Checklist of tasks for MSOs of large organisations

- **Make an assessment of the quality of reports of patient safety incidents (PSIs)** that can be used in future to monitor for improvement, such as:
  - How often fields are accurately completed
  - The number of times PSIs are revisited to update information, paying attention to serious harm
  - Develop a system to aggregate RCAs and find out if they did actually lead to safer practice
  - Survey staff groups, particularly nurses to determine their understanding of 'level of harm'
  - Investigate mechanisms locally for conveying to practitioners what has been done as a consequence of their reporting – see section on feedback below
  - Investigate the results of the Medicines Optimisation Dashboard and the Medication Safety Thermometer as independent surrogate measures of quality improvement

- **Identify a Board level Director**

- **Set up a generic e-mail** that can be accessed by or provided as a group email for the covering person during MSO planned and unplanned absence (this may also be helpful where there is a team supporting the MSO role)

- **Identify an MSO and covering arrangements** for the role during planned and unplanned absence
  - Notify NHS England of named MSO contact details and also generic e-mail addresses

- **Identify a new or existing multidisciplinary group**
  - Check representation against Alert requirements
  - Agree Terms of Reference with respect to reviewing medication incident reports, improving reporting and learning, taking local action to minimise harm to patients
  - Clarify roles in the organisation with respect to medication incident reporting
  - Agree mechanisms to feedback data on medication incidents to reporters. Does your local database allow automatic feedback to the reporter?
• **How is medication incident reporting is managed in your organisation?**
  The MSO (and team) will need to review all medication incident reports to ensure data quality for local and national learning and where necessary investigate and find additional information from reporters.
  - Understand how serious medication incidents are reported and dealt with. Ensure that these are also reported onto the NRLS
  - Understand how local reports are made and how these are transmitted to the NRLS

• **NRLS**
  - Build relationship with existing organisation risk management or clinical governance team(s)
  - Obtain permissions to access NRLS ‘live’ so that amendments can be made
  - Investigate reports that are available to you locally from the NRLS data e.g. your organisation’s data compared to selected others
  - Make arrangements to regularly review and amend the quality of the reports for all identified serious and moderate incidents

• **How is information on reported medication incidents fed back?**
  - Think about how to examine data on reporting rates. By area, division, team? Per 100 bed days? Target groups that have a low level of reporting?
  - Do you produce a regular bulletin that highlights reports and medication safety issues?
  - How do staff groups know what to report?

• **Networking**
  - Attend monthly MSO webinars organised by NHS England
  - Plug in to ‘regional’ or area MSO network(s)
  - Look out for the MSO Conferences being organised in the future
  - Keep up to date with the content of the webinars and other information on [http://www.patientsafetyfirst.nhs.uk](http://www.patientsafetyfirst.nhs.uk) (National Safety Networks)