
Improving reporting and learning of medication errors

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We will cover....

- New style Patient Safety Alerts from NHS England
- Recent Alerts
- New Alerts
- Patient safety Collaboratives
- The future
New style Patient Safety Alerts (PSAs)

- A new system was launched on 31st January 2014 for alerting the NHS to emerging patient safety risks
- The new system allows for timely dissemination of relevant safety information to providers, as well as acting as an educational and implementation resource
- It builds on the best elements of the former National Patient Safety Agency (NPSA) system
- It will be known as the National Patient Safety Alerting System (NPSAS)
New style Patient Safety Alerts (PSAs)

- A three-stage system, based on that used in other high risk industries.
- Used to disseminate patient safety information at different stages of development, to ensure newly identified risks can be quickly highlighted to providers.
- Allows rapid dissemination of urgent information, as well as encouraging information sharing between organisations and providing useful education and implementation resources for use by providers.
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
National Patient Safety Alerting System

Alerts are issued on the basis of a set of agreed principles and may cover issues including the following:

1. New or under recognised patient safety issues;

2. Widespread, common and challenging patient safety issues not solved by alerts in isolation; or,

3. Improving systems for clinical governance, reporting and learning.
Advantages of the NPSAS

- Gives organisations the opportunity to tackle emerging risk in their own way and to establish a sense of ownership
- Through stage two alerts, organisations will be provided with potential solutions and resources to mitigate the risk.
- Encourages voluntary compliance for the early adopters, allowing providers to find solutions that best suit their individual organisations and minimises the requirement for directives.
Alert compliance sign-off

• Providers will be issued with required actions to be signed-off in a set timeframe in accordance with the Central Alerting System (CAS) sign-off process. The actions will be tailored for each patient safety issue.

• All three stages of alert are likely to be used for issues representing a major risk. However, on occasions it may only be necessary to use part of the alert process. For example, issues of a widespread and well known nature may not require a Stage One: Warning, while those where a clear and specific solution exists may be addressed only with a Stage Three: Directive.
Consequences of failing to sign-off stage one, two or three alerts by their deadline

- By April 2014, we will publish data monthly on any trusts who have failed to declare compliance with any NPSAS alerts by their due date.
- Failure to comply is likely to be used by the CQC in their Intelligent Monitoring System and by commissioners responsibilities for improving quality.
- Failure to comply with a Stage Three Alert: Directive within the deadline will be a cause for significant concern on the part of regulators, commissioners and most importantly, patients.
Targeting of alerts to reach relevant audiences

• Alerts will be targeted as narrowly as possible in order to keep them relevant to those receiving them

• Target audience will be identified in consultation with the sponsoring NHS England Patient Safety Expert Group (PSEG) and relevant experts

• In some cases it may be difficult to identify a definitive audience and therefore it may be necessary to issue an alert to a wider audience
Dissemination

- Alerts will be disseminated via the Central Alerting System (CAS).
- CAS will be used to share alerts with:
  - Area teams;
  - CCGs (who register for CAS);
  - Secondary and tertiary care providers;
  - Primary care providers (via area teams).
- The relevant organisation will be advised of the “expected” audience, but will have the freedom to share more widely as they see fit, recognising local variation in provision of service.
Governance for alert development

- Responsibility for the development of alerts rests with the NHS England Patient Safety Domain in collaboration with subject experts and relevant organisations
- Alert development will be sponsored, wherever possible, by the relevant NHS England Patient Safety Expert Group (PSEG)
- Final approval for all alerts will come from the National Director of Patient Safety before they are released
New Alerts - Drivers for change

- New EU Directive on Pharmacovigilance
  - ADR definition now includes medication errors
  - Requirement for regulator to implement a reporting and learning system for medication errors / closer working with MHRA
- Poor quality reports to the NRLS
- Increase numbers of reports from primary care and the independent sector including home health care companies
- The Berwick Report on Patient Safety
- Improve governance arrangements for medication safety in healthcare organisation
- Introduce an effective multi-sector system – after closure of NPSA and re-organisation of the NHS
New Alerts

• National Director for Patient Safety sign off yesterday
• CAS dissemination tomorrow, Thursday
• You can’t have the slides until tomorrow 😊
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.

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 NRLS using the e-form on the NRLS 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. identify a MSO and email their contact details to the CAS team. This person will be a member of the National Medication Safety Network, support reporting and learning and take local action to improve medication safety.

6. regularly review information from the NRLS 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 a 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:

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 Device Safety Network, support reporting and learning and take local actions to improve medical devices 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, networks, multi-professional committees and commissioners.

Healthcare Professionals and Patients Identify and REPORT Medicines Safety Officer (MSO) Quality Assurance

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

Adverse drug reactions (ADRs) but not Medication errors

Analysis & regulatory action

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

Request additional information

Local Medication Safety Committee Oversight and Support

NHS England Presentation 19th March 2014
MHRA’s Yellow Card Scheme
www.mhra.gov.uk/yellow card
Analysis & regulatory action

National Medication Safety Network
National learning & safety communications

Feedback and action to minimise risk

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

Local Medication Safety Committee
Oversight and support

Healthcare Professionals
Implementation

Medicines Safety Officer
Ensures implementation

two way interaction and dissemination of safety communications

education, training and support

NHS England Presentation 19th March 2014
What is in store for the MSO MDSO?

• Roles and responsibilities are defined for the MSO and MDSO
• Committee responsibilities are defined
• There will be a dedicated email address
• Heavy use of WebEx
• Feedback mechanisms
• Conferences x 2 each year
• NETWORKS
What can you do?

• Read them really carefully
• You have until 19 September 2014

Contact us if anything is unclear

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Key messages

A promise to learn – a commitment to act

Improving the Safety of Patients in England

National Advisory Group on the Safety of Patients in England
Key messages

• The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.

• We have made specific recommendations around this point, including the need for improve training and education, and for NHS England to support a network of safety improvement Collaboratives to identify and spread safety improvement approaches across the NHS.
Improvement methodology
The future

- Bottom up – top down shared approach
- Critical mass
- A lot of business will be conducted within the networks
- Patient safety alerts – will be considered when the networks identifies a need for one
- Continue to evolve, find new ways of reporting, learning and working together
- Med safety topics in scope
  - Use of LMWH – in patients with a contra-indication
  - Therapeutic overdose of controlled drugs
  - Redesigned national steroid card
  - Minimising harms from re-exposure to known drug allergy
  - Use of bar codes on medicine products
Many thanks for your time

What have I forgotten?