The Concise Safe Systems Checklist

## Introduction

During the development of the Patient Safety Toolkit the study team identified a number of important aspects of patient safety not currently covered by any existing tools or legislation and which specifically relate to background systems in practices. We formed the checklist from these concepts and have tested it in GP surgeries in stage 2 of this project. The tool is intended to prompt internal discussion in your practice rather than be simply a tick-box exercise.

## Instructions

This practice-wide checklist should be filled in by a senior member of practice staff. Please answer for the practice as a whole not for your individual role. Please consider each statement and indicate whether or not you are satisfied with the system your practice has in place to address each issue. If you answer No to a statement, or there are any improvements which you think could be made to your existing system, please document them below and use this document for reference in future meetings or audit. If the system is not applicable to your practice please indicate N/A. If you are uncertain whether your practice has systems in place in relation to each of the issues please investigate so you can give an answer.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | N/A | Any changes required? |
| All incoming clinical information is seen by nominated members of the team trained (or with relevant clinical experience) to deal appropriately with this information before the information is filed in the patient’s record. |  |  |  | Click here to enter text. |
| Where incoming clinical information requires follow-up or diarised activity this is recorded in the patient’s record and acted upon |  |  |  | Click here to enter text. |
| Where a clinician decides it is indicated, the patient (or where appropriate the patient’s representative) is informed of abnormal investigation results in an appropriately and timely manner and this contact is documented in the patient’s record. |  |  |  | Click here to enter text. |
|  | Yes | No | N/A | Any changes required? |
| The practice keeps a log of minor operations containing all the following information   * Date/patient’s name * Procedure performed * Who performed the operation and who assisted * Consent taken * Any complications * Specimen sent for Histology Y/N * Patient informed of result |  |  |  |  |
| Up-to-date information on practice policies, procedures and local facilities/services is provided to guide all temporary clinical staff (including GP registrars). |  |  |  | Click here to enter text. |
| Vulnerable patients discharged from hospital are followed-up by a member of the clinical team within 1 month |  |  |  | Click here to enter text. |
| Non-collection of prescriptions is monitored or followed-up and is a trigger for review and audit in partnership with local pharmacies |  |  |  | Click here to enter text. |
| The indication for all repeat medications is coded within the electronic record (excluding topical preparations) |  |  |  | Click here to enter text. |
| All staff are trained to make safe use of the prescribing elements of the clinical IT system which are relevant to their role |  |  |  | Click here to enter text. |