**NHS England and Improvement – South West**

 **Primary Care Significant or Serious Incident Notification Form**

The purpose of this form is to comply with national guidance and enable timely information sharing and facilitate learning from Serious Incidents (SI’s) requiring Investigation, and Significant Event Audits (SEAs) in Primary Care. Please complete this form with as much detail as possible.

**Please email your form to**: england.pharmacysouthwest@nhs.net **NHS England Ref: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO NOT INCLUDE PATIENT IDENTIFIABLE INFORMATION OR THAT OF INDIVIDUALS OTHER THAN THOSE OF THE REPORTER FOR COMMUNICATION PURPOSES.**

**In your opinion is this incident a Significant Incident (SI) SIRI ☐ or a Significant Event Audit (SEA)? *(See below for definition of incidents)* SEA ☐**

**When, Where and Your Details**

|  |  |
| --- | --- |
| **Type of Incident (a)** *(Please see appendix for list of Incident types)***Further descriptor for incident (b)** | **Reporting Organisation:** |
| **Date of Incident:**  | **Reporter Name:**  |
| **Time of Incident:**  | **Reporter Job title/Role:**  |
| **Location of Incident:**  | **Reporter Tel No:**  |
| **Date Incident Identified:**  | **Reporter Email:**  |
| **Name of other Organisations Involved (where relevant):** *eg: GP Practise, Hospital, Ambulance Service, OoH, Care Homes, Mental Health Services, Police, etc.* |
| **Care Sector:***eg: General Practice, Dentistry, Pharmacy, Optometrists, Other. If Other please specify.*  |

**Patient Details** *This information should only be supplied if this form is transmitted via a secure transmission – NHS.Net email account or a safe haven fax – please do not include patient name or other patient identifier.*

|  |  |
| --- | --- |
| **Patient Date of Birth:**  | **Patient Gender:**  |
| **Patient Registered GP Practice:**  | **Patient Ethnic Group:**  |
| **Patient NHS Number:**  |  |

**What Happened?**

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| **Description of What Happened including how the SI/SEA was identified:**  |
| **Immediate Action Taken:** |
| **Any Further Information:**  |
| **Details of any Police, Media Involvement/Interest:** |
| **Please indicate which other organisations have been notified?** **[ ]  CQC** **[ ]  IG Toolkit** **[ ]  HSE** **[ ]  MHRA** **[ ]  NRLS** **[ ]  CCG** |
| **Details of contact with or planned contact with patient/family or carers:** |

 **Learning Outcomes:**

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| **What lessons might be learned and shared with others?**  |
| **Have you identified any factors you are not in a position to change?**  |
| **ACTION POINT** | **WHO** | **BY WHEN** |
|  |  |  |
|  |  |  |

**What impact or potential impact did the event have on the patient?**

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| **Apparent Outcome of Incident:** *Please describe:**Please categorise significance/potential significance (tick A for actual harm and P for potential harm) Definitions of harm can be found in the National Framework.* |
| **None** | **Low Harm** | **Moderate Harm** | **Severe Harm** | **Death** |
| **PA** | **PA** | **PA** | **PA** | **PA** |
| **Likelihood of Reoccurrence: *Before reviewing this event –*** *Please attempt to assess the likelihood of a similar event happening again.*  |
| **Almost certain** | **Likely** | **Don’t know** | **Unlikely** | **Rare** |
| **Definition of Serious, Significant and Never events** |
| **SI - Definition of a Serious Incident** - The definition of a ‘Serious Incident’ is set out in the ‘Serious Incident Framework March 2015 – (NHS England Patient Safety Domain). Broadly, ‘Acts and/or omissions occurring as a part of NHS funded healthcare’ , including the community) that resulted in;• Unexpected or avoidable death, serious harm, injury, abuse, psychological or psychological; or where healthcare did not take appropriate action• or a Never Event – see never events policy.• Or an event that seriously prevents or threatens to prevent an organisations ability to continue to deliver an acceptable quality of healthcare. | **SEA - Definition of a Significant Event -**  The Royal College of General Practitioners (RCGP) states that significant events suitable for analysis 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’), but these incidents involve a lower level of safety concern than a ‘serious incident’ |

**APPENDIX - Incident Types a) and further information b)**

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| --- | --- |
| **Type of incident a) general** | **Type of incident b) descriptor** |
| Access, admission, transfer, discharge (including missing patient) | Cold chain |
| Clinical assessment (including diagnosis, scans, tests, assessments) | Communication - 111, Out of Hours |
| Consent, communication, confidentiality | Communication failure |
| Disruptive, aggressive behaviour (includes patient-to-patient) | Confidentiality & Communication - Breach of confidentiality |
| Documentation (including electronic & paper records, identification and drug charts) | Consent - failure to gain consent |
| Implementation of care and ongoing monitoring / review | Diagnosis - delay, failure to |
| Infection Control Incident | Diagnosis - wrong |
| Infrastructure (including staffing, facilities, environment) | Discharge - delay, failure |
| Medical device / equipment | Do not resuscitate (DNR) |
| Medication | Documentation - missing, delayed, inadequate |
| Other | Documentation - patient incorrectly identified |
| Patient abuse (by staff / third party) | End of Life issue |
| Patient accident | Healthcare professional issue |
| Self-harming behaviour | Immunisation, vaccination |
| Treatment, procedure | Infection control - Cdiff |
|   | Infection control - MRSA |
|   | Infection control - Other |
|   | IT system failure |
|   | Prescribing/Dispensing - lost prescription |
|   | Prescribing/Dispensing - Other |
|   | Prescribing/Dispensing - preparation incorrect |
|   | Prescribing/Dispensing - wrong dose, quantity |
|   | Prescribing/Dispensing - wrong drug |
|   | Prescribing/Dispensing - wrong label |
|   | Prescribing/Dispensing - wrong patient |
|  | Prescribing/Dispensing - EPS |
|   | Pressure ulcer |
|   | Professional Registration issues |
|   | Referral - delayed 2WW |
|   | Referral issue |
|   | Safeguarding concern |
|   | Scans, X-rays, specimens  |
|   | Screening incident |
|   | Sepsis |
|   | Sharp incident |
|   | Slip, Trip, Fall |
|   | Suicide suspected |
|   | Test results or reports - failure to report, act, receive, incorrect, missing |

**This form should be completed and sent to NHS England and Improvement South West as soon as possible to when the incident was identified.**

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