

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)

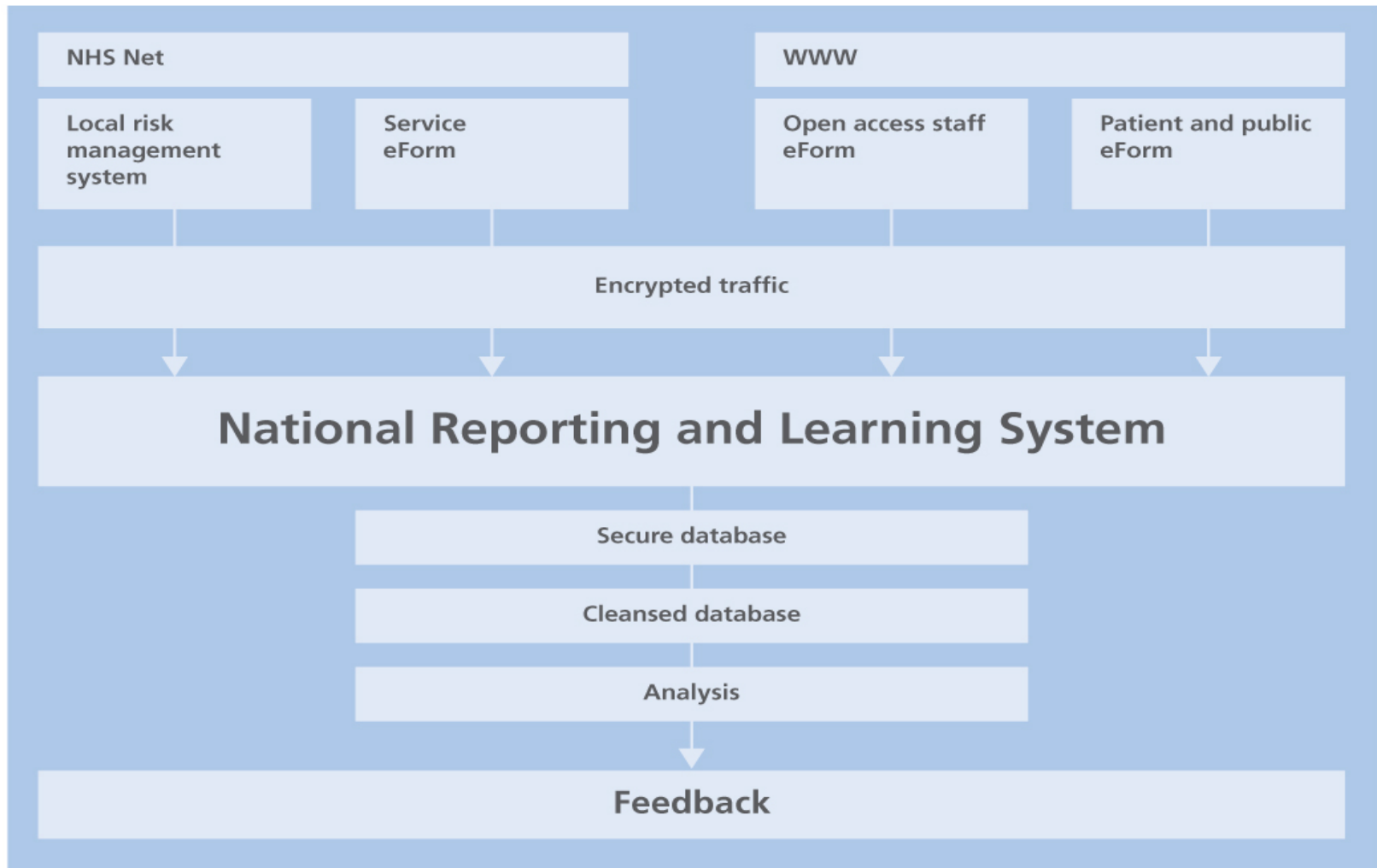


The National Reporting Learning System

- 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

Figure 1: The National Reporting and Learning System



Change of Direction

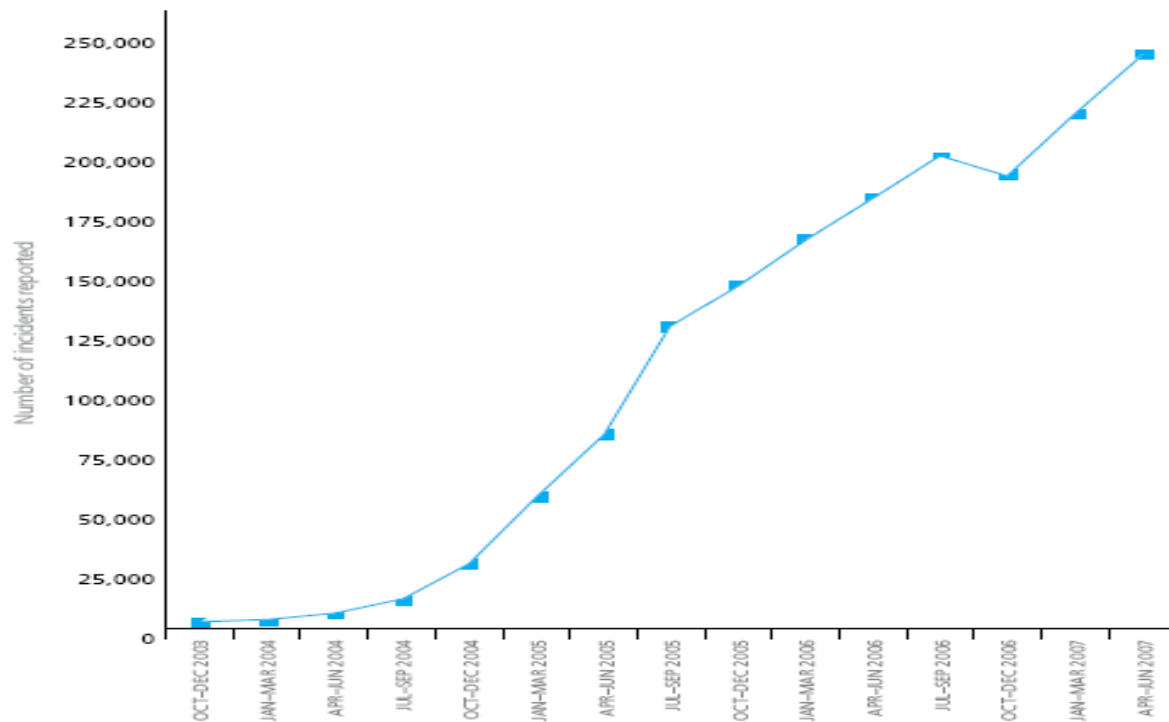


- Rapid reporting of Patient Safety incidents that involve serious patient harm and death within 36 hours of the report.

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.

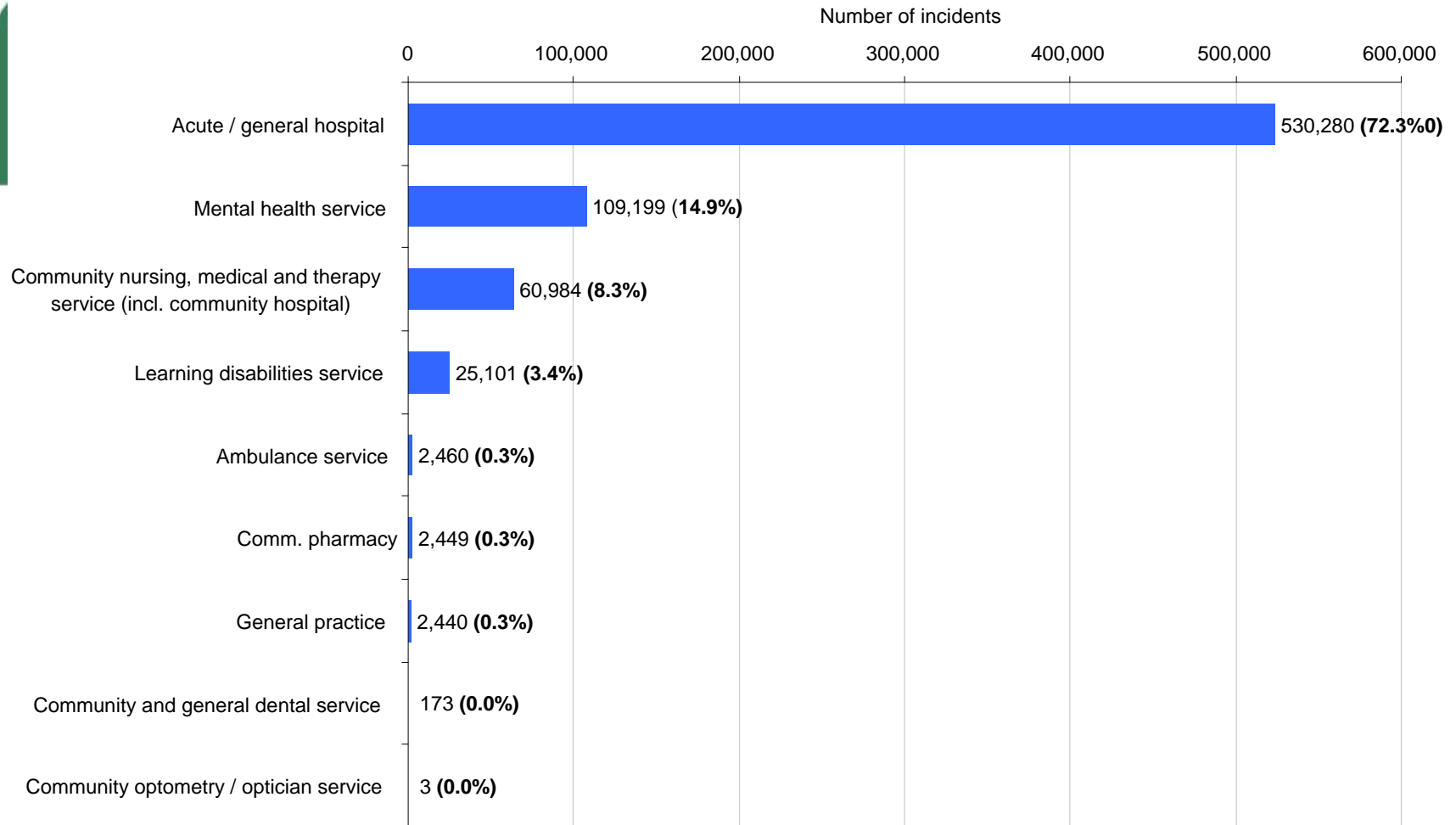
Source of Notification to NRLS, by quarter July 2006 to June 2007

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

Care setting of incident reports, July 2006 to June 2007



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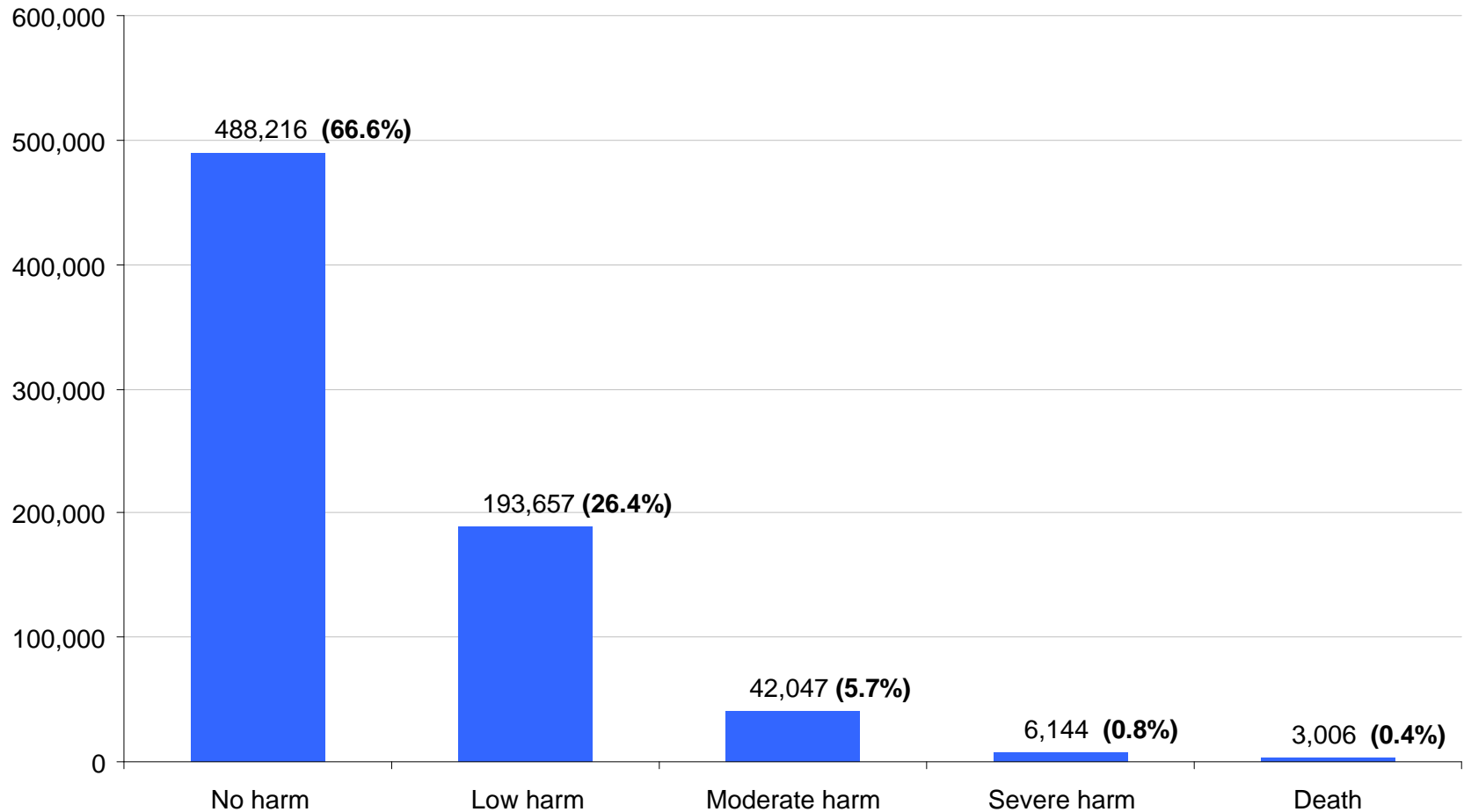
Source: Data is based on date the reported incident occurred, using data as of 04 July 2007

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



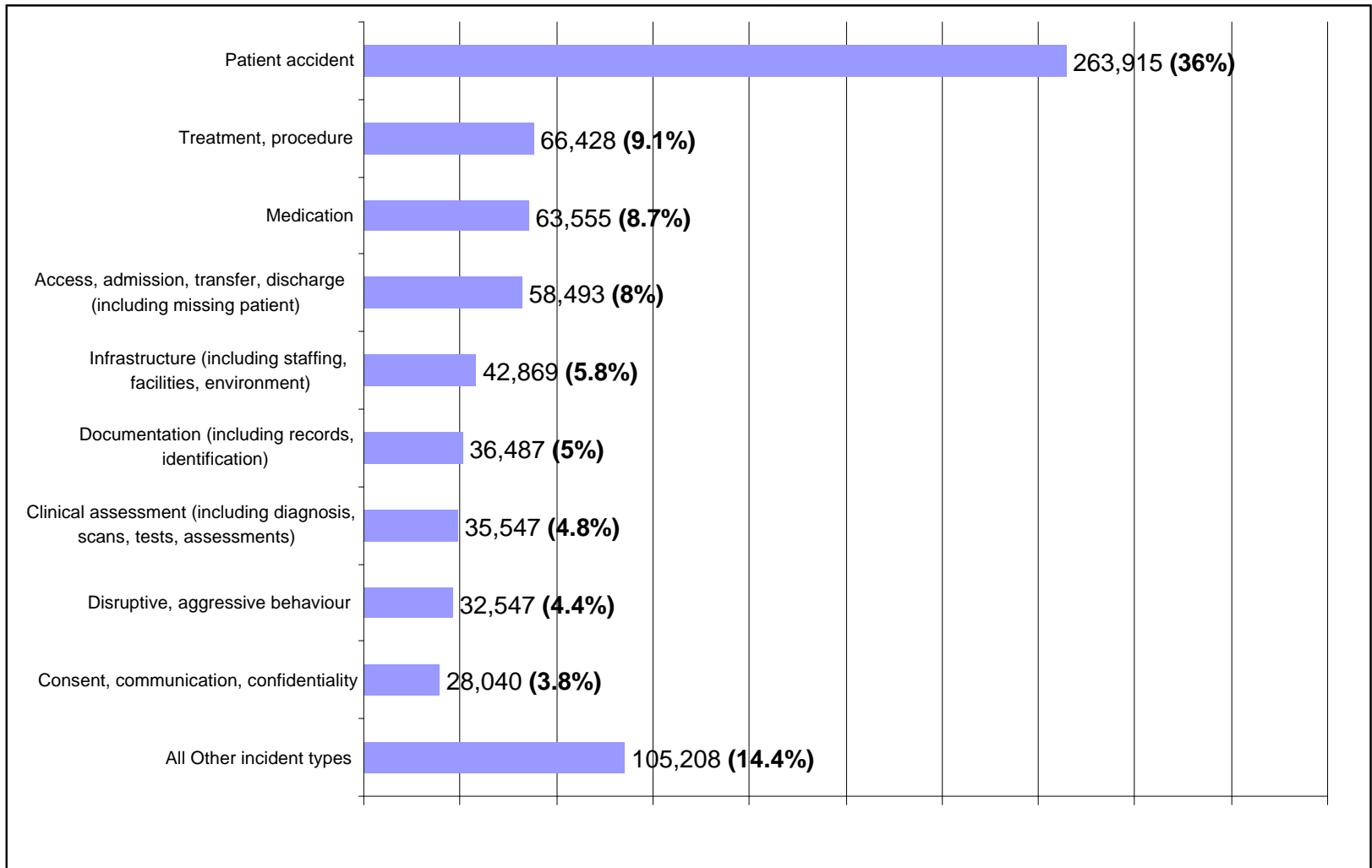
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Number of incidents



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



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 Amphotec®). 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 rr@npsa.nhs.uk


DH Gateway number: 8726

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

Initiatives to Make Care Safer

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Patient safety alert 19



Alert

28 March 2007

Promoting safer measurement and administration of liquid medicines via oral and other external 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 medicines¹ 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,^{2,3} 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

- Design, supply and use of oral/external syringes
 - only use **labelled oral/external** 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/external 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 external syringes.
- Design, supply and use of external feeding systems
 - external feeding systems should not contain parts that can be connected to intravenous syringes or that have end connectors that can be connected to intravenous or other parenteral lines;
 - external feeding systems should be labelled to indicate the route of administration;
 - three-way taps and syringe tip adaptors should not be used in external feeding systems because connection design safeguards can be bypassed.

By request for

- 20 NHS and independent sector organisations in England and Wales

Key advice for

- Design of oral/external syringes and external feeding systems
- Supply and use of oral/external syringes and external feeding systems
- Supply and use of oral/external syringes and external feeding systems


For information on

- Design of oral/external syringes and external feeding systems
- Supply and use of oral/external syringes and external feeding systems
- Supply and use of oral/external syringes and external feeding systems

Ref: NPSA/2007/19

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Safer practice notice 17



Notice

26 February 2007

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 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(09) Safe Use of Bed Rails¹ and Device Alert 2007(009) Bed Rails and Grab Handles.² 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:

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

For information on

- Design of oral/external syringes and external feeding systems
- Supply and use of oral/external syringes and external feeding systems
- Supply and use of oral/external syringes and external feeding systems

Ref: NPSA/2007/17

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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

- Use patient wristbands that meet the NPSA's design requirements. See www.npsa.nhs.uk
- 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 Circular¹).
- 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.
- 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.

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

National Patient Safety Agency

Design out the potential for harm

Make incorrect actions correct

Make wrong actions more difficult

Make it easier to discover errors

Involvement of Patients



National Patient Safety Agency

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

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Safer practice notice 11



Notice

22 November 2005

Wristbands for hospital inpatients improves safety

All hospital inpatients in acute settings should wear wristbands (also known as identity bands) with accurate details that correctly identify them and match them to their care.

Between November 2003 and July 2005, the National Patient Safety Agency (NPSA) received 236 reports of patient safety incidents and near misses relating to missing wristbands or wristbands with incorrect information. Research and anecdotal evidence shows that patients often do not have wristbands and that this increases the risk of them being incorrectly identified and given the wrong care.

NPSA staff have told the NPSA that this notice will help them to promote the use of wristbands for inpatients in acute care settings. It is the first phase of a programme of NPSA work on safer patient identification. For further information, see the background and research section on page 1 or visit the NPSA website at www.npsa.nhs.uk/ndivide.

Actions for the NHS

By May 2006, NHS organisations providing acute services in England and Wales should have either:

- implemented the NPSA's recommendations (see page 2), stating that all inpatients should wear wristbands that identify them and match them to their care. Formally risk-assessed alternatives should be made for patients for whom this is not possible or practical (such as pre-term babies), patients with some skin conditions and those with learning disabilities. Arrangements should also be made for implementing and monitoring this advice; or
- other formally risk-assessed arrangements. Monitoring should show that these arrangements are as effective as those set out in this notice.

Wristbands do not remove clinicians' responsibility for checking patients' identity. They are an important way of validating identification particularly when a patient is unable to provide their own details.

The recommendations in this notice relate to care in acute settings. The NPSA will be considering how these recommendations can be transferred to other areas of care such as outpatients and primary care.

Who reports to:

- new organisations providing acute services

For action by:

- directors of hospitals in England and Wales

Who recommend you also inform:

- medical directors
- clinical governance leads and risk managers
- senior clinical governance staff
- service managers

The areas that interest:

- chief executive/clinical director and clinical governance leads in acute health services
- general and hospital medical staff
- hospital managers
- medical directors
- clinical governance and supply agencies
- local clinical governance
- NHS trusts
- health service organisations and

Who might be responsible for:

- implementing the recommendations
- confirming the initial risk assessment
- reviewing the effectiveness of the arrangements
- quality improvement/clinical governance
- compliance with health
- identity banding

Ref: NPSA2005/11

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Patient briefing 11

Patient briefing



Information

22 November 2005

This information is for hospital inpatients

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

When you are in hospital, it is essential to wear a wristband (also known as an identity band) with accurate details about you so it is ensured that staff can identify you correctly and give you the right care. The National Patient Safety Agency (NPSA) has received 236 reports of incidents relating to missing wristbands or wristbands with incorrect information on them. These patients had unnecessary drugs, those patients received the wrong treatment, and an allergy was inadequately recorded.

The NPSA has issued advice to the NHS on how to promote the use of wristbands and therefore reduce the chances of these errors occurring again.

What to expect when you are in hospital

It should be explained to you, either in a pre-admission letter or when you are admitted to hospital, that you are expected to wear a wristband at all times to ensure your safety during your stay. A member of staff should put a wristband on you as soon as you are admitted to hospital and you should wear this throughout your stay. If you do not have a wristband, please ask a member of staff for one. If it comes off or is uncomfortable, ask a member of staff to replace it.

The wristband will be placed on the arm that you use for writing. This is because the other arm may be used for medical procedures requiring, for example, a drip. These bands to be placed in the non-writing arm so that the inconvenience to you is minimised. Placing the wristband on the writing arm means that there is less chance of it being removed during a procedure on the other arm.

The wristband will include all essential information about you that staff need. All hospital patients, including babies, children and older people should wear a wristband at all times.

Further work on patient identification

New technologies such as barcodes and radio tags are being introduced in some hospitals to help identify patients and confirm initial checks by hospital staff. These will be included in the wristbands alongside the patient details.

The NPSA is working on standardising wristbands so that they have the same design and contain the same information in all hospitals across the NHS. This will help staff who work in a variety of NHS organisations across England and Wales to make patient care safer. The NPSA will publish further information on this in due course.

More information

If you would like more information about the NPSA's work on wristbands or patient identification, visit our website at www.npsa.nhs.uk/ndivide

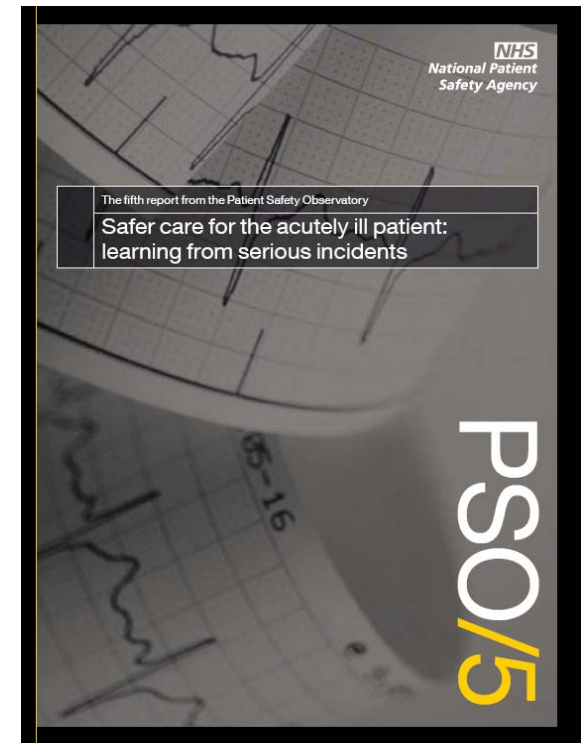
Using systematic analysis and the 'observatory' approach to learn and respond

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)



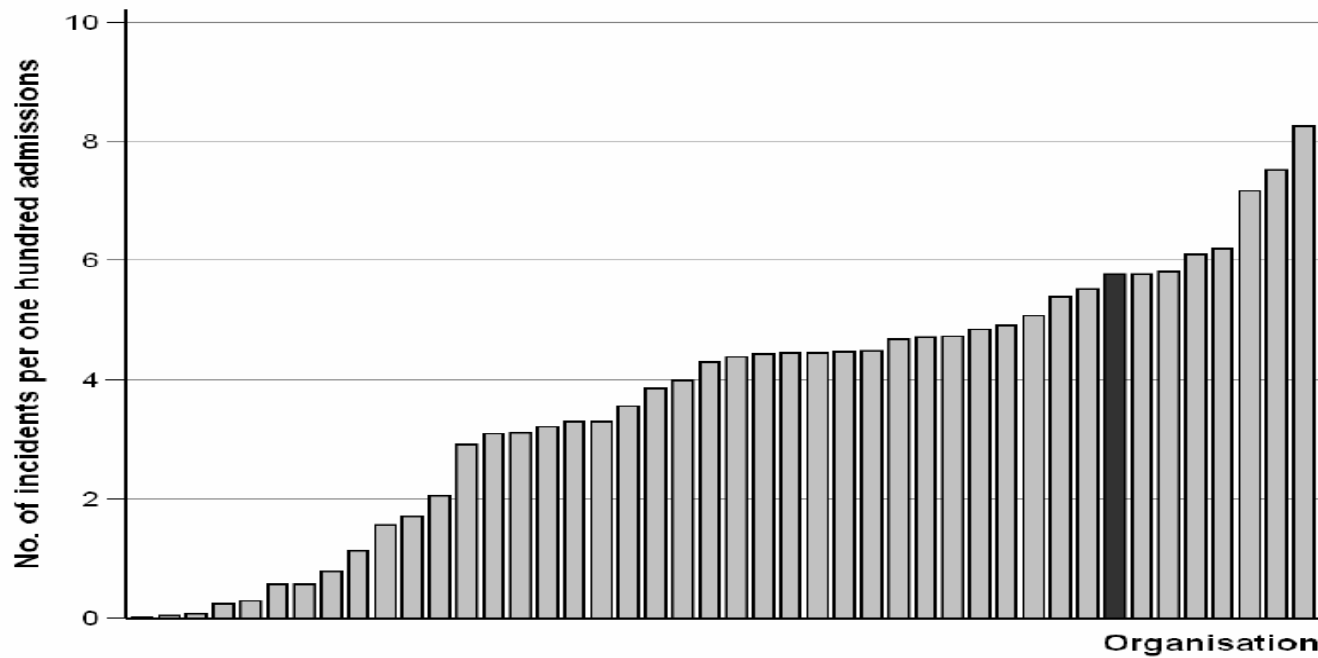
Role of Qualitative Data in Reporting Systems

- 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