St Peter's Medical Centre

GP Incident Reporting Procedure

What is the NRLS?

NRLS enables patient safety incident reports to be submitted to a national database. It was designed by the National Patient Safety Agency based on international experience and best practice: it is the most comprehensive of its kind in the world, receiving over 1.5 million incident reports (NLRS data) from healthcare professionals in 2013 alone. This provides the opportunity to ensure that the learning gained from the experience of a patient in one part of the country is used to reduce the risk of something similar occurring elsewhere.

NHS England is making it easier than ever before for general practice staff to report patient safety incidents.

Reports of harm or near misses to the NRLS provide NHS England with important insight of incidents from across the country. This enables risks to be identified and appropriate action to be taken to prevent incidents – such as the cascading of patient safety alerts, developing learning resources and holding workshops for NHS staff.

Incident reporting is also important at a local level because it helps the healthcare system to learn what can be done locally to keep patients safe from avoidable harm.

With 360 million consultations each year, general practice is the most common place for patient interaction with the health service. Despite this, the number of safety incidents reported to the NRLS from primary care remains low compared to the almost 1.5 million reports each year from hospital-based care. This makes it difficult to develop appropriate and relevant support and learning resources for practice staff.

The new e-form, which has been developed in consultation with general practice staff, can be completed in a matter of minutes, with many questions requiring quick and simple answers – such as the location of where the incident happened and the patient's age. Practice staff can use the form to report anything from administration errors to incidents relating to sepsis.

Practices can choose to include their practice code or can submit a report entirely anonymously. Patient identifiable information is also not required.

GPs can also gain Continuing Professional Development (CPD) credits by submitting incident reports via the e-form. Upon submission of the incident report there is the option to request a bounce back email with a Significant Event Audit template which can be used for CPD, Appraisal and Revalidation. This can also provide evidence of patient safety activity during CQC inspections.

Dr Mike Durkin, Director of Patient Safety at NHS England, said: "More reports from general practice will help us to achieve an improved picture of patient safety in primary care and to share vital learning from near misses and when things go wrong. This information will be used to build a safer NHS as we strive to continually protect our patients from avoidable harm."

All patient safety incidents (clinical and non-clinical) should be reported where a patient was harmed or could have been harmed. This includes near misses and incidents where positive action prevented an incident from occurring

How to report a patient safety incident to the NRLS?

Patient safety incidents can be reported via local reporting management systems or directly to NRLS via an electronic reporting form (eForm). NHS England has commissioned a new general practice specific eform, available with supporting information from 26 February 2015. This eform will contain enhanced features to enable quick and easy completion together with an associated Continuing Professional Development / Significant Event Analysis reflective template to enable rapid documentation of learning and impact for CPD, Appraisal and Revalidation.

Link to form:

What should be reported? https://report.nrls.nhs.uk/GP_eForm

All patient safety incidents should be reported through NRLS. A patient safety incident can be defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare.

All levels of harm, defined below, should be reported even if no actual harm to the patient has occurred.

Term	Definition	Clinical example
No harm	Any patient safety incident that did not result in harm or injury or that had the potential to cause harm but was prevented, resulting in no harm (near miss)	A GP prescribes the twice the recommended dose of a new drug, which the local community pharmacist picks up when dispensing the prescription.
Low harm	Any patient safety incident that required extra observation or minor treatment	A patient's home visit is missed; the patient has cellulitis of the right leg; this was picked up the following day resulting in the GP deciding to prescribe I.V. rather than oral antibiotics which need to be delivered by community frailty team.
Moderate harm	Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm	Continuing treatment with warfarin without monitoring INR for 6 weeks. The patient had an upper GI bleed and was admitted to hospital for 5 days for monitoring and follow-up. It was noted on admission that the INR was 7.
Severe harm	Any patient safety incident that appears to have resulted in permanent harm.	A patient who is a heavy smoker with a persistent cough is noted to have a suspicious lesion on a chest x-ray. The GP messages the practice reception to arrange an urgent appointment with the patient, although there is no answer on the patient's home telephone as he is on holiday. The message to follow up is missed. Two months later the patient presents with shortness of breath and haemoptysis. He is admitted to hospital via MAU and is diagnosed

		with lung cancer.
Death	Any patient safety incident that directly resulted in death	A patient is on a repeat prescription for morphine sulphate 10mg twice a day for chronic pain. The patient requests a prescription and, in error, a prescription is issued for morphine sulphate 100mg twice a day. The medication is dispensed and the patient's wife, who looks after his medicines, gives her husband 100mg tablets of morphine sulphate. He takes 2 doses over the next day and then his wife is unable to rouse him in the morning. He is admitted to hospital where he has a cardiac arrest and dies.

What happens to the reports?

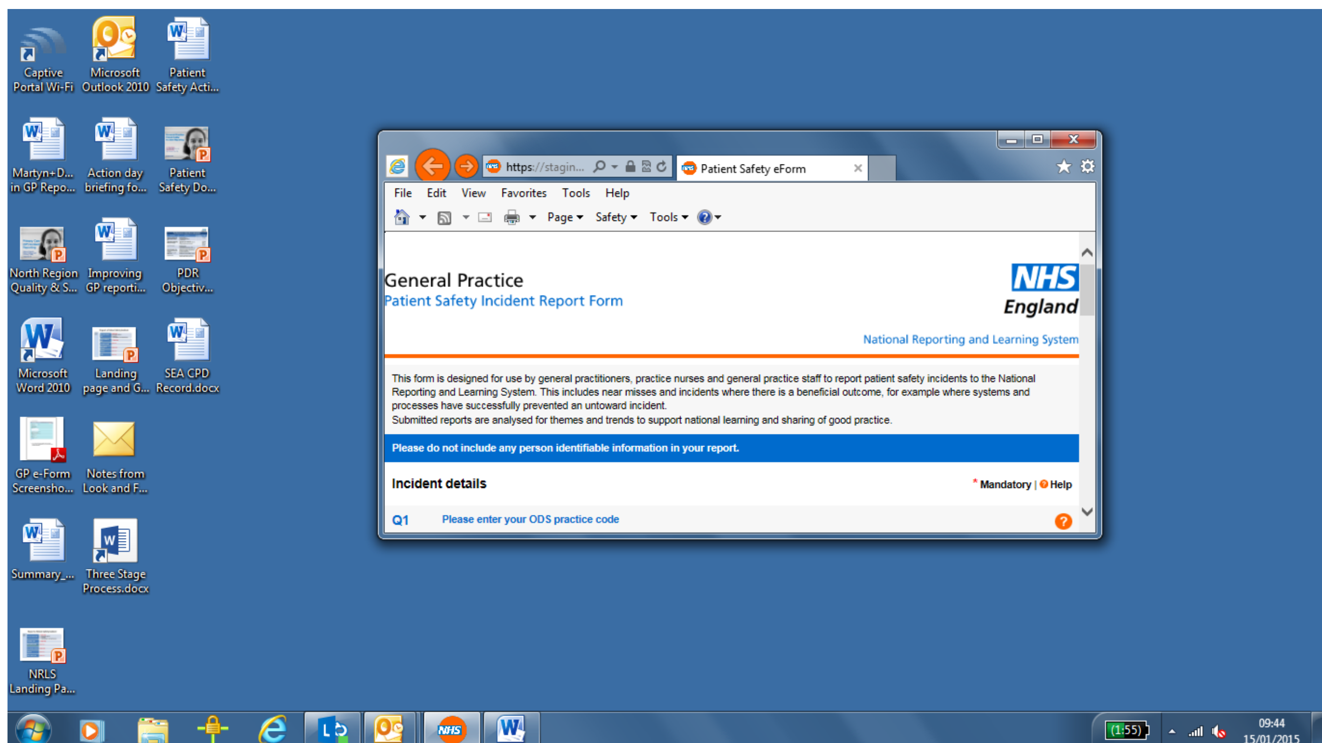
When patient safety incidents are reported, the data is aggregated and analysed with expert clinical input and computerised analytical tools to help understand the frequency and types of patient safety incidents, patterns, trends and underlying contributory factors. This analysis will inform national learning about risks to patient care, establish priorities for action and work to develop practical solutions to improve patient safety.

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 .

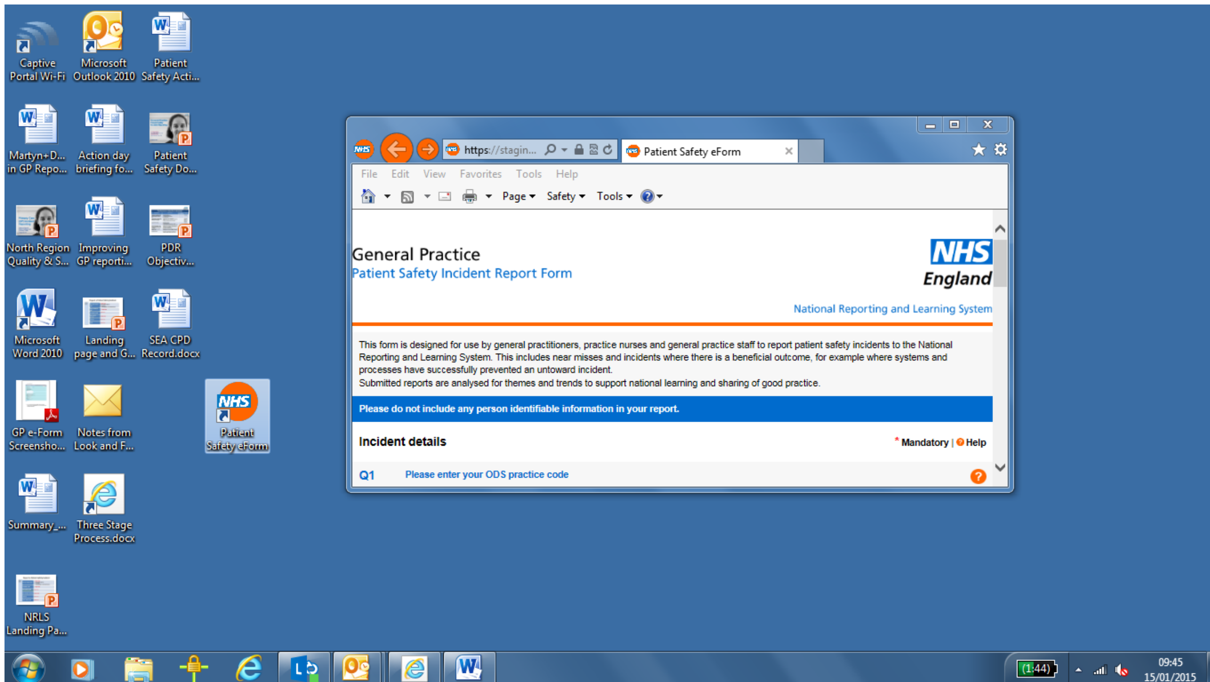
Step 2 – minimise the web page.



Step 3 – click on the icon in the address bar and drag this to the desktop

St Peter's Medical Centre

GP Incident Reporting Procedure



Step 4 – the icon will now appear on your desktop and can be clicked on to directly access the e-form.