Guide for general practice staff on reporting patient safety incidents to the National Reporting and Learning System

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Contents

1   Introduction

This guide has been produced for staff working in general practice as an introduction to the National Reporting and Learning System (NRLS), the NHS' national database of patient safety incidents. It also introduces a new e-form developed by the NHS England Patient Safety Domain specifically to make it quick and easy for general practice staff to report a patient safety incident.

2   Why should I report patient safety incidents?

Reporting incidents to a national central system helps protect patients from avoidable harm by increasing opportunities for the NHS to learn when things go wrong. The NHS England Patient Safety Domain uses patient safety incident reports submitted to the NRLS to identify key themes and trends and take action at a national level to prevent similar incidents from occurring, often via Patient Safety Alerts. These alerts are a crucial part of the NHS' work to rapidly alert the healthcare system to risks and to provide guidance on preventing potential incidents that may lead to avoidable harm or death. Patient Safety Alerts are cascaded to general practice via their local NHS England sub region.

Incident reporting is also important at a local level as it supports commissioners, clinicians and the whole practice team to learn about the root cause of an incident and what can be done locally to keep patients safe from avoidable harm.

3   Why has the general practice e-form been created?

The NRLS was launched in 2003 as a national database for patient safety incident reports and now receives over 1.5 million reports each year. As these reports are almost entirely from secondary care, support and resources generated from the learning is not always directly applicable to general practice.

The level of reporting of patient safety incidents from general practice is low in comparison to acute/secondary care. Based on feedback from colleagues within general practice we have developed a new e-form, specifically designed to make it

quick and easy for general practice staff to submit patient safety incident reports to the NRLS.

These reports will help build an accurate picture of patient safety in general practice to enable us to work together to actively develop ways to address underlying causes of harm that may currently be unrecognised within general practice. Fully utilising the NRLS as a safety reporting tool for all patient safety incidents will ultimately lead to better learning about patient safety, the sharing of best practice solutions and the innovation of new and improved ways to keep our patients safe from avoidable harm.

Reporting to the NRLS using the GP e-form can also support local learning as it provides the option to share your report with your local Clinical Commissioning Group.

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

We have developed a new GP e-form specifically designed to make it quick and easy for those working in general practice to submit a report to the NRLS.

The e-form can be accessed via https://report.nrls.nhs.uk/GP_eForm . However, we recommend that you download the 'e-form icon' to your desktop (a simple drag and drop process, see Appendix 1). This will allow you to access the e-form via a single click.

Using the e-form it can take as little as a few minutes to submit a patient safety incident report to the NRLS. Many of the questions are quick completion questions, such as the location where the incident occurred and the patient's age and gender.

See screenshot of the e-form below:

General Practice
Patient Safety Incident Report Form

NHS England

National Reporting and Learning System

Q1 Please enter your ODS practice code ❓

ODS Code   **Click here to verify code**

☐ Share with CCG

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* ❓

⦿ Within the GP Practice   ◯ Outside the GP Practice

Please Select ▾

Q5 Please categorise the Patient Safety Incident from the following choices* ❓

Please Select ▾

Q6 Was this incident a never event? ❓

◯ Yes   ◯ No   ◯ Unsure

Q7 Was the incident shared or discussed with the patient, carer and/or family? ❓

◯ Yes   ◯ No   ◯ Unknown

Q8 Using the following grading, please indicate the degree of harm to the patient* ❓

◯ No Harm   ◯ Low Harm   ◯ Moderate Harm   ◯ Severe Harm   ◯ Death

Q9 Please use only one of the following options to add the age of the patient to the incident* ❓

⦿ Date of birth   Day ▾ Month ▾ Year ▾

or ◯ Age   Year ▾ Please Select ▾

or ◯ Unknown

Q10 What is the sex of the patient?* ❓

◯ Male   ◯ Female   ◯ Indeterminate   ◯ Not stated / unknown

Q11 Please select the staff group that you belong to* ❓

⦿ GP and Medical staff group   ◯ Other staff group

Please Select ▾

Q12 Insert your email address to receive email confirmation and an SEA template for CPD, Appraisal and Revalidation ❓

Email Address

5   Can I report anonymously?

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).

6   What should I be reporting?

All patient safety incidents (clinical and non-clinical) should be reported where a patient was harmed or could have potentially been harmed. This includes near misses and incidents where there is a beneficial outcome, for example, where appropriate barriers and defences prevented an incident from occurring. Reporting these incidents identifies what has worked in practice and are excellent sources of learning. It is important to share these locally and nationally to help develop and spread best practice.

The vast majority of the 1.5 million incidents reported to the NRLS each year result in no harm, with the most recent data showing that 69.1% of incidents resulted in no harm (September 2014).

Examples of patient safety incidents with corresponding levels of harm*

Category of harm	Definition	Examples
No harm (impact prevented)	Any unexpected or unintended incident which was noticed and halted or reversed before it was able to cause harm to a patient.	• A GP prescribes an inappropriate dose of a drug, which the local community pharmacist picks up when dispensing the prescription.
No harm (impact not prevented)	Any unexpected or unintended incident which did not lead to harm on this occasion.	• A patient is on medication that requires blood pressure monitoring. The hospital

		discharge letter does not mention this to the GP, which results in the patient not being followed up appropriately. However, it is noted when the patient visits the GP for a further prescription. The patient's observations are then found to be normal.
Low	Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons.	• A patient's home visit is missed. The terminally ill patient required a pain assessment. This was picked up the following day, resulting in the patient continuing to be in pain until the medication was altered. • A patient trips and falls in the practice, resulting in a graze which requires a dressing.
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.	• Continuing treatment with warfarin without monitoring clotting levels for a length of time which results in an overdose and bleeding problems that require close monitoring and follow-up. • Patient with external infusion line (e.g. Hickman line) gets an infection while at home following repeated disconnections, requiring a hospital admission for antibiotic therapy.
Severe	Any unexpected or unintended incident that caused permanent or long term harm to one or more persons.	• The parents of a four year old child contact the GP out of hours service with a history of recurrence of a high temperature following the onset of a presumed middle ear infection five days ago. The child is four days into a course of oral antibiotics. There is no face-to-face consultation and it is suggested that the child contact their own GP in the

morning. On arrival at the surgery the following morning the child is pale and subdued, has a raised respiratory rate, prolonged capillary refill time and tachycardia. The GP arranges immediate admission to hospital by ambulance where the child is diagnosed with sepsis and requires two days of high dependency unit care before being transferred to the ward. After a further four days as an in-patient the child is discharged home with some permanent effects on hearing.

- A patient, who is a heavy smoker, visits the GP with a cough. The patient's name is Mr Jones. He has a chest X-ray and the report suggests a suspicious lesion with the advice to refer for further investigations. The GP writes on the report that an urgent appointment is needed and the receptionist files the report in Mr Jones's file. Mr Jones rings the surgery for his results and the receptionist looks in his file and says that no report has been received yet and that the practice will ring him if there is any news in the next week. Mr Jones does not hear so assumes everything is OK. Two months later Mr Jones visits the GP on a routine appointment and Mr Jones's urgent request is found. Mr Jones is referred and it is found that he has lung cancer.

- Continuing treatment with warfarin without monitoring clotting levels for a length of time which results in a brain haemorrhage and brain damage.

Death	Any unexpected or unintended incident which caused the death of one or more persons. The death must relate to the incident rather than to the natural course of the patient's illness or underlying condition.	• A patient suffering from chest pain is asked to wait for a free slot in the GP surgery. As he feels difficulty in getting his breath, he goes for a walk, collapses and dies in the GP surgery's car park. • A practice receives a telephone call from a mother with a small child who seems unwell. The details are taken and a non-urgent note is left for the GP to give the mother a call at the end of surgery. When the GP rings, the child is now quite ill with suggested meningitis symptoms. The GP immediately visits the child and gives antibiotics and arranges an emergency admission. However, the child collapses on route and is pronounced dead on arrival to hospital.

*Examples of incidents from *Seven steps to patient safety for primary care*.

7   Gain Continuing Professional Development (CPD) credits by reporting to the NRLS

By reporting a patient safety incident to the NRLS you can gain 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 CQC inspections.

8   What happens after I submit a report?

After a patient safety incident report has been submitted to the NRLS it is entered into a national database which is analysed by national patient safety experts to spot trends, specific incidents of concern, or emerging risks to patient safety.

When a trigger incident or group of incidents of particular concern is identified, action is then taken to help address the identified issues/risks through the provision of advice and guidance which is disseminated as appropriate across the NHS, e.g. through a Patient Safety Alert. This provides the opportunity to ensure that the learning gained from the experience of a patient safety incident reported in one part of the country can be used countrywide to reduce the risk of something similar occurring.

Although you may not receive any formal feedback on an individual incident you report, you can be assured that by feeding into a national system you are making a difference to the bigger picture of patient safety.

9   If my practice begins reporting a number of incidents, will that be used to show us as being unsafe?

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. Practices with a culture of high reporting are more likely to have developed proactive reporting and learning to ensure the services they provide are safe.

Therefore, an increasing trend of reporting is actually a good thing, and that's why for acute trusts both the NHS Outcomes Framework look to see an increase in incidents reported to the NRLS and the CQC uses low reporting rates of incidents as a concern in their Intelligent Monitoring System. Year-on-year the number of incidents reported to the NRLS continues to increase and we are hoping to see the same trend across general practice.

Experience in other industries, such as the airline industry, has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening patient safety, but rather as an increasing level of awareness of safety issues and a more open and transparent culture. This will positively enhance learning and show you are taking pro-active steps to keep your patients safe.

10 Do you publish data on incidents reported to the NRLS?

At present we only publish data on incidents reported to the NRLS by NHS trusts. These reports are published every six months as part of our commitment to be open and transparent.

As the number of incidents reported to the NRLS by general practice is currently low, we presently have no obligation to publish data around incidents that occur in general practice. If this situation does change we will inform you through NHS England's communication channels.

11 Sign up to Safety

General practices are also encouraged to Sign up to Safety. The Sign up to Safety campaign is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement.

For further information about how you can get involved and access a range of resources to help you keep your patients safe, visit: www.signuptosafety.nhs.uk

12 Further information

Further information about patient safety in general practice can be found on our web page http://www.england.nhs.uk/ourwork/patientsafety/general-practice/

If you have any specific questions or queries please email:

NHS England Patient Safety Domain: patientsafety.enquiries@nhs.net

Appendix 1 - Instructions for saving the GP reporting e-form icon to desktop for quick access

Please note: some earlier versions of web browsers do not allow you to save icons to your desktop in the way instructed below. If you are having problems we recommend bookmarking the page or saving it to your favourites so you can still quickly access the e-form.

Step 1 – close any open documents so that desktop is visible and open the e-form by following the link: https://report.nrls.nhs.uk/GP_eForm .

Step 2 – minimise the web page.
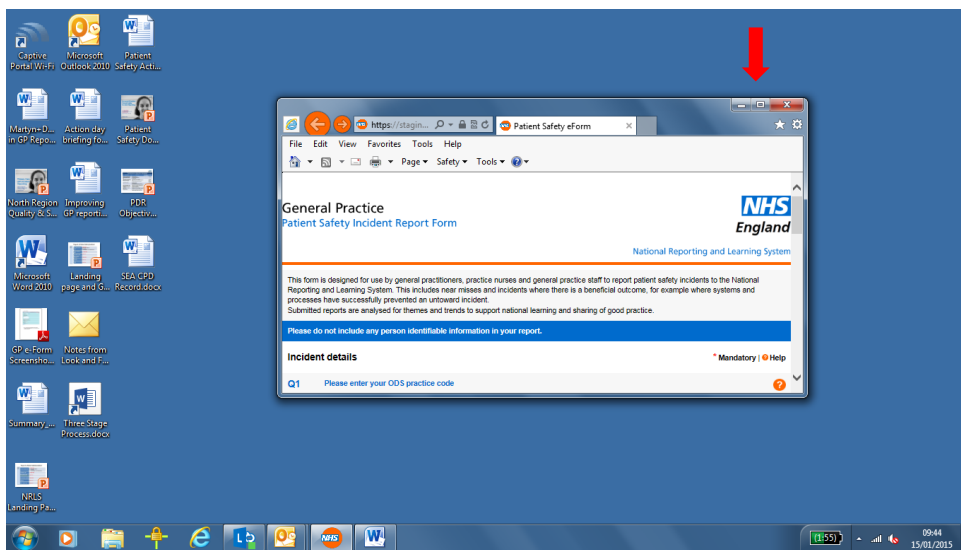
Step 3 – click on the icon 🔶 in the address bar and drag this to the desktop.
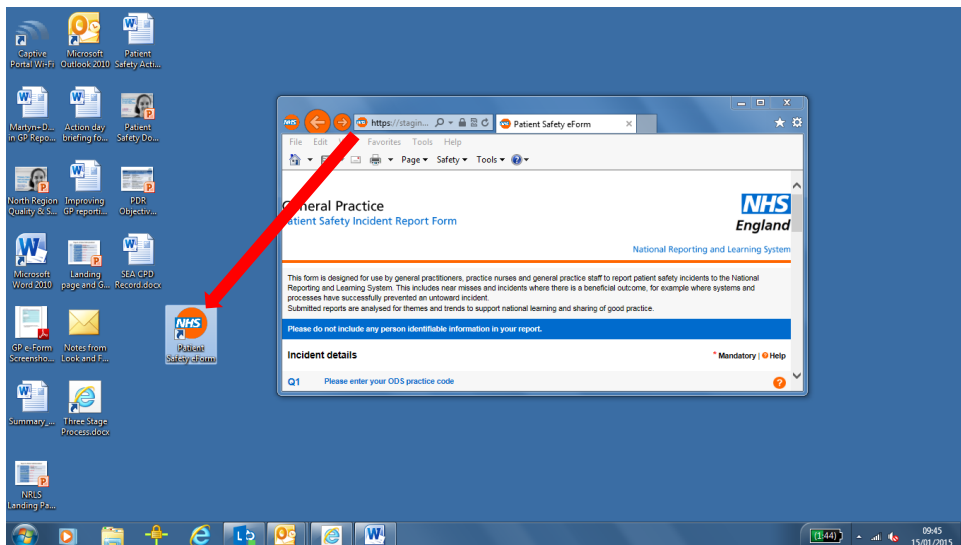
Step 4 – the icon will now appear on your desktop and can be clicked on to directly access the e-form.