



Improvement

Patient safety review and response report April to September 2016

A summary of how we reviewed
and responded to the patient
safety issues you reported

June 2017

support collaborate challenge improve inspire

Delivering better healthcare by inspiring
and supporting everyone we work with,
and challenging ourselves and others to
help improve outcomes for all.

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Why publish this report?

Reporting all patient safety incidents, whether they result in harm or not, is fundamental to improving patient safety. The national action we take as a result of what we learn from incident reports is vital in protecting patients across the NHS from harm.

Year-on-year reporting to the [National Reporting and Learning System](#) (NRLS) continues to grow and we now receive over two million incident reports each year. This report explains how we reviewed those reports in the period April to September 2016 and describes the action we took as a direct result – whether by issuing a Patient Safety Alert or working with partners.

First and foremost this publication is a thank you to all the staff, patients and members of the public who have taken the time to report incidents. By showing the difference your efforts have made, we hope you find this report both informative and inspirational, and that it encourages you and your colleagues to continue to report all incidents so that together we can improve patient safety and protect our patients from harm.

How we review and respond to new or under-recognised risks

Most patient safety challenges, such as reducing diagnostic error, preventing self-harm, avoiding falls or managing long-term anticoagulation, are well recognised. These ‘giants’ of patient safety have complex causes and no simple solutions. They are the focus of wide, long-term programmes, including initiatives led by NHS Improvement and by other organisations, and through partnerships. The information we routinely collect through the NRLS and other sources can help inform this work.

But a national system can also identify new or under-recognised patient safety issues that may not be obvious at local level. When we identify these issues, we work with frontline staff, patients, professional bodies and partner organisations to decide if we need to issue advice and guidance to reduce risks, or if we can influence or support others to take action.

You can watch a [short video](#) on how we do this. You can also read about our three types of [Patient Safety Alert](#).

Information review

Our role starts with our clinical patient safety teams reviewing information from a range of sources to identify new or emerging issues that may need national action.

In the six months covered by this report our clinical teams reviewed:



9,488

Incidents reported to the NRLS with an outcome of death or severe harm (including reviewing each update of these incident reports)



12

Issues raised by direct communication (eg emails or phone calls to the national team)



4

Regulation 28 letters (letters from coroners where they have identified a need for action to prevent further deaths)



45

Incidents reported to the NRLS by patients or the public (we review all these even if not reporting harm)



415

NRLS incidents from areas of special focus (currently including all GP eform reports of moderate harm, all anaesthetic eform reports)



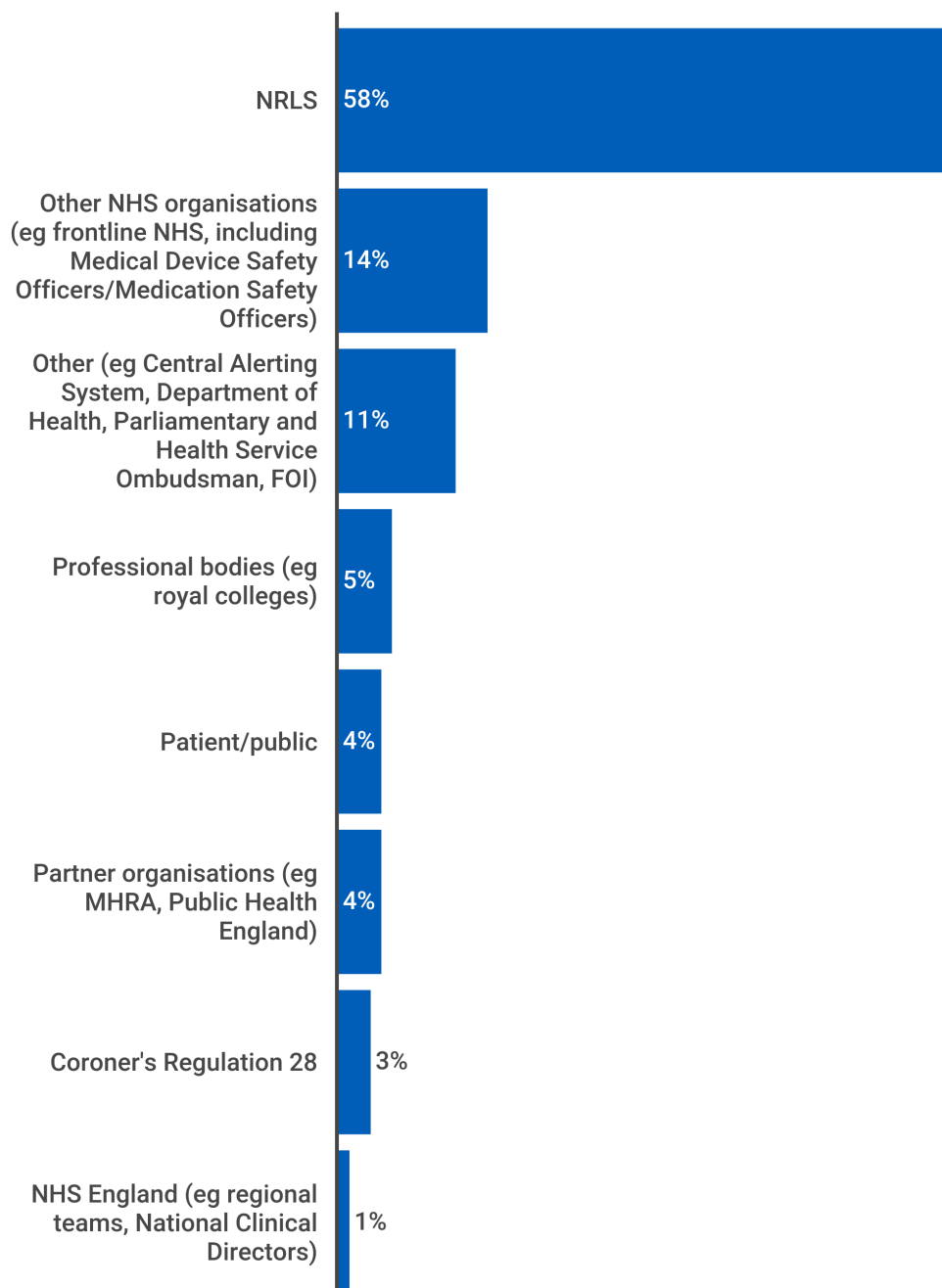
142

StEIS incidents from areas of special focus (currently including all Never Events)

Where any of these sources suggest there could be a new or under-recognised issue that requires national action, we explore further. Although this process is often triggered by a single patient safety **incident**, from that point onwards we work to understand the patient safety **issue** – the wider pattern revealed from looking at previous reported incidents, including no harm ‘near miss’ incidents, and focus on what could go wrong in future.

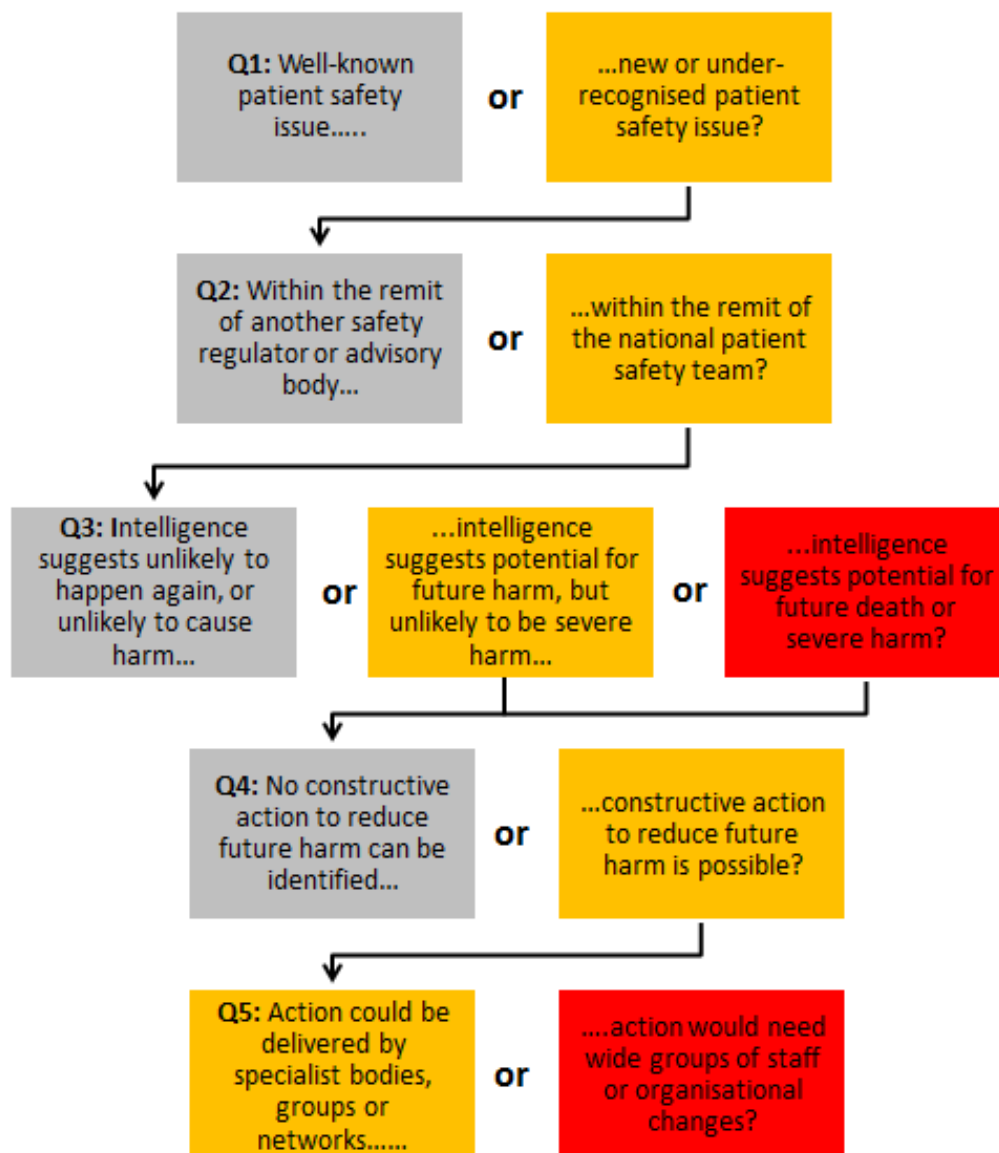
The chart below shows the sources of the issues our clinical teams identified between April and September 2016 and took forward for potential action.

Figure 1: Sources of issues reviewed by patient safety clinical teams



To decide whether national action is needed, and what type of action, we work through the flow diagram below (Figure 2). Where an answer falls into a grey box, the risk is **not** a new or under-recognised issue that we can act on. Where answers for a risk only fall into amber boxes we will look to share our findings with partners working in a particular specialty, such as a Royal College, and support them to develop ways to further prevent the risk (examples of this can be found later in this report). If an issue works its way through the process and falls into both red boxes it will be considered for a potential Patient Safety Alert.

Figure 2: Our process to determine a new or under-recognised risk



For all of these questions, the answers are rarely at our fingertips and to provide them we seek more information or challenge our own thinking. We:

1. Talk to experts, patients and their families, and frontline staff to check whether even well-known patient safety issues could have aspects that are new or under-recognised; these groups may have different perspectives.
2. Check whose remit an issue falls under, as some aspects of patient safety are handled by other national organisations. On this basis we decide whether to pass it to another organisation or take action ourselves.¹

¹ Examples of issues we initially explored but passed to other organisations for investigation and action in the period covered by this report include: two ligature point issues (DH Estates and Facilities), a surgical device issue (Medicines and Healthcare products Regulatory Agency (MHRA)), an anaesthetic device issue (MHRA) and a medication packaging issue (MHRA).

3. Look for up to date detail about the issue in the NRLS, research studies and other published material, and seek advice from specialists and frontline staff on any differences between recommended practice and typical practice in varying care settings and organisations.
4. Explore whether organisations can do something more constructive than simply raising awareness and warning people to be vigilant against error, and the options for this action.
5. Consider our audience. If a patient safety issue could be addressed at source, for example by the manufacturer of a device, or if an issue is only relevant to a specialist service or specific specialist healthcare group, it can be more effective to communicate with them directly rather than to issue an alert.

Our main routes to the right insights to help us understand each patient safety issue are frontline staff, patients, professional bodies and partner organisations on our [National Patient Safety Response Advisory Panel](#). This panel is made up of:



20%

Patient and public voice



40%

Frontline staff from providers and commissioners in all healthcare sectors



40%

Key national and professional stakeholders

If you would like to know more about why we have designed our clinical review and response process as we have, read this [journal article](#) which links our process to underpinning patient safety theories.

What action did we take?

Below we give examples of the action we took between April and September 2016 as a direct result of our reviews of incidents.

Patient Safety Alerts

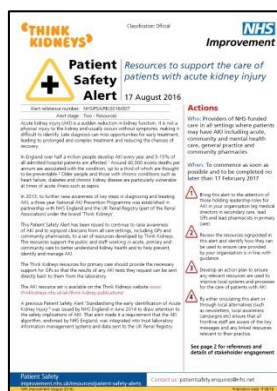
Between April and September 2016 we issued five Patient Safety Alerts:



7 September 2016 Restricted use of open systems for injectable medication

This [alert](#) was issued to stop the use of open systems for injectable medication, with the single exception of where the practice is used for embolisation procedures.

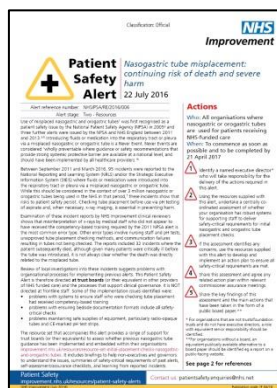
The use of open systems for injectable medication risks harm from one medication being confused with another, and medication intended for injection being confused with other substances, such as skin antiseptics, that are routinely contained in gallipots or other open containers.



17 August 2016 Resources to support the care of patients with acute kidney injury

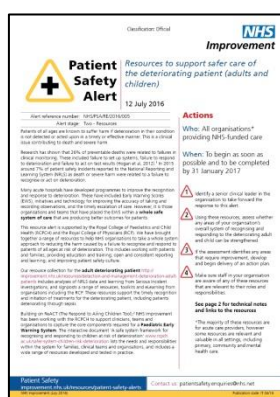
This [alert](#) was issued to raise awareness of acute kidney injury (AKI) and to signpost clinicians to resources developed by Think Kidneys.

These resources support the public and staff working in acute, primary and community care to better understand kidney health and to help prevent, identify and manage AKI.



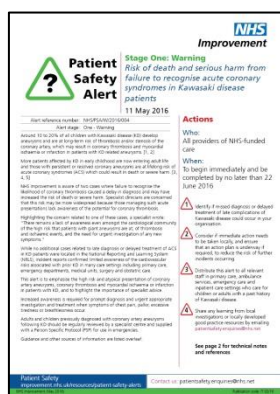
22 July 2016 Nasogastric tube misplacement: continuing risk of death and severe harm

This [alert](#) was issued to highlight patient safety incidents involving the misplacement of nasogastric and orogastric tubes. It is directed at trust boards, or their equivalent in other providers of NHS-funded care, to support them in assessing whether previous alerts and guidance have been implemented and embedded within their organisations.



12 July 2016 Resources to support safer care of the deteriorating patient (adults and children)

This [alert](#) was issued to provide resources to support the timely identification, response and management of the deteriorating patient (adults and children).



11 May 2016 Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients

This [alert](#) was issued to mitigate the risk of death and serious harm from failure to recognise acute coronary syndromes in patients with Kawasaki disease.

We share our alerts with the devolved nations of Scotland, Wales and Northern Ireland and they choose whether or not to use or adapt learning in their own countries.

Scotland disseminated the following NHS Improvement alerts published in the period covered by this report:

- Restricted use of open systems for injectable medication.
- Resources to support the care of patients with acute kidney injury.
- Nasogastric tube misplacement: continuing risk of death and severe harm.
- Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients (disseminated to the Scottish Cardiac Society only).

Wales issued the following publications based on NHS Improvement alerts published in the period covered by this report:

- [Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients](#) (issued 28 June 2016).
- [Restricted use of open systems for injectable medication](#) (issued 10 January 2017).

Northern Ireland issued the following publications based on NHS Improvement alerts published in the period covered by this report:

- [Restricted use of open systems for injectable medication](#) (issued 12 September 2016).
- [Resources to support the care of patients with acute kidney injury \(AKI\)](#) (issued 29 September 2016).
- [Nasogastric tube misplacement: continuing risk of death and severe harm](#) (issued 12 August 2016).
- [Resources to support safer care of the deteriorating patient \(adults and children\)](#) (issued 26 July 2016).
- [Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients](#) (issued 18 May 2016).

Issues where we advised or influenced others on action



Risks with text messaging in community nursing teams

We identified risks associated with community nursing teams using text messaging in two separate NRLS incident reports. Text messages were used to communicate important information about the care and treatment of patients but this was either not transmitted or not read in a timely manner.

In the first incident report the phone company's processing of the message delayed its receipt. The second report referred to delays in the recipient of the text message being aware that information requiring action had been sent.

We were concerned about a potential impact on patient safety unless there was a systematic approach to checking messages had been received and teams had capacity to respond. We asked the Royal College of Nursing (RCN) to address the issue. Its District Nurse Forum worked with its membership to ensure community nurses understood the problem and developed a protocol with safeguards for the use of text messaging.



Harm from off-licence use of chlorhexidine in women's health

We identified an incident where the off-licence use of Hibitane (chlorhexidine 1%) cream in vaginal packs following gynaecological procedures had caused chemical burns.

We subsequently identified further incidents in the NRLS and shared these findings with our stakeholder group. Although the practice

appeared limited to a minority of providers, we asked the Royal College of Obstetricians and Gynaecologists (RCOG) to take action and it agreed the profession needed to be made aware of the potential risk of harm.

Because the safety issue was relevant to a specific professional group, this was done via the [RCOG monthly newsletter](#), drawing the matter to the attention of clinicians and urging them to take local action. We also shared the findings with the medication safety officer (MSO) network.

Preventing and managing haemorrhage from arteriovenous fistulas



Arteriovenous fistulas are created to allow patients to receive renal dialysis, but the arterial blood flow into the fistula combined with the frequent puncture wounds risk haemorrhage that can be rapid and potentially fatal.

We were contacted by an NHS trust that had recently experienced two life-threatening incidents relating to haemorrhaging renal fistulas and sought our support to explore opportunities to promote shared learning. We carried out a clinical review of reports to StEIS (the serious incident database) and identified six similar events in the preceding year. The results were anonymised and the findings discussed with the British Renal Society (BRS), which agreed to use our review and the local learning to support the work of the BRS Vascular Access Special Interest Group. This group is developing resources for renal units across the NHS to help them prevent and manage the risk of 'life-threatening haemorrhages from vascular access for haemodialysis'.

We will work with the BRS to support dissemination of relevant resources to health and care professionals beyond the renal community.

Failure to remove cardiac monitor electrodes before MRI scan



Magnetic resonance imaging (MRI) scanners generate strong magnetic fields. This means any loose metallic objects brought near to active MRIs can become dangerous projectiles, while any metallic material attached to the skin will be rapidly heated.

Our regular clinical review of severe harm reports revealed a scanned patient who suffered burns from electrodes that had not been removed as part of routine checking before the scan. We were keen to understand whether failure to do this was because it was not included in national guidance or because it was omitted when translating national guidance into local checklists for performing MRI scans. We sought expert advice from the Royal College of Radiologists (RCR), which confirmed that local checklists for MRI scans should be based on [existing national guidelines \(MHRA 2015\)](#) and that this national guidance referred to electrodes.

We asked the reporting organisation to submit its (anonymised) summary of the incident and investigation to the RCR Radiology Events

and Discrepancies process (a confidential system for sharing incidents, events and discrepancies in radiology), which is widely read by the radiology community. Our team introduced the two organisations, which agreed to work together to improve local checking processes.

Harm from inadvertently ingesting thickening agent capsules



The MHRA informed us that a patient had suffered serious harm after swallowing an agent used to thicken the contents of stoma bags. The thickening agent comes in capsule form and the patient had mistaken it for their medication. As the thickening agent was not a medication or medical device, the issue was not within MHRA's remit.

We found the thickening agent capsule looked very similar to some oral medication capsules, making it difficult for patients to distinguish between the two, particularly when not in their original packaging. We wrote to the manufacturer of the thickening agent capsule and recommended it change the appearance and introduce extra measures to prevent the product from being accidentally swallowed. As a result of our intervention the manufacturer has changed the labelling and introduced a red flash warning, and is exploring options for marking the thickening agent capsules with 'do not swallow'.

We found no indications that similar products from other manufacturers could be mistaken for oral medication and therefore no further national action was required.



Incorrect use of 'u' as abbreviation for unit of insulin by transcription services

We were informed that a company that typed dictated medical notes and discharge letters for several NHS providers was abbreviating 'units' to 'u' when referring to concentration of insulin. This is against [published safety guidance](#), as 'u' can be misread as a zero, risking a 10-fold dose error which could prove fatal with insulin. The [Never Events framework](#) was amended in 2015 to take this into account.

We asked the company to take action to stop this practice. The company retrospectively searched transcribed correspondence and identified two similar errors, introduced by an individual staff member operating outside company policy. Managers took action related to staff training and accuracy checks to avoid repeat incidents.

We found no indications other transcription companies were using the abbreviation and therefore no further national action was required.



Air embolism from uncapped central venous catheter (CVC) ports

We received a coroner's Regulation 28 letter describing the death of a patient from cerebral infarction caused by air entering the circulation via a CVC port. The coroner raised specific concerns about nurses' awareness of the risk of air embolism from CVCs, and a lack of guidance relating to the risk of air entry when a CVC port is in use.

We reviewed NRLS incidents for safety issues relating to CVCs, and identified the key organisations producing relevant guidance and asked them to take action. The Safe Anaesthesia Liaison Group (SALG) and the College of Operating Department Practitioners (CODP) agreed to raise awareness among their members about the risk of leaving a CVC line uncapped during use. These organisations are well positioned to influence professional leadership, training and supervision, and can reach staff providing direct care.



New or under-recognised ligatures, ligature points or other means of self-harm

Prevention of self-harm ultimately relies on improvements in the therapeutic environment, not solely environmental safety. But to improve environmental risk assessments in mental health units, we routinely notify the Mental Health Directors of Nursing network of new or under-recognised methods of self-harm or methods of concealing items for self-harm, via a confidential route. In the period covered by this report, we shared three risks through this route. Sharing information on these through published documents would be unsafe as this could give people ideas on how to harm themselves.



Providing safe care after sudden GP practice closure

A GP practice made a report to the NRLS some months after taking on at short notice patients from another practice that had been closed. The GP practice was continuing to find it difficult to ensure all their new patients had safe care because of missing records and misfiled information.

We contacted NHS England which provided extra support for the practice. NHS England used this as a learning opportunity to improve the support it offered, including the option to secure patient records at an earlier stage if quality concerns suggest a GP practice may be closed.



Left atrial appendage occlusion (LAAO); learning from incidents with innovative procedures

LAAO is an emerging procedure for the prevention of thromboembolism in patients with atrial fibrillation. It involves inserting a small mesh into the left atrium of the heart using a catheter introduced via the left femoral

vein. The mesh blocks the appendage, preventing blood clots forming and entering the main circulation.

We found two incidents relating to this procedure in our regular clinical review of the NRLS: one concerning the introduction of a large air embolism into the coronary arteries and the second, haemorrhage as a result of stabilising wires tearing a coronary artery. We informed the 10 centres commissioned to trial this procedure as part of the [Cardiology Commissioning through Evaluation](#) programme about the risk, with support from the relevant national clinical director.



Patient safety during GP list cleansing

A GP contacted us to raise concerns that patients, particularly those whose first language is not English, may not understand the letters being sent out as part of a national GP 'list cleansing' initiative. This initiative involved sending letters to patients who had not had any contact with their GP for some time and appeared to have moved away. Patients were asked to make contact if they had not moved and wanted to remain on their GP's list.

Recognising the potential risks we referred the matter to the Primary Care Commissioning team at NHS England. It provided assurance around existing arrangements for translation and safeguards to protect vulnerable patients, and used the GP's concerns to inform additional efforts to address language barriers.



Falls from hospital beds used in people's homes due to the design of bed brakes

A coroner's Regulation 28 letter raised concerns regarding the home use of hospital-style beds. A patient had died after falling from a bed with brakes on each of its four wheels. When the bed was placed in the corner of a room against a wall, only three brakes could be locked, allowing the bed to move away from the wall and the patient to fall to the floor through this gap.

We worked with the Medicines and Healthcare products Regulatory Agency (MHRA) and the following stakeholder groups:

- College of Occupational Therapists (COT)
- Royal College of Nursing (RCN)
- National Association of Equipment Providers (NAEP)
- Independent Standard Body for Disability Equipment (CECOPS)
- Carers UK.

We asked them to consider changes in equipment design, instructions for use, and guidance for professionals and carers to reduce the risk. To

help this information reach the right audiences, all stakeholders agreed to place relevant information on their public websites and COT agreed to produce a [Practice Briefing](#) for professional staff who linked to these. The Practice Briefing was circulated to the membership of these stakeholders and reached a wide range of staff providing care in people's homes.



Harm from intravenous paracetamol in patients of low body weight

Intravenous paracetamol is a very effective painkiller, but it accumulates in the liver when taken in excessive doses, causing acute liver failure which can be fatal. The effective dose for an adult of average body weight can be harmful to a patient of lower body weight, especially if administered over several days. Patients who weigh less than 50 kg, which is not an unusually low weight, are at risk.

After receiving two reports of deaths involving failure to adjust intravenous paracetamol doses in lower body weight patients, we reviewed NRLS data and identified similar cases where paracetamol was reported to have caused moderate or lower harm.

Via our MSO network, we obtained and reviewed a selection of local guidance used in acute hospitals, and identified that this did not consistently provide dose reductions for patients of lower body weight. We also contacted companies providing e-prescribing and dispensing systems, and found these did not routinely request a patient's weight and use this to set limits on paracetamol dosing. We identified that the main reason neither local guidelines nor e-prescribing systems were effectively addressing the risk was because their key source was the British National Formulary (BNF), and this did not include intravenous paracetamol dose adjustments for lower body weight patients.

We worked with United Kingdom Medicines Information (UKMi) to search the literature for further evidence for the potential for harm, and consulted the Safer Anaesthesia Liaison Group, which confirmed our findings were consistent with its experience. We brought all our findings to the attention of the BNF and asked it to change its guidance to address the risk for lower body weight patients.

As a result of our intervention, the BNF now includes guidance for lower body weight patients requiring intravenous paracetamol, and this feeds through to local guidance and e-prescribing systems.



Confusion between management of accidental ingestion of turpentine and of white spirit

We became aware of an incident involving a toddler who swallowed white spirit by accident at home. Staff in the A&E department incorrectly

followed 'Turps' (turpentine) ingestion guidance from [TOXBASE](#). Turps and white spirit are very different substances that need different approaches to treatment if ingested, but it is easy for staff to confuse these as the products are used for the same purposes in the home.

We brought this to the attention of the National Poisons Information Service (NPIS) which is responsible for the provision of TOXBASE information used by emergency services, and worked with it to strengthen its guidance. Prompts were included to ensure staff determined whether Turps or white spirit was involved, and clinical information added to the Toxbase guidance, including:

- clinical advice on when a chest X-ray is required
- patients who are not admitted or who are discharged are told to seek medical attention immediately if symptoms subsequently develop.

We shared what we learnt from this incident with the ambulance MSO network, and used it to reinforce the importance of collecting and communicating the clearest possible information on patients who have ingested any poisonous substance.



Fire hazards from skin preparations containing lower concentrations of paraffin

A fire safety officer contacted us about a fatal fire involving a patient in their own home. Large amounts of skin emollient containing paraffin had been applied to the patient's skin, this soaked into their clothing and bedding and caught fire when they were smoking in bed. We also received a coroner's Regulation 28 letter related to a similar incident in a care home. The preparations in question contained a relatively low concentration of paraffin, lower than the 50% paraffin in an emollient in a previous report of a fatal fire, for which a [Patient Safety Alert](#) was issued in 2007.

We informed the MHRA of this new risk of fire with lower paraffin concentrations and it issued a [Drug Safety Update](#) in April 2016. While the coroner had contacted the company producing the brand of emollient used in the second fire and it amended its packaging to include a specific warning of fire risk, we were concerned the same risk could apply to similar skin creams. We contacted the BNF and because of our intervention it enhanced its warnings to include risk from lower paraffin concentrations and soaking into clothing and bedding.

We also developed information for those most likely to be in contact with smokers using large amounts of skin emollients and disseminated it through:

- the Care Quality Commission's newsletter to care homes
- The Royal College of Nursing's newsletter
- NHS England's GP bulletin.



Liquid and tablet forms of posaconazole requiring different doses

Posaconazole is a broad-spectrum anti-fungal agent used in patients with compromised immune systems and those who do not respond to first-line treatments for conditions such as thrush.

We received a severe harm report to the NRLS involving a dosing error when changing between liquid and tablet forms of posaconazole. This is an issue as the two pharmaceutical preparations have different bioavailability (that is, the amount of the active ingredients that is absorbed). This means that an appropriate dose in a liquid form could cause renal damage if given in a tablet form. The MSO at the reporting organisation presented this incident at an MSO WebEx event to raise awareness across the network. As well as the MHRA, we told the BNF that the information for posaconazole did not clearly highlight the non-interchangeability of doses in the different preparations as this information appeared towards the end of the section. As a result of our intervention, the BNF changed how it displayed this information and added further details about the importance of adjusting the dose when changing between liquid and tablet forms.



Look-alike or sound-alike errors: confusion between clonazepam and clobazam

Look-alike, sound-alike errors (LASA) are a known risk when selecting a medication from prescribing and dispensing software, pharmacy shelving or medication trolleys. LASA errors result from similarities in product names, and can be increased when systems organise products alphabetically. The risk of error can also increase when packaging or presentation is similar. International and [national efforts](#) to reduce similarities are being made and we use learning from the NRLS to suggest further areas where the risks of LASA errors need to be addressed.

Preventing two medications used as anticonvulsants, clonazepam and clobazam, from being confused is one example of our work to prevent LASA errors. A member of the public contacted us after clonazepam was wrongly dispensed for their child, not the prescribed clobazam. Our regular reviews of severe harm highlighted a similar issue, and our search of the NRLS found 20 additional lower harm reports of this nature. We identified that clonazepam and clobazam appeared on the same page in the paper version of the BNF, a major reference source for prescribers and dispensers of medicines in England, and considered this

increased the risk of LASA error. We contacted the BNF, which agreed to separate where the two medications appeared and to add warnings to highlight the risk of confusion.

Acting through our MSO and MDSO networks

The MHRA and NHS Improvement jointly support the medication safety officer (MSO) and medical device safety officer (MDSO) networks. These networks were established following Patient Safety Alerts issued in March 2014 asking providers to identify an [MSO](#) and [MDSO](#) in their organisation. All NHS trusts have MSOs and MDSOs, and an increasing proportion of CCGs and private providers of NHS-funded care have also created MSO and MDSO roles. Many new and under-recognised patient safety issues relate to medications or medical devices, partly because of the level of innovation and new products, so these networks are a key route for communicating new or under-recognised risks. But they do much more than this. Below we highlight what the MSO and MDSO networks have worked on in the period covered by this report.

The MDSO network

Monthly WebEx meetings for the MDSO network were held in the period covered by this report, jointly hosted by MHRA and NHS Improvement.

The WebEx meetings are a key route for gaining insight into patient safety issues identified through our review of NRLS incident reports or other sources. We involve the MDSO network at an early stage in our exploration of patient safety issues, before deciding the best way to act. The MDSO network has also been invaluable in bringing to our attention issues that may need national action, including through Patient Safety Alerts.

Each month presentations on areas of patient safety relevant to medical devices are selected and shared across the network, with viewers able to ask questions and feedback to a national poll. Speakers belong to the MDSO network, the wider NHS and the MHRA or work in procurement and industry. Subjects have included:

- update on GS1 bar coding
- medical device user manuals
- the Central Alerting System (CAS)
- point of care and self-test blood glucose monitors
- NHS master indemnity process
- medical device time clock settings
- non-automatic weighing instruments and patient weighing
- company reps credentialing review
- good practice for patient safety investigation

- cluster analysis for medical device-related incidents
- supply disruption alerts
- medical device training
- new medical device regulation a
- value of multiple reporting sources for in-vitro diagnostic devices.

We also routinely include updates on all recent Patient Safety Alerts, focusing on how MDSOs can support effective implementation. We share advice and guidance issued through routes other than alerts; several examples are given earlier in this report.

The WebEx meetings are supported by a national ‘forum’ where members can develop new themes and raise concerns at an early stage.

In the period covered by this report, over 300 MDSOs signed into the WebEx and forum pages, and there were over 40 discussion threads.

Want to find out more about MDSOs?

The role of the MDSO varies from organisation to organisation and may be allocated to more than one person. MDSOs are nominated by their organisation and are registered and obtain forum log in details via safetyalerts@dh.gsi.gov.uk. If you are unsure who the MDSO in your organisation is, your risk manager or clinical governance team will be able to tell you.

The MSO network

One-hour WebEx meetings for the MSO network were held each month with direct involvement of NHS Improvement, the MHRA and specialist pharmacy services. The latter provide both a co-ordinating function and, through the UKMi group, produce a monthly round-up of relevant national and international information.

The WebEx meetings include calls for insights into patient safety issues identified through our review of NRLS incident reports, incidents and issues identified by MSOs, and other sources. As with MDSOs, we involve the MSO network in our exploration of patient safety issues at an early stage to gauge opinion and seek advice before deciding the best way to act. Importantly, MSOs have been invaluable in providing local intelligence in relation to specific potential safety issues.

For example, the 159 MSOs in acute hospital providers were asked to provide their local standard operating procedures (SOPs) for intravenous paracetamol (see above). The BNF was identified as the primary reference source and this allowed us to identify that altering the instruction in the BNF would ensure that safer practice would filter through to SOPs. From the advice from the MSOs we knew how to act.

Through email and the discussion forum we routinely include updates on all recent Patient Safety Alerts, focusing on how MSOs can support effective implementation. We also use the MSO network to share advice and guidance issued through routes other than alerts.

During the period covered by this report the MSO network has matured to a point where discrete groups are working more autonomously. A [handbook](#) explaining the role of MSOs is available.

In September 2016 there were 389 MSOs listed with CAS, and for the devolved nations of Wales, Scotland and Northern Ireland a further 31 were in similar roles.

Want to find out more about MSOs?

The role of the MSO varies from organisation to organisation and may be allocated to more than one person. MSOs are nominated by their organisation and are registered and obtain forum log in details via safetyalerts@dh.gsi.gov.uk. If you are unsure who the MSO in your organisation is, your chief pharmacist will be able to tell you.

Inspired to report?

For staff working in most NHS organisations, including NHS trusts and NHS foundation trusts, the most effective way to report to the NRLS is via your own local reporting system. Reporting to your local system means local action may be taken, and your report will also be anonymously shared with the NRLS through a weekly or monthly upload of data.

If you belong to a small organisation such as a community pharmacy or GP surgery, you can report directly to the NRLS using our [eForm](#) or [GP eForm](#).

Patients and the public can report to us via the [public reporting portal](#) (please note we do not investigate individual reports but we do record public concerns and use this information to improve safety).

If you are aware of a new or under-recognised issue that you believe we should be acting on, we can be contacted via patientsafety.enquiries@nhs.net

Interested in finding out more?

Researchers or healthcare professionals who would like to use NRLS data for learning should contact NHSI.NRLSDataRequest@nhs.net

This report describes one aspect of our work, focused on new or under-recognised risks to patient safety. Please see our [webpages](#) for a broader understanding of all the ways we work to improve the safety of patients.

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