



Developing a Patient Centred Incident Reporting Medical Device Framework

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BACKGROUND

In Malta, there is a significant rate of under-reporting of medical device related incidents. Implementing an incident reporting (IR) framework that encourages communication and transparency with stakeholders will reduce risk to users and improve the quality of medical devices on the market.

PURPOSE

To develop a patient-centred IR framework that allows for communication and transparency with stakeholders in concluding IR for the benefit of patient safety.

METHOD

The methodology was divided into three phases:

Phase 1: *Needs assessment*, IR systems of European Member • States available on the respective National Competent Authority (NCA) websites were reviewed. Common themes and data fields used were identified and discussed through an expert panel. An IR Form for healthcare professionals and another for patients were developed and validated by the same expert panel.

Table 1: Expert Panel Members*						
Clinicians	Pharmacists	Stakeholders**				
* 2 members of each group **representatives from medical device sector						

- Phase 2: Development of quality management system supporting the IR framework, focused on the development of SOPs that related to the receipt and processing of IRs, the liaison with other NCA and notified bodies as necessary. As well as the procedure for discussion through an Incident Action Group consisting of representatives from the national procurement unit of medical devices, the clinicians as end users and the NCA. **Economic operators were invited accordingly for their input. The** SOPs compiled were reviewed by the same expert panel.
- Phase 3: Implementation of the IR framework focused on the \bullet pilot implementation of the structure.

RESULTS

Phase 1: Eight themes were included in the IR forms as identified

through the expert panel (Table 2). The validated Incident Report

Form is shown in Fig 1.

Table 2: Themes included in IR forms				
Device and patient data	Device performance and malfunction			
Incident details	User error			
Adverse events	Follow up actions			
Suspected cause	Reporter details			

Phase 2: Three SOPs were compiled. All the expert panel agreed that the SOPs were clear, concise, robust and served their intended purpose.

Phase 3: The IRs reported between 2022 and March 2023 were 216, **207** of which were received from Healthcare Professionals with the National Health Service. The IRs were classified during 14 2-hour incident group action meetings, 186 IRs were successfully classified





🗆 No

Section A: Details of Reporter Tick the box if you wish to keep the below information confidential.					Brand name:			
			ntial.	If 'Yes', add all	CPSU Ref Number:			
					relevant details of other	er Product Code/Reference (Ref):		
Name & Surname Contact Number	Position			products	Serial/ Batch/ Lot Number:			
				Was the device used in coproduct?	ombination with a medicinal	□ Yes		
Email Address	Signature of Reporter		Date		If 'Yes' add all relevant	Brand name:		
			details of other	Batch Number:				
				products	Other (e.g. dose/ flow rate):			
	Section B: In	ncident Details			Was a serious incident			
A1. Place of Incident				suffered?	suffered?			
Entity/ Hospital					If 'Yes', indicate the type	e of incident:		
A2. Device Details - Ple	ease include all the k	nown/ visible de	etails of th	he device	Causal relationship be	tween the incident and the medical de	evice	
Brand Name Product Co			uct Code/ Reference (Ref)		□ Serious public health threat			
CPSU Sage Ref Number (if applicable) Batch/Lot Nu		t Number		\Box Death of a patient, user or other person				
					□ Unanticipated serious deterioration in a person's state of health			
Manufacturer		Quantity known to be defective (if any)		defective (if any)	\Box Other (please specify):			
Is the product CE Marked	🗆 Yes 🗆 No	Sterile		□ Yes □ No	Classify the severity of	🗆 High Risk		
A sample of the defective device must be retained where possible. If a sample cannot be retained, support this report with photos.			e possible. th photos.	the incident	□ Medium Risk			
				-		🗆 Low Risk		
Has a sample been \Box Yes \boxtimes retained?		If 'NO' specify reason:		Description of Incident				
A3. Incident Details					If a sample cannot be ret	ained, support this report with photos	s or any other	relevant
	Name of the				information.			
Date of Incident (DD-MM-YYYY)	ward/unit of where the incident occurred	Functional Us Product	e of		Other comments:			
Was the device used in o devices?	combination with oth	er medical		es 🗆 No				

Figure 1: Adaptation of the Incident Report form developed for **Healthcare Professionals**

CONCLUSION

The pilot implementation of the framework showed positive results, with a significant number of healthcare professionals reporting incidents, and the Incident Action Group successfully closing most of the reported incidents. The implementation of the patient-centred IR framework can contribute significantly to reducing adverse events, promoting patient safety, and enhancing the quality of healthcare services. Future research should aim to assess the long-term impact of the framework on patient outcomes and its effectiveness in different healthcare settings.