

TOP TIPS FOR USING THE eFORM



The anaesthetic eForm is a tool for reporting patient safety incidents and near misses that occur in the anaesthetic pathway. It provides an enhanced dataset for anaesthesia and a rapid mechanism for learning via the Safe Anaesthesia Liaison Group (SALG). All reports received by SALG are completely anonymised. The eForm is available for use in England and Wales.

1 CLICK THIS LINK FROM ANY COMPUTER

You can access the eForm from any computer or Smartphone from [this link](#). You don't need any software, just click and go.

2 DON'T FORGET TO SAVE A LOCAL COPY

You can either print or save a copy of your submission by following the instructions given when you've completed the form. This gives you the opportunity to use the data for local learning.

3 MAKE FRIENDS WITH YOUR RISK MANAGER

Let your risk manager know that you will be using the eForm. Your eForm submissions will be viewable in their usual NPSA portal by clicking the eForm tab.

4 BE CONFIDENT THAT YOUR REPORT WILL BE WITH YOUR RISK MANAGER INSTANTLY

Reports submitted via the eForm reach your risk manager in real time. As soon as you submit, the report reaches both the Trust's local portal and the national database (NRLS).

5 LET IT ALL OUT

The eForm has been designed to capture the anaesthesia specific details that other forms will not. There is plenty of space for free text so you don't need to hold anything back. If you are in doubt as to whether any aspect of your incident is important, please include it. A detailed understanding of the incident will ensure optimum learning locally and nationally.

6 FAMILIARISE YOURSELF WITH GRADES OF HARM

If you are unsure about the grading of harm that applies to your incident you will find the help box next to the grading field on the eForm helpful. It gives definitions from page 100 of the publication [Seven Steps to Patient Safety](#) and some examples.

7 LOOK OUT FOR YOUR REPORT IN THE PATIENT SAFETY UPDATE

All reports submitted to the eForm are anonymised. They are then read by a consultant anaesthetist and accounted for in the quarterly [Patient Safety Update](#). Deaths and severe incidents submitted using this tool are read by clinical reviewers and shared, where appropriate, with a consultant anaesthetist on a weekly basis. Look out for the Update and see where your report fits in to the national picture.

8 REMEMBER TO REPORT

Reporting critical incidents and near misses is imperative to the advance of patient safety in our specialty. Please remember to report.