



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

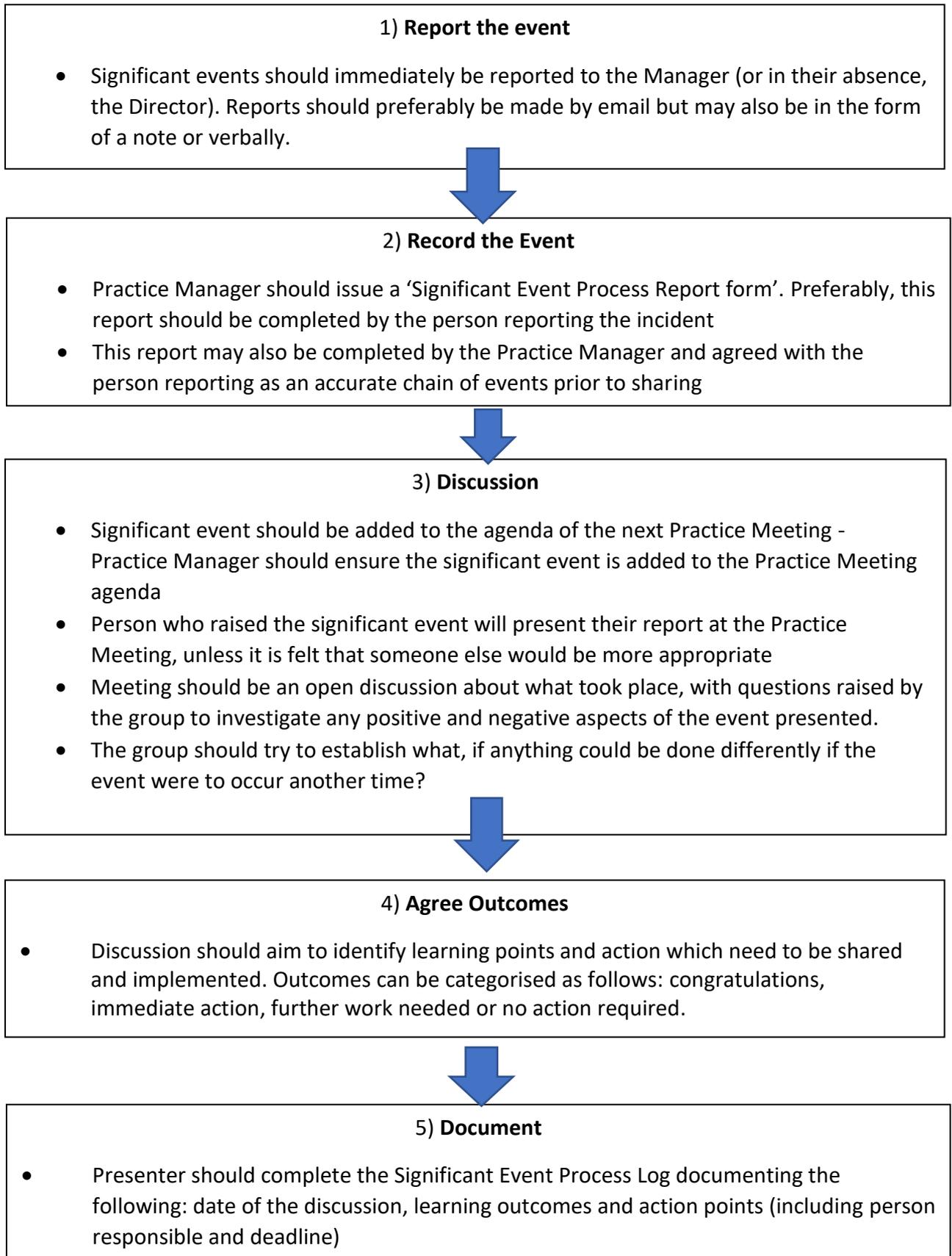
This process should only be used for reports of a 'significant' nature and should not be used for 'minor' occurrences. For example, a patient being a bit off with reception should not be documented whereas serious verbal or physical abuse would clearly be significant. If in doubt, please refer to the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

## **The Procedure**

The following sequential steps need to be taken:

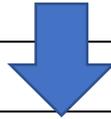
1. Report the event
2. Record the event
3. Discussion
4. Agree outcomes
5. Document
6. Share the learning
7. Review

**Significant Event Procedure Flowchart:**



### 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.

### 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\***



## **Significant Event Reporting Form**

**\*CONFIDENTIAL\***

**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:

*(Continue on a separate, labelled*

DOB:

*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:*



**Significant Event Log**

**\*CONFIDENTIAL\***

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:**