Learning from experience

Sir Liam Donaldson

Faculty of Medicine
The Complutense University of Madrid
Spain
27th October 2011

Key lessons

Standardisation works

Cultural change also needed

Good data ensures accountability

Celebrate and communicate success

Sustainability is the greatest challenge

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Second Global Patient Safety Challenge

WHO Surgical Safety Checklist

Surgical Safety Checklist

World Health Organization | Patient Safety

Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

Safe Surgery saving lives

	Baseline	Checklist	P value
Cases	3733	3955	-
Death	1.5%	0.8%	0.003
Any Complication	11.0%	7.0%	<0.001

Haynes et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. *New England Journal of Medicine* 360:491-9. (2009)


World Health Organization
Patient Safety
A World Alliance for Safer Health Care
Surgical Safety Web Map
+Actively using the checklist: 1657
+Total Registrants: 3865 7-9-2010
9-1-10
Go!
About these maps...
Contact us
Show Map Legend
Map
Satellite
Hybrid
Terrain
Box Zoom
Canada
Russian Federation
Россия
Russia
Participating Hospitals: 3,865
Actively Using the Checklist: 1,657
Brasil
Brazil
South Pacific Ocean
South Atlantic Ocean
Indian Ocean
Angola
Namibia
Botswana
Madagascar
Australia
New Zealand
Center for Geographic Analysis
Harvard University
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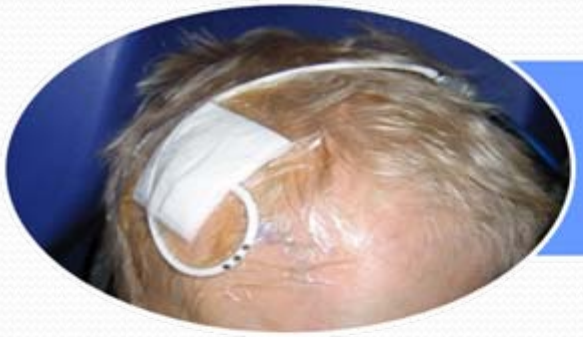
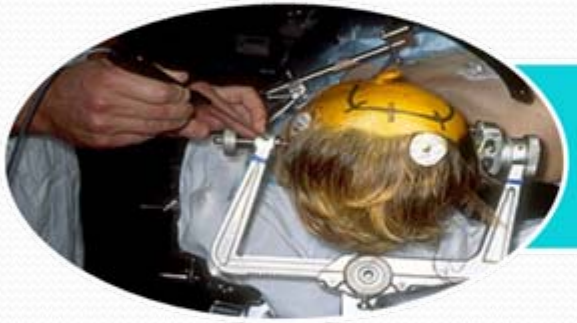
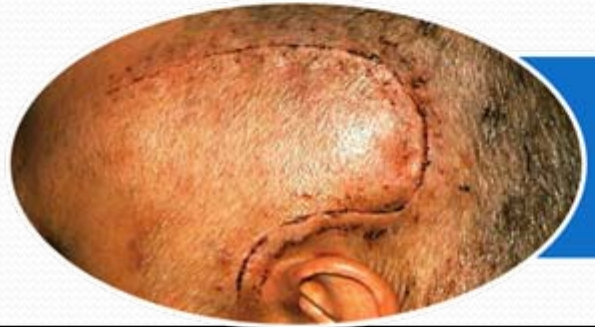
2007: a year of wrong site neurosurgery



January

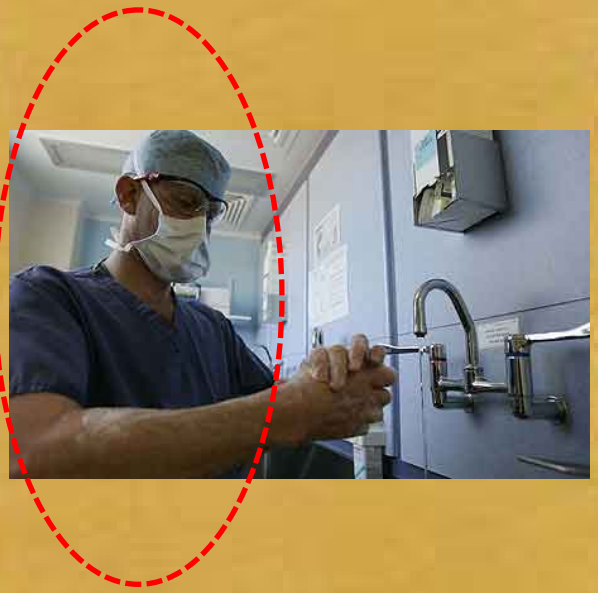


July

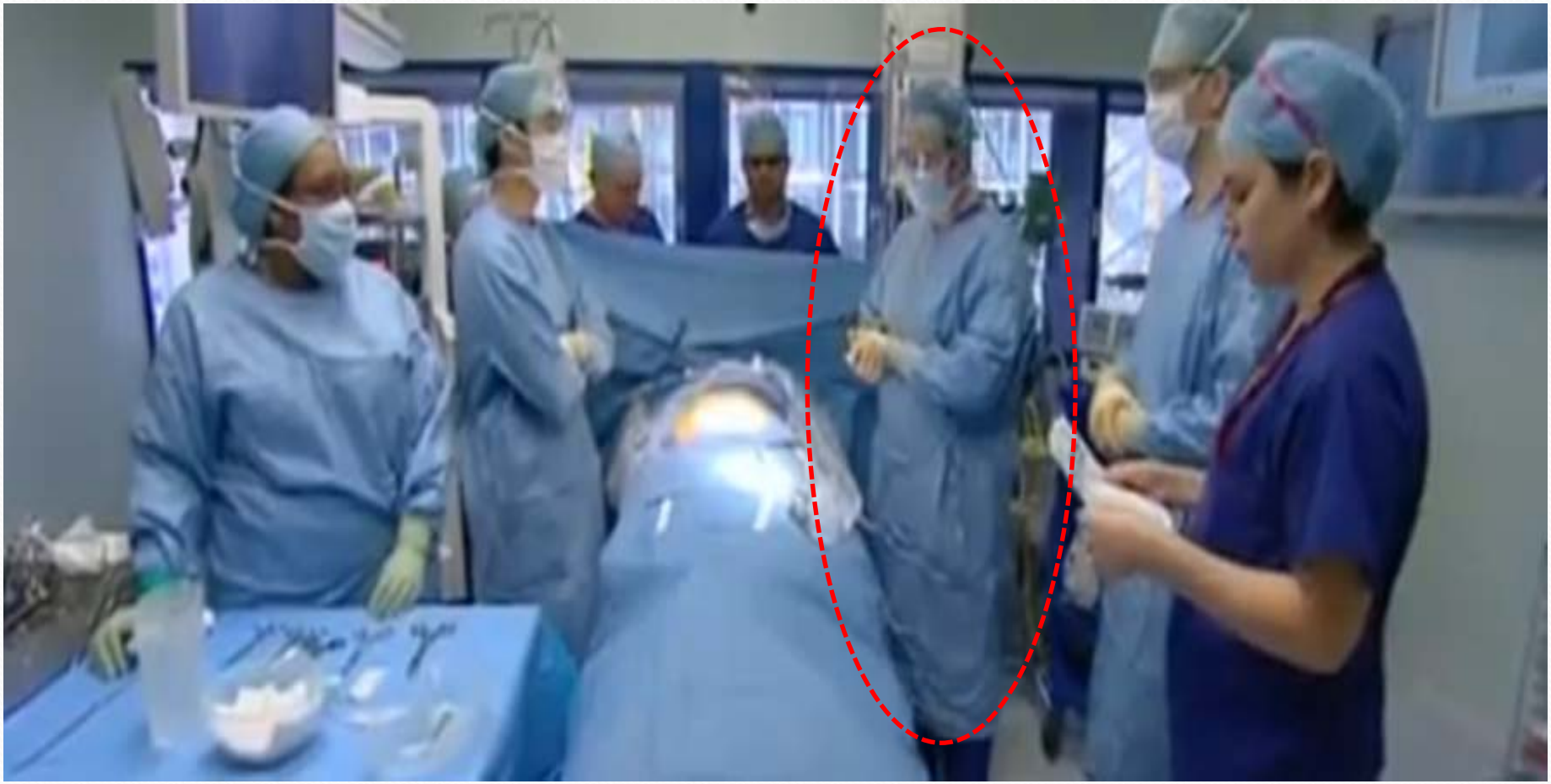


November

Incorrect use of the checklist



Correct use of the checklist



Buy-in from the board

Patient Safety Newsletter

Nottingham University Hospitals NHS
NHS Trust

Issue 8 – July 2011

Chief Executive's message

This issue of the safety newsletter includes updates on the thematic review of Never Events that have occurred at NUH over the last year. There are some important learning points and actions for individuals and teams. These patient-harm events were preventable. Please dedicate time to discuss these important matters at your team meetings and with colleagues so that we can take collective action to keep our patients ever safer.

I would like to acknowledge the application of colleagues to improve VTE risk assessment in recent months. We have some way to go, but our efforts are taking us ever closer to the required 90% national standard. I am confident we will get there by December if we continue this level of focus.

Peter Homa, Chief Executive

Nine 'Never events' are nine too many

In the 12 months to June, nine patients have experienced a Never Event while in our care: six retained surgical swab/pack/microclamp, one wrong site surgery, and two procedures on the wrong patient. These are **preventable** patient harms: we and our systems failed each of these patients. We implement actions and changes after each investigation, monitored by the Clinical Risk Committee. We have undertaken an expert review of many of these events: this describes themes for improvement.

Notably we must all give precedence to patient-safe team working over all other considerations – we must all feel and be able to intervene if we see or hear safety rules or behaviours being broken. Teams must elevate safety communications above traditional hierarchies or ways of working, and safer practices must be followed (e.g. surgical checklists).

A wide-reaching programme of team development and improvement is being developed, informed by our thematic review. **Meantime, please be bold and be a vocal champion and stickler for safety rules - they do keep patients safer.**

Please feel able to contact the Safety Team if you have concerns.

Contact: Wayne Robson, Patient Safety Programme Lead at wayne.robson@nuh.nhs.uk or call 76014.

VTE assessment "improved, but must do better"

Thank you to everyone for their help: we have improved VTE e-risk assessment. In the last two months performance has improved from 30% to over 50%.... but we have to keep improving by 10% each month to achieve the 90% standard by

We are here for you

Standardisation works

Cultural change also needed

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Celebrate and communicate success

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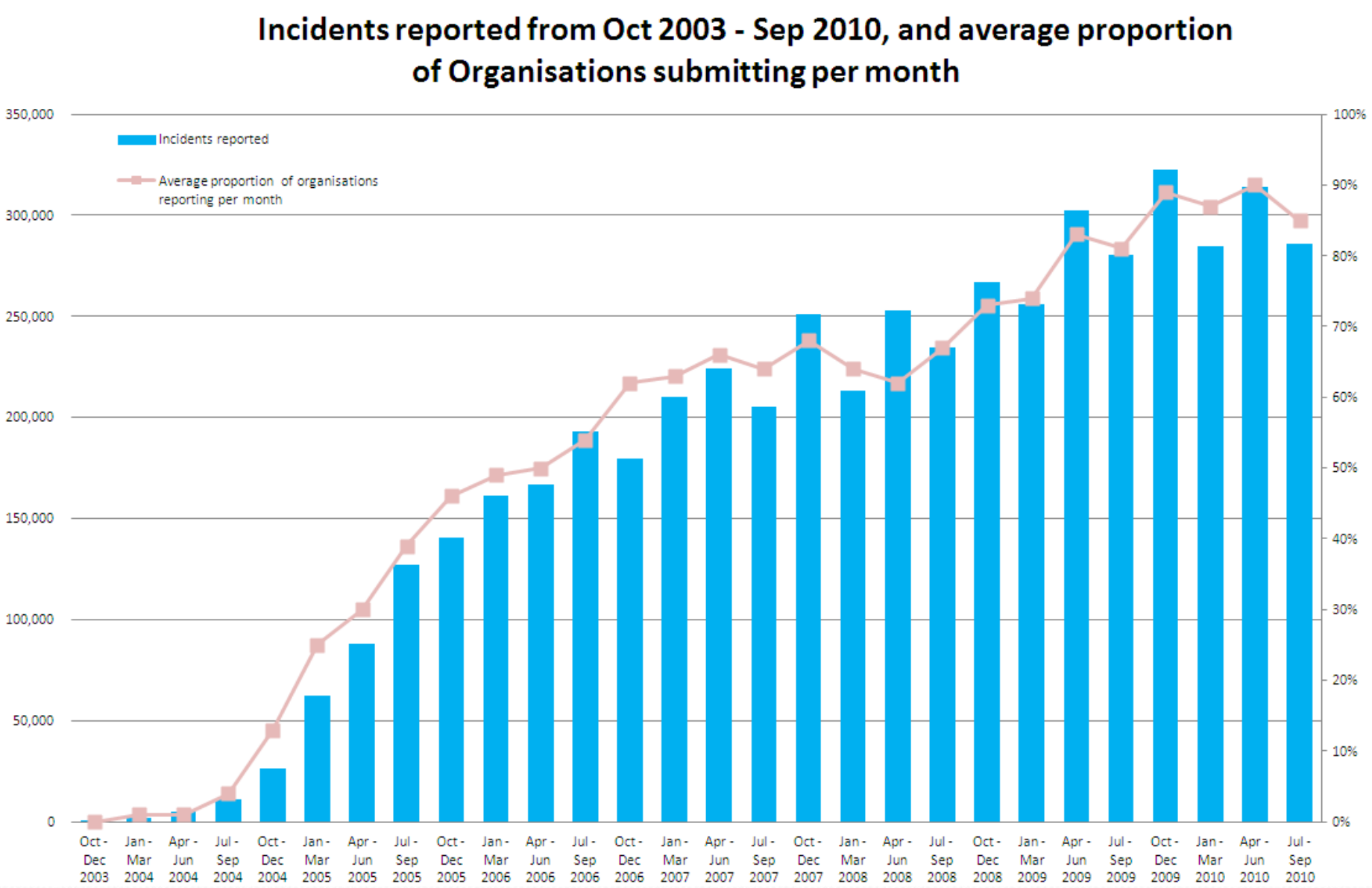
Reporting from a database of errors

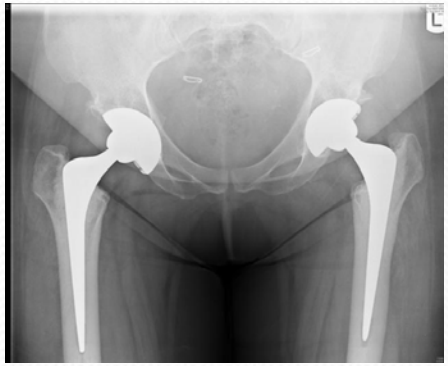


Source: National Patient Safety Agency, 2010

A sample of safety alerts produced by the NPSA

Risks from the use of cement in hip arthroplasty

Trigger incident: *"Patient having cemented hip prosthesis inserted for fractured neck of femur. Cement inserted… bradycardic … failed CPR … patient died."*



NHS
National Patient Safety Agency

Rapid Response Report

NPSA/2009/RRR001

From reporting to learning — 11 March 2009

Mitigating surgical risk in patients undergoing hip arthroplasty for fractures of the proximal femur

Cement

Risks from diverse crash call numbers

27 different crash call numbers! Which one?

NHS
National Patient Safety Agency

Patient safety alert 02

Alert

24 February 2004

2222

[1] A crash call number is the internal telephone number dialled to summon the emergency team following a cardiac arrest in hospital.

Establishing a standard crash call telephone number in hospitals

Problem

Having 27 different crash call[1] telephone numbers in NHS hospitals causes uncertainty and delay for staff contacting the switchboard in an emergency to summon the resuscitation team. This is a potential risk to patient safety.

The increased use of agency and locum staff and greater staff mobility mean that risks of delay are greater than in the past. **Trusts in England and Wales are advised to standardise to the number 2222.**

Information on which this alert is based comes from a feasibility study carried out in England and Wales by the NPSA in 2002/03 on behalf of the Department of Health and the Cabinet Office, with input from the Welsh Assembly Government.

Action for the NHS

The NPSA recommends that Trusts that have not standardised to 2222 should review the costs involved locally in standardising to 2222, and either:

- plan a date for conversion if the change is feasible, or;
- where conversion costs are prohibitive, identify opportunities in the future to convert to the recommended number as part of planned switchboard changes.

The NHS Information Authority (NHSIA) and Health Solutions Wales (HSW) can provide technical advice on conversion.

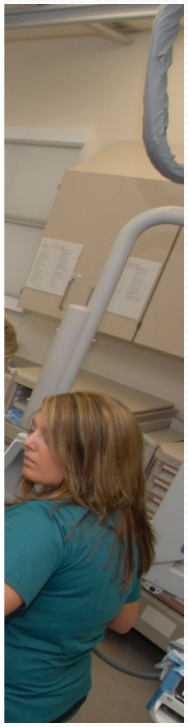
For the attention of:
- Chief Executives of acute NHS Trusts (for information)
- Directors of Finance of acute NHS Trusts (director responsible for telecoms) (for action)

For action by:
- Directors of Finance and Switchboard Managers (or equivalent personnel)

To be disseminated by the NPSA to:
- NHS acute Trust Chief Executives and Finance Directors
- Chief Executives and clinical governance leads of Strategic Health Authorities (England) and Regional Offices (Wales)
- The Independent Hospitals Association (IHA)
- The Commission for Health Improvement (CHI)
- The Commission for Healthcare Audit and Inspection (CHAI), England
- Community Health Councils, Wales

Within Trusts – to be disseminated by Trust Finance Directors to*:
- Telecommunications/Switchboard Managers
- Medical Directors
- Heads of clinical governance
- Directors of Nursing
- Risk Managers
- Lead Consultants/Clinical Directors – critical care areas
- Resuscitation officers
- Communications leads*
- Patient Advice and Liaison Service (PALS) staff*

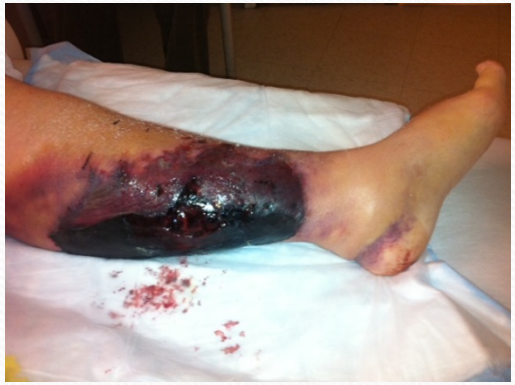
* A full and summary/lay version of the alert is available at **www.npsa.nhs.uk/alerts/h_profalerts.asp** for use in briefing staff groups and for general enquiries. Hard copies of the full alert can be obtained from the Department of Health order line by telephoning 08701 555455 and quoting reference number PSA02.



2222

Risks from treatment dose errors with low molecular weight heparins

Trigger incident: *"Patient prescribed 100,000 units of fragmin instead of 10,000 units (10 times dose)…transferred to ICU for respiratory support "*



NHS National Patient Safety Agency

Rapid Response Report

NPSA/2010/RRR014

From reporting to learning — 30 July 2010

Reducing treatment dose errors with low molecular weight heparins

Heparin

Standardisation works

Cultural change also needed

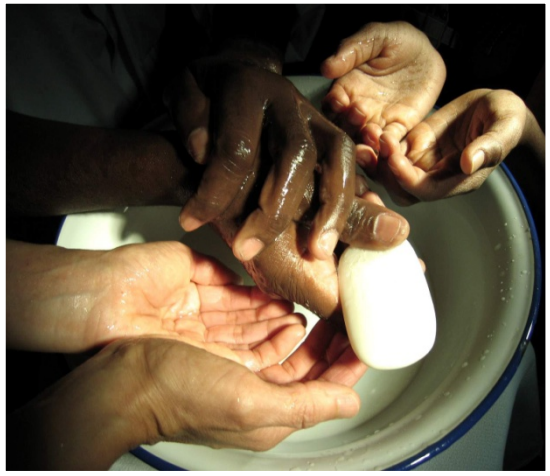
Good data ensures accountability

Celebrate and communicate success

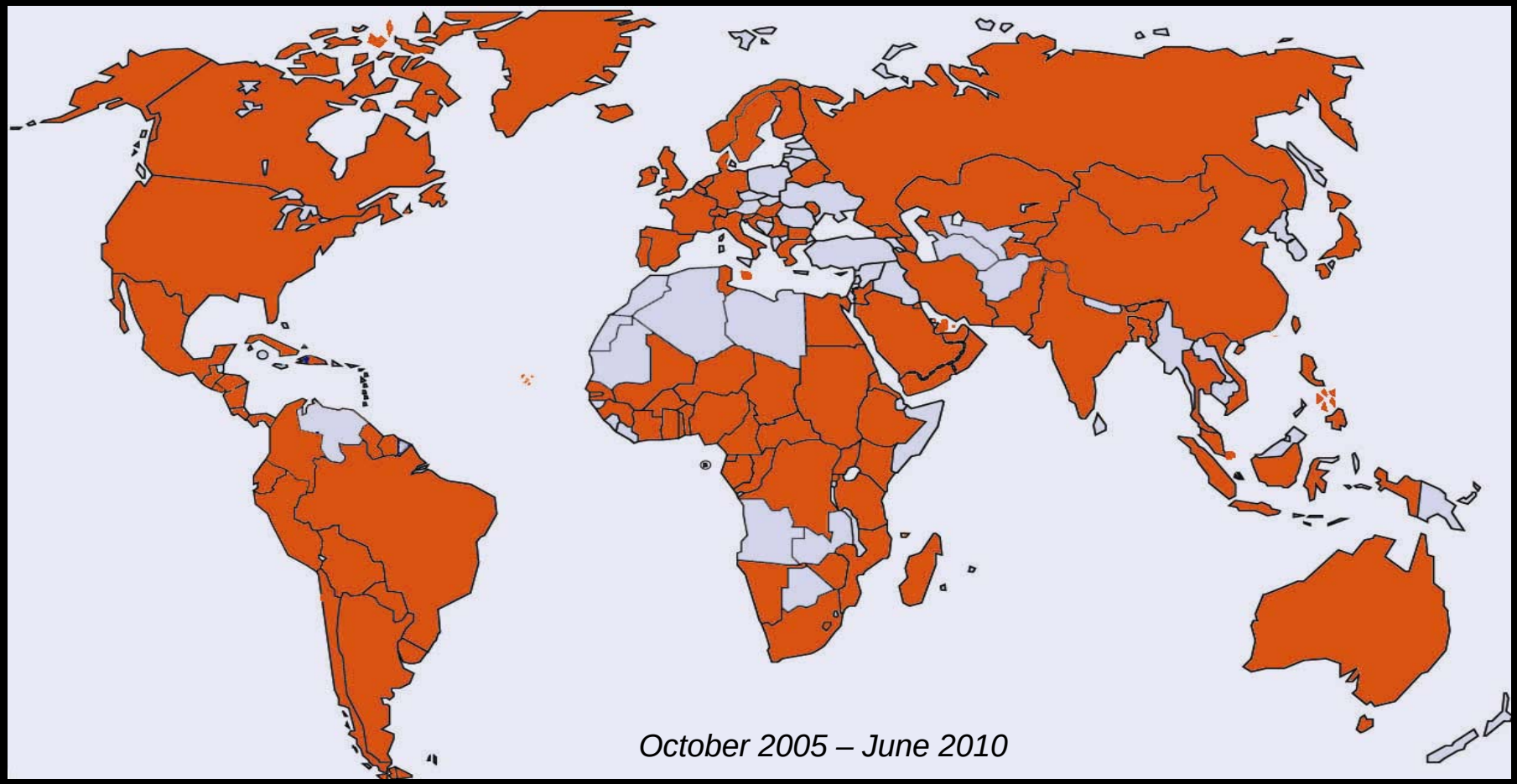
Sustainability is the greatest challenge

Clean Care is Safer Care

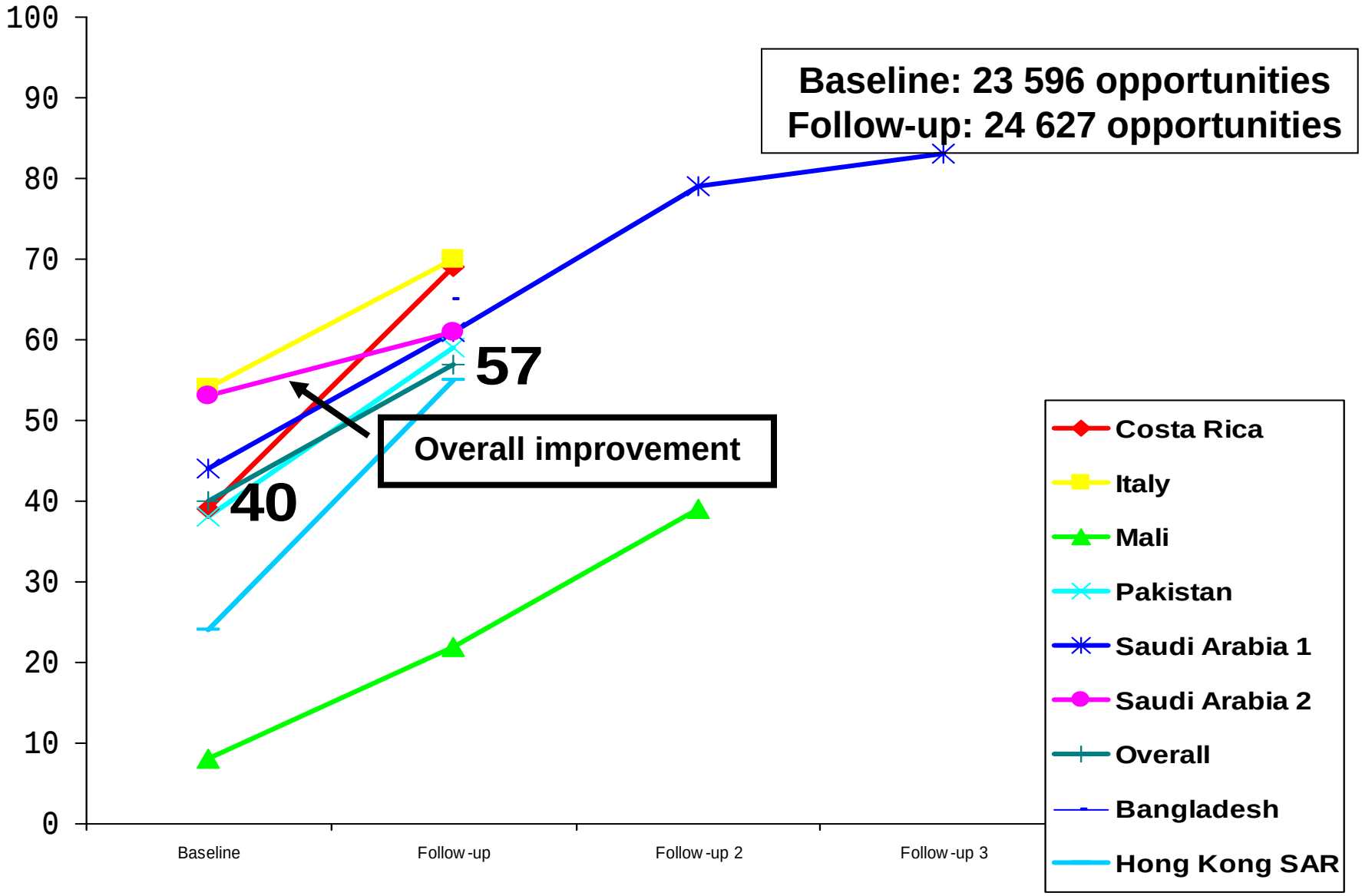
First Global Patient Safety Challenge



124 countries committed to address health care associated infection 89.3% world population coverage



Hand hygiene compliance improvement around the world



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Maurice Murphy – killed 2011

London Evening Standard
standard.co.uk

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News

HEADLINES: UK counts cost of botched mission..... Downing St ba

Star Wars and Harry Potter musician died after 'doctor put food tube into his lung'

Mark Blunden and Josie Hinton
27 Jan 2011

Recommend 2K

A celebrated trumpet player who featured on the soundtracks to Star Wars and Harry Potter died after a hospital feeding tube was mistakenly inserted into his lung, an inquest heard.

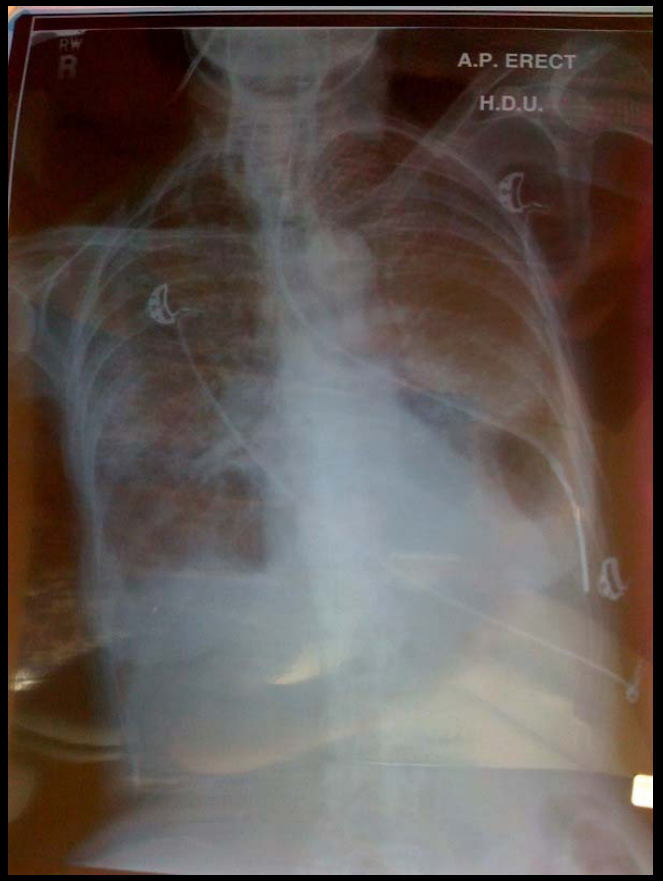
Maurice Murphy, 75, was being treated for a liver complaint at the Royal Free Hospital, Hampstead, when a tube was fed through his nose into his right lung rather than his stomach, causing fatal pneumonia.

Poplar coroner's court heard that a junior doctor, Jonas Woo, overruled a nurse who questioned the procedure, despite a radiologist's report saying the tube was in the wrong place.

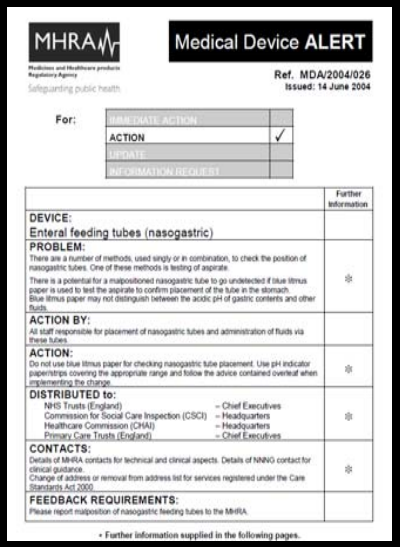
Talented: Maurice Murphy with wife Shirley. He died in the Royal Free Hospital

Source: London Evening Standard, January 2011

Absence of procedure



The risks of nasogastric tubes


MHRA

Medical Device ALERT

Ref. MDA/2004/026
Issued: 14 June 2004

For:

IMMEDIATE ACTION	
ACTION	✓
UPDATE	
INFORMATION REQUEST	

	Further information
DEVICE: Enteral feeding tubes (nasogastric)	
PROBLEM: There are a number of methods, used singly or in combination, to check the position of nasogastric tubes. One of these methods is testing of aspirate. There is a potential for a malpositioned nasogastric tube to go undetected if blue litmus paper is used to test the aspirate to confirm placement of the tube in the stomach. Blue litmus paper may not distinguish between the acidic pH of gastric contents and other fluids.	*
ACTION BY: All staff responsible for placement of nasogastric tubes and administration of fluids via these tubes	
ACTION: Do not use blue litmus paper for checking nasogastric tube placement. Use pH indicator paper/strips covering the appropriate range and follow the advice contained overleaf when implementing the change	*
DISTRIBUTED to: NHS Trusts (England) – Chief Executives; Commission for Social Care Inspection (CSCI) – Headquarters; Healthcare Commission (CHAI) – Headquarters; Primary Care Trusts (England) – Chief Executives	*
CONTACTS: Details of MHRA contacts for technical and clinical aspects. Details of NNIG contact for clinical guidance. Change of address or removal from address list for services registered under the Care Standards Act 2000	*
FEEDBACK REQUIREMENTS: Please report malposition of nasogastric feeding tubes to the MHRA.	

* Further information supplied in the following pages.

2004

11 deaths,
1 severe
harm*
(2003-2005)


NHS
National Patient Safety Agency

Patient safety alert 05

Reducing the harm caused by misplaced nasogastric feeding tubes

Alert

21 February 2005

Immediate action	☑
Action	☐
Update	☐
Information request	☐

2005

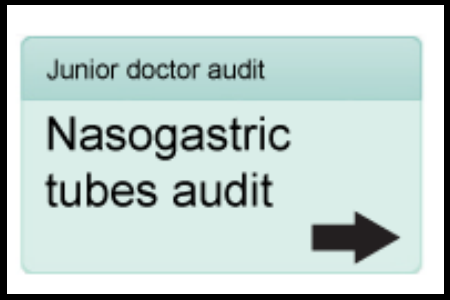
Imperial College London

2006

5 deaths,
6 severe harm
(2008)

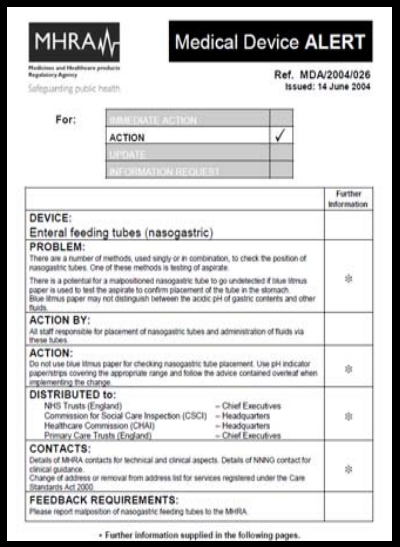
2009

21
deaths
(to date)



2010

The risks of nasogastric tubes



MHRA

Medicines and Healthcare products Regulatory Agency

Safeguarding public health

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Ref. MDA/2004/026
Issued: 14 June 2004

For:

IMMEDIATE ACTION	
ACTION	✓
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NHS National Patient Safety Agency

National Reporting and Learning Service

Never Events

NeverEvents

2009

21
deaths
(to date)

Alert

Patient Safety Alert

NPSA/2011/PSA002
10 March 2011

NHS National Patient Safety Agency

Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants

Action for the NHS

2011

Key lessons

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