Why Safety Matters

Kate Beaumont
Strategy Advisor, NPSA
Head of Clinical Interventions, National Patient Safety Campaign

Catherine.beaumont@npsa.nhs.uk
www.npsa.nhs.uk
About the NPSA

What we are:
- Arm’s Length Body of the Department of Health
- Organised as three Divisions with distinct functions:
  - National Clinical Assessment Service (NCAS)
  - National Research Ethics Service (NRES)
  - Patient Safety Division (PSD)

Our vision:
- to lead and contribute to improved, safe patient care by informing, supporting, and influencing organisations and people working in the health sector.
Why is patient safety important?

- **Unsafe care:**
  - significant source of patient morbidity and mortality
  - major cause of distress to patients and families

- **Safer care:**
  - more than just a by-product of well educated, well intentioned clinicians
What these figures might mean to you locally…

- Potentially an average of 7,300 patients per year per trust suffer an adverse event
- Double Decker bus seats 73 people
- 100 bus loads of patients per year per trust
- Nearly 2 bus loads per week per trust
So...where are we now?
“We are still unable to assure NHS patients that all organisations are learning from experience in ways that prevent harm to future patients.”

Sir Liam Donaldson
Safety First,
December 2006
Organisational environment

- Greater awareness and understanding
- Growing evidence base for safer practices
- Difficult for clinicians to report safety concerns
- Frontline clinical teams not well engaged
- Not implementing what we know works
- Boards not putting patient safety first
- Weak patient voice
National priorities

• Reporting and learning
• Clinical buy-in
• Implementation
Number of patient safety incidents reported Oct 2003 to Dec 2007
Reported incidents by type July 2006 to June 2007

- Consent, communication, confidentiality
- Disruptive, aggressive behaviour
- Clinical assessment (including diagnosis, scans, tests, assessments)
- Documentation (including records, identification)
- Self-harming behaviour
- Medical device/equipment
- All other incident types
- Patient accident
- Treatment, procedure
- Medication
- Access, admission, transfer, discharge (including missing patient)
- Infrastructure (including staffing, facilities, environment)

733,089 Total no. of incidents
Reported degree of harm to patients, July 2006 to June 2007

- Severe harm
- Death
- Moderate harm
- Low harm
- No harm

Total no. of incidents: 733,070
The response system is more important than the reporting system.
Rapid Response Report
22 January 2009

Risks of Incorrect dosing of oral anti-cancer medicines

Comprising incidents occurring between April 2007 and September 2007

For any queries, please contact: e-mail: npsa.nhs.uk

Putting patient safety first.
Challenges

- Feedback
- Actionable learning - moving from the ‘what’ to the ‘why’
- Interpreting and using safety data
- Making reporting easier
- Learning from more than the tip of the iceberg
• Analysis of deaths reported in 2005 (1804).
• 576 considered attributable to a patient safety incident
• 3 main themes:
  – Diagnostic error
  – Deterioration not recognised or not acted upon
  – Resuscitation

www.npsa.nhs.uk
Recognising and responding appropriately to early signs of deterioration in hospitalised patients

November 2007
“To help make care safer, we should support the National Patient Safety Agency (NPSA) in establishing a single point of access for frontline workers to report safety incidents”
How can the NPSA help?

Now:

- data searches
- feedback
- rapid responses

www.npsa.nhs.uk
Rapid Responses in Production

- Heparin Flushes
- High Dose Opiates
- Chest drains: risks associated with incorrect insertion
- Fluid Bags & Arterial Line Sampling
- Bowel Cleansing Preparations
- Midazolam
- Potassium Permanganate
- Vinca Alkaloids in Mini Bags
- Burr Hole Correct Site Surgery
Blaming people when things go wrong only drives problems underground.
The Medical Director sent a letter to all medical staff reassuring them that any error they promptly reported would be exempt from disciplinary procedures unless there was malice or blatant recklessness.
In the same week.... the Nurse Director sent a letter to all nurses reminding them that if they in the course of their career at the trust report a second drug error, they could expect a final warning. On the third drug error, they would be suspended and may be dismissed.
“Although the report suggests we were very good as a trust at reporting and demonstrated a good safety culture throughout, the CEO, Director of Nursing and his Deputy felt that we report too much compared with other trusts in our cluster and would like us to reduce what we report as it appears that we have more incidents than other trusts of this size.”
How can the NPSA help?

Now:

- Safety culture tools (MaPSAF, foresight training)
- Incident decision tree
- Patient Safety Action Teams

[www.npsa.nhs.uk](http://www.npsa.nhs.uk)
PATIENT SAFETY FIRST

Making the safety of patients everyone’s highest priority
Problem to be solved

- Inspiring staff to make care as safe as possible
- Not accepting ‘complications’
- Making safety ‘real’ for frontline clinicians
- Visible local leadership
- Reliable implementation nationally of proven practices
The campaign cause and aim

The cause

To make the safety of our patients everyone’s highest priority

The aim

To build a culture of ‘no avoidable death, no avoidable harm’
Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act  Plan

Study  Do

Putting Patient Safety First
Leadership for safety

**Understand your own outcomes**

Review and monitor your hospital standardised mortality rate and mortality rate in the chosen topic area

Hospital leadership can have a significant impact on quality improvement

**Get the Board involved**

Set a Board goal for reducing avoidable mortality in the chosen topic area and monitor it

Demonstrates the Board is serious about protecting the lives of their patients

**Provide visible leadership**

Talk to your staff via structured patient safety walkabouts

Demonstrates commitment and creates a safety culture
Clinical Interventions

• Reduction of harm from deterioration.
• Care bundles
  - ventilator care
  - peri-operative care - surgical site infection
• Reduction of harm from high risk medications (to include Anticoagulants, Narcotics, Insulin, Sedatives)
Intervention: reducing harm from deterioration

- Acutely Ill Patients in Hospital: Recognition of and response to acute illness in adults in hospital (NICE, 07/07)
- Recognising and responding appropriately to early signs of deterioration in hospitalised patients (NPSA, 11/07)
- WHO Collaborating Centre for Patient Safety Solutions
Key elements to include:

• Ensuring a track and trigger system is in place throughout acute trusts and used at all times
• Ensuring use of a communication tool such as SBAR
• Ensuring the NICE graded response strategy is utilised at all times
• Ensuring an escalation policy is in place and utilised at all times
• Ensuring response is timely and appropriate
• Use of DH competences
Weekly Cardiac Arrests Outside A/E Department

Special Cause Flag

Patients Initiative

Mortality (in hospital) | Diagnoses - HSMR

Luton and Dunstable NHS Hospital Trust
GW: Crash Call Rate per 1000 Discharges
Intervention: Ventilator Care Bundle

- Elevation of the head of the bed to between 30 and 45 degrees
- Daily awakening: “sedation vacation”
- Daily assessment of readiness for weaning
- DVT prophylaxis (unless contraindicated)
- Stress bleeding prophylaxis
Being error wise

• Accept errors can and will occur
• Assess the local constraints before embarking on a task
• Have contingencies ready to deal with anticipated problems
• Be prepared to seek more qualified assistance
• Overcome professional courtesy and check colleagues’ knowledge and expertise
• Appreciate that the path to incidents is paved with false assumptions
Feral vigilance
Three-bucket model

- Self
  - Level 1: Good stuff
  - Level 2: Bad stuff
  - Level 3: Good stuff

- Context
  - Level 1: Good stuff
  - Level 2: Bad stuff
  - Level 3: Good stuff

- Task
  - Level 1: Bad stuff
  - Level 2: Good stuff
  - Level 3: Bad stuff
Active failures are like mosquitoes. They can be swatted one by one, but they still keep coming.

The best remedies are to create more effective defences and to drain the swamps in which they breed.

The swamps, in this case, are the ever present latent conditions.

James Reason
Thank you for listening

Putting Patient Safety First