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National Patient Safety Agency

Lessons Learnt by the National Patient Safety Agency

14th December 2007

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NPSA

Overview

- Background to NPSA
- National Reporting and Learning System in England and Wales
- Using information to make change
- Approaches to Solutions Development
- Involvement of Patients

England and Wales

- **No. Population:** *53,728,800*
- **No. of Organisations in NHS:** *429*
- **No. of consultations:**

  Over 1.5 million patients and their families are in contact with NHS services every day
- **No. of Staff:** *1.3 million people employed in NHS*

NPSA: Background

- **An organisation with a memory (2000)**
- **Building a safer NHS for patients (2001)**
- **Safety First: A report for patients, clinicians and healthcare managers (DH 2006)**

The National Reporting Learning System

- All NHS organisations (acute, mental health and primary care) are connected
- Confidential reporting
- Incidents are mainly reported electronically and uploaded from Local Risk Management Systems 99%
- Direct Reporting

NRLS

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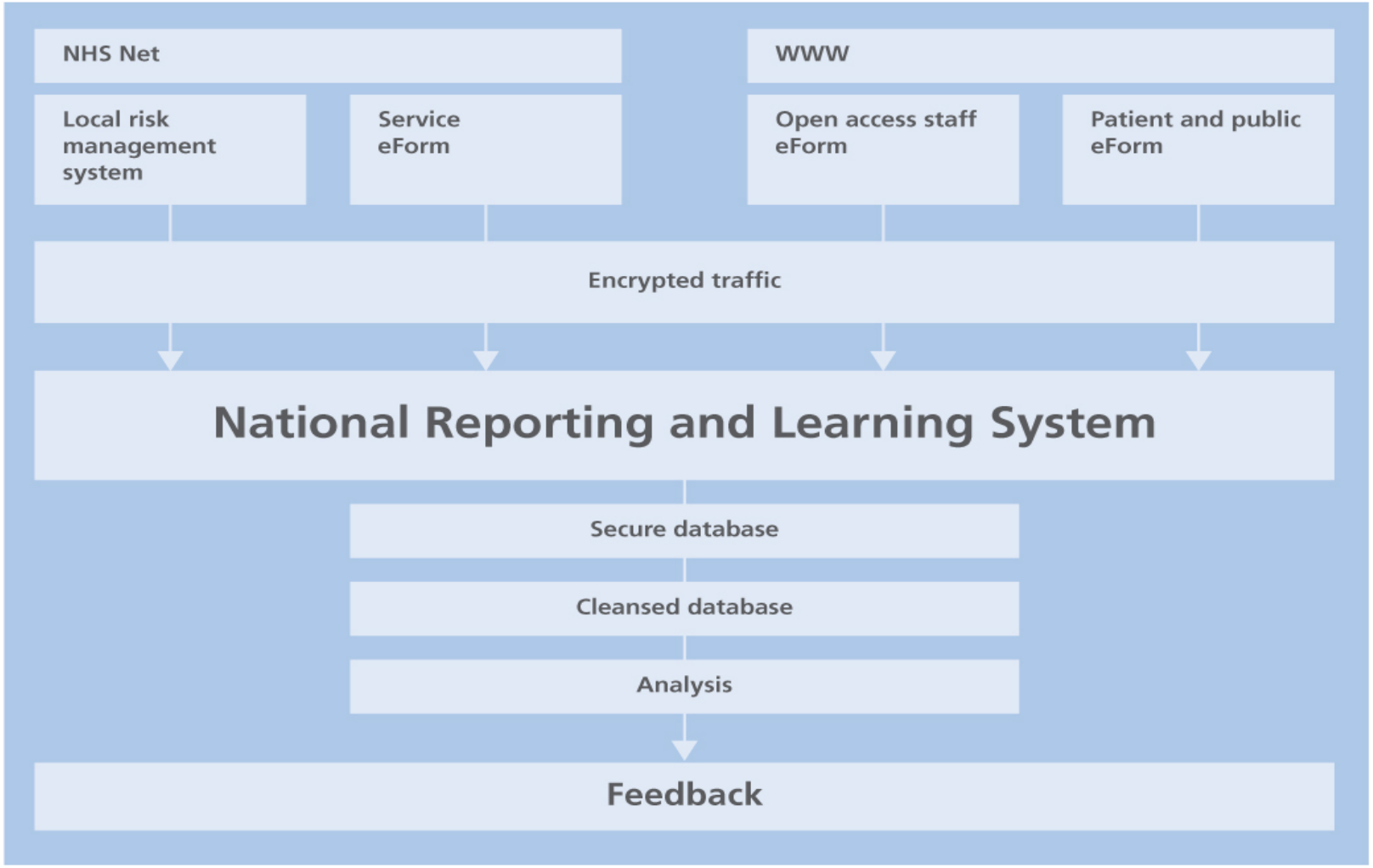
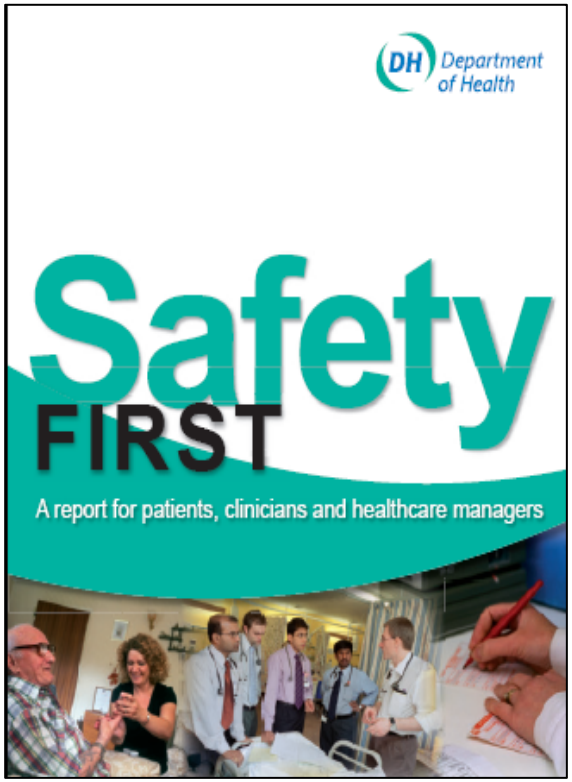
Figure 1: The National Reporting and Learning System



Change of Direction

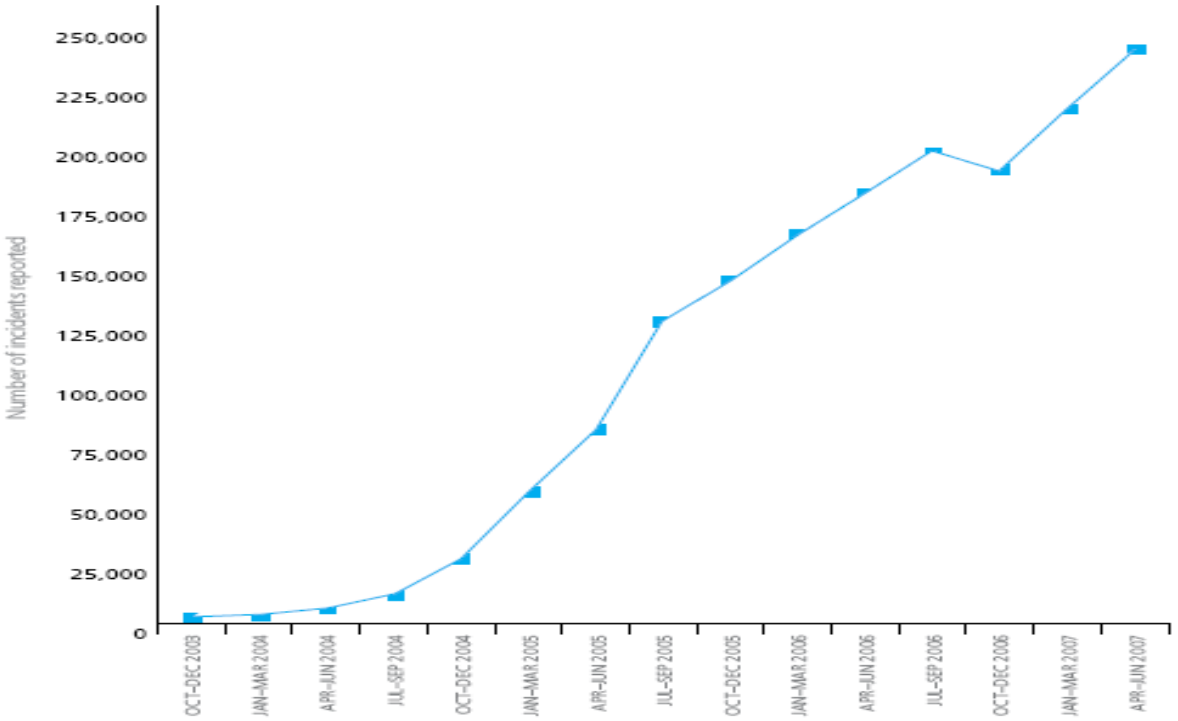


- Rapid reporting of Patient Safety incidents that involve serious patient harm and death within 36 hours of the report.

Purposes of the National Reporting and Learning System

- To identify similar incidents and learning to those reported through rapid reporting
- Follow-up of similar incidents
- Identify trends and patterns for priority action in the future
- Surveillance of incidents related to risk prevention strategies
- Evaluate and inform policy development

Number of patient safety incidents reported by quarter, November 2003 to June 2007



*Source: Data are based on date the incident was reported to the NRLS.

Source of Notification to NRLS, by quarter July 2006 to June 2007

Source of Notification	2006				2007			
	Jul - Sep		Oct - Dec		Jan - Mar		Apr - Jun	
	No. of Incidents	%	No. of Incidents	%	No. of Incidents	%	No. of Incidents	%
LRMS	200,178	99.0	185,620	98.5	217,752	98.5	239,657	98.8
Eform	1,940	1.0	2,538	1.3	2,685	1.2	2,118	0.9
Community Pharmacy	62	0.0	229	0.1	527	0.2	820	0.3
Total	202,180	100.0	188,387	100.0	220,964	100.0	242,595	100.0

Source: Data is based on date the incident was reported to the NRLS.

Care setting of incident reports, July 2006 to June 2007

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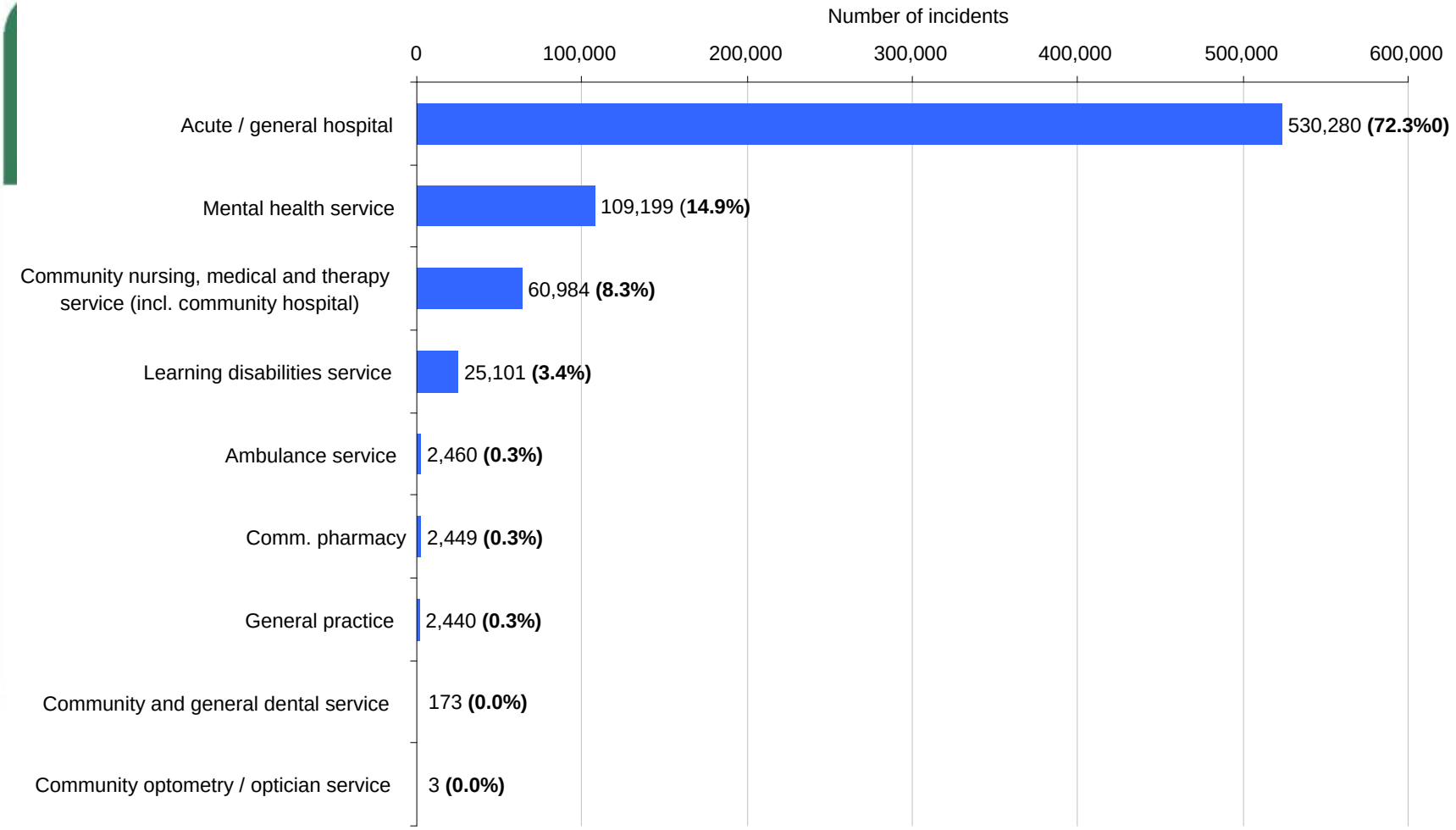

Source: Data is based on date the reported incident occurred, using data as of 04 July 2007

Reported degree of harm to patients, July 2006 to June 2007

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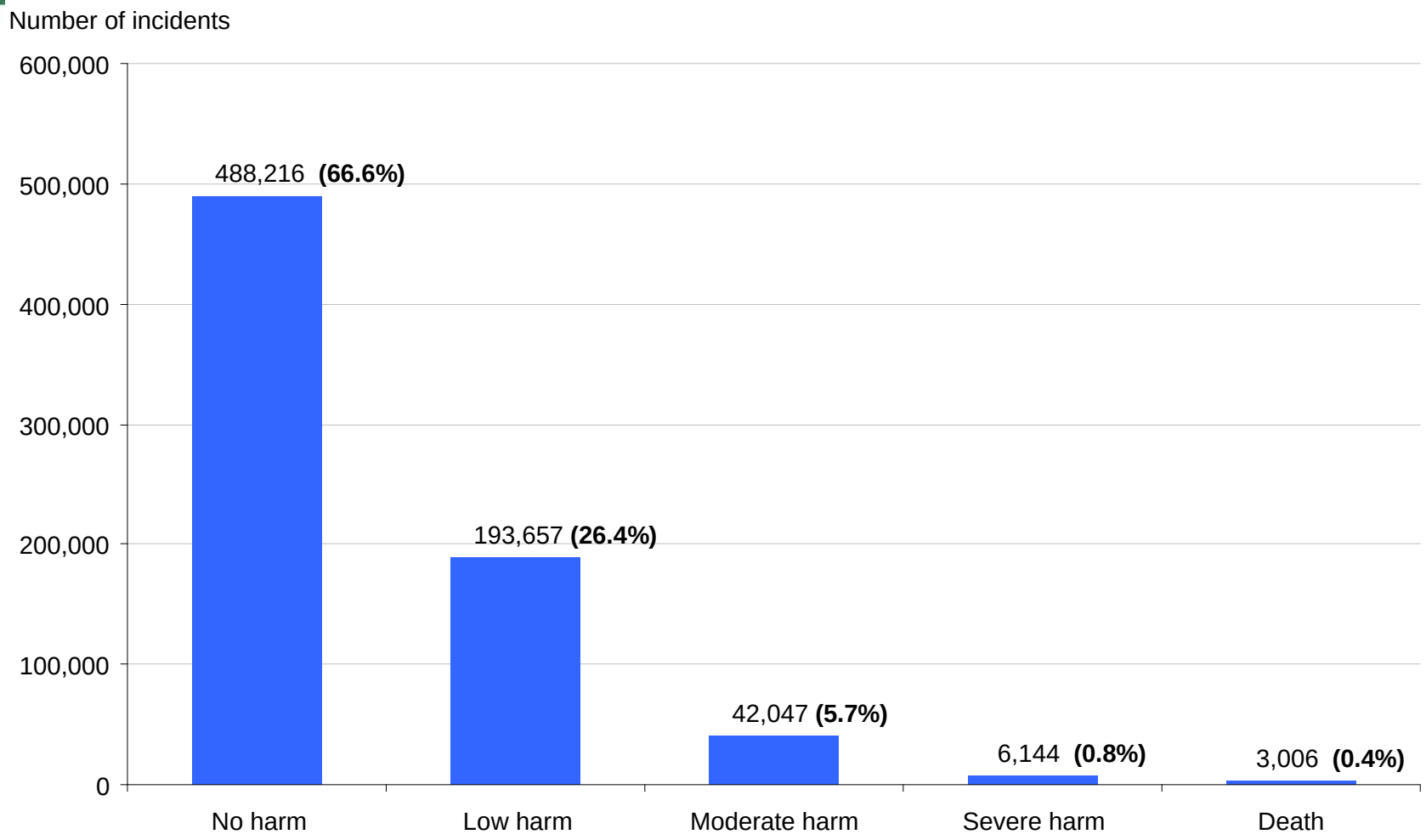

Source: Data is based on date the reported incident occurred, using data as of 04 July 2007. Patient groups and incidents with a missing degree of harm are excluded.

Reported Incidents Type between July 2006 to June 2007

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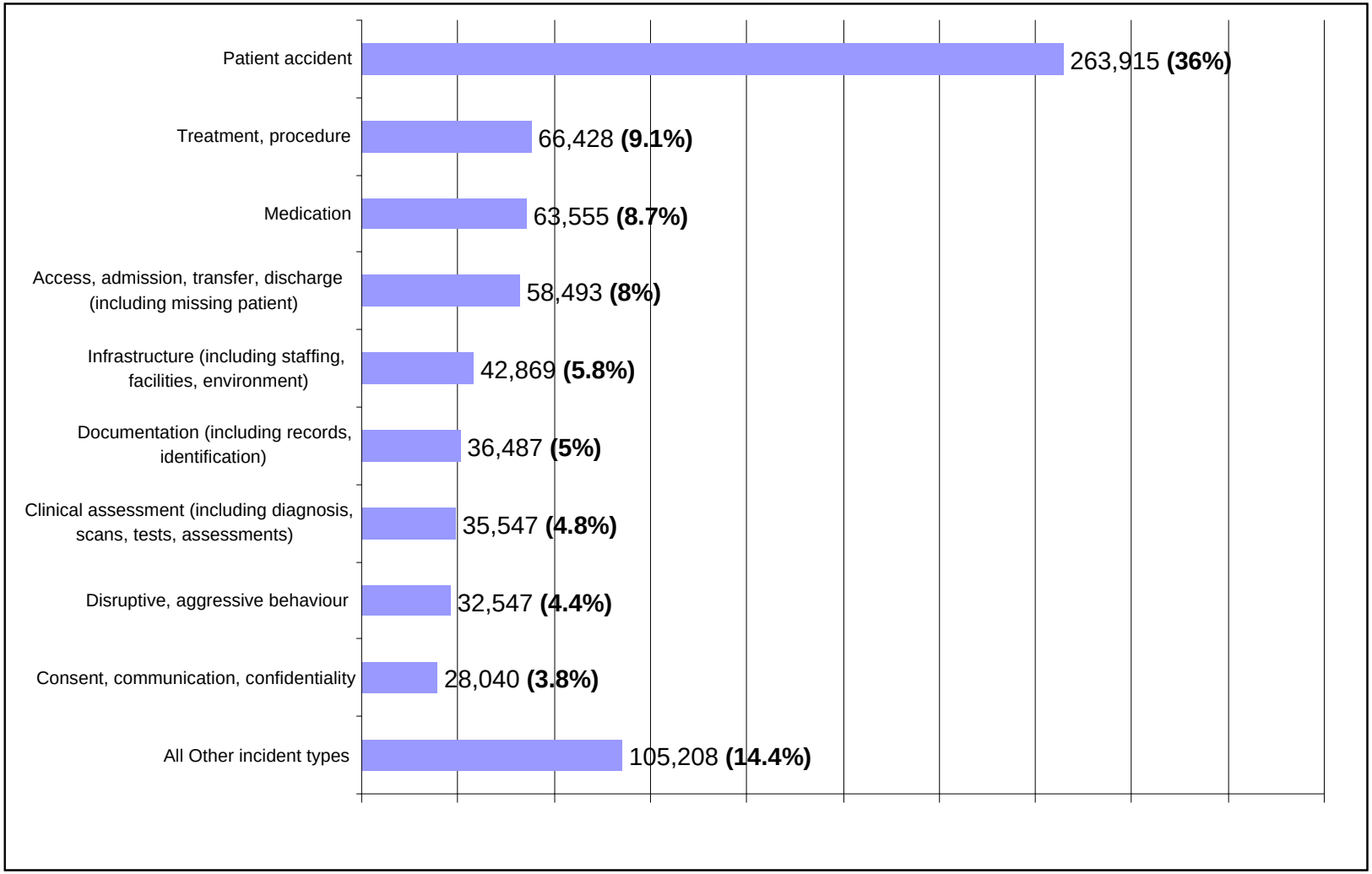
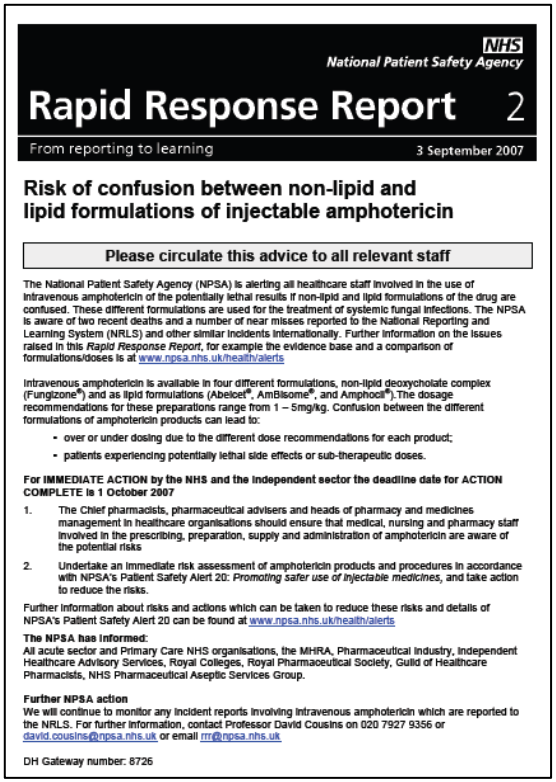


Using Reporting Systems to make change

- Initiatives to make patient care safer
- Initiatives to improve the quality of reporting and promote a safety culture

Initiatives to Make Care Safer



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Rapid Response Report 2

From reporting to learning — 3 September 2007

Risk of confusion between non-lipid and lipid formulations of injectable amphotericin

Please circulate this advice to all relevant staff

The National Patient Safety Agency (NPSA) is alerting all healthcare staff involved in the use of intravenous amphotericin of the potentially lethal results if non-lipid and lipid formulations of the drug are confused. These different formulations are used for the treatment of systemic fungal infections. The NPSA is aware of two recent deaths and a number of near misses reported to the National Reporting and Learning System (NRLS) and other similar incidents internationally. Further information on the issues raised in this *Rapid Response Report*, for example the evidence base and a comparison of formulations/doses is at www.npsa.nhs.uk/health/alerts

Intravenous amphotericin is available in four different formulations, non-lipid deoxycholate complex (Fungizone®) and as lipid formulations (Abelcet®, AmBisome®, and Amphocil®).The dosage recommendations for these preparations range from 1 – 5mg/kg. Confusion between the different formulations of amphotericin products can lead to:

- over or under dosing due to the different dose recommendations for each product;
- patients experiencing potentially lethal side effects or sub-therapeutic doses.

For IMMEDIATE ACTION by the NHS and the independent sector the deadline date for ACTION COMPLETE is 1 October 2007

1. The Chief pharmacists, pharmaceutical advisers and heads of pharmacy and medicines management in healthcare organisations should ensure that medical, nursing and pharmacy staff involved in the prescribing, preparation, supply and administration of amphotericin are aware of the potential risks
2. Undertake an immediate risk assessment of amphotericin products and procedures in accordance with NPSA's Patient Safety Alert 20: *Promoting safer use of injectable medicines*, and take action to reduce the risks.

Further information about risks and actions which can be taken to reduce these risks and details of NPSA's Patient Safety Alert 20 can be found at www.npsa.nhs.uk/health/alerts

The NPSA has informed:
All acute sector and Primary Care NHS organisations, the MHRA, Pharmaceutical Industry, Independent Healthcare Advisory Services, Royal Colleges, Royal Pharmaceutical Society, Guild of Healthcare Pharmacists, NHS Pharmaceutical Aseptic Services Group.

Further NPSA action
We will continue to monitor any incident reports involving intravenous amphotericin which are reported to the NRLS. For further information, contact Professor David Cousins on 020 7927 9356 or david.cousins@npsa.nhs.uk or email rrr@npsa.nhs.uk

DH Gateway number: 8726

- Raise Awareness
- Issued within two weeks
- Identifies immediate action
- System to track activity
- Deadline for completion

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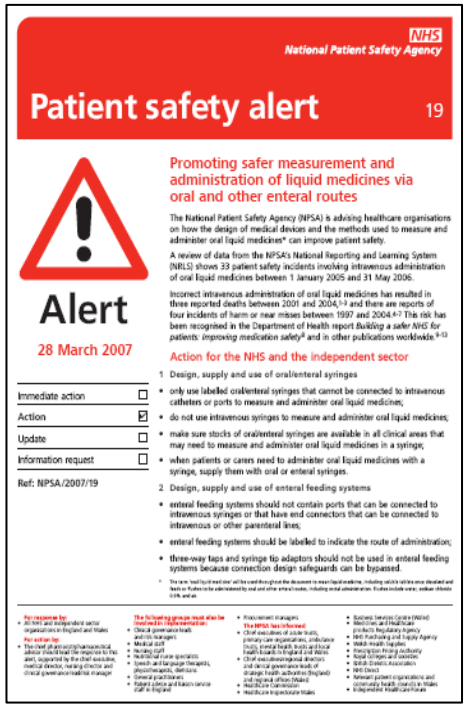
Initiatives to Make Care Safer



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Patient safety alert 19

Alert

28 March 2007

Immediate action ☐
Action ☑
Update ☐
Information request ☐

Ref: NPSA/2007/19

Promoting safer measurement and administration of liquid medicines via oral and other enteral routes

The National Patient Safety Agency (NPSA) is advising healthcare organisations on how the design of medical devices and the methods used to measure and administer oral liquid medicines* can improve patient safety.

A review of data from the NPSA's National Reporting and Learning System (NRLS) shows 33 patient safety incidents involving intravenous administration of oral liquid medicines between 1 January 2005 and 31 May 2006.

Incorrect intravenous administration of oral liquid medicines has resulted in three reported deaths between 2001 and 2004,[1–3] and there are reports of four incidents of harm or near misses between 1997 and 2004.[4–7] This risk has been recognised in the Department of Health report *Building a safer NHS for patients: Improving medication safety*[8] and in other publications worldwide.[9–13]

Action for the NHS and the independent sector

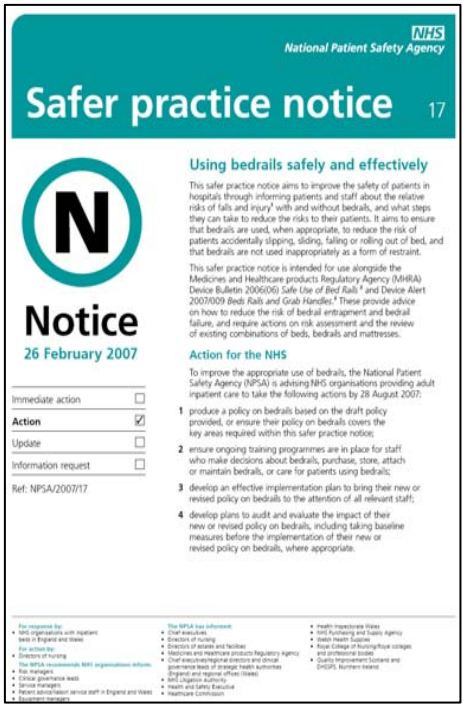
1 Design, supply and use of oral/enteral syringes

- only use labelled oral/enteral syringes that cannot be connected to intravenous catheters or ports to measure and administer oral liquid medicines;
- do not use intravenous syringes to measure and administer oral liquid medicines;
- make sure stocks of oral/enteral syringes are available in all clinical areas that may need to measure and administer oral liquid medicines in a syringe;
- when patients or carers need to administer oral liquid medicines with a syringe, supply them with oral or enteral syringes.

2 Design, supply and use of enteral feeding systems

- enteral feeding systems should not contain ports that can be connected to intravenous syringes or that have end connectors that can be connected to intravenous or other parenteral lines;
- enteral feeding systems should be labelled to indicate the route of administration;
- three-way taps and syringe tip adaptors should not be used in enteral feeding systems because connection design safeguards can be bypassed.

* The term 'oral liquid medicines' will be used throughout the document to mean liquid medicines, including solids taken once dissolved and feeds or flushes to be administered by oral and other enteral routes, including rectal administration. Routes include orally, sublingually, buccally, via nasogastric tubes, via gastrostomy tubes, via jejunostomy tubes, rectally and as a vaginal pessary.



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Safer practice notice 17

Notice

26 February 2007

Immediate action ☐
Action ☑
Update ☐
Information request ☐

Ref: NPSA/2007/17

Using bedrails safely and effectively

This safer practice notice aims to improve the safety of patients in hospitals through informing patients and staff about the relative risks of falls and injury[1] with and without bedrails, and what steps they can take to reduce the risks to their patients. It aims to ensure that bedrails are used, when appropriate, to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed, and that bedrails are not used inappropriately as a form of restraint.

This safer practice notice is intended for use alongside the Medicines and Healthcare products Regulatory Agency (MHRA) Device Bulletin 2006(06) *Safe Use of Bed Rails*[2] and Device Alert 2007/009 *Beds Rails and Grab Handles*.[3] These provide advice on how to reduce the risk of bedrail entrapment and bedrail failure, and require actions on risk assessment and the review of existing combinations of beds, bedrails and mattresses.

Action for the NHS

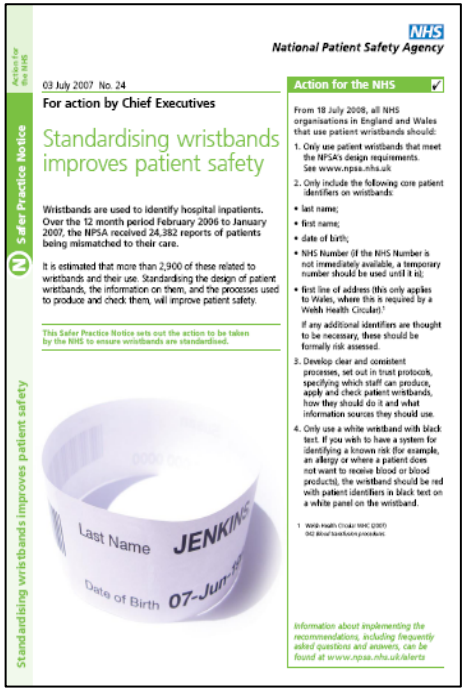
To improve the appropriate use of bedrails, the National Patient Safety Agency (NPSA) is advising NHS organisations providing adult inpatient care to take the following actions by 28 August 2007:

1 produce a policy on bedrails based on the draft policy provided, or ensure their policy on bedrails covers the key areas required within this safer practice notice;

2 ensure ongoing training programmes are in place for staff who make decisions about bedrails, purchase, store, attach or maintain bedrails, or care for patients using bedrails;

3 develop an effective implementation plan to bring their new or revised policy on bedrails to the attention of all relevant staff;

4 develop plans to audit and evaluate the impact of their new or revised policy on bedrails, including taking baseline measures before the implementation of their new or revised policy on bedrails, where appropriate.



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Action for the NHS

Safer Practice Notice

Standardising wristbands improves patient safety

03 July 2007 No. 24

For action by Chief Executives

Standardising wristbands improves patient safety

Wristbands are used to identify hospital inpatients. Over the 12 month period February 2006 to January 2007, the NPSA received 24,382 reports of patients being mismatched to their care.

It is estimated that more than 2,900 of these related to wristbands and their use. Standardising the design of patient wristbands, the information on them, and the processes used to produce and check them, will improve patient safety.

This Safer Practice Notice sets out the action to be taken by the NHS to ensure wristbands are standardised.

Action for the NHS ✓

From 18 July 2008, all NHS organisations in England and Wales that use patient wristbands should:

1. Only use patient wristbands that meet the NPSA's design requirements. See www.npsa.nhs.uk
2. Only include the following core patient identifiers on wristbands:
   - last name;
   - first name;
   - date of birth;
   - NHS Number (if the NHS Number is not immediately available, a temporary number should be used until it is);
   - first line of address (this only applies to Wales, where this is required by a Welsh Health Circular).[1]

   If any additional identifiers are thought to be necessary, these should be formally risk assessed.
3. Develop clear and consistent processes, set out in trust protocols, specifying which staff can produce, apply and check patient wristbands, how they should do it and what information sources they should use.
4. Only use a white wristband with black text. If you wish to have a system for identifying a known risk (for example, an allergy or where a patient does not want to receive blood or blood products), the wristband should be red with patient identifiers in black text on a white panel on the wristband.

1 Welsh Health Circular WHC (2007) 042 *Blood transfusion procedures*

Information about implementing the recommendations, including frequently asked questions and answers, can be found at www.npsa.nhs.uk/alerts

Solutions: preventing errors: a hierarchy

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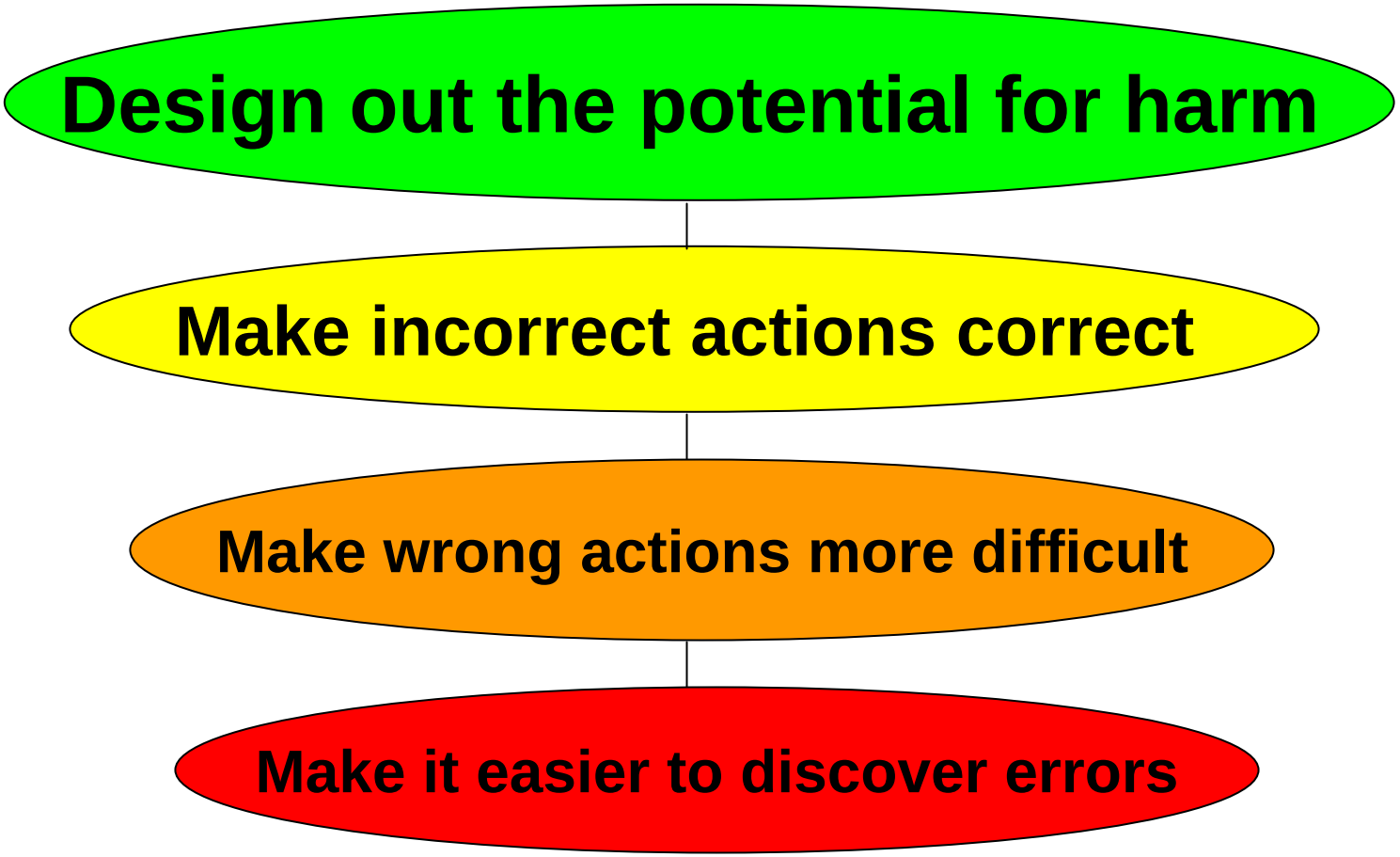

Involvement of Patients

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- Understand the issues
- Part of the solution
- Produced health service and patient Briefing

NHS National Patient Safety Agency

Safer practice notice 11

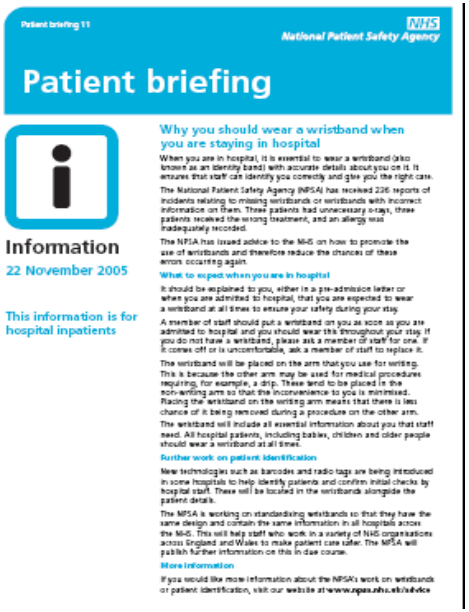
Notice

22 November 2005

Wristbands for hospital inpatients improves safety

Immediate action ☐
Action ☑
Update ☐
Information request ☐

Ref: NPSA/2005/11



Patient briefing 11

NHS National Patient Safety Agency

Patient briefing

Information

22 November 2005

This information is for hospital inpatients

Why you should wear a wristband when you are staying in hospital

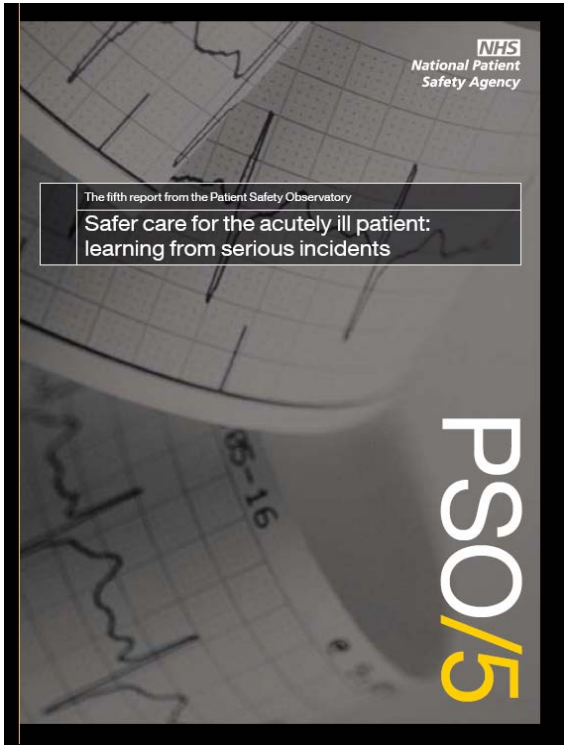
Using systematic analysis and the 'observatory' approach to learn and respond

Monthly systematic analysis of deaths reported to the NRLS in 2005 (n = 1,804)

Of these – maybe or was considered directly attributable to a Patient Safety Incident (n = 576)

Reveals 3 main themes:

1. Diagnostic error (n = 86)
2. Deterioration not recognised or not acted upon (n = 66)
3. Resuscitation (n = 59)



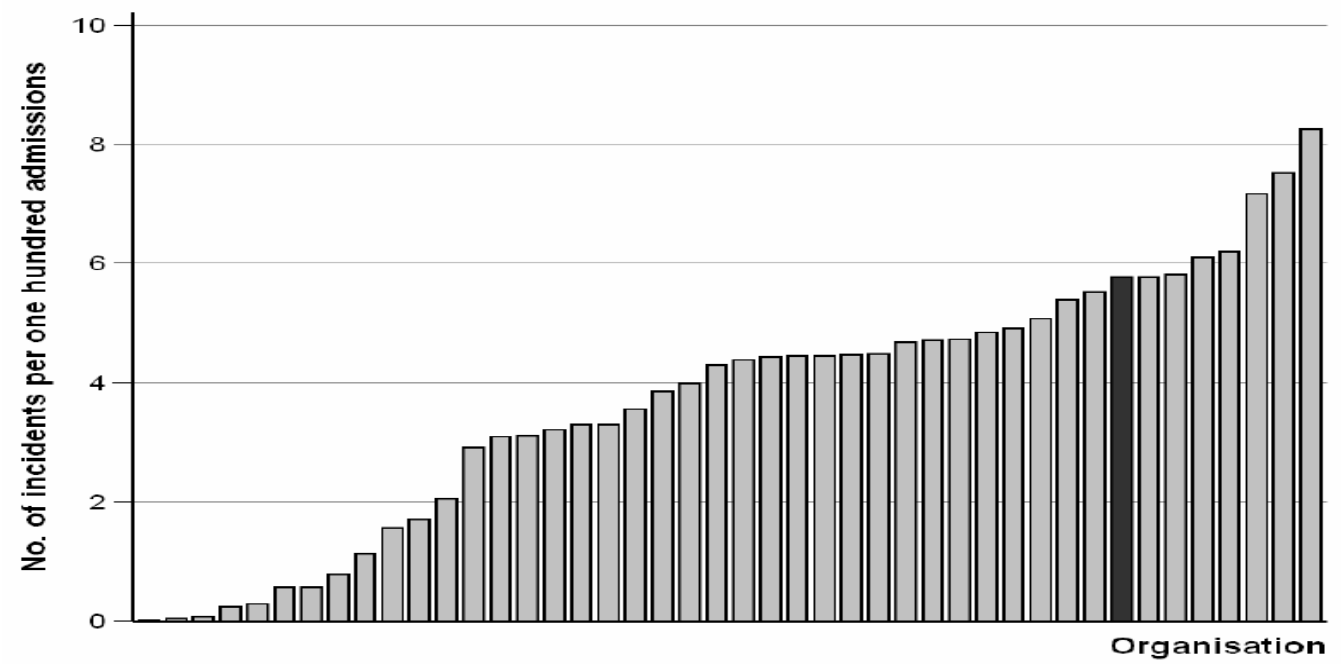
Role of Qualitative Data in Reporting Systems

- Provides useful additional information for learning
- Provides case studies to illustrate points which front-line clinicians relate to
- Brings incidents and learning alive

Initiative to improve the quality and reporting and promote a safety culture

- Quality Feedback Reports to Trusts

Figure 2: Incident rate per one hundred admissions



Source: patient safety incident reports successfully submitted to the NRLS where the incident occurred during the period 1 October 2006 to 31 March 2007

Sharing Information for NRLS to improve Patient Safety

- Regulator of Health Care (Healthcare Commission)
- Commissioners of Health Care
- Performance Management of Health Care

Summary

Lessons from NPSA:

- National Reporting and Learning System is important for making change
- Quality of data is a challenge
- Need new approaches to Solution Development
- Involvement of Patients – important element to raise awareness to be part of the solutions