How the new network of NHS Medication Safety Officers and Medical Device Safety Officers are affecting patient safety

9th December 2015
Dr David Gerrett
Senior Pharmacist
Patient Safety NHS E
1. Scene setting
2. MSO and MDSO responsibilities
3. Making it safer in the NHS
4. How are MSO and MDSO affecting patient safety?
Agenda

1. Scene setting
2. MSO and MDSO responsibilities
3. Making it safer in the NHS
4. How are MSO and MDSO affecting patient safety?
Medication safety in the NHS

At the heart of future NHS challenges 20% of people over 70 years old take five or more medicines. With an ageing population and multiple chronic medical conditions these numbers will just keep increasing.

600,000 non-elective hospital admissions are due to medicines 70% of these are preventable.

1 billion prescriptions are issued every year in primary care.

2.5 million doses of medicines are administered every year in the average acute hospital.

1/2 million inpatient prescriptions every year in the average acute hospital.

45,000 prescribing errors with 550 potentially fatal.

40–100 dispensing errors.

2,500 preventable deaths across all acute hospitals are due to medicines.

50 million prescribing errors.

400,000 dispensing errors.

400,000 33 million patients admitted to all acute hospitals suffer from harm due to medicines.

97,000 patients admitted to all acute hospitals suffer from harm due to medicines.

97% of medication errors reported to the NHS result in no or low patient harm.
Pharmacovigilance Under paragraph 5

For the sake of clarity, the definition of the term ‘adverse reaction’ should be amended to ensure that it covers noxious and unintended effects resulting not only from the authorised use of a medicinal product at normal doses, but also from medication errors and uses outside the terms of the marketing authorisation, including the misuse and abuse of the medicinal product.
ADE’s ADR’s and Medication Errors

No harm
Low harm
Things we don’t know
NHS E

Medication errors

THE FOCUS
Preventable (ADEs, ADRs and AEs)
NHS E

ADE’s

Non preventable
(ADR, MHRA)

Intercepted
NHS E

Potential ADE’s

ADE’s ADR’s and Medication Errors

The focus: Preventable (ADEs, ADRs and AEs)

- No harm
- Low harm
- Things we don’t know

Medication errors

- Potential ADE’s
- NHS E add MHRA

Non preventable (ADR, MHRA)

Intercepted NHS E

PSIs

Unsafe acts

Intended actions

Mistakes

Violations

Slips

Unintended actions

Routine Reasoned Reckless & Malicious

Rule & Knowledge Based errors

Skill based errors Memory failures

Skill based errors Attentional failures
Consciously competent

Learn

Unconsciously competent

Assess and learn
PSDA

Unconsciously incompetent

Consciously competent

Practice

Unconsciously competent

Lapse

The implications: we are all capable of error and things change

NPC. MeReC bulletin.2011;22(no1)

Slide 9   NHS E | Presentation for NHSLA 9th December 2015
Patient safety Incidents reported from Oct 2003 - Dec 2014
Estimates suggest that up to 10% of people may be harmed during the course of their healthcare.

The NHS leads the world in incident reporting, with the National Reporting and Learning System. It has received over 9 million incident reports since late 2003, and receives over 100,000 incidents reported monthly.

Incidents reported to the NRLS (annual figures for 2013)

- Patient accident 364,586
- Medication 158,394
- Treatment, procedure 146,205
- Implementation of care and ongoing monitoring / review 110,948
- Access, admission, transfer, discharge (including missing patient) 108,204
- Documentation (including records, identification) 79,902
- Infrastructure (including staffing, facilities, environment) 63,504
- Clinical assessment (including diagnosis, scans, tests, assessments) 62,845
- Disruptive, aggressive behaviour 47,265
- Self-harming behaviour 46,492
- Consent, communication, confidentiality 46,294
- Medical device / equipment 42,465
- Other 82,520

Outcome | Number | %
--- | --- | ---
No harm to the patient (near misses) | 892,525 | 68%
Low harm | 333,982 | 25%
Moderate harm | 82,597 | 6%
Severe harm | 7,175 | 0.5%
Death | 3,504 | 0.3%
In 2014 the absolute number of medication reports to the NRLS increased more than in any previous year, representing a 15.6% increase on the year before.
New style Patient Safety Alerts (PSAs)

- **Stage One Alert: Warning**
  - Warns organisations of emerging risk. It can be issued very quickly once a new risk has been identified to allow rapid dissemination of information

- **Stage Two Alert: Resource**
  - Provision of resources, tools and learning materials to help mitigate risk identified in stage one

- **Stage Three Alert: Directive**
  - Organisations are required to confirm they have implemented specific actions or solutions to mitigate the risk
Medication Safety Officer

Actions (Target date for completion 19 September 2014)

All large* healthcare providers including NHS Trusts, community pharmacy multiples, home healthcare companies and those in the independent sector should:

1. identify a board level director (medical or nursing supported by the chief pharmacist) or in community pharmacy and home health care, the superintendent pharmacist, to have the responsibility to oversee medication error incident reporting and learning;

2. identify a Medication Safety Officer (MSO) and email their contact details to the Central Alerting System (CAS) team. This person will be a member of a new National Medication Safety Network, support local medication error reporting and learning and act as the main contact for NHS England and MHRA; and,

3. identify an existing or new multi-professional group to regularly review medication error incident reports, improve reporting and learning and take local action to improve medication safety.

Small* healthcare providers including general practices, dental practices, community pharmacies and those in the independent sector should:

4. continue to report medication error incidents to the NRSL using the e-form on the NRSL website, or other methods and take action to improve reporting and medication safety locally, supported by medication safety champions in local professional committees, networks, multi-professional groups and commissioners.

5. Healthcare commissioners including Area Teams, and Clinical Commissioning Groups are invited to:

6. regularly review information from the NRSL and the MHRA to support improvements in reporting and learning and to take local action to improve medication safety. This should be done by working with medication safety champions in local professional committees and networks, and with new or existing multi-professional group.

Supporting information

* More detailed information to support the implementation of this guidance is available at:
www.england.nhs.uk/patientsafety/PSA
Medical Device Safety Officer

Actions (Target date for completion 19 September 2014)

1. Identify a board level director (medical or nursing supported by a senior healthcare professional) or in community pharmacy, or home health care, a senior manager (for example a Superintendent Pharmacist) to have the responsibility to oversee medical device incident reporting and learning.

2. Identify a Medical Devices Safety Officer (MDSO) and email their contact details to the Central Alerting System (CAS) team. This person will support local medical device incident reporting and learning, act as the main contact for NHS England and the MHRA and medical device manufacturers and be a member of the new National Medical Devices Safety Network and.

3. Identify an existing or new multi-professional group to regularly review medical device incident reports, improve reporting and learning and take local action to improve the safety of medical devices.

4. Small* healthcare provider organisations including general practices, dental practices, community pharmacies and those in the independent sector should continue to report incidents involving medical devices to the NRLS using the e-form on the NRLS website, or other methods. Report also to the MHRA’s online reporting system. Take action to improve reporting and learning locally, supported by medical device safety champions in local professional committees, networks, multi-professional committees and commissioners.

5. Healthcare commissioners including Area Teams, and Clinical Commissioning Groups are invited to: identify a Medical Devices Safety Officer (MDSO) and email their contact details to the CAS team. The MDSO will be a member of the National Medical Devices Safety Network, support reporting and learning and take local actions to improve medical device safety. The MDSO can use learning to influence policy, planning and commissioning as part of clinical governance in the commissioning organisation, and regularly review information from the NRLS and the MHRA to support improvements in reporting and learning and to take local action to improve the safety of medical devices. This should be done by working with medical devices safety champions in local professional committees and networks, and with a new or existing multi-professional group.

6. All large* healthcare provider organisations including NHS trusts, community pharmacy multiples, home healthcare companies and those in the independent sector should:
   - reviewing medical device incident reports, improve reporting and learning and take local action to improve the safety of medical devices.
   - Small* healthcare provider organisations including general practices, dental practices, community pharmacies and those in the independent sector should continue to report incidents involving medical devices to the NRLS using the e-form on the NRLS website, or other methods. Report also to the MHRA’s online reporting system. Take action to improve reporting and learning locally, supported by medical device safety champions in local professional committees, networks, multi-professional committees and commissioners.

*All large* healthcare provider organisations including NHS trusts, community pharmacy multiples, home healthcare companies and those in the independent sector should:
- Report all medical device incidents to the NRLS using the e-form on the NRLS website, or other methods. Report also to the MHRA’s online reporting system. Take action to improve reporting and learning locally, supported by medical device safety champions in local professional committees, networks, multi-professional committees and commissioners.

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**Stage Three: Directive**

Improving medical device incident reporting and learning

20 March 2014

[Image: NHS England logo]
### Which organisations?

As of 2\textsuperscript{nd} November 2015

Guests: + 60

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<th>Row Labels</th>
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<td><strong>Grand Total</strong></td>
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Healthcare Professionals and Patients Identify and REPORT Medication Incident

Medication errors

Risk /Complaint Managers Oversight & Quality Assurance

Medicines Safety Officer (MSO) Quality Assurance

Submit reports to NRLS through organisation’s system or online e-form

MHRA & NHS England Analysis

Request additional information

Adverse drug reactions (ADRs) but not Medication errors

Report to MHRA via Yellow Card Scheme
www.mhra.gov.uk/yellowcard

Analysis & regulatory action
MHRA’s Yellow Card Scheme
www.mhra.gov.uk/yellowcard
Analysis & regulatory action

MHRA safety communications:
- Drug Safety Update (monthly)
- Safety Warnings (as required)
- Alerts (as required)
- Recalls (as required)

NHS England safety communications:
- Formally by three stage Alerts,
- Organisational Patient Safety Incident to NHS organisations by NRLS reports (6 monthly)
- Publication in professional journals

National Medication Safety Network
National learning & safety communications

Feedback and action to minimise risk

Medicines Safety Officer
Ensures implementation

Local Medication Safety Committee
Oversight and support

Healthcare Professionals
Implementation

two way interaction and dissemination of safety communications

Support

Education, training and support

Feedback and interaction loop
Agenda

1. Scene setting
2. MSO and MDSO responsibilities
3. Making it safer in the NHS
4. How are MSO and MDSO affecting patient safety?
Beware the detail
MSO responsibilities

*Responsibilities should include the following:*

i. active membership of the National Medication Safety Network;

ii. improving reporting and learning of medication error incidents in the organisation;

iii. managing medication incident reporting in the organisation. This may entail reviewing all medication incident reports to ensure data quality for local and national learning and where necessary to investigate and find additional information from reporters. Also, to authorise the release of medication error reports to the NRLES each week;

iv. receiving and responding to requests for more information about medication error incident reports from the Patient Safety Doman in NHS England and the MHRA;

v. work as a member of the medication safety committee to deliver the responsibilities listed in 7.1.4; and,

vi. supporting the dissemination of medication safety communications from NHS England and the MHRA throughout the organisation.
Committee responsibilities should include the following:

i. improving reporting and learning of medication error incidents in the organisation;

ii. analysing incident data, audit and other data to identify, prioritise and address medication risks to minimise harm to patients;

iii. identifying, developing and promoting best practice for medication safety. This will include supporting the implementation of external patient safety guidance from NHS England, MHRA, NICE and other organisations - implementation will require coordination and support for process and system changes to reduce the likelihood of serious medication errors occurring and recurring, providing regular feedback to clinical staff, patient care areas and hospital committees on medication risks and planned action to minimise these risks;

iv. coordinating education and training support to improve the quality of medication error incident reports and safe medication practices; and,

v. assisting in development and review of medication-use policies and procedures.
MDSO responsibilities

Role responsibilities should include:

i. active membership of the National Medical Devices Safety Network;
ii. improve reporting of and learning from medical devices incidents in the organisation;
iii. manage medical device incident reporting in the organisation, review all medical devices incident reports to ensure data quality for local and national learning, where necessary investigate and get additional information from reporters;
iv. make sure that medical device incidents are sent to the NRLS as soon as possible and at least every week;
v. receive and respond to requests for more information from the Patient Safety Domain in NHS England and the MHRA about medical device incident reports;
vi. work as a member of the medical devices safety committee to deliver the responsibilities listed in 9.1.4;
vii. act as an additional senior point of contact for manufacturers and support local actions on Field Safety Notices; and,
viii. improve reporting of medical devices incidents and support the dissemination of medical devices safety communications from NHS England and the MHRA throughout the organisation.
MDSO responsibilities

Committee responsibilities should include the following:

i. improving reporting of and learning from medical device incidents in the organisation;
ii. analysing of incident data, audit and other data to identify, prioritise and address medical devices risks to minimise harm to patients;
iii. identifying, developing and promoting best practice for medical devices safety - this will include supporting the implementation of external patient safety guidance from NHS England, MHRA, NICE and other organisations. Implementation will need coordination and support for process and system changes to reduce the likelihood of serious medical device incidents occurring or reoccurring;
iv. providing regular feedback to clinical staff, patient care areas and hospital committees on the risks of medical devices and planned action to minimise these risks;
v. coordinating education and training support to improve the quality of medical devices error incident reports and safe medical devices practices; and,
vi. assisting in the development and review of medical device use policies and procedures.
1. Scene setting
2. MSO and MDSO responsibilities
3. Making it safer in the NHS
4. How are MSO and MDSO affecting patient safety?
10 years of Medication 2002-2012
Devices 2010-2012

Medication
• 45 Alerts, Rapid Response Reports
• Signals
• 6 design guides
• Medication Safety updates
New style Patient Safety Alerts (PSAs)

**Stage One: Warning**
Risk of death or severe harm due to inadvertent injection of skin preparation solution

26 May 2015

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**Actions**

**Who:**
All organisations providing NHS-funded care where skin preparation agents are used prior to an invasive procedure.

**When:**
As soon as possible but no later than 7 July 2015.

1. Identify if invasive procedures involving injection alongside skin preparation are taking place in circumstances where unintended injection of skin preparation solution has or could occur.

2. Consider if immediate action needs to be taken locally, and ensure that an action plan to reduce the risk of incidents occurring is underway if required.

3. Circulate this alert to all relevant staff.

4. Share any information on areas of clinical practice where use of open systems for injection appears to have persisted (and why), any learning from local investigations, and any locally developed good practice resources by emailing: patientsafetyenquiries@nhs.net

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Contact: patientsafetyenquiries@nhs.net
New style Patient Safety Alerts (PSAs)

Slide 29   NHS E | Presentation for NHSLA 9th December 2015

Stage One: Warning
Minimising risks of omitted and delayed medicines for patients receiving homecare services
10 April 2014

Actions
Who: All healthcare organisations that commission clinical homecare services
When: As soon as possible but no later than 9 May 2014

1. Establish if medicine homecare services are used within your organisation and if incidents of omitted and delayed medicines have occurred.
2. Consider if immediate action needs to be taken locally and develop an action plan, if required, to reduce the risk and the potential risk to patients.
3. Disseminate this alert to all medical, nursing, pharmacy and other staff who are involved in the care of patients receiving medicine homecare services.
4. Report relevant patient safety incidents, including those reported to you by patients, to the National Reporting and Learning System. Include in the report the term ‘medicine homecare service’ in the text description of the incident to aid analysis.
5. Share any learning from local investigations or locally developed good practice resources by emailing: patientsafety.enquiries@nhs.net.

Supporting Information:
More detailed information to support the implementation of this alert is available at: www.england.nhs.uk/patientsafety/psa

Contact us: patientsafety.enquiries@nhs.net
Sign up for regular updates: www.england.nhs.uk/patientsafety
New style Patient Safety Alerts (PSAs)

**Stage One: Warning**

Harm from using Low Molecular Weight Heparins when contraindicated

19 January 2015

**Actions**

**Who:** All hospitals and community services providing NHS funded care where Low Molecular Weight Heparins are prescribed, dispensed or administered.

**When:** To commence immediately and be completed by 2 March 2015

1. Establish if incidents have occurred, or could occur, in your organisation where Low Molecular Weight Heparins have been used despite a known contraindication.

2. Consider if immediate action needs to be taken locally and ensure that an action plan is underway, if required, to reduce the risk of further incidents occurring.

3. Disseminate this alert to all medical, nursing, pharmacy and other staff who are involved in the prescribing, dispensing and administering of Low Molecular Weight Heparins.

4. Share any learning from local investigations or locally developed good practice resources by emailing ENGLAND.Medication-Safety@nhs.net.
New style Patient Safety Alerts (PSAs)

Stage One: Warning
Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment
20 November 2014

Alert reference number: NHS/PSAW/2014/616
Alert stage: One - Warning

Naloxone is an opioid/opiate antagonist licensed for use in:
- complete or partial reversal of central nervous system depression and especially respiratory depression, caused by natural or synthetic opioids;
- treatment of suspected acute opioid overdose or intoxication.

Naloxone must be given with great caution to patients who have received longer-term opioid/opiate treatment for pain control or who are physically dependent on opioids. Use of naloxone in patients where it is not indicated, or in larger than recommended doses, can cause a rapid reversal of the physiological effects for pain control, leading to increased pain and distress, and an increase in sympathetic nervous system activity and cytokine release precipitating an acute withdrawal syndrome. Hypertension, cardiac arrhythmias, pulmonary oedema and cardiac arrest may result from inappropriate doses of naloxone being used for these types of patients.

The British National Formulary (BNF) recommends a dose range to reverse acute opioid/opiate overdose in adults by intravenous injection of naloxone of 400 micrograms to 2mg. If there is no response, the dose is to be repeated at intervals of two to three minutes to a maximum of 10mg.

The BNF highlights that doses used in acute opioid/opiate overdose may NOT be appropriate for the management of opioid/opiate-induced respiratory depression and sedation in those receiving palliative care and in chronic opioid/opiate use. The recommended dose for adults in post-operative respiratory depression and for palliative care and chronic opioid/opiate use (intravenous injection 100 to 200 micrograms (0.5 to 3 micrograms/kg). If the response is inadequate, give subsequent dose of 130 micrograms every two minutes. The naloxone doses in the BNF may differ from those in product literature. Even where doses are given as recommended, there is still a need for care to be taken in monitoring of vital signs in maintaining or restoring pain relief.

NHS England has received details of three patient safety incidents describing failure to follow the BNF guidance, including two incidents that resulted in death. Because this risk appears under-recognized, there may be significant under-reporting.

Additional safeguards that have been locally implemented include raising awareness of the risk of inappropriate doses of naloxone, the use of lower dose of naloxone in clinical protocols and education drug training, teaching correct use of naloxone in annual cardiopulmonary resuscitation training sessions, and providing guidance on clinical monitoring and access to specialist pain relief advice after naloxone administration.

### Actions

<table>
<thead>
<tr>
<th>Who</th>
<th>All organisations providing NHS-funded care where naloxone is prescribed, dispensed and/or administered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When</td>
<td>As soon as possible but no later than 22 December 2014.</td>
</tr>
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</table>

1. Establish if incidents involving inappropriate use of naloxone have occurred or have the potential to occur in your organisation.

2. Consider if immediate action needs to be taken locally and ensure that an action plan is underway, if required, to reduce the risk of further incidents occurring.

3. Disseminate this Alert to clinical staff who prescribe, dispense or administer naloxone injection.

4. Share any learning from local investigations or locally developed good practice resources by emailing: England.medication-safety@nhs.net
Patient Safety Alert

Stage Two: Resources

Support to minimise the risk of distress and death from inappropriate doses of naloxone

26 October 2015

Alert reference number: NHSPSAR/2015/0059
Alert stage: Two - Resources

Further clarifications have been required for a patient following a management of reduced consciousness (some palliative care patients). We did not have this patient’s experience, and there are some of these patients, that is if the patient is more specifically in the Palliative Care Formulary. It is important to be aware of all of these scenarios.

- A number of naloxone practice resources are available. Safety First website: http://www.patient-safety.nhs.uk/

- Further clarification has been required for a patient following a management of reduced consciousness (some palliative care patients). We did not have this patient’s experience, and there are some of these patients, that is if the patient is more specifically in the Palliative Care Formulary. It is important to be aware of all of these scenarios.

- UK Medicines Information (UKMI) has highlighted that naloxone should be used in the same way as is used in adults to reverse the effects of opioids or opiates.

- The working group publishing the 2007 Drug misuse and dependence - UK guidelines on clinical management has produced preliminary advice on naloxone without addressing its use and supply in all settings and circumstances when naloxone is indicated. http://www.evidence.nhs.uk/search/?%22what%20are%20naloxone%20doses%20that%20should%20be%20used%20in%22&title=2007+Drug+misuse+and+dependence+-+UK+guidelines+on+clinical+management

- The working group publishing the 2007 Drug misuse and dependence - UK guidelines on clinical management has produced preliminary advice on naloxone addressing its use and supply in all settings and circumstances when naloxone is indicated. http://www.evidence.nhs.uk/search/?%22what%20are%20naloxone%20doses%20that%20should%20be%20used%20in%22&title=2007+Drug+misuse+and+dependence+-+UK+guidelines+on+clinical+management

- A reminder covers naloxone dosing in overdose situations, take-home naloxone products that can be supplied and training that should be provided, now and following legislation to make naloxone more widely available from October 2015 onwards.


- These resources emphasise that there should be no conflict between the needs of patients with drug misuse and dependence who overdose, and those whose chronic pain or in end of life care. The safety of all patients depends on staff who understand that doses can be life-saving for one patient group and set of circumstances, it can be life-threatening for another patient group.

- This is especially important in the case of naloxone use in children and young people, and in the case of naloxone use in the elderly. The safety of all patients depends on staff who understand that doses can be life-saving for one patient group and set of circumstances, it can be life-threatening for another patient group.

- Whilst these resources focus primarily on the circumstances where naloxone use is - or is not - appropriate, it is important to remember that for patients, local protocols and local advice for managing withdrawal, lost pain control, and other effects.

- Share locally developed resources and local learning via the Medication Safety Officers network or by emailing: England.medication-safety@nhs.net

Actions

Who: All organisations providing NHS funded care where naloxone is prescribed, dispensed and/or administered

When: As soon as possible, and in parallel with any changes to naloxone use that are being considered in response to legislative change, but no later than 26 April 2016

1. Bring this Alert and linked resources to the attention of those in the organisation with responsibilities for local training, procedures and protocols for naloxone use

2. Use the resources in this Alert and any other relevant local or national resources to review, and if necessary revise, local training, procedures and protocols for naloxone use

3. Commence implementation of procedures and practice compliant with these resources within cycles of continuous improvement including consideration of teamwork and training, human factors and cultural aspects of compliance.

4. Share locally developed resources and local learning via the Medication Safety Officers network or by emailing: England.medication-safety@nhs.net
New style Patient Safety Alerts (PSAs)

Stage One: Warning
Risk of death or serious harm from accidental ingestion of potassium permanganate preparations
22 December 2014

Actions
Who: All providers of NHS funded care
When: To commence immediately and be completed by 22 January 2015

1. Identify if potassium permanganate preparations are used in your organisation, and if accidental ingestion has or could occur.
2. Consider if immediate action needs to be taken locally, and ensure that an action plan is underway if required, to reduce the risk of further incidents occurring.
3. Circulate this alert to all relevant medical, nursing, pharmacy and other staff.
4. Share any learning from local investigations or locally developed good practice resources by emailing patientsafety.enquiries@nhs.net.

Patient Safety Alert

Alert reference number: NHPSM/W/2014/18
Alert stage: One - Warning

Potassium permanganate is used in wound care because of its antiseptic and antimicrobial properties. It is available as a solution for further dilution and as a tablet preparation, which is dissolved in water and further diluted to a specified concentration. It is for external use only and can be fatal if ingested orally due to local inflammatory reactions that block the airways or cause perforations of the gastrointestinal tract. It can also cause death through toxicity and organ failure[1,2]. NHS England has been informed of an incident where a patient died after ingesting potassium permanganate.

While this death remains under investigation, analysis of the National Reporting and Learning System (NRLS) has identified 43 incidents in the past three and a half years where potassium permanganate tablets have been ingested orally by patients. Although none of these incidents were reported as causing severe harm or death, any later effect on the patient was not always clearly described.

An example incident reads:
Patient prescribed potassium permanganate for soaking of legs, tablet was diluted, but I did not communicate to my fellow colleague that it was not for oral consumption. Patient drank approximately 120-150mls of diluted preparation.

Although packaging clearly states potassium permanganate should not be swallowed, it is very unusual for a topical preparation to come in a tablet form, and therefore some staff, patients and carers may accidentally treat it as an oral preparation. The risk of error appears to increase when the term 'potassium permanganate tablets' is used rather than a term such as 'potassium permanganate soak'. The risk of accidental ingestion also increased where receptacles that implied oral ingestion were used, such as plastic cups or jugs. Other incidents involved potassium permanganate being directly dispensed to vulnerable patients in their own homes and the patient misunderstanding that the tablets were not for oral ingestion. Where accidental ingestion had occurred, staff did not always appear aware of the need to treat this as a medical emergency.

Analysis of the NRLS reports suggested that arrangements for supply, storage and preparation varied greatly among healthcare providers. Barriers related to the Control of Substances Hazardous to Health[3] include; separate storage, additional hazard labelling, and issue only to staff and patients who have been educated to understand its safe use.

Contact us: patientsafety.enquiries@nhs.net

www.england.nhs.uk/patientsafety

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New style Patient Safety Alerts (PSAs)

Stage One: Warning
Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder
05 February 2015

Actions
Who: All providers of NHS funded care where thickening agents are prescribed, dispensed or administered.

When: To commence immediately and be completed by no later than 19 March 2015

1. Identify if the accidental ingestion of dry thickening powder has occurred, or could occur, in your organisation.

2. Consider if immediate action needs to be taken locally, and ensure that an action plan is underway if required, to reduce the risk of further incidents occurring.

3. Distribute this alert to all relevant staff who care for children or adults in primary care, emergency care, and inpatient care settings, including mental health and learning disability units.

4. Share any learning from local investigations or locally developed good practice resources by emailing patientsafety.enquiries@nhs.net

Identify if the accidental ingestion of dry thickening powder has occurred, or could occur, in your organisation.
New style Patient Safety Alerts (PSAs)

Ensure staff have access to both adult, paediatric and infant sepsis screening and action tools that can be used for patients presenting on first attendance, or developing suspected infection as an in-patient. Examples of such tools can be found at the resource links given in this alert.

By either circulating this alert or through local alternatives (such as newsletters, local awareness campaigns, etc.) ensure that all relevant staff are aware of the key messages and the linked resources (or local equivalents) so they can be introduced into clinical practice; in particular the administration of antibiotics within one hour of suspicion of sepsis and early escalation to senior medical management.

Share local good practice or further locally developed resources relating to sepsis via the deterioration page of the Patient Safety First website.
New style Patient Safety Alerts (PSAs)

Stage One: Warning
Risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care
29 August 2014

Alert reference number: NPSA/SW01G014014
Alert stage: One - Warning

Between October 2012 and September 2013 there were around 10,000 reports to the National Reporting and Learning System (NRLS) of patient safety incidents related to discharge. The handover of patients when discharged from secondary to primary, community and social care is a complicated and multifaceted process.

Communication at handover is identified as a particular area of risk and accounted for approximately 39% of the 10,000 incidents reported to the NRLS. Review of these incidents identified that patients are sometimes discharged without adequate and timely communication of essential information at point of handover to all relevant staff and teams in primary and social care, including out of hours, and that information is not always acted on in a timely manner.

This can result in avoidable death and serious harm to patients due to a failure in continuity of care as well as avoidable readmission to secondary care. An example incident:

"Continuing Care Team (CCT) received hospital discharge fax to provide daily wound care for a patient who was being discharged after a long inpatient stay with a right grain bopy wound. Patient however being discharged after long inpatient stay with end stage thoracic lung disease. There was no mention on the fax that the patient was for end of life care. There was very poor communication from the ward and medical team to the GP and CCT at time of discharge and no end of life drugs, Gawain or reference for community end of life care."

NHS England is leading a national programme of work to support organisations in improving the communication and management of information at discharge by building an enormous local and national initiative already in place. This Stage 1 Alert is asking organisations to help form a national picture by informing us in these areas. We have developed and shared examples of what they have done to improve the quality and timeliness of communication with primary and social care on discharge. This includes GPs, community nurses, social care, voluntary sector and medicines reconciliation; and initiatives may include system design, policy, strategy and handover tools. To collect the required information local sector specific questionnaires and a best practice template have been developed.

Information received through the questionnaires and best practice template will be used to inform a subsequent Stage 2 Alert (resolution), which will provide a range of resources and recommendations to support organisations in improving safety of handover at a national level.

NHS England will also build a web-based best practice resource and are collaborating with local and national experts and enthusiasts in the field to provide series of webinars to facilitate system wide learning on this subject. Start can sign up for these webinars at the Patient Safety First website.

Actions
Who: All NHS organisations, other providers of NHS funded care and social care sector

When: To commence immediately and be completed by 13 October 2014

1. Identify any work that your organisation is undertaking or has undertaken to ensure that communication during handover at time of discharge is safe and timely, including medicine reconciliation, which could benefit other organisations and share via the online template.

2. Identify a person within your organisation to be the link with NHS England on this programme of work and email their contact details to patientsafety.enquiries@nhs.net. They will be contacted about forthcoming discharge webinars.

3. Complete the anonymous online questionnaire(s) relevant to your sector to inform the identification of national priorities for safety improvement relating to communication during handover at time of discharge here.

4. Share this alert with the main voluntary sector organisations that you work in partnership with on discharge and invite them to access the resources accessible on the Patient Safety First website.

Slide 36  
NHS E | Presentation for  
NHSLA 9th December 2015
How are MSO and MDSO affecting patient safety?
MSOs/MDSOs local and national focus

Essential focus
1. Local learning from PSIs
2. Taking National messages and implementing [Alerts] locally
3. Frequency and quality of reporting
4. Identifying and disseminating best practice
5. Conduit between NHS England/MHRA and practice
Hello David,

I hope that this email finds you well.

Please find attached the following items of info from Derby Hospitals, as requested via the MSO network & following on from your email prompt to us this week:
1) Paracetamol dosing info
2) Critical medicines list - please note that we are currently updating ours to also include Desmopressin following on from a recent incident.

I hope that this information is useful to you and your team.

Look forward to seeing you guys at the MSO conference in Birmingham next week.

Kind regards,

Jazz.
Lead to a topic presentation on a MSO event
Other hospitals saying it was an issue
A NRLS scope
Presentation to MSOs by a consultant directly involved in fatal incidents
Dissemination of previous information (sureMED)
SureMED Alert

SureMED alerts are published to raise awareness of risks with medicines. Their aim is to minimise harm to patients by promoting safe use of medicines and reducing the risk of medication errors.

**DRUG:** Desmopressin

**ERROR TYPE:** Omission

**POTENTIAL FOR ERROR**

Omission of desmopressin in patients who regularly take the medication can cause serious patient harm or death.

Desmopressin (DDAVP) is a hormone which is used to treat diabetes insipidus, a condition where the pituitary gland produces insufficient antidiuretic hormone (ADH). The kidney is unable to conserve water and large volumes of urine are produced. The same symptoms of polyuria and polydipsia occur following surgical removal of the pituitary gland.

The usual dose of desmopressin orally is 100mg 2 - 3 times a day and for maintenance 100 – 200mg taken 2 - 3 times a day.

If patients do not receive desmopressin when it is prescribed they are at risk of serious harm due to polyuria and hypernatraemia.

**DO NOT OMIT unless advised by a DOCTOR!**

If patients do not receive desmopressin when it is prescribed they are at risk of serious harm due to polyuria and hypernatraemia.

DO NOT OMIT unless advised by a DOCTOR!

Therefore, if a patient has been prescribed Desmopressin orally, all necessary steps must be taken to obtain the medication for administration at the right time.

If patients do not receive desmopressin when it is prescribed they are at risk of serious harm due to polyuria and hypernatraemia.

DO NOT OMIT unless advised by a DOCTOR!
1. Scene setting
2. MSO and MDSO responsibilities
3. Making it safer in the NHS
4. How are MSO and MDSO affecting patient safety?
1. …..are formally recognised healthcare practitioners working for the improvement of patient safety across the landscape of healthcare
2. …..are a conduit between front-line practice and NHS England
3. …..have a role to improve the quality and frequency of medication and/or device incident reporting and to promote local learning from such adverse incidents
4. How are they affecting patient safety….they are improving it every day, in their own way!