# NAMDET 2019

## Training, Risk & Governance – implications for patient safety

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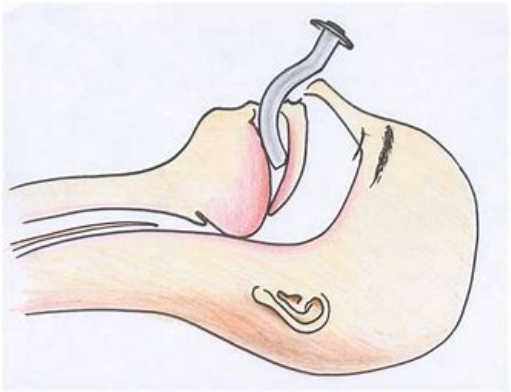
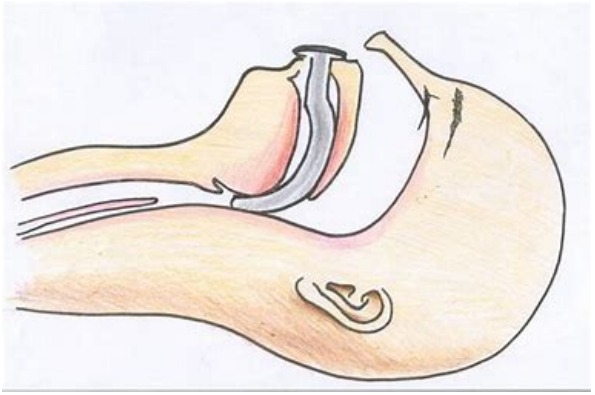
NHS England and NHS Improvement

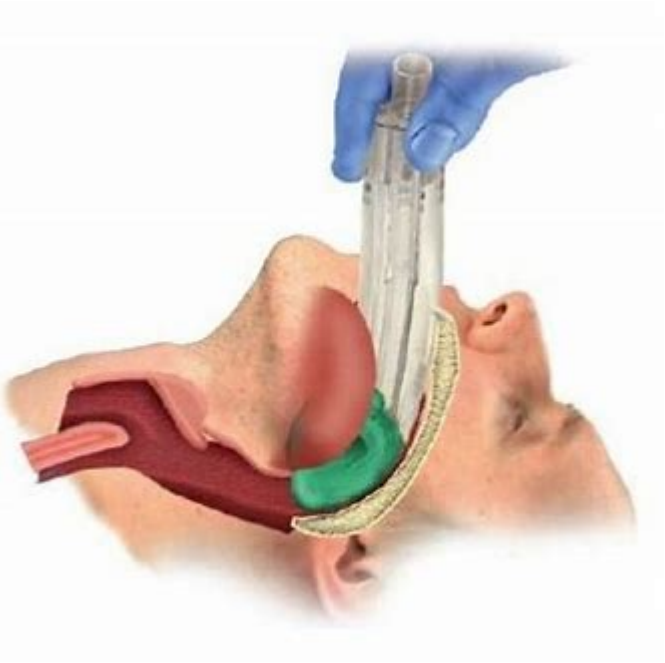
# What could go wrong?

When we become ‘patients’ we are already in a vulnerable position. When patients needs require intervention with medical devices, as part of diagnosis or treatment, they should be protected from any risks that could further impact on their condition.

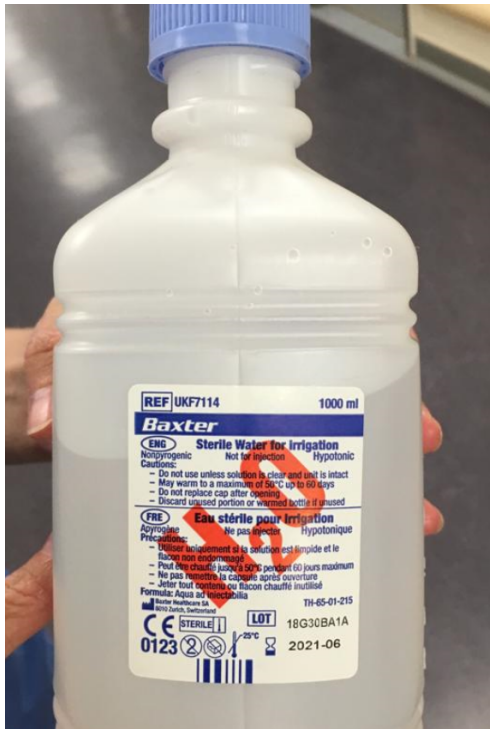
# Assumption and negative transfer



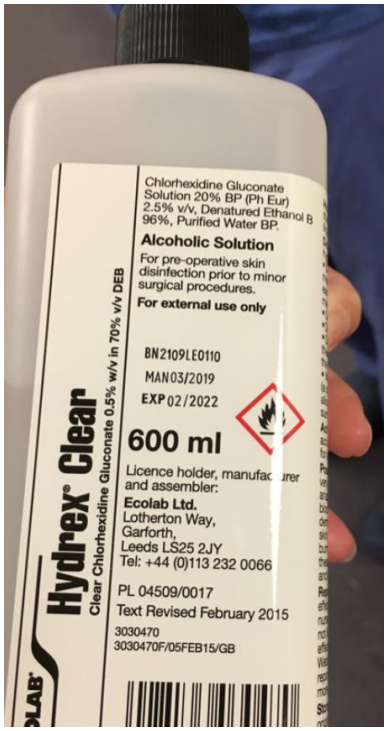




# Look-a-like connectivity risks





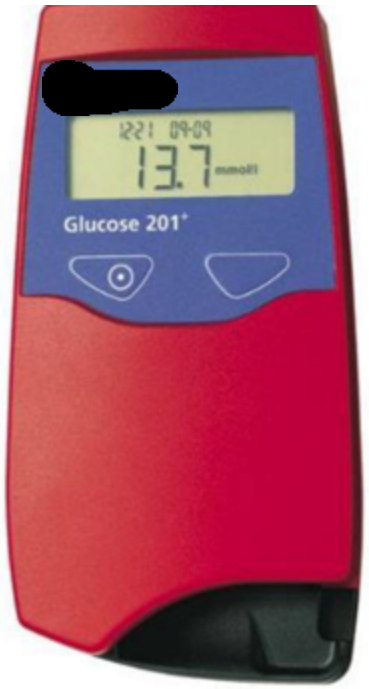


# Look-a-like connectivity risks


NHS England and NHS Improvement

# Templating


Measuring range : 0-256 g/L




Measuring range: 0 –22.2 mmol/L

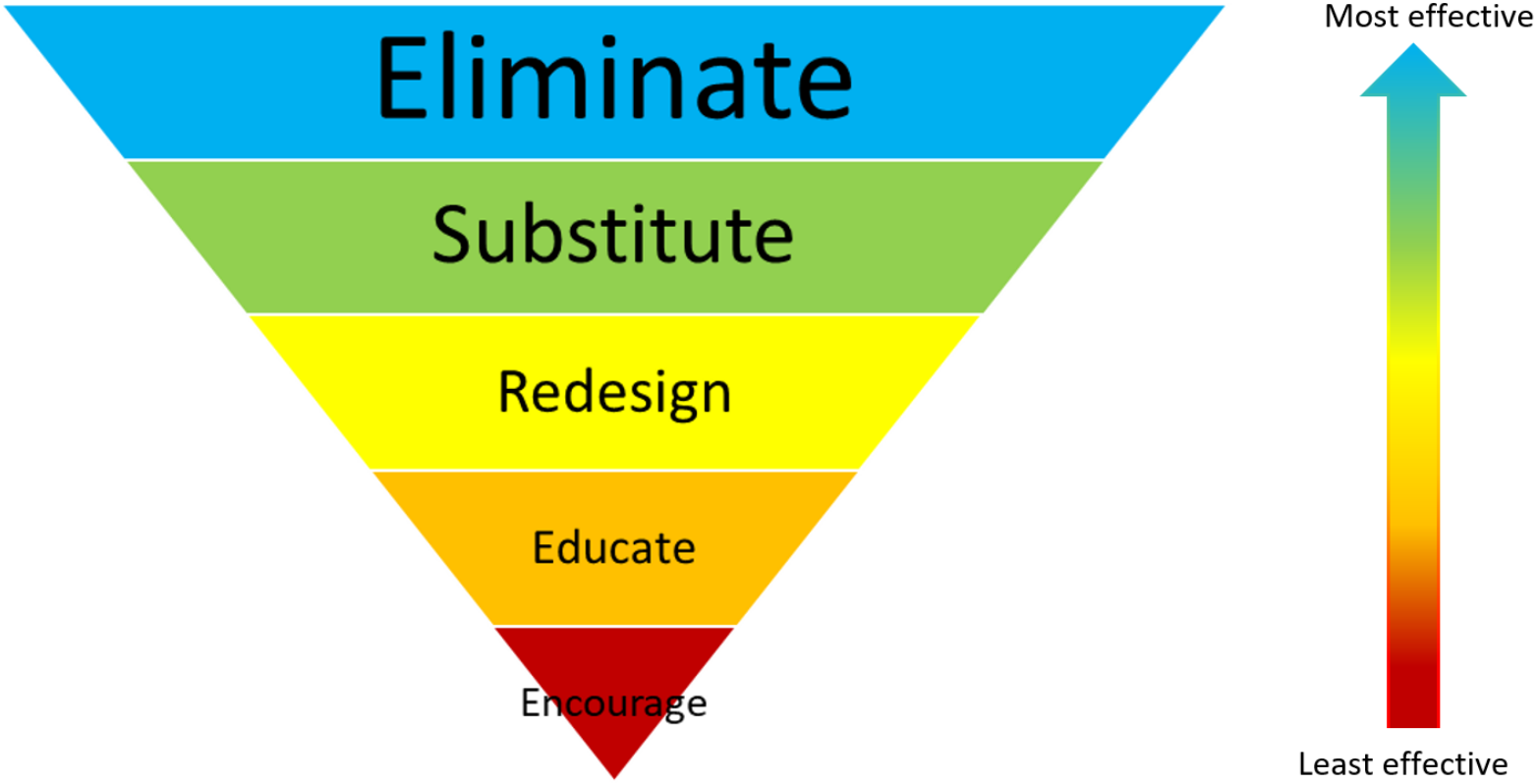
# Automation


*….there was still 200ml in the bag which hadn't been infused….*

*……the pump gave 10 times more than prescribed*

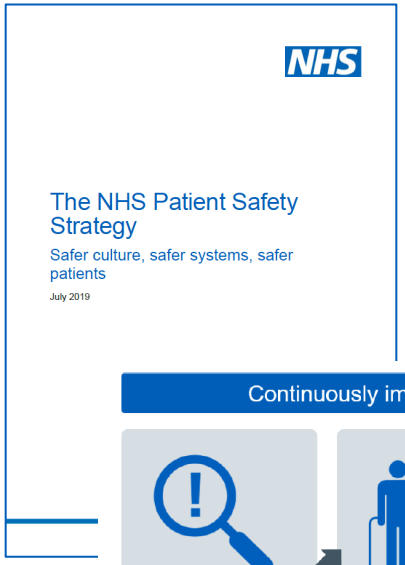
*…..called equipment library as pump keeps alarming……*

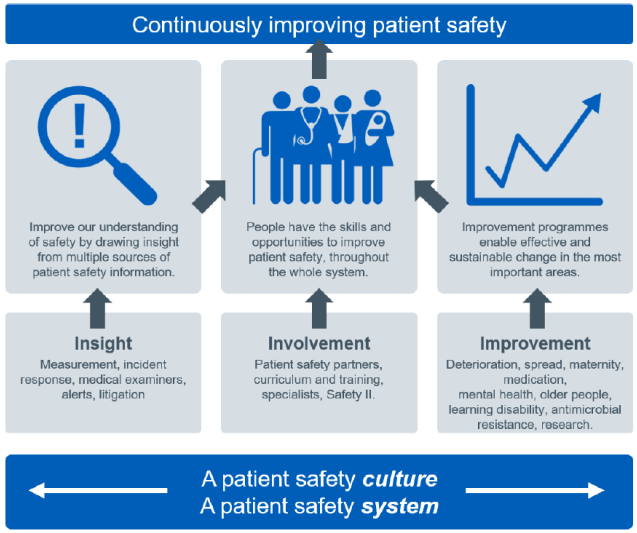
# Hierarchy of effectiveness of barriers

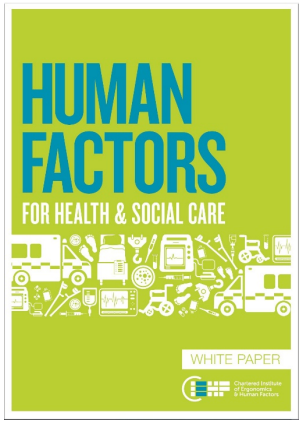


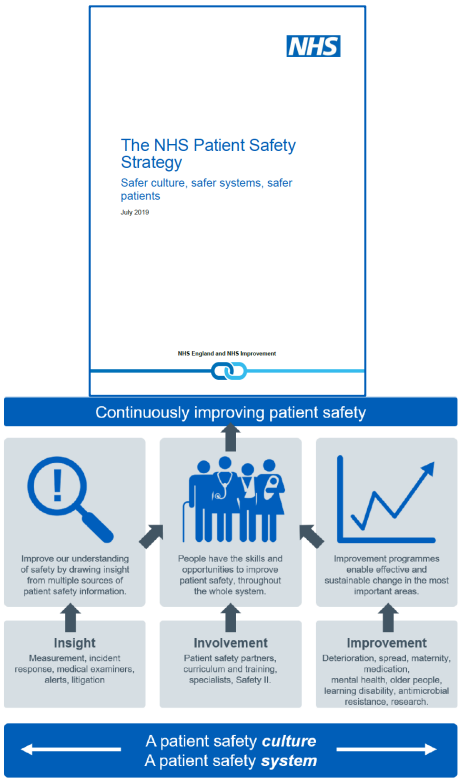

## Our recommendations

1. NHS Improvement should work in partnership with Health Education England and others to make sure that the entire NHS workforce has a common understanding of patient safety and the skills and behaviours and leadership culture necessary to make it a priority. NHS Improvement and Health Education England should also develop accessible, specialist training in patient safety that staff can study as part of their clinical education or as a separate discipline.
2. The National Patient Safety Strategy must support the NHS to have safety as a top priority. Driven by the National Director of Patient Safety at NHS Improvement, it should set out a clear vision on patient safety, clarifying the roles and responsibilities of key players, including patients, with clear milestones for deliverables. It should ensure that an effective safety culture is embedded at every level, from senior leadership to the frontline.
3. Leaders with a responsibility for patient safety must have the appropriate training, expertise and support to drive safety improvement in trusts. Their role is to make sure that the trust reviews its safety culture on an ongoing basis, so that it meets the highest possible standards and is centred on learning and improvement. They should have an active role in feeding this insight back to NHS Improvement so that other NHS organisations can learn from it, as is the case in other industries.
4. NHS Improvement should work with professional regulators, royal colleges, frontline staff and patient groups to develop a framework for identifying where clinical processes and other elements, such as equipment and governance processes, can and should be standardised.
5. The National Patient Safety Alert Committee (NaPSAC) should oversee a standardised patient safety alert system that aligns the processes and outputs of all bodies and teams that issue alerts, and make sure that they set out clear and effective actions that providers must take on safety-critical issues.
6. NHS Improvement should work with professional regulators and royal colleges to review the Never Events framework, focusing on leadership and safety culture, and exploring the barriers to preventing errors such as human behaviours.
7. CQC will use the findings of this report to improve the way we assess and regulate safety, to ensure that the entire NHS workforce has a common understanding of leadership and just culture, and the skills and behaviours necessary to make safety a priority.






Rare can be simple – and *'rare but could recur'* is what a national safety function is uniquely placed to detect

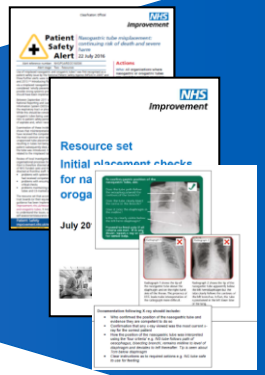
WEEKS

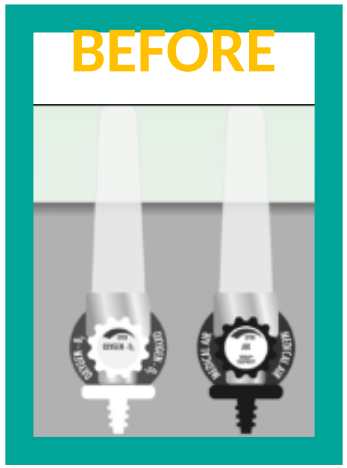
Known issues on a manageable scale, where significant progress could be made with extra support and resources

MONTHS

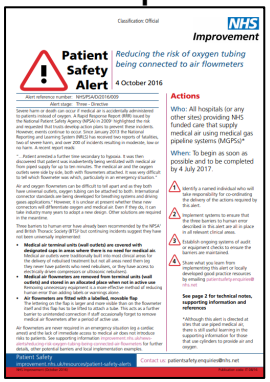
Very common is always complex – 'wicked problems' needing long term focus via improvement programmes

YEARS




‘In almost all clinical settings, power driven nebulisers can be used instead, and all air flowmeters can be permanently removed and disposed of, with air outlets blocked off. In the rare clinical setting where it is impossible to use power-driven nebulisers due to lack of space, air flowmeters need to be separately stored and should be brought out of storage only for the ten minutes or so required to deliver the nebuliser.’


Classification: Official

NHS Improvement

Patient Safety Alert

*Reducing the risk of oxygen tubing being connected to air flowmeters*

4 October 2016

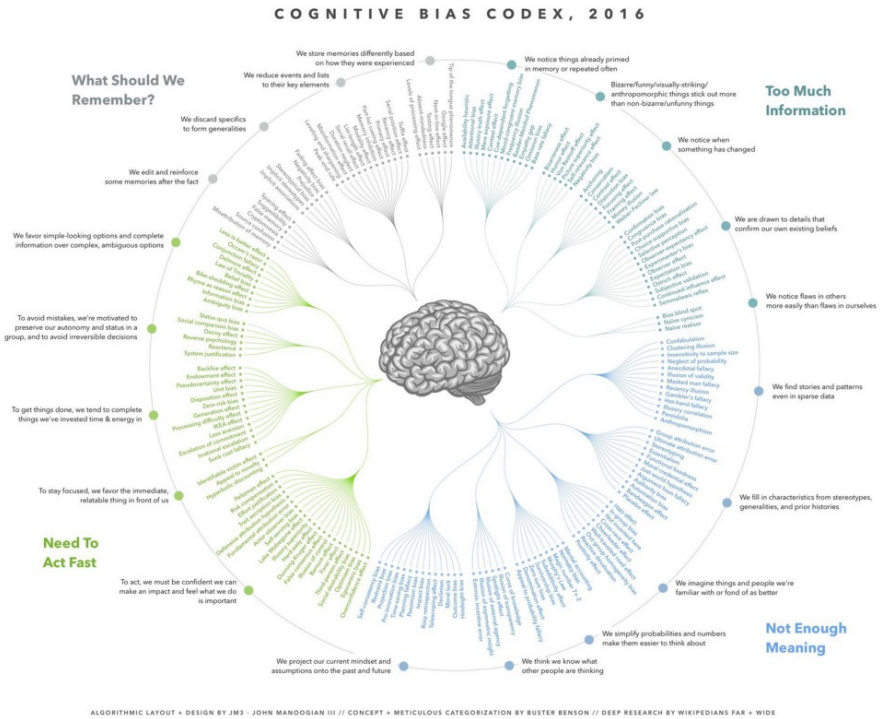
Alert reference number: NHSPSA/A(2016)009

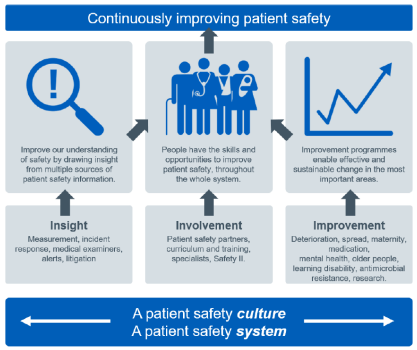
Actions

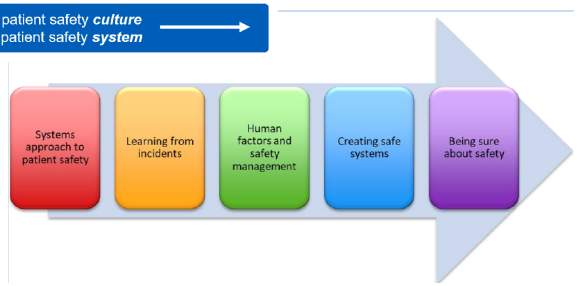
Who: All hospitals (or any other sites) providing NHS funded care that supply medical air using medical gas pipeline systems (MGPSs)*

When: To begin as soon as possible and to be completed by 4 July 2017.

*“When we received the Patient Safety Alert we undertook a risk assessment. This risk assessment [allowed] continuing use of air flowmeters in situ.”*






*"It is recommended that signage should be installed to alert staff that both piped Oxygen and Air is available and remind them to choose the correct gas."*

*"We should use Patient Safety Boards in wards to display alerts."*

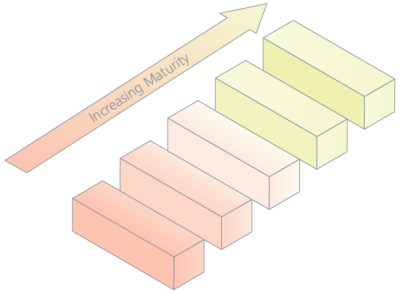
*"The case will be reported in the monthly departmental newsletter which is emailed to all nurses and doctors"*

**Box 14: Patient safety specialists**

Feedback from the consultation strongly supported the development of a network of patient safety specialists in local systems.

These specialists should be recognised as key leaders within the safety system, visible to their organisations and others, able to support their organisations' safety work. In some ways the concept is similar to designating someone a Caldicott Guardian,[62] Director of Infection Prevention and Control[63] or Freedom to Speak Up Guardian.[64] But in contrast to these designations we want the introduction of the patient safety specialist concept to develop existing people and roles rather than create new posts.

| | |
|---|---|
| A – Pathological | Why do we need to waste our time on patient safety issues? |
| B – Reactive | We take patient safety seriously and do something when we have an incident. |
| C – Bureaucratic | We have systems in place to manage patient safety. |
| D – Proactive | We are always on the alert/thinking about patient safety issues that might emerge. |
| E – Generative | Managing patient safety is an integral part of everything we do. |




*"[General surgery] divisional governance team planning to purchase powered nebulisers"*

*"We have removed all air outlet valves from the Emergency Department [and provided] nebuliser boxes."*

Inspected and rated
Good
CareQuality Com

Inspected and rated
Outstanding
CareQuality Commission

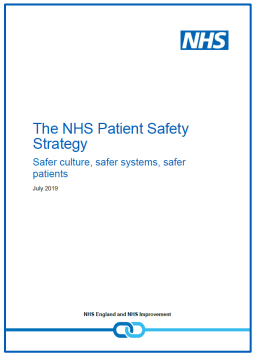
*“We have audited [all areas of the trust] to demonstrate that all medical air flow meters have been removed and replaced with electronic nebulisers, and that air outlets have been capped.”*

*“As part of the investigation of this Never Event, we have reviewed current arrangements and developed a process for nominating a Patient Safety Alert lead for every alert the trust receives, describing their role and providing guidance on how to manage a Patient Safety Alert.*

*In future, no alerts will be closed off [as action completed] until assurance of implementation has been provided to the executive quality group.”*


The National Patient Safety Alert Committee (NaPSAC) should oversee a standardised patient safety alert system that aligns the processes and outputs of all bodies and teams that issue alerts, and make sure that they set out clear and effective actions that providers must take on safety-critical issues.

CQC will use the findings of this report to improve the way we assess and regulate safety

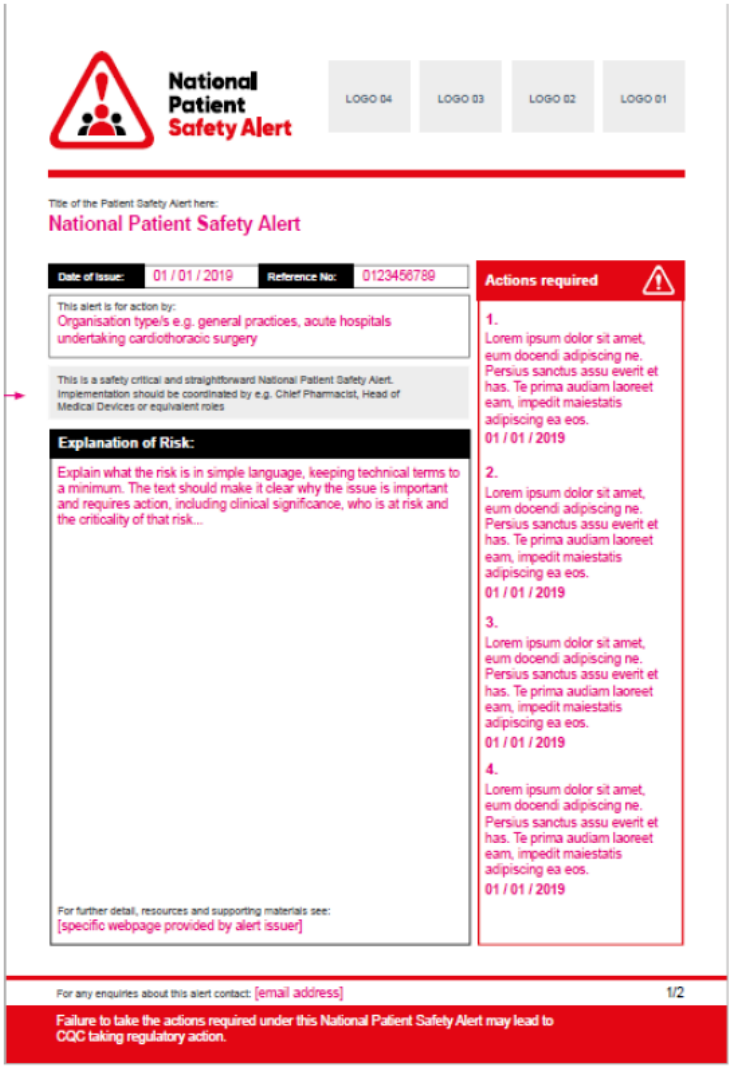



## The National Patient Safety Alerts Committee

The National Patient Safety Alerting Committee (NaPSAC)[45] was set up in 2018 at the request of the Secretary of State for Health and Social Care following evidence that the safety advice and guidance issued to the NHS was not having the required impact. It is working to align all national alert issuing bodies and teams to ensure future National Patient Safety Alerts set out clear and effective actions that local systems must take on safety-critical issues.

The Chief Medical Officer, DHSC Supply Disruption, MHRA, NHS Digital, NHS England, NHS Improvement Estates and Facilities, national patient safety team and Public Health England (PHE) all currently issue safety messages, notices, letters or alerts through the Central Alerting System (CAS). NaPSAC is developing common standards and thresholds across these organisations. A single format for alerts will make it much easier for local systems to see what they need to do, by when and why. The standards and thresholds agreed by NaPSAC will underpin CQC's inspection of National Patient Safety Alerts and any regulatory response to non-compliance.

# National Patient Safety Alert Committee NaPSAC



National Patient Safety Alert

LOGO 04 LOGO 03 LOGO 02 LOGO 01

Title of the Patient Safety Alert here:

National Patient Safety Alert

Date of issue: 01 / 01 / 2019 Reference No: 0123456789

This alert is for action by:
Organisation type/s e.g. general practices, acute hospitals undertaking cardiothoracic surgery

This is a safety critical and straightforward National Patient Safety Alert. Implementation should be coordinated by e.g. Chief Pharmacist, Head of Medical Devices or equivalent roles

**Explanation of Risk:**

Explain what the risk is in simple language, keeping technical terms to a minimum. The text should make it clear why the issue is important and requires action, including clinical significance, who is at risk and the criticality of that risk...

For further detail, resources and supporting materials see:
[specific webpage provided by alert issuer]

**Actions required**

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For any enquiries about this alert contact: [email address] 1/2

Failure to take the actions required under this National Patient Safety Alert may lead to CQC taking regulatory action.

- All alerts will be National Patient Safety Alerts
- Each alerting body to go through the process of accreditation against the thresholds and criteria agreed by NaPSAC to ensure they meet the requirements. Dual running for next 12 months
- Alerts will have clear and effective actions that providers must take on safety-critical issues

## Bodies accredited to date

NHS Improvement Patient Safety Team – accredited for 3 years from July 2019

National Patient Safety Alert

LOGO 04 LOGO 03 LOGO 02 LOGO 01

NHS

# Action

- Identify appropriate escalation routes for National Patient Safety Alerts to ensure senior oversight

- Embed process for ensuring senior oversight and actioning National Patient Safety Alerts within your internal SOPs

- The standards and thresholds agreed by NaPSAC will underpin the CQC inspection of National Patient Safety Alerts and the potential for regulatory response for non-compliance

- Responses to National Patient Safety Alerts will still need to be made via the CAS system.

# Thank you for listening
# Any questions?