Tudor Medical Matters

Significant Event Policy

For review: January 2020

Introduction:

Tudor Medical Matters aims to review all significant events as a positive way of enabling staff to communicate best practice with colleagues both internally and externally. Significant event audit should be viewed as a positive and supportive process designed to aid problem solving, improve patient safety, encourage communication, develop a spirit of openness and trust and help develop confidence. The policy is not designed to apportion blame and the procedure should not be viewed as threatening. Instead the process should be used to share learning of positive events as well as adverse incidents.

The policy applies to all employees, clinical and non-clinical as well as others who work at Tudor Medical Matters such as self-employed staff, temporary staff and contractors.

The Policy

Lead Staff

The significant event lead is the Practice Manager (Dr. Gary Tudor) and in his absence the Practice Director (Mrs Jane Tudor). The role of the lead is to co-ordinate the process, ensuring that all significant events are documented, presented, communicated and reviewed following the procedure as outlined in this policy.

Examples of Significant Events

The types of events which should be reported through this process may include, but not exclusively, the following:

1. Unexpected patient death
2. Death on practice premises
3. Injury on premises to a patient
4. Injury to a staff member (e.g. needlestick)
5. Referrals not sent
6. Confidentiality breach
7. Significant equipment or computer failure
8. Misdiagnosis
9. Abusive or threatening patient
10. Patient complaints
11. Patient given wrong vaccination or same one twice
12. Fire, theft or vandalism

Positive significant events may include, but not exclusively:

1a. Well managed terminal death at home
2a. Well managed incident e.g. patient collapse in the surgery

This process should only be used for reports of a 'significant' nature and should not be used for 'minor' occurrences. For example, a patient being a bit off with reception should not be documented whereas serious verbal or physical abuse would clearly be significant. If in doubt, please refer to the Practice Manager.

The Procedure

The following sequential steps need to be taken:

1. Report the event
2. Record the event
3. Discussion
4. Agree outcomes
5. Document
6. Share the learning
7. Review

Significant Event Procedure Flowchart:

1) **Report the event**

- Significant events should immediately be reported to the Manager (or in their absence, the Director). Reports should preferably be made by email but may also be in the form of a note or verbally.

2) **Record the Event**

- Practice Manager should issue a 'Significant Event Process Report form'. Preferably, this report should be completed by the person reporting the incident
- This report may also be completed by the Practice Manager and agreed with the person reporting as an accurate chain of events prior to sharing

3) **Discussion**

- Significant event should be added to the agenda of the next Practice Meeting - Practice Manager should ensure the significant event is added to the Practice Meeting agenda
- Person who raised the significant event will present their report at the Practice Meeting, unless it is felt that someone else would be more appropriate
- Meeting should be an open discussion about what took place, with questions raised by the group to investigate any positive and negative aspects of the event presented.
- The group should try to establish what, if anything could be done differently if the event were to occur another time?

4) **Agree Outcomes**

- Discussion should aim to identify learning points and action which need to be shared and implemented. Outcomes can be categorised as follows: congratulations, immediate action, further work needed or no action required.

5) **Document**

- Presenter should complete the Significant Event Process Log documenting the following: date of the discussion, learning outcomes and action points (including person responsible and deadline)

6) **Share the Learning**

- If learning outcomes need to be cascaded to other team-members or external parties, this should be documented as an action point and responsibility assigned to a member of the team with a deadline.
- How the learning is to be shared is dependent upon the type of event and those concerned – may require a special meeting OR may be sufficient to disseminate via paper information.

7) **Review**

- Significant Events will be reviewed at a Practice Meeting, quarterly basis. A list of all significant events reported in that quarter should be kept and a date set for the review meeting.
- Person who presented the event should ideally discuss with the group the actions which have been implemented or appoint a representative to do this for them.
- In the review discussion, the group will explore the effects of the learning outcomes and action points to assess whether the action has been successful.

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External Cascade

It may be necessary and beneficial for the event to be shared externally. For example, in the cases of misdiagnosis it may be beneficial for other GPs to learn from the experience of those involved. In such cases, the Primary Care Organisation's (PCO) Patient Safety team should be informed and it may also be necessary to liaise with the LMC. Significant events should only be shared externally by the Practice Manager, and everyone involved should be anonymised, including GPs and other staff.

In some circumstances, it may be necessary to call a special meeting with attached staff eg. safeguarding teams, to ensure that information is also shared with them.

Please file the 'Significant Event Recording Form', 'Significant Event Log' and any meeting/review notes together and in confidential, locked filing cabinet

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Significant Event Reporting Form

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Reporter -

Event Number:

Name:

Job Title:

Contact e-mail:

Time and date that significant event occurred: _____

What type of significant event was this? (see policy) _____

Please detail what happened (use additional labelled pages if necessary):

Which patient/s was/were involved in this incident? (delete as appropriate):

Name:

DOB:

(Continue on a separate, labelled page if necessary)

How did this incident affect the patient?

Name

DOB:

How did this incident affect the patient?

Please indicate which staff members were involved in this event – what was their contribution? (use additional labelled pages if necessary):

Signature of reporter: _____ Date: _____

Reviewed by (initials):

Date reviewed:

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Significant Event Log

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Date of the discussion: _____

Staff members present: _____

Learning Outcomes (please continue on a separate, labelled sheet if necessary):

Action points (please continue on a separate, labelled sheet if necessary):

Person responsible:

Event Number:

Deadline for reviewing action points: