Learning from incidences in Primary Care
October 2018

Information Governance

a)

A patient and her daughter's records had been accessed by the clerical staff member.
The staff member knew she shouldn't be looking at the patients records without any work related reason.

Learning points:

1) Unsure how this could have prevented as the staff member concerned had received all the appropriate training and was aware that they should not be looking at the patient record without a work related reason to do so. Full clinical access to all patients' records was necessary to be able to fulfil her job role;
2) This incident is to be used by the practice as an anonymised example in induction training to ensure all staff are aware of the impact on both the patient, staff member and surgery if they do not adhere to the confidentiality policy of the surgery;
3) Member of staff has been dismissed due to gross misconduct.

b)

A new patient was register but the incorrect patient was selected where the first name, surname and date of birth matched but the middle name did not. All consultations, clinical correspondence and medication requests following registration were therefore entered on the records of the wrong patient.

Learning points:

1) This was very difficult and time consuming to correct and put right;
2) This event stresses the importance of everyone thoroughly checking patient details;
3) Reception staff really must check, and re-check thoroughly all patient details including forename, surname, middle name and date of birth, before entering/finalising patient data;
4) If the middle name had been checked this situation would not have occurred;
5) GPs must not assign patients to the spine; very important that this is left to reception staff to do (the GPs are likely to get it wrong).

c)

The Practice has two patients registered, with the same name who live in the same road. HM Courts & Tribunal Service requested copy notes of a patient records but the wrong notes were sent.

Learning points:

1) Reminder sent to all staff to ensure date of birth always checked;
2) Patient alerts on both patients added to show same road and same name, advising caution and additional checking.

Cold chain - Duty of Candour

There was a cold chain incidence with child vaccines.

Learning points:

1) Reinforcing messages of checking fridge temperatures twice daily, not relying solely on temperature recorders;
2) Ensuring staff are up to date with the appropriate policy;
3) Acknowledging that manufacturers' recommendations may differ from the PHE national immunisation team.

Patients who received the off-label vaccination after the vaccine was quarantined were made aware of this as part of their informed consent process at the time of the immunisation. However, those patients who had been vaccinated

with the off-label vaccine before it was quarantined have not been made aware of this. Due to this inconsistency, it has been recommended that the practice write to these patients under Duty of Candour.

NHS England South West Primary Care Significant Events data (SEA)

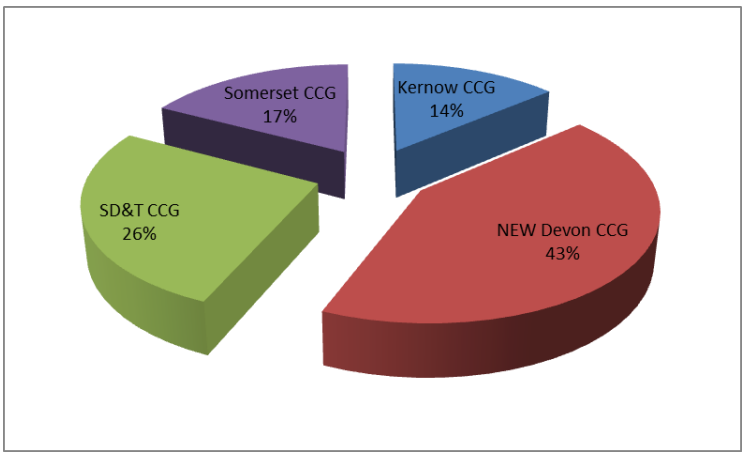
Significant Events involve a lower level of safety concern than a 'serious incident'. They are events where the practitioner can identify an opportunity for making improvements, either because the outcome was substandard or because there was a potential for an adverse outcome ('near miss').

The recording of Significant Events is a valuable means of sharing learning and capturing themes and trends within Primary Care. A Significant Event Audit (SEA) is a technique to reflect on and learn from individual cases to improve quality of care overall. SEA's should form part of individual and practice based learning, and quality improvement. Whether clinical, administrative or organisational, the SEA process should enable a practice to answer the following questions:

1) What happened and why?
2) How could things have been different?
3) What can we learn from what happened?
4) What needs to change?
5) What was the impact on those involved (patient, carer, family, GP, practice)?

Below is a summary of the 'significant events' that have been reported in Kernow, NEW Devon, SD&T and Somerset CCGs 2018/19 Q1 and Q2. Dorset CCG is delegated therefore this information is with the CCG and not NHSE, hence why they are not included in the attached data.

SEAs per CCG (incident date for Q1 & Q2)							
CCG	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Total
Kernow CCG	3	4	0	1	4	0	12
NEW Devon CCG	7	4	8	7	7	4	37
SD&T CCG	6	9	3	2	3	0	23
Somerset CCG	0	5	3	3	3	1	15
Total	16	22	14	13	17	5	87



SEA - Care Sector per CCG (incident date for Q1 & Q2)								
CCG	Acute Hospital	Community Hospital	Community Services	Dentist	General Practice	Mental Health Provider	Pharmacy	Total
Kernow CCG	0	2	1	1	7	1	0	12
NEW Devon CCG	4	0	0	0	31	1	1	37
SD&T CCG	0	6	1	1	14	0	1	23
Somerset CCG	0	0	0	0	15	0	0	15
Total	4	8	2	2	67	2	2	87

SEAs - level of incident per CCG (incident date for Q1 & Q2)				
CCG	SE - Not Serious Harm	SI - Serious Harm	Never Event	Total
Kernow CCG	10	1	1	12
NEW Devon CCG	30	7	0	37
SD&T CCG	14	9	0	23
Somerset CCG	14	1	0	15
Total	68	18	1	87

SEA - Type of Incident per CCG (incident date for Q1 & Q2)										
CCG	Number of incidents	Access, admission, transfer, discharge (including missing patient)	Clinical assessment (including diagnosis, scans, tests, assessments)	Cold chain	Communication failure	Consent, communication, confidentiality	Death	Documentation (including electronic & paper records, identification and drug charts)	Immunisation, Screening, Vaccination	Implementation of care and ongoing monitoring / review
Kernow CCG	12	0	2	1	0	2	0	2	0	2
NEW Devon CCG	37	2	3	1	1	3	4	6	7	3
SD&T CCG	23	0	8	0	0	5	2	3	1	0
Somerset CCG	15	0	2	0	0	0	4	0	5	0
Total	87	2	15	2	1	10	10	11	13	5

CCG	Lost or missing documents	Medical device / equipment	Medication	Other	Patient Abuse (by Staff / third party)	Referral - delayed 2WW	Self-harming behaviour	Treatment, failure to monitor	Treatment, procedure
Kernow CCG	1	0	0	0	0	0	0	1	1
NEW Devon CCG	0	2	4	0	1	0	0	0	0
SD&T CCG	0	0	2	0	0	0	1	0	1
Somerset CCG	0	0	0	1	0	3	0	0	0
Total	1	2	6	1	1	3	1	1	2