found on the dedicated primary care LFPSE webpage.

- It is recommended that individuals register with LFPSE to allow local sharing and learning from patient safety events
- Practice staff can use the form to report anything from administration errors to patient safety events relating to sepsis.
- Patient identifiable information is not required AND SHOULD NOT BE INCLUDED
- Reporting patient safety events via LFPSE can gain CPD credits.
- Practices can print or save a summary of the information provided. This can be used for appraisal and revalidation.
- This can also provide evidence of patient safety activity during CQC inspections.

Information about the form:

- The form can be accessed via the online recording service. It is recommended that the 'form icon' is downloaded to desktops (a simple drag and drop process) for quick access to the new GP form.

9.5 REVALIDATION & CONTINUING PROFESSIONAL DEVELOPMENT (CPD) CREDITS FOR GPS

For the purposes of appraisal and revalidation a 'significant event' is any unintended or unexpected event, which could or did lead to harm of one or more patients. They are also known as critical incidents/events or patient safety incidents/events.

Learning from events should be considered a normal part of review of practice and examples included in quality improvement activities.

A downloaded pdf of any patient safety event submitted can be kept as evidence.

The GMC says:

- You must declare and reflect on every significant event you were involved in since your last appraisal (this can be via the LFPSE form as well as significant event analysis (SEA) forms)
- Your discussion at appraisal should focus on those significant events that led to a change in your practice or demonstrate your insight and learning
- Your reflection and discussion should focus on the insight and learning from the event, rather than the facts or the number you have recorded

CPD credits

Learning arising from significant events is eligible for CPD credits. This can also provide evidence of patient safety activity during CQC inspections.