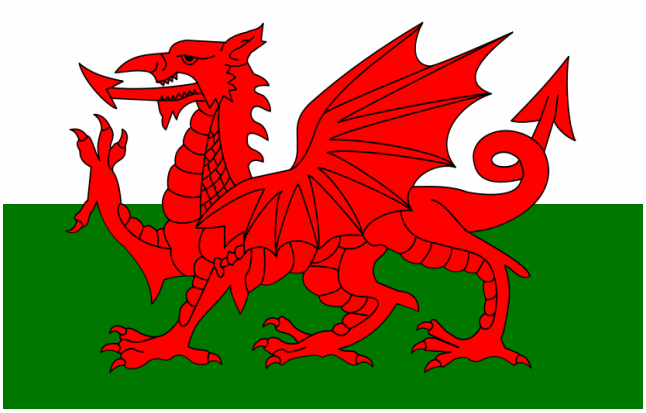
IMPLEMENTATION OF

PATIENT SAFETY ALERTS

IN WALES



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Background

This report has been produced by Action against Medical Accidents (AvMA), the patient safety charity. The object was to establish to what extent patient safety alerts issued by the National Patient Safety Agency (NPSA), which had already passed the deadline for completion, had been complied with by Health Boards in Wales. Patient Safety Alerts (also referred to as "safer practice notices" or "rapid response alerts") are issued by the NPSA about issues which are known to have gone wrong in the NHS on a repeated basis, causing harm or even death. Examples include alerts designed to avoid mistakes with various high risk medicines; use of naso-gastric tubes; giving the right patient the right blood; and ensuring that implements are not left in patients' bodies after surgery. A number of 'required actions' for Health Boards are identified, with a deadline specified by which all of the actions should be completed. Compliance with the alerts is mandatory. The Standards for Health Services in Wales published by the Welsh Assembly Government in 2010[1] includes this standard:

"22. Managing Risk and Health and Safety: organisations and services will have systems in place which comply with legislation and guidance that ……acts upon safety notices, alerts and other such communications".

This report follows a report AvMA published in June 2011, which found that 170 alerts had not been complied with and that not a single Health Board was 100% compliant. AvMA made three key recommendations for improvement:

1 Each Health Board should publish its action plan and timetable for completing the required actions in outstanding patient safety alerts. This should be completed within the shortest possible timescale.
2 The status of each Health Board's compliance with patient safety alerts should be publicly available on an on-going basis on their own and other appropriate websites.
3 There should be an urgent review of how compliance with patient safety alerts should be monitored and regulated. This should include all key stakeholders including Welsh Assembly Government, Health Inspectorate Wales, representatives of Health Boards, AvMA and Community Health Councils.

The core data on which this report is based relates to the position as it stood on July 5th 2012 when the data was obtained from Welsh Assembly Government in response to a Freedom of Information Act request by AvMA. The core data (see appendix) details status of alerts by individual alert and Health Board where the work was due to be completed before July 2012. There are 70 alerts that fall in this category. The alerts themselves can be found on the NPSA website: **www.nrls.npsa.nhs.uk/resources/type/alerts**. For the purposes of this report, any alert where the Health Board has declared work as 'ongoing' is described as "not complied with" or "outstanding". This is because all of the required actions in the alert should have been completed by the stated deadline across the whole Health Board. (It does not mean that no part of the Health Board is complying with the alert).

The status of each alert is presented in the form that it had been reported to Welsh Assembly Government by each Health Board. There has not necessarily been any independent verification that actions on a given alert reported as "complete" actually are complete. Note also that the report relates to the position on a specific date in July when the information was collected. It is possible that Health Boards will have since become compliant with some of the alerts since that date, but it still means that they were overdue at the time of the data collection.

For this year's report, AvMA also took the step of asking each individual Health Board to provide information about their action plan, if one existed, for completing all the overdue required actions on patient safety alerts; about how this issue was considered at each Health Board's public meetings; and what information they made available to the public about compliance with patient safety alerts. We also conducted our own review of each Board's website.

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[1] *Doing Well, Doing Better: Standards for Health Services in Wales, 2010*
http://www.nhswalesgovernance.com/Uploads/Resources/pWIHKe4fu.pdf

Key Findings

Details of each patient safety alert and its status within each Health Board, as supplied by the Welsh Assembly Government, can be found in the tables in the appendix. The key findings are:

- Not a single Health Board in Wales had complied with all patient safety alerts for which the deadline for completion had already passed, in spite of the report of June 2011. Some of the outstanding alerts were years past the deadline for completion.

- There were 140 instances of an alert not having been complied with, compared with 170 in 2011. This represents an 18% improvement on the situation in 2011.

- The best rate of compliance was Aneurin Bevan Health Board at 84% compliance. (This Health Board's rate of compliance in 2011 was 70%).

- The worst rate of compliance was at Betsi Cadwaladr University Health Board, which had not complied with 34 (almost half) of the alerts which had passed the deadline for completion (51% compliance).

- The best improvement in compliance with alerts was at Abertawe Bro Morgannwg University Health Board, who increased their rate of compliance from 47% to 77%.

- Although 6 of the 7 Health Boards had shown some level of improvement with compliance since 2011, Powys Teaching Health Board actually got worse, falling from 89% to 79% compliance.

- A survey of all Health Board websites and those of Health Inspectorate Wales and Welsh Assembly Government found little or no information available for members of the public on compliance with patient safety alerts or action plans for becoming compliant.

Summary for each Health Board (2012 results in **bold,** 2011 results in brackets)**:**

Health Board	**No. of Alerts outstanding 2012 (**2011)	**Rate of Compliance 2012** (2011)
Abertawe Bro Morgannwg University Health Board	**16** (34)	**77%** (47%)
Aneurin Bevan Health Board	**11** (19)	**84% (**70%)
Betsi Cadwaladr University Health Board	**34** (33)	**51%** (48%)
Cardiff & Vale University Health Board	**12** (15)	**83%** (77%)
Cwm Taf Health Board	**25** (32)	**64%** (50%)
Hywel Dda Health Board	**27** (29)	**61%** (55%)
Powys Teaching Health Board	**15** (7)	**79%** (89%)

(Total number of NPSA alerts past the deadline for completion = 70)

Information on compliance with alerts

Our survey of all Health Board websites, and those of Health Inspectorate Wales and Welsh Assembly Government, found little or no information available for members of the public on compliance with patient safety alerts or action plans for becoming compliant. In order to obtain the core information on which this report is based, we had to apply under the Freedom of Information Act.

The only example we found of what might be described as an action plan for complying with outstanding alerts was a report to the Cardiff and Vale University Health Board's 'Quality & Safety' sub committee on 21st February 2012 which was 'noted'. The minutes show that it was also noted that some of the outstanding alerts had been issued 'several years ago'.

We also asked each Health Board to provide copies of action plans and any information made available to the public about compliance with patient safety alerts. Only three Health Boards responded: Hywel Dda; Powys; and Betsi Cadwaladr. Each pointed to work they were doing with respect to patient safety alerts, but were unable to provide an action plan. These Health Boards delegated Patient Safety Alerts to the Quality and Safety Committee, and the Quality and Safety Committee reports were noted by the main Board. However, it was difficult to find these papers on their websites and they did not provide detailed information on compliance with alerts.

Conclusions

Whilst there has been some improvement across the board since our report last year, and considerable improvement in the case of Abertawe Bro Morgannwg University Health Board, the overall picture is still worrying and disappointing. Abertawe Health Board's performance shows that with the right commitment dramatic improvement in compliance can be achieved. This has also been the case in England since AvMA started publishing similar reports. Last year's report should have served as a real wake up call for all the Health Boards in Wales. Patent Safety Alerts are supposed to be implemented by the deadline which is set by experts following consultation with the service. Failure to do so inevitably leaves patients at unnecessary risk. Whilst there is a lot of good work on patient safety in Wales about which we should be proud, and the vast majority of NHS care in Wales is high quality and safe, the service has taken its eye off the ball over this very specific but vitally important part of the patient safety 'jigsaw'. Urgent action is required by the Health Boards themselves to implement all outstanding alerts as soon as possible.

Action is also needed by Welsh Assembly Government and Health Inspectorate Wales to ensure that the system of monitoring and regulating patient safety in Wales is robust. Compliance with alerts is supposed to be a statutory requirement laid out in the Standards for Health Services in Wales. However, we can see no evidence that action has been taken to bring Health Boards into line with this standard - even those with very low levels of compliance and with alerts outstanding which are years past the deadline. How can the public therefore be confident that other essential standards are being appropriately monitored and regulated?

An important step forward which we recommended last year was making Health Boards' compliance with patient safety alerts and Health Boards' action plans (where they exist) more transparent and accessible to the public. It was very disappointing to find little or no information on any of the websites, and little evidence that serious attention is being given to this issue at public Board meetings. More transparency would go a long way to motivating all concerned to address this issue.

Recommendations

1. **All Health Boards should prioritise implementation of all the required actions in patient safety alerts which are passed the deadline for completion, and comply with future alerts by the deadline which has been given.**

2. **All Health Boards should publish their status vis a vis patient safety alerts and their action plans for complying with them on their own websites in a user-friendly way,**

which is accessible to the public. Progress with complying with patient safety alerts should be considered at public Board meetings, and/or Quality and Safety meetings should be held in public.

3. **Representatives of Welsh Assembly Government, Health Inspectorate Wales, and the Health Boards should meet with AvMA and the Board of Community Health Councils in Wales to discuss arrangements for monitoring and regulating compliance with patient safety alerts and information which should be available to the public.**

APPENDIX: Status of compliance with each alert by Health Boards as at July 2012 as supplied by Welsh Assembly Government

Rapid Response Reports	Date issued	Abertawe Bro Morgannwg University Health Board	Aneurin Bevan Health Board	Betsi Cadwaladr University Health Board	Cardiff & Vale University Health Board	Cwm Taf Health Board	Hywel Dda Health Board	Powys Teaching Health Board
Risk of confusion between cytarabine and liposomal cytarabine (Depocyte®)	18/06/2007	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable
Risk of confusion between non-lipid and lipid formulations of injectable amphotericin	03/09/2007	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Emergency support in surgical units:Dealing with haemorrhage	10/09/2007	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Fire hazard with paraffin based skin products on dressings and clothing	26/11/2007	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Risks of incorrect dosing of oral anti-cancer medicines	22/01/2008	Complete	Complete	Ongoing	Complete	Complete	Complete	Not Applicable
Risks with Intravenous Heparin Flush Solutions	24/04/2008	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable
Risks of chest drain insertion	15/05/2008	Complete	Complete	Ongoing	Complete	Ongoing	Ongoing	Not Applicable
Reducing Dosing Errorswith Opioid Medicines	04/07/2008	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Problems with infusions and sampling fromarterial lines	28/07/2008	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable

Using Vinca Alkaloid Minibags(Adult/Adolescent Units)	11/08/2008	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable
Risks to haemodialysis patients from water supply(hydrogen peroxide)	30/09/2008	Complete	Complete	Complete	Complete	Not Applicable	Complete	Not Applicable

Risks of omitting Hib when administering Infanrix-IPV+Hib	21/10/2008	Not Applicable	Complete	Complete	Complete	Complete	Complete	Complete
Avoiding wrong side burr holes / craniotomy	12/11/2008	Not Applicable	Not Applicable	Not Applicable	Complete	Not Applicable	Not Applicable	Not Applicable
Resuscitation in mental health and learning disability settings	26/11/2008	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable
Reducing risk of overdose with midazolam injection in adults	09/12/2008	Complete	Complete	Complete	Complete	Ongoing	Complete	Complete
Reducing riskof harm from oral bowel cleansing solutions	19/02/2009	Complete	Complete	Ongoing	Complete	Ongoing	Ongoing	Complete

Mitigating surgical risk in patients undergoing hip arthroplasty for fractures of the proximal femur	11/03/2009	Complete	Complete	Complete	Complete	Ongoing	Complete	Not Applicable
Female urinary catheters causing trauma to adult males	30/04/2009	Complete	Complete	Ongoing	Complete	Complete	Complete	Complete

Preventing harm to children from parents with mental health needs	28/05/2009	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Preventingdel ay to follow up for patients with glaucoma	11/06/2009	Ongoing	Complete	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Minimising risks of suprapubic catheter insertion (adults only)	29/07/2009	Complete	Complete	Ongoing	Complete	Ongoing	Ongoing	Not Applicable
Oxygen safety in hospitals	29/09/2009	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

Reducing risks of tourniquets left on after finger and toe surgery	09/12/2009	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete
Vaccine cold storage	21/01/2010	Complete	Complete	Complete	Complete	Complete	Ongoing	Complete
Reducing harm from omitted and delayed medicines in hospital	24/02/2010	Ongoing	Ongoing	Ongoing	Complete	Complete	Ongoing	Ongoing
Early detection of complications after gastrostomy	31/03/2010	Complete	Complete	Ongoing	Complete	Ongoing	Complete	Not Applicable
Checking pregnancy before surgery	28/04/2010	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete
Reducing the risk of retained swabs after vaginal birth and perinealsuturi ng	26/05/2010	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete
Safer Administration of Insulin	16/06/2010	Ongoing	Complete	Ongoing	Complete	Complete	Ongoing	Ongoing

Reducing Treatment dose errors with low molecular weight heparins	30/07/2010	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete
Prevention of over infusion of intravenous fluid* and medicines in neonates	26/08/2010	Complete	Complete	Ongoing	Complete	Ongoing	Ongoing	Not Applicable
Laparoscopic surgery: Failure to recognise post-operativedeterioration	23/09/2010	Complete	Ongoing	Ongoing	Complete	Ongoing	Ongoing	Complete
The transfusion of blood and blood components in an emergency	21/10/2010	Complete	Complete	Ongoing	Ongoing	Ongoing	Complete	Ongoing
Essential Care After an inpatient fall	13/01/2011	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Preventing fatalites from medication loading doses	25/11/2010	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Complete	Ongoing

Safer amulatory syringe drivers	16/12/2010	Complete	Complete	Ongoing	Complete	Complete	Complete	Ongoing
Minimising Risks of Mismatching Spinal, Epidural and RegionalDevices with Incompatible Connectors	28/11/2011	Ongoing	Ongoing	Complete	Complete	Ongoing	Ongoing	Not Applicable
Keeping newborn babies with a family history of MCADD safe in the first hours and daysof life	26/10/2011	Ongoing	Complete	Complete	Complete	Ongoing	ongoing	Ongoing

Harm from flushing of nasogastric tubes before confirmation of placement	22/03/2012	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

Safer Practice Notices - strongly advises implementingparticular recommendations or solutions	Date issued	Abertawe Bro Morgannwg University Health Board	Aneurin Bevan Health Board	Betsi Cadwaladr University Health Board	Cardiff & Vale University Health Board	Cwm Taf Health Board	Hywel Dda Health Board	Powys Teaching Health Board
Improvinginfusion device safety	20/05/2004	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Ensuring safer practice withRepevax and Revaxis vaccines	29/04/2005	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Being open when patients are harmed	15/09/2005	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Safer Patient Identification	22/11/2005	Complete	Complete	Complete	Complete	Complete	Complete	Complete
High dose ampoules of diamorphine and morphine	25/05/2006	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Right Patient right Blood	09/11/2006	Complete	Ongoing	Ongoing	Complete	Complete	Complete	Complete
Colour coding hospital cleaning materials and equipment	10/01/2007	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Earlyindentification of failure to act on radiological imaging reports	05/02/2007	Complete	Ongoing	Ongoing	Ongoing	Complete	Complete	Complete
Using Bedrails safely andeffectively	26/02/2007	Complete	Complete	Ongoing	Complete	Complete	Complete	Complete
Standardising wristbands improvespatient safety	03/07/2007	Complete	Complete	Complete	Ongoing	Ongoing	Complete	Complete
Risk to patient safety of not using the NHSNumber as the national identifier for all patients	24/06/2009	Complete	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

Reducing the risk of retained throat packs after surgery	28/04/2009	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete

Alert	Date issued	Abertawe Bro Morgannwg University Health Board	Aneurin Bevan Health Board	Betsi Cadwaladr University Health Board	Cardiff & Vale University Health Board	Cwm Taf Health Board	Hywel Dda Health Board	Powys Teaching Health Board
Preventing accidental overdose of intravenous potassium	23/07/2002	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Standardising crash call numbers	24/02/2004	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Reducing the harm caused by oral methotrexate	29/07/2004	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Clean hands help to save lives	02/09/2004	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Correct site surgery	02/03/2005	Complete	Complete	Complete	Complete	Complete	complete	Complete
Reducing the harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units.	18/09/2005	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable
Improving compliance with oral methotrexate guidelines	01/06/2006	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Actions that can make anticoagulant therapy safer	28/03/2007	Ongoing	Complete	Ongoing	Complete	Ongoing	Ongoing	Complete
Epiduralinjections and infusions	28/03/2007	Complete	Complete	Complete	Complete	Complete	Complete	Not Applicable
Reducing the risk of hyponatraemia when administering intravenous infusions to children	28/03/2007	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Not Applicable
Promoting safer use of injectable medicines	28/03/2007	Ongoing	Complete	Ongoing	Ongoing	Ongoing	ongoing	Complete

Promoting safer measurement and administration of liquid medicines via oral and other enteral routes	28/03/2007	Complete	Complete	Ongoing	Complete	Complete	Ongoing	Complete

Clean hands saves lives	02/09/2008	Complete	Complete	Complete	Complete	Complete	Complete	Complete
WHO Surgical SafetyChecklist	26/01/2009	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Being Open	19/11/2009	Ongoing	Complete	Ongoing	Ongoing	Ongoing	Complete	Ongoing
Safer lithium therapy	01/12/2009	Ongoing	Complete	Complete	Complete	Ongoing	Ongoing	Ongoing
Safer use of intravenous gentamicin for neonates	09/02/2010	Ongoing	Complete	Ongoing	Complete	Ongoing	Ongoing	Not Applicable
Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants	10/03/2011	Ongoing	Complete	Ongoing	Complete	Ongoing	Ongoing	Ongoing
The adult patient's passport to safer use of insulin	30/03/2011	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Complete	Ongoing