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Submitted to **Individual Sign up to Safety form**

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Sign up to Safety form

Contact details:

Title::

Dr

First name::

Julian

Last name::

Hart

Organisation name::

Queen Camel Medical Centre

Job title::

GP

Email address::

julian.hart@queencamelsurgery.nhs.uk

The five Sign up to Safety pledges - tell us what actions you will undertake for each pledge (in less than 140 characters):

I will::

Queen Came Medical Centre pledges to work towards the NHS shared goals of reducing avoidable harm to patients. This will be achieved by re-affirming and strengthening its commitment to be a transparent and reflective practice that uses lessons learned from reported incidents.

I will::

Queen Camel Medical Centre uses feedback from a number of sources, including but not confined to, Friends and Family Test, dialogue with Patient Participation Group, complaints, staff forums and opportunistically with patients to measure and monitor how safe services are. The weekly partners business meeting reviews and minutes all feedback and determines the next steps – including the responsibility for raising a significant event and sharing outcomes with colleagues. Our quarterly practice closure always includes discussion of all significant events both for the whole practice and for the clinical staff only. All incidents are written up and circulated within the practice and outside when appropriate.

I will::

Queen Camel Medical Centre fosters a culture of honesty and candour when something goes wrong. The accent is always on learning from an incident rather than apportioning blame. This is made clear during staff recruitment and training and partners take pains to model openness as an example to staff.

I will::

Queen Camel Medical Centre will support the CCG priorities, in particular increasing the reporting of medication incidents in primary care and the handover and discharge process.

Whenever an incident is reported that warrants sharing with colleagues a significant event is created and logged, these are shared internally by email and externally using either the dedicated CCG email address (significantevents@somersetccg.nhs.uk) or via the National Reporting and Learning Service (NRLS) website. Patient experience about the safety and quality of services are reported using the CCG Healthcare Professional Feedback Scheme desktop link and medication incidents are reported using the Medication Incident Reporting link. All incoming patient safety alerts that are received are disseminated within 48 hours of receipt and there is a robust process to ensure this continues during key staff absence.

I will::

The induction process is the starting point where new staff members are encouraged to champion the ethos the practice has towards patient safety. This is then built upon using the annual appraisal process. All staff have the opportunity to review why things go wrong and reflect on how to avoid a repetition. Regular staff meetings and practice education events examine feedback and celebrate improvements.