## Name of Policy: PATIENT SAFETY ALERTS

<table>
<thead>
<tr>
<th>Date Adopted at Partners Meeting</th>
<th>Amendment Date</th>
<th>Reason for Amendment</th>
<th>Policy Renewal Date</th>
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<tr>
<td>14th March 2016</td>
<td>1/8/2016</td>
<td>Additional checking per Para 2.</td>
<td>March 2019</td>
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<tr>
<td></td>
<td>15/12/2016</td>
<td>Revised Drug Safety Alerts procedure</td>
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**Content:**

1. Safety Alerts Procedure
2. Medical Devices and Drugs Alerts.
1. SAFETY ALERTS PROCEDURE

The practice procedure to follow on receipt of a Medical Device Alert (MDA) which are disseminated via NHS England’s Central Alerting System and will also apply to Drug Alerts. Patient alerts are received via North Derbyshire Clinical Commissioning Group.

This procedure will be followed when these, or similar alerts requiring specific safety action are received, such as drug alerts or recalls.

The MHRA encourages the active reporting of adverse incidents from both clinicians and members of the public involving the use of medical devices via their on-line reporting system and practices should normally liaise with North Derbyshire CCG accordingly.

Both the MHRA and local NHS organisations and practices may learn from safety incidents and examine their own local procedures to ensure that risks in these areas are minimised.

An adverse incident is one involving a device which has the potential to cause unwanted effects which may compromise patient or user safety. This may include design faults, maintenance effects, error in method of use or application, lack of adequate use instructions, need for additional user training etc.

A report should be made where the incident could lead to:

- Death or serious injury
- Medical or surgical intervention
- Unreliable test results

But lesser incidents or effects should also be reported as these may lead to further trend investigations. Serious incidents should be reported with some urgency.

Where a device is the subject of an alert this should be:

- Quarantined along with all packaging
- Retained securely (not returned to the supplier)
- Held pending further instructions

2. Medical Devices and Drugs Alerts.

The practice has registered for alerts via the MHRA e mail address (email.support@mhra.gsi.gov.uk) Medical Device, Drug and Patient Alerts may be distributed to practices via email. These E-mails arrive via the practices generic e mail address and practice managers e mail address and are then sent by the secretary’s team to the Practice Manager in the first instance or Deputy Practice Manager in their absence.
The following procedure will apply within the practice:

- Email will be accessed daily and alerts will be retrieved
- The email is then sent to the Practice Manager at: martin.donohoe@nhs.net
- Each alert will contain an indication of the timescales or urgency with which it should be actioned.
- The Practice Manager will then record the type of alert, the name of the patient where applicable, the date the alerts were received, the issue and the action taken on the “Alerts Spreadsheet” located at “shared drive/AA Alerts.”
- Drugs and devices alerts are then recorded in the register of alerts and sent to all GPs by the practice manager. Advice sought from the clinical team who will instruct on the course of action to be taken.
- As a safety check the practice manager will check the weekly alerts for any issues relating to general practice and save a copy of the screen print at shared drive/Alerts/Alerts 2016.

3. Patient Safety Alerts

These alerts are received directly by the practice manager via North Derbyshire Clinical Commissioning Group and are subject to password access which is “HPANAlerts.”

Upon receipt of the alerts the detail will be recorded as detailed at paragraph 2 above and sent to the administration team to note. Each member of the team is required to sign the alert to confirm that they have read the information and these are then filed in the “Information and Alerts” located on reception.