Bpac^{nz} launches the Patient Safety **Incident Reporting** System **for primary care**

Bpac^{nz} is pleased to announce the launch of the national primary care Patient Safety Incident Reporting System.

Patient safety incidents in the hospital setting have received significant attention recently with the release of the DHBs' Serious and Sentinel Events Reports. Although hospitals have always collected data about patient safety incidents, this was the first time it has been compiled into one report. The aim is to improve safety by encouraging open and transparent reporting of incidents.

While reporting of patient safety incidents in the hospital setting is well established internationally, incident reporting systems for primary care have only recently been introduced. Until now there has been no national patient safety incident reporting system for primary care in New Zealand.

Why have a Patient Safety Incident Reporting System for primary care?

International studies have shown that patient safety incidents are reasonably common in primary care and that most are preventable. Having a system that encourages open reporting, review of incidents and promotes the sharing of solutions has the potential to prevent recurrence of incidents, making primary care safer for both patients and health care professionals.

What is a patient safety incident?

Previously referred to as medical errors, patient safety incidents can be defined as: [1]

- Anything administrative or clinical, that you identify as something to be avoided in the future
- Something that happened in your practice that should not have happened and that you do not want to happen again

Organisations such as the Medical Council and the Health and Disability Commission have processes that hold clinical professionals accountable for the quality of their work and aim to maintain professional standards. Patient safety incident reporting is a separate process from this.

Patient safety incident reporting is a "no blame" approach designed to focus on systems and how they can be improved to minimise the risk to patients. This recognises that individuals are seldom solely responsible for errors and that targeting individuals, but not addressing faulty systems or process, will not prevent future incidents.

1. Adapted from Dovey SM, Meyers DS, Philips RL, et al. A preliminary taxonomy of medical errors in family practice. Qual Saf Health Care 2002;11:233-8.

The bpac^{nz} Patient Safety Incident Reporting System

The bpac^{nz} Patient Safety Incident Reporting System is for designed for people working in primary care (e.g. general practitioners, practice nurses, pharmacists, administrators) to report and review patient safety incidents.

The system is:

- Non-punitive and independent of any authority with the power to punish
- Completely anonymous, no identifying information is collected or recorded
- Focused on systems or processes rather than individuals

The primary purpose of the bpac^{nz} Patient Safety Incident Reporting System is to improve safety by identifying the factors that commonly contribute to incidents in primary care, and sharing solutions to prevent these incidents from occurring again.

Reports will be analysed by experts in primary care and clinical systems, and regular feedback based on these analyses will be published on the bpac^{nz} website and in the Best Practice Journal. As well as published analyses, brief summaries of individual incident reports can be reviewed online. This online review facility includes the ability to comment on reports and view comments and observations made by peers on an incident.

How do I make a report?

Reports can be made using the form included with this BPJ or online by following the link from the bpac^{nz} home page: **www.bpac.org.nz**

By submitting a report you are making an important contribution to the safety of your patients and colleagues.

For more information go to:

www.bpac.org.nz/safety