Patient safety incident reporting

In March 2010 bpac[nz] launched the Patient Safety Incident Reporting System for primary care. Since then, a steady stream of reports has been flowing in and the incident database is growing.

A patient safety incident can be defined as:

- A clinical or administrative incident or issue, which could have, or did, lead to harm for one or more patients, identified as something to be avoided in the future

This includes incidents that you were directly involved in, that you witnessed or that were prevented before they occurred.

The bpac[nz] Patient Safety Incident Reporting System is designed to be used by all people working in primary care, e.g. general practitioners, practice nurses, pharmacists, administrators. Reports are completely anonymous and independent of any disciplinary body.

Reports can be made online at: **www.bpac.org.nz/safety**

Even if you are not making a report, you are encouraged to review reports by others and provide feedback on the incident and your thoughts on how it could have been prevented.

Some recent reports

"Lung tumour failed to be followed up due to lack of communication between providers"

Patient seen at After Hours clinic with suspected chest infection. After Hours GP ordered a chest x-ray. Results were sent to the After Hours clinic, pulmonary nodule noted in results by radiologist, with follow-up suggested. After Hours Clinical Leader relayed results via a note to the patients named GP. However, named GP had not seen patient for ten years and presumed that the After Hours doctor who ordered the chest x-ray was taking responsibility for follow-up. Patient subsequently enrolled with a new GP, who assumed that the previous GP had actioned the follow-up. Patient presented to the new GP one year later with persistent cough. The GP ordered a chest x-ray which showed a large lung tumour.

This report highlights several issues:

- All four GPs involved made the incorrect assumption that someone else was responsible for the care of the patient
- None of the practitioners made contact to confirm that the necessary follow-up had taken place
- Administrative/clinical staff did not confirm that the patients details were up to date

...and lessons that can be learned:

- Never assume that someone else is taking

responsibility for a patient's care – make telephone contact to confirm who is arranging patient follow-up

- Confirm with the patient that they attended the follow up appointment or received the follow-up investigations
- When a new patient enrols at the practice, make a time to go through their previous notes with them and question them about any past medical history and the outcome of any events

"Ceftriaxone diluted incorrectly causing seizures"

An eight month old child presented to a rural practice with suspected meningitis. After consulting with a paediatrician, the GP decided to administer IV ceftriaxone while awaiting the ambulance. The practice nurse assisting the GP was asked to prepare the IV solution and in error, diluted the ceftriaxone in 2% xylocaine solution (based on the IM protocol for giving ceftriaxone). The GP did not check the dilutent (which should have been sterile water for IV administration) and administered 7 mL of the solution. Shortly after, the infant experienced two tonic-clonic seizures. The child was airlifted to hospital and fully recovered.

Following discussion of this event, the practice staff decided on the following points:

- Clearer instructions regarding doses and administration of emergency drugs would be obtained and kept in an emergency drug folder at the practice
- The doctor administering or prescribing a drug in an emergency setting is responsible for checking the dose and administering the drug
- The practice aims to develop a culture where GPs and nurses dealing with emergencies could ask for help from colleagues

This report is an excellent example of how a practice can learn from an incident and make changes to prevent the incident from occurring again in the future.