

Learning from Primary Care

SIGNIFICANT EVENT AUDITS

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Contents:	Pg:
WHY? Significant event audits (SEAs)	1
Contacts – Quality & Safety Team	1
What we do with <i>your</i> SEAs	2
NRLS – report only once!	2
The Primary Care Quality Hub	3
Cold calling – advice	3
SEA incidents shared learning	4 -10

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Why share Significant Event Audits (SEAs)

Carry on reporting

Serious or significant incidents in healthcare are rare, but it is acknowledged that systems and processes have weaknesses and that errors will inevitably happen. But, a good organisation will recognise harm and the potential for harm and will undertake swift, thoughtful and practical action in response, without inappropriately blaming individuals.

Incidents require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these.

Definition of a SEA

The Royal College of General Practitioners (RCGP) states that significant events suitable for analysis are events where the practitioner can identify an opportunity for making improvements, either because the outcome was substandard or because there was a potential for an adverse outcome ('near miss'), but these incidents involve a lower level of safety concern than a 'serious incident'.

Definition of a Serious incident (SI):

SI's usually involve a patient safety element (adverse outcome - GMC definition). In broad terms, serious incidents in health care where the potential for learning is so great, or the consequences to patients, families and carers. Staff or organisations are so significant that they warrant using additional resources to mount a comprehensive response – full RCA type investigation; for example

- Unexpected or avoidable death – (caused or contributed by weaknesses in care/service delivery)
- Unexpected or avoidable injury to one or more people that requires further treatment to prevent death, or serious harm
- Actual or alleged abuse, where healthcare did not take appropriate action or intervention to safeguard
- An incident or series of incidents that prevents or threatens to prevent an organisation's ability to continue to deliver an acceptable quality of healthcare services.



Spreading the word...

In Devon, Cornwall and the Isles of Scilly, the NHS England local office had implemented a system of recording incidents reported by General Practitioners and Dentists using the SEA form.

With the merger of the two local NHS England areas to now include Bristol, North Somerset, Somerset & South Gloucestershire, we are now slowly rolling out the SEA process to Primary Care in these areas too.



What happens to SEAs & SI's reported?

The incidents you return to NHS England are reviewed by the Quality and Safety Team, and follow two routes:

- **SI's - Serious harm (to patients or the reputation of the NHS)** are reported on the national Strategic Executive Incident system (STEIS) on your behalf and the Serious Incident Framework covers how these incidents are handled.

<http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

- **SEA's – Significant harm to patients (or NHS) but not of such a "Serious" nature (as to cause significant harm)** are handled via the SEA form and recorded on the Quality and Safety Primary Care database.

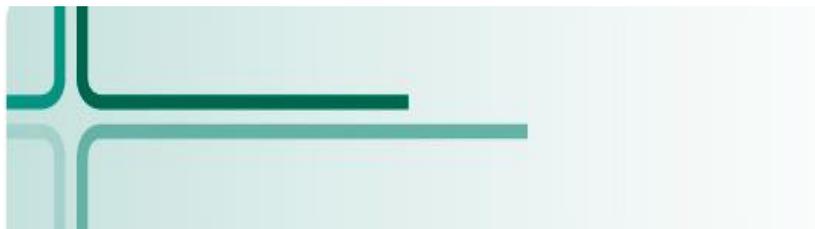
Both STEIS & SEA reporting tools are analysed to prevent future incidents through shared NHS learning - for dissemination, identification of emerging trends or training development needs for staff.

THANK YOU ...
for reporting SEAs &
sharing *your* learning



75% of General Practices are now reporting SEAs

	Jan-June 2015	2014-15	2013-14
Significant Event Audits reported per year by Primary Care NHS England South West – South	181	443	223



NHS
National Patient Safety Agency

Report once not twice!

National Reporting Learning system e-form

If you are thinking of submitting incidents via the new National Reporting Learning system (NRLS) e-form now, **please remember:**

- to tick the box to share the form with Devon & Cornwall Isles of Scilly area team (NHS England South - SW),
- **to include your learning and action points**, to share with others GPs, via your text on the incident, this will save you having to do another SEA form to us!



The newly launched GP eform can be accessed via <http://www.england.nhs.uk/ourwork/patientsafety/general-practice/>.

The CQC have also published an article relating to reporting that general practices will find useful. This is available at the following link <http://www.cqc.org.uk/content/gp-mythbuster-24-reporting-patient-safety-incidents-national-reporting-and-learning-system>

The Primary Care Quality Hub

This meeting of key Quality and Safety personnel from NHS England's Primary and Contract staff, CCGs, and CQC, is held monthly. It ensures that NHS England delivers its statutory responsibilities in regard to the safety and quality of its commissioned primary care services (GPs, Dentists, Optometrists and Pharmacists) in Devon, Cornwall and Isles of Scilly (DCIOS).

The Quality Hub provides a forum for the triangulation of information and intelligence providing assurance to NHS England (DCIOS) Executive team and to the Quality Surveillance Group that:



- primary care services commissioned by NHS England (DCIOS) are safe, are of a consistently high standard and are responsive to patient care needs and experiences;
- commissioned services meet the necessary standards of quality specified in all relevant regulatory requirements, standard contracts, professional guidance, the NHS Outcomes Framework and other relevant sources;
- commissioned services maintain quality standards and drive improvements in health outcomes and patient experience within available resources;
- there are robust contract monitoring arrangements in place for all providers, using hard and soft intelligence such that any serious failures are prevented or identified at an early stage and resolved;
- providers have effective governance processes, patient safety and experience policies and processes to capture and act upon patient feedback;
- providers are reporting incidents appropriately and are implementing actions following analysis of incident data and sharing learning;
- there is a culture of open and honest cooperation so that staff, patients and the public are proactively listened to in order to understand their concerns and the experiences;
- The identification and mitigation of the high quality risks
- Complaints which raise concern may be discussed and that all actions identified as a result of a complaint are followed up.
- Themes of concern are identified and escalated to the QSG.



NHS England SSW has received a number of incidents concerning the cold-calling of patients by sales representatives who seem to know the patient's medical history.

Some companies allegedly claim to have obtained this information from the patient's GP surgery.

The companies are selling a variety of products, beds, chairs, vitamins and pressurise the customer into buying or agreeing to a sales appointment. Some vulnerable patients have parted with money!

If you hear of such an incident, please do the following:

- Get as much information about the call from the patient as you can.
- inform us immediately via the Significant Event Audit form to england.devcorn-incident@nhs.net
- Inform the **Action Fraud** online service - (and obtain and inform NHS England of the Police incident number)
- Inform the LMC,

We will inform the Head of Primary Care, Commissioning and Contracting on your behalf, as well as the Information Governance Lead and Communications department.



Helpful information on fraud & scams

The Action Fraud site has general fraud prevention information.

- [Protect yourself from fraud](#)
- [Protect your business from fraud](#)
- [Report fraud or scams](#)



Action Fraud is not an emergency service dial 999 if you are in immediate danger.

Learning from Primary Care incidents.....

Incident type	What happened	Learning
Faulty defibrillator - staff training	<p>Patient X requiring ECG as pulse was fast and irregular, to establish if patient was in AF. No domiciliary ECG service available and patient attended the GP surgery.</p> <p>On arriving at the surgery X felt unwell in the car park and was transferred to a wheelchair. The GP went to the car park to assess X who looked unwell but was making spontaneous respiratory effort which seemed abnormal. X was not responding to voice or touch.</p> <p>X was moved into the surgery in the wheelchair and put in the supine position on the floor of the registrar room. The GP called for assistance, for the resuscitation kit, and asked for an ambulance to be called.</p> <p>X was found not to have a pulse and chest compressions were started. The resuscitation equipment arrived and X's clothes were cut off. The defib was attached. The defib established that X was in a non-shockable rhythm.</p> <p>CPR was continued. Airway management was instituted.</p> <p>IV access was established.</p> <p>None of the medical or nursing staff were familiar with the adrenaline products in the resus kit and did not feel confident of the correct dose of adrenaline to give intravenously. Before adrenaline was given, X regained a spontaneous circulation. X regained consciousness and was transferred to hospital.</p> <p>The defibrillator did not provide the expected verbal prompts.</p>	<p>Need identified for new defib equipment and also need for medical staff training re the use of adrenaline.</p> <p>Periodic checks of defibrillator established.</p> <p>Patients requiring an ECG at home should be able to have this test done on a domiciliary basis. This should be the responsibility of the organisation providing district nursing services.</p> <p>Surgery actions: Laminated drug dose sheet Logbook for recording times of shocks, drugs etc. Identify an arrest 'leader'</p>
Staff training, familiarity with Resus kit bag equipment	<p>Patient X was returning home from shopping – GP was passing in car and witnessed X collapse in the street. GP stopped and found X to be in cardiorespiratory arrest so called 999 and the surgery (close by) and commenced chest compressions.</p> <p>Several GPs arrived from the surgery, including (resuscitation trainer) and attended with resuscitation kit and defibrillator. X received 6 cycles of CPR and required 4 shocks prior to the paramedics arriving and on their arrival X had an output and was transferred to the Acute hospital.</p>	<p>GPs worked effectively as a team and gave good quality CPR</p> <p>We failed to locate the I-gel airways in our resuscitation kit and subsequently have identified that they were in a pocket hidden by the opening of the bag- these will be moved and the "hidden" pocket will not be used.</p> <p>We will also periodically go through the resuscitation kit bag in a clinical meeting to keep familiar whereabouts all the equipment is in the bag.</p> <p>We identified that our resuscitation update sessions have too many people attending for it to be of maximum benefit to individuals- we are planning to reduce the number of people per session and are liaising with the Resus trainer about the format of the sessions.</p>

Incident type	What happened	Learning
GPS viewing more than one patient - wrong patient	<p>Patient X presented in the Dispensary and handed back a box of HEPARIN ampoules and SODIUM CHLORIDE ampoules. X had collected medication but wasn't sure why he/she was prescribed them.</p> <p>Dispenser looked in the record and couldn't find any information in the PMR or consult to state why X would require them. Dispenser said the GP would be contacted to ask why they were prescribed. Dispenser promised to let X know the outcome.</p> <p>GP was unsure why X had been prescribed the medication and that GP thought they were prescribed for another patient.</p>	<p>1- GPS having more than one patient up on system one at the same time. There should be only ONE patient retrieved at any time and if more PMR'S are required then staff should be using a different system one screen.</p> <p>2- Patient X could have potentially used the Heparin & Sodium Chloride if they had not questioned it with Dispensary.</p> <p>3- The correct Patient for the medication could have suffered harm by not receiving the medication required in the first instance.</p>
Medication - Adverse drug reaction	<p>Acute reporter - Patient X had been to GP in recent past (6 weeks) with low sodium reported. Patient subsequently saw a different GP at practice and was prescribed sertraline & indapamide (both associated with depleted sodium). Patient admitted to hospital, suffering a fit due to low sodium levels and subsequent admission to intensive care for management.</p> <p>GP - Patient seen by GP at beginning of month with mild hyponatraemia, (suspected over drinking water). At the end of the month a blood test for X showed normal sodium. Sertraline was started a few weeks later for depression. Hyponataemia is a rare side effect of sertraline and there is no way of predicting this. Patient has moderate/severe anxiety depression and required treatment.</p>	<p>Profound hyponatraemic effect of sertraline and indapamide together in patient X who had previously been hyponatraemic.</p> <p>The rare and unpredictable side effects of sertraline were discussed amongst the doctors. X's patient records were tagged as being sertraline sensitive as X had a severe and acute drop in sodium presumed caused by the sertraline, although since this time it has been discovered that the patient has been over hydrating with water.</p> <p>GP made colleagues aware of the rare and unpredictable side effects of sertraline.</p>
Access to appointment, treatment delay/ health professionals communication.	<p>GP reported - Patient X complained that 'On 2 occasions my child had been refused an appointment to see the Dr. 1st time my child had conjunctivitis and I had to buy the medicine drops myself as couldn't get appt. 2nd time premature baby was ill. H/V wanted him seen by a Dr asap & asked me to go to the GP as she thought he was dehydrated from being ill. The receptionist didn't even look at H/V letter & said no appointments. I took him A&E where the baby was admitted</p> <p>GP response - The baby was seen at A&E and was admitted overnight for dehydration, 6 week history of cough & congestion and concern that his weight had dropped from the 25th to 9th centile. He had been seen a GP at the surgery on 5 occasions in quick succession. Our receptionists do not recall the mother attending or ringing the surgery asking for an urgent appt as advised by a H/V.</p> <p>The mother attended an appt for baby imms after these incidents made no mention of the baby's admission or her anonymous complaint.</p>	<p>All health professionals to be e-mailed again with our surgery bypass number & informed that if they have concerns about a patient they need to speak to a GP directly or Practice Manager & Senior Partner.</p> <p>Staff should be extra vigilant when it comes to unwell children & bring concerns & requests for urgent appointments to the attention of GPs for them to make a clinical decision as to whether they should be seen.</p> <p>Staff to have a refresher training session in basic triage.</p>

Incident type	What happened	Learning
	<p><i>Continued from above:</i> A HV phoned one of GPs shortly after, saying that she had seen the family and the baby was OK. She also mentioned about us not giving the mother an appt when requested especially as they had written their concerns down for her in her red book. GP suggested that the team should phone us if they have concerns and urgent appointments are required so we know to expect them and can make the necessary arrangements.</p>	
<p>Prescriptions for wrong patient</p>	<p>Locum pharmacist on duty received a complaint from Surgery citing two separate occasions where the Pharmacy had requested repeat prescriptions for items for the wrong patient. Using the computer PMR, a repeat prescription request for 5 items were made for the wrong patient in month and two items in month. The error was intercepted by the Surgery. Hence the error did not go any further.</p> <p>Patients contacted and inquiry made as to whether any patient had received medication in error. Neither had. PMR corrected immediately after the incident came to light.</p>	<p>Caution when merging duplicate PMRs on computer, checking all names, date of birth, address and NHS Number match before submission.</p> <p>Ensure repeat prescription requests are checked against current repeat slips checking for name, DOB, address and NHS Number.</p> <p>Prevent the creation of duplicate PMRs by ensuring current and correct patient details are entered on the computer.</p> <p>Incident discussed with all colleagues, root cause and actions discussed.</p>
<p>Staff handover after sickness</p>	<p>Nurse administered incorrect vaccination, Menitorix administered instead of Neisvac-C. This was identified when the nurse was adding the details to the electronic record.</p>	<p>It is recognised that this mistake could have been made on a normal day working day, though risk is mitigated as the two vaccines are separated and well labelling in the fridges and on the log out sheet.</p> <p>Other factors contributed to this error on the day; on the date the SI took place, it was the administering nurses first day back at work following 5 weeks sickness absence. During this time there had been some changes to processes, one of these being a move the practice vaccine fridges and also changes to consent processes which meant the nurse was running late at the start of clinic.</p> <p>Adequate time was not allotted for the nurse to receive a hand over and return to work briefing. This has been recognised by the practice and processes changed to allow for return to work briefing following any extended period of absence.</p>

Incident type	What happened	Learning
<p>Understanding role in an emergency situation</p>	<p>Patient collapsed whilst standing at the reception desk. The senior receptionist immediately alerted a GP in her consulting room, by walking to the room just yards from the incident. By chance the practice business manager had just come into reception with a guest, she told the receptionists to press the panic button. A couple of seconds were then lost as one had forgotten how to do this so a second did it. The second one was the receptionist who had been at the front desk – she is the apprentice and said afterwards that when the man collapsed she did not know if she should press the panic, or not, so she hadn't. The GP attended to the patient. The senior receptionist stood at reception to stop patients getting near the scene, she and the practice business manager moved furniture to create a barrier. The practice business manager told receptionists to deal with patients at another reception window away from the scene. Nurses arrived, one HCA arrived and looked for instruction the practice business manager indicated she could return upstairs. The upstairs admin staff stated afterwards that they did not attend as a HCA was in their room and they knew she had responded. Other GP's did not respond. Other members of staff also did not respond.</p> <p>The GP went to look up patient records The senior nurse stayed to assist the paramedic as he could not use anything but an electronic blood pressure machine due to restrictions in his hearing and he required an ECG both of which the senior nurse assisted him with. The patient had suffered from a collapse due to lack of food and water, he was therefore stable again in a short time period, the GP sorted for him to receive meals at his home.</p>	<p>Need to remind staff in training how to use panic button – as it is not something regularly needed so can be forgotten, and that is it ok to press it.</p> <p>All aware that no assumption should be made as to the reason why a panic has been activated at a particular location (i.e. a back reception desk not in direct relation to patients) – all staff should respond and then be set down as appropriate</p> <p>Regular training needed to ensure roles understood, i.e. who to call ambulance</p>
<p>Medication - statin use MHRA guidelines</p>	<p>Patient X was commenced on Simvastatin 40mg. 7 years later. Amlodipine was started.</p> <p>Simvastatin dose should have been reduced to 20mg in line with MHRA notified interaction (Aug 2012) and BNF 64 (Sept 2012). The error was picked up by a locum GP when a request for more meds came through. GP changed the Simvastatin dose from 40mg to 20mg. X then contacted us asking why his dose had changed. A GP phoned X and enquired whether X had experienced any muscle problems to which he replied 'no'. The GP then explained the reason for the dose change. Patient was happy and agreeable to the plan and didn't want to pursue the matter.</p>	<p>All clinicians advised of the MHRA guidelines with regard to statin use.</p> <p>When authorising scripts extra care needs to be taken to check medication doesn't interact with other.</p> <p>Search to be conducted on clinical system for patients taking a statin and Amlodipine to ensure same error has not occurred to any other patient.</p>

Incident type	What happened	Learning
Sharps	<p>Elderly diabetic patient with increased confusion. Seen by GP on home visit. Went to check BM. After initial use of finger pricking device insufficient sample obtained. Went to use + re-load finger pricking device . In so doing doctor's finger was pricked by the used needle.</p> <p>Finger held under running water. Dry dressing applied. Patient and family informed of events. Occupational health informed on return to surgery. Blood taken from GP same day. Blood from patient sent off for viral serology.</p>	<p>Continuing care and precautions with sharps. Consider using gloves for finger pricking.</p>
Information governance	<p>2 red patient folders found in surgery that did not belong to us (presumably handed in by relatives) were sent to Castle Circus NHS address instead of Union House NHS address, inadvertently.</p> <p>They were transported via the NHS courier system so did not leave the NHS.</p>	<p>Initially not sure where the folders had come from so Practice Manager emailed all staff at the surgery to ask if anyone knew about them.</p> <p>One staff member then replied to say she had sent them on to the incorrect NHS address as though they belonged to the District Nurses..</p> <p>Email sent to all surgery staff emphasising importance of sending mail to the correct place. Also we should have enclosed a compliments slip as a minimum to make it clear where the folders had come from.</p> <p>Whilst patient information still within the healthcare 'group' we should try to avoid this happening in future taking into account confidentiality and time wasting.</p>
Incorrect dose	<p>Child prescribed different formulation of Furosemide but with correct dosage ie 3.5ml of 5mg/5ml instead of 0.35ml of 5mg/5nm. The issue was identified during an admission to Acute Hospital when the child presented with increasing shortness of breath due to heart failure. Parents had not understood that an increased volume of Furosemide was needed with the change in formulation.</p> <p>It is not clear from the discharge summary from the Acute nor from subsequent clinic letters what information the parents were given when the dosage error was discovered nor whether the parents recalled any conversation with the GP about dosage or formulation. Having spoken to the Consultant Paediatrician, in charge of this admission and after reviewing the hospital records , it would appear that little was made of the incident other than to remind the child's parents of the importance of checking the dose on the label of any medication prescribed.</p> <p>GP contacted the parents to apologise that I had not explained fully enough the change in formulation.</p>	<p>The discharge summary of (X date) quoted in the Acute incident form was not received by GP Surgery. It was requested 2 and a half months later when GP learnt about the incident from NHS England. This is the only record of the change of medication causing a problem and it appears that nobody at the GP Surgery was made aware of the Significant event by the Acute hospital.. If we had, we would have done an internal SEA at the time of receiving the discharge summary. It was not immediately apparent from the child's hospital record who it was of the hospital team that completed the SEA form. Make all Prescribers aware that a change in formulation needs to be clearly and appropriately explained with the reason for making the change (and documented as such).</p>

Incident type	What happened	Learning
Out of date vaccine	<p>Patient X attended surgery with mother for blood test, and enquired about school leaver booster. The Nurse in the consultation agreed to give them whilst here as she was due a hospital appointment next week to discuss commencement of clyclosporin treatment for Eczema. Revaxis and Neisvac-C were given to the patient and whilst documenting them in the records noticed the Revaxis was out of date (09/14), other boxes in the fridge had expiry date of 09/15 which had been seen by the nurse when removing from the fridge but had picked out an expired vaccine, and the nurse hadn't rechecked date once removed from fridge.</p> <p>Clinical Lead and Practice Manager informed of incident by Practice Nurse. Immunisation co-ordinator also contacted for advice. Documented incident in patient's notes. Details of contact with patient:</p> <p>Further telephone conversations were had with the mother to confirm the Meningitis vaccine was in date, and apologies made. Reassured that the practice would investigate the incident and implement changes to ensure it doesn't happen again. Contacted by Practice Manager and apology given. Will be contacted by the clinical lead to apologise again and discuss follow-up vaccination and when to give following advice from the immunisation advice team.</p>	<p>Vaccine stock checks need to be more vigilant and recorded monthly by the lead nurse on a computer spreadsheet and stock rotated to ensure older vaccines used first. It is vital that every clinician checks batch numbers and expiry dates before administration.</p>
Wrong patient	<p>Wrong patient with same name booked in for telephone consultation. Patient prescribed medication over telephone. Only identified as wrong patient by chemist when picking up the script.</p> <p>Actions: Both patients' notes were corrected and updated. Drugs removed from wrong patient screen. Correct script faxed to chemist.</p>	<p>The importance of adhering to practice policy of cross checking date of birth and address when booking patients.</p>
Capsules empty	<p>Patient X attended appointment with GP to ask for further prescription for Tiotropium capsules, X explained he/she had taken the medication and identified no taste or sound, he/she tried twice then opened a capsule from the pack and found it empty. X was concerned as he/she noticed a deterioration in the respiratory symptoms (has COPD). X returned to the pharmacy and explained findings and asked the pharmacist to open a capsule – it too was empty.</p> <p>X was told they could not replace medication and advised to see own GP. X also stated he had been given a ventolin inhaler which on getting home X found it was empty but said the pharmacy replaced this for him.</p>	<ul style="list-style-type: none"> • Immediate assessment of clinical status – no further action required at that time. • Further script for Tiotropium issued • Reported as a significant event and contacted colleagues to enquire if further episodes had been reported and to warn of event. <p>Of considerable concern as medication is in a capsule form which is inhaled making it almost impossible to identify empty capsules, X was suspicious as X's COPD had deteriorated and had been using the medication for some time so was aware of a taste which was then missing.</p>

Incident type	What happened	Learning
<p>Communication between health professionals & Treatment Escalation Plans</p>	<p>Community Nurse received referral requesting urgent review of a patient X who was struggling to manage at home. Referral made by GP who had not yet seen X but had received message from ambulance service to say X was found banging his stick on his bin to get attention, neighbour had called for an ambulance. When paramedics arrived they found the patient had oxygen saturation levels of 61% on air, and respirations were up, BP low, temperature normal. Paramedics wanted to admit patient to hospital but patient declined. Paramedics felt X had capacity to do this.</p> <p>Nurse visited with Social worker and it was evident that X had not been coping at home for some time. X was very thin and malnourished. Consent gained for observations, X declined hospital admission or ambulance to be called. It was deemed that X had capacity at this time.</p> <p>Contacted GP to express concerns. GP prescribed antibiotics for his chest infection and UTI. Explained we would set up rapid response four times daily and attempt to sort out his social situation, regarding cleaning and food. However, GP needs to review as self-neglect despite appearing to have capacity.</p> <p>This scenario was repeated several times and after several visits GP advised prior to visiting X that TEP form was needed as patient clinically unwell and declining hospital admission. Received phonecall from GP following visit. GP advised TEP not completed as patient did not want to be for resus. Advised GP that this was okay and that patients can still be for resus but that guidance surrounding fluids/feeding and hospital admission should still be considered. GP was still very reluctant to complete TEP. Advised that if X was to become so unwell he was unable to inform us of his/her wishes that we would have to admit X in their best interest and that Support workers and staff needed some guidance surrounding this. GP not clear if TEP would be completed or not.</p> <p>GP - The community nurse had asked me to consider filling out a TEP form for X. I discussed specifically the form with X who still did not want to go into hospital, but when I asked X about resuscitation, this was not a concern to him, even when we discussed the possibility of X's heart stopping. X did not want to discuss this further at that time. It was a difficult situation as there was no reason in my mind that X would not be for resuscitation, as X had previously been physically well and was not particularly old. However often resuscitation requires admission into hospital, if the patient is at home. Whilst X was conscious and able to decline going into hospital I felt it was reasonable to allow X to state this intention without the need for a TEP form confirming this.</p> <p>X recovered slightly but was eventually found collapsed at home with pneumonia and was taken to hospital - X died there.</p> <p>When X was found unconscious it would not have been appropriate to have left X at home, as there would not have been anyone able to stay with X whilst he was unconscious and dying. Therefore, admission to hospital was actually the only solution and a TEP form which said tha X did not want to go into hospital, is unlikely to have changed the outcome.</p> <p>GPs in surgery have reviewed the case as a Practice and suggest that clarification is required as to the purpose of TEP forms. Our understanding is that they were originally introduced to give patients the option to plan and document their future care wishes with their GP. This patient was offered this opportunity and declined.</p>	<p>Treatment Escalation Plans (TEP) continue to be part of many SEAs that we receive. They are not always the direct focus of the significant event, more often communication between different professionals/ agencies is however we have identified some learning opportunities. These include use of correct form, how to use the form, changes following clinical review and best interest meetings. Please see useful links providing current information:</p> <ul style="list-style-type: none"> • New version of TEP (v10) now in use – this incorporates new section to document mental capacity/ best interest meetings • Guidance on completing the form available http://www.devontep.co.uk/?p=44 • 2 short films available <ul style="list-style-type: none"> o Q & A session regarding TEP form & process o A GP in a patients home discussing End of Life Care • Devon TEP website can be found http://www.devontep.co.uk/ • Supplies of TEP forms for NEW Devon CCG from 01752 246501 or tep-sw@nhs.net/ jade.marshall@stlukes-hospice.org.uk <p>In addition, the Devon TEP (treatment escalation group) are currently gathering views on the Devon TEP, if you have anything to add please click on the very short survey</p> <p>https://www.surveymonkey.com/r/V7GLDB5</p>