Improving the Reporting, Learning & Sharing of Patient Safety Incidents in Primary Care

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Background

Ensuring the safe care of patients is a primary goal for health care systems and practitioners.

Safety-related incidents in primary care are usually reported and analysed as 'Significant Events.' All surgeries take part in the process of Significant Event Audit (SEA), however, I had anecdotally observed that:

- the frequency of reporting and quality of learning from SEA was variable between surgeries; and
- sharing learning outside the surgery was rare.

The aim of this project was to understand and improve the practice of reporting, sharing and learning from patient safety incidents in primary care.
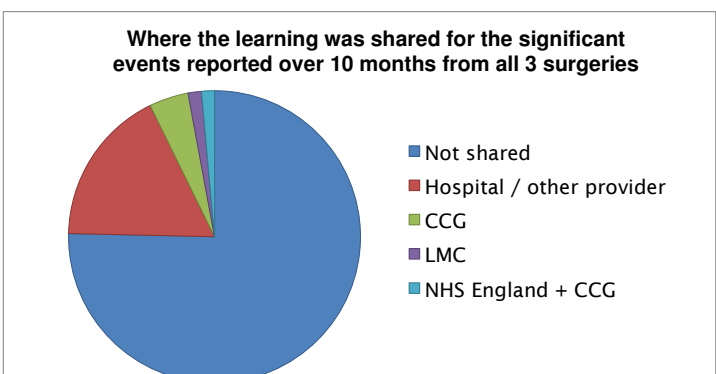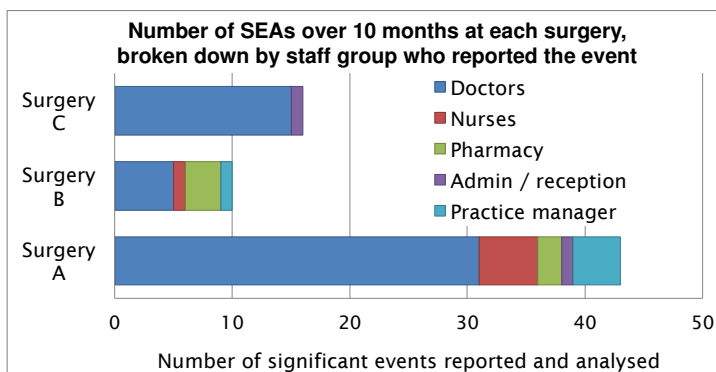
Method

3 GP surgeries within Wessex participated in this project.

Surgery A 16,000 patients Training practice	**Surgery B** 18,000 patients Non-training practice	**Surgery C** 9,000 patients Training practice

Baseline data gathered retrospectively
The number and nature of SEAs over 10 months in 2014.
The staff groups involved in reporting those SEAs.
Where, if at all, the learning had been shared.

Baseline data

Number of SEAs over 10 months at each surgery, broken down by staff group who reported the event

Legend: Doctors, Nurses, Pharmacy, Admin / reception, Practice manager

Number of significant events reported and analysed

Where the learning was shared for the significant events reported over 10 months from all 3 surgeries

Legend: Not shared, Hospital / other provider, CCG, LMC, NHS England + CCG

Changes made

A variety of changes were introduced at each surgery to improve reporting and learning from incidents.

Surgery A	· NHS England GP e-form for reporting incidents · Improved documentation of SEAs
Surgery B	· NHS England GP e-form for reporting incidents · New SEA reporting policy · Patient safety guidance on intranet · New designated patient safety lead
Surgery C	· NHS England GP e-form for reporting incidents · New designated administrative support · Improved documentation of SEAs

Outcomes

Documentation of significant events has improved and some doctors at each surgery are now using the NHS England GP e-form. Use of this tool contributes to the national database of patient safety incidents.

There has been some resistance to using the e-form, which included:

- difficulty accessing e-form at time of need;
- on initial use, e-form is more challenging to use and takes longer to complete than current paper-based system;
- fear of punitive consequences from outside agencies; and
- lack of belief that contribution to national database will result in significant improvements to patient care.

MDT involvement in the SEA process remains a challenge.

Involvement in this project has increased awareness of patient safety issues and has encouraged discussion about safety in all participating surgeries.

Conclusions

For successful sharing of incidents and learning from primary care services there needs to be:

- a system that is **easy and quick** to use;
- a mechanism for **collating and disseminating** shared learning at both local and national level, with assurances of **support and resources** to help create systematic changes;
- culture change within the NHS to **remove fear of blame**, increase trust and **collaborative working** between different NHS agencies, and to create **dedicated time** for responding to, and learning from patient safety concerns;
- **MDT engagement** – from reporting to analysis – to facilitate systematic learning and change; and
- strong **local leadership** to provide support and guidance.

Open the conversation about safety in your practice today.

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