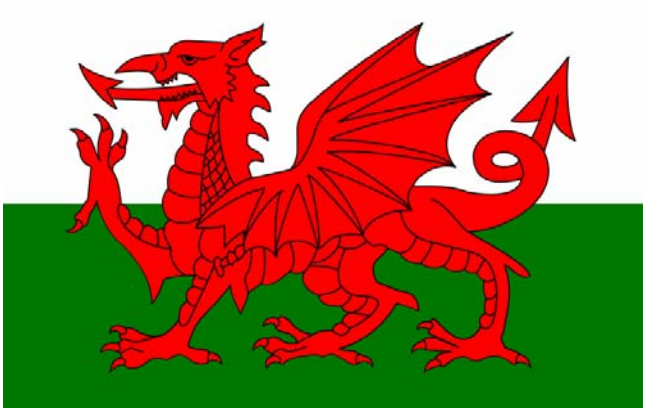
IMPLEMENTATION OF

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. The data relates to the position as it stood on May 6th 2011 when the data was collected by Welsh Assembly Government in response to a Freedom of Information Act request from 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 May 2011. There are 64 alerts that fall in this category. 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.

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. These alerts are only issued about the most serious issues where it is known steps can be taken to avoid the adverse incident. 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 supposed to be mandatory. The Standards for Health Services in Wales published by the Welsh Assembly Government 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".

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 May when the information was collected. It is possible that Health Boards will have since become compliant with some of the alerts.

It should be noted that there has been substantial re-organisation of the NHS in recent years involving the merging of various NHS bodies into the seven Health Boards. This has made the task of ensuring Board-wide compliance with alerts very challenging. The reorganisation also creates opportunities for better co-ordination of work on patient safety in the long term. This report is not intended to be a commentary on patient safety work in Wales as a whole. It has to be acknowledged that some of the patient safety work in Wales is very impressive. For example, the 1,000 Lives campaign. The report deals solely with one discreet but vitally important aspect of patient safety – the implementation of patient safety alerts.

The alerts themselves can be found on the NPSA website:
www.nrls.npsa.nhs.uk/resources/type/alerts

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, and there were 170 instances of an alert not having been complied with.

- 11 of the alerts which had not been complied with by at least one Health Board were at least 3 years past the deadline for completion.

- The best rate of compliance was Powys Teaching Health Board at 89% compliance.

- The worst rate of compliance was at Abertawe Bro Morgannwg University Health Board, which had 34 alerts outstanding (47%) compliance.

Summary for each Health Board:

Health Board	No. of Alerts outstanding	Rate of Compliance
Abertawe Bro Morgannwg University	34	47%
Aneurin Bevan Health	19	70%
Betsi Cadwaladr University	33	48%
Cardiff & Vale University Health Board	15	77%
Cwm Taf Health Board	32	50%
Hywel Dda Health Board	29	55%
Powys Teaching Health	7	89%

(Total number of NPSA alerts past the deadline for completion = 64)

Conclusions

Notwithstanding the challenges posed by reorganisation and all the good work that is being done on patient safety in Wales, for over a third of vitally important patient safety alerts not to have been fully implemented by the given deadline is simply unacceptable. By definition, a patient safety alert not complied with leaves patients' safety at unnecessary risk. For alerts which are years past the deadline still to be outstanding is even more inexcusable. It is possible that harm may have been caused or even lives lost as a result of not complying with patient safety alerts. In England where we carried out similar research, this was found to be the case.

It is notable that it was necessary for AvMA to make a request under the Freedom of Information Act in order to obtain the information about compliance with alerts. We feel that this information should be easily accessible for members of the public, and that this in itself would be a powerful incentive for Health Boards to comply with alerts by the given deadline.

We are conscious that NHS restructuring in Wales may have made the task more difficult. We have been assured that intensive work is being conducted by Welsh Assembly Government and Health Boards to ensure compliance with outstanding patient safety alerts and that action plans exist. We are also impressed with much of the work on patient safety being done in Wales including the 1,000 Lives campaign. However, the simple fact is that all the alerts have a specific deadline for completing all the required actions, which it is supposed to be mandatory to meet in order to protect patients. There is no escaping the fact that in this specific respect the system has failed patients in Wales. Consideration should be given both as to how the NHS can be supported in complying with alerts, and how compliance should be monitored and action taken over non-compliance.

Recommendations

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 ongoing 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.

Rapid Response Reports

	Date issued	Action for	Action	Action by	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-Jun-07	NHS Trusts	The Chief Pharmacist should ensure that medical, nursing and pharmacy staff involved in intrathecal chemotherapy are aware of the potential risk Take local actions to minimise potential risk.	18/07/2007	Complete	Complete	Complete	Complete	N/A	Complete	N/A
Risk of confusion between non-lipid and lipid formulations of injectable amphotericin	03-Sep-07	NHS Trusts	The Chief pharmacists, pharmaceutical advisers and heads of pharmacy and medicines management in healthcare organisations should ensure that medical, nursing and pharmacy staff involved in the prescribing, preparation, supply and administration of amphotericin are aware of the potential risks Undertake an immediate risk assessment of amphotericin products and procedures in accordance with NPSA's Patient Safety Alert 20: Promoting safer use of injectable medicines, and take action to reduce the risks	01/10/2007	Complete	80% Complete	Complete	Complete	Complete	Complete	Complete

Emergency support in surgical units: Dealing with haemorrhage	10-Sep-07	NHS Trusts	Managers of surgery should advise surgeons, nursing staff, operating department practitioners and other healthcare professionals of the issues and ensure: 1. A co-ordinated system for the urgent supply of blood products is established and maintained. Blood must be available quickly for all operative procedures. This will include the ability to communicate directly and immediately with the transfusion laboratory and for blood products to be transported between the laboratory and the unit without delay. All units have access to emergency equipment that may be required in the event of haemorrhage, such as the appropriate sutures and packs. This emergency surgical and resuscitation equipment will need to reflect the range of surgery undertaken in the unit and the degree of geographical isolation from other healthcare services. A formal check should be carried out before every procedure. A formal backup system for surgeons and anaesthetists is essential so that consultants have a system for summoning help in emergency situations.	30/11/2007	Complete	Complete	Complete	Complete	Complete	Complete	Complete

Fire hazard with paraffin based skin products on dressings and clothing	26/11/2007		The following actions should apply to all patients in all settings being dispensed, or treated with, large quantities (100g or more) of paraffin based products: • Information should be given about the potential fire risks of smoking (or being near to people who are smoking), or exposure to any open flame or other potential cause of ignition during treatment; and about regularly changing clothing or bedding impregnated with paraffin based products (preferably on a daily basis) as the paraffin soaks into the fabrics and can potentially be a fire hazard. This information should be given on the first occasion that such treatment is prescribed, dispensed or administered by a healthcare professional and a record kept confirming that such advice has been given. A check should be made on subsequent occasions that the advice has been received previously and understood. Fire safety information should be displayed prominently in every clinical area where patients may be treated with large quantities of paraffin based products. If, against advice, a hospitalised patient intends to leave the ward to smoke, they should be informed of the risk and advised to wear a thick outer covering that has not been contaminated with paraffin based products.	26/02/2008	Complete	Complete	On-going	Complete	Complete	Complete	Complete

			Relatives or carers should be informed if a patient does not comply with safety advice.								
Risks of incorrect dosing of oral anti-cancer medicines	22/01/2008		Doctors, nurses, pharmacists and their staff must be made aware that the prescribing, dispensing and administering of oral anti-cancer medicines should be carried out and monitored to the same standard as injected therapy. This requires that: • Healthcare organisations should prepare local policies and procedures that describe the safe use of these oral medicines. Treatment should be initiated by a cancer specialist All oral anti-cancer medicines should be prescribed only in the context of a written protocol and treatment plan. Non-specialists who prescribe or administer on-going oral anti-cancer medication should have ready access to appropriate written protocols and treatment plans including guidance on monitoring and treatment of toxicity Staff dispensing oral anti-cancer medicines should be able to confirm that the prescribed dose is appropriate for the patient, and that the patient is aware of the required monitoring arrangements, by having access to information in the written protocol and treatment plan from the hospital where treatment is initiated and advice from a pharmacist with experience in cancer treatment in that hospital. Patients should be fully informed and receive verbal and up-to-date written information about their oral anticancer therapy from the initiating hospital.	22/07/2008	Complete	Complete	Complete	Complete	Complete	Complete	N/A

			Patients should be fully informed and receive verbal and up-to-date written information about their oral anticancer therapy from the initiating hospital. Full use should also be made of NHS cancer centre web sites to provide information for healthcare staff, patients and carers to ensure the safe use of oral anti-cancer medicines								
Risks with Intravenous Heparin Flush Solutions	24/04/2008		Organisations should review local policies to minimise the use of heparin flush solutions in all devices, including complex central venous or arterial catheters. This should take into account the evidence reviewed by UK Medicines Information (UKMi) which confirms that heparin flushes should not normally be used to flush peripheral intravenous catheters. All flush solutions should only be administered following a prescription or patient group direction Local policy and procedures should be reviewed to ensure risk with heparin flush solutions is minimised Healthcare organisations should ensure that all relevant staff are made aware of this guidance and revised policy	24/07/2008	Complete	Complete	Complete	On-going	On-going	Complete	N/A
Risks of chest drain insertion	15/05/2008		Clinical governance leads in local organisations should audit current practice and develop local policies to ensure: • Chest drains are only inserted by staff with relevant competencies and adequate supervision Ultrasound guidance is strongly advised when inserting a drain for fluid Clinical guidelines are followed and staff made aware of the risks, reflecting the questions above	17/11/2008	On-going	Complete	On-going	On-going	On-going	On-going	N/A

			Identify a lead for training of all staff involved in chest drain insertion Written evidence of consent is obtained from patients before the procedure, wherever possible Local incident data relating to chest drains is reviewed and staff encouraged to report further incidents								
Reducing Dosing Errors with Opioid Medicines	04/07/2008	Chief Pharmacist or Pharmaceutical Advisor	When opioid medicines are prescribed, dispensed or administered, in anything other than acute emergencies, the healthcare practitioner concerned, or their clinical supervisor, should: • Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records. Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose). Ensure they are familiar with the following characteristics of that medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effects.	03/01/2009	Complete	Complete	On-going	complete	On-going	Complete	Complete

Problems with infusions and sampling from arterial lines	28 July 2008.	Medical Directors	Sampling from arterial lines is risky and should only be done by competent, trained staff. Trusts should raise awareness of risks and review local guidelines. These should include criteria for requests for blood gas analyses; sampling technique, monitoring and interpretation of results (including unexpected results). Arterial infusion lines must be clearly identified. This means labelling or use of other safety solutions such as marked lines adopted by some trusts (see supporting information). Any infusion (or additive) attached to an arterial line must be prescribed and checked before administration. Further checks should be made at regular intervals and key points (such as shift handover). Staff should use only sodium chloride 0.9% to keep lines open Labels should clearly identify contents of infusion bags, even when pressure bags are used. Over time, manufacturers should develop a universal system to address this problem.	30/01/2009	Complete	Complete	Complete	Complete	Complete	Complete	N/A
Using Vinca Alkaloid Minibags (Adult/Adolescent Units)	11/08/2008	Chief Pharmacist	When vinca alkaloids are prescribed, dispensed or administered in adult and adolescent units: • Doses in syringes should no longer be used. The prescribed dose should be supplied from the hospital pharmacy ready to administer in a 50ml minibag of sodium chloride 0.9% (for some brands of vinorelbine glucose 5% solution for injection may be used instead of sodium chloride 0.9%).	06/02/2009	Complete	Complete	Complete	Complete	Complete	Complete	N/A

			The following warning should be prominently displayed on the label of ALL vinca alkaloid doses 'For Intravenous Use Only – Fatal If Administered by Other Routes'. There should be judicious use of colour and design on the label, outer packaging and delivery bags to further differentiate minibags containing vinca alkaloids from other minibag infusions. The vinca minibag should be infused intravenously over 5 - 10 minutes and the patient closely monitored for signs of extravasation. Incidents of extravasation should be reported and shared via the National Extravasation Information Service (www.extravasation.org.uk). Chemotherapy policies and procedures should be amended to reflect these requirements Staff should be alerted and trained to follow the new practice. Practice should be audited to ensure compliance with the revised safety procedure.								
Risks to haemodialysis patients from water supply (hydrogen peroxide)	30/09/2008	Medical Directors, Renal Clinical Directors and Technical Managers, Clinical Governance Leads and Estates/Facilities Managers	Local organisations should ensure that: • This RRR is circulated to all clinical staff involved in the care of patients receiving haemodialysis so that they can be alert to clinical signs and symptoms.	31/10/2008	Complete	Complete	Complete	Complete	N/A	Complete	N/A

			Working groups and decisions on future changes to water supply include appropriate clinical input, with active engagement of renal technicians. The Medical Director is aware of water supply feeds to dialysis patients, any chemicals added to the water supply, timetable for disinfection and action to implement DH Estates & Facilities Alert 2008-08. Clinical staff continue to report incidents, including serious near misses, through local systems and upload these promptly to the RLS to share learning of urgent risks.								
Risks of omitting Hib when administering Infanrix-IPV+Hib	21/10/2008	Immunisation Leads in Local Health Boards	All staff who prepare and administer childhood vaccines are aware of correct methods of preparation for all vaccines, including Infanrix-IPV+Hib where the powdered Hib needs to be reconstituted before administration, using contents of the pre-filled syringe. • They have checked that PILs and instructions for use in English are available with each dose at the time it is given. • They have procedures in place to review practice for administering Infanrix-IPV+Hib and for identifying all children in the current Hib Catch-up campaign at risk of not receiving the Hib component of this vaccine. These children should be invited back to receive a separate dose of Menitorix (Hib/MenC) before March 2009, in line with DH advice in the letter of 26 September 2008 [Gateway 10633] and WAG on 1 October 2008.	04/11/2008	Complete	Complete	Complete	Complete	Complete	Complete	Complete

			• They have procedures in place to review practice for administering Infanrix-IPV+Hib and for identifying all children in the current Hib Catch-up campaign at risk of not receiving the Hib component of this vaccine. These children should be invited back to receive a separate dose of Menitorix (Hib/MenC) before March 2009, in line with DH advice in the letter of 26 September 2008 [Gateway 10633] and WAG on 1 October 2008. • Local procedures and policies have been reviewed to incorporate the above and this is reflected in Patient Group Directions (or equivalent in Wales), where applicable. • Problems such as these are reported via local incident reporting systems.								
Avoiding wrong side burr holes / craniotomy	12/11/2008	Clinical Directors for surgery	Local organisations should review current policy and practice for neurosurgery in both adults and children. Key actions to reduce risks of wrong site surgery include: • Marking the side of intended surgery •Time out must take place in theatre before final positioning, head pins inserted or incision made. •Local practice should be audited and staff encouraged to report further incidents.	12/05/2009	N/A not performed	N/A not performed	N/A not performed	Complete	N/A not performed	N/A not performed	N/A not performed
Resuscitation in mental health and learning disability settings	26/11/2008	Medical & Nurse Directors	Their rolling programme of basic life support (BLS) training for all staff is based on Resuscitation Council (UK) standards1 that include the management of choking. All patient areas have immediate access to appropriate BLS equipment (e.g. self-inflating bag-mask devices, or mouth-to-mask devices).	20/05/2009	Complete	Complete	Complete	Complete	Complete	Complete	Complete

			All patient areas where a cardiac arrest might be expected at least once every five years should have access to Automated External Defibrillators (AEDs) within three minutes. All units where rapid tranquilisation, physical intervention, or seclusion may be used have access to staff trained in immediate life support (ILS) and to all equipment specified in NICE Guideline 25 (including AEDs). Wherever feasible, their training includes regular practices or drills in addition to classroom teaching. A leadership role for resuscitation issues is identified (including within organisations whose resuscitation training is contracted out) and levels of attendance at life support training are routinely audited, reported to a senior level of the organisation, and any lapses acted on.								
Reducing risk of overdose with midazolam injection in adults	09/12/2008	Executive director	Ensure that the storage and use of high strength midazolam (5mg/ml in 2ml and 10 ml ampoules; or 2mg/ml in 5ml ampoules) is restricted to general anaesthesia, intensive care, palliative medicine and clinical areas/situations where its use has been formally risk assessed, for example, where syringe drivers are used. Ensure that in other clinical areas, storage and use of high strength midazolam, is replaced with low strength midazolam (1mg/ml in 2ml or 5ml ampoules).	09/06/2009	Complete	Complete	Complete	Complete	On-going	Complete	Complete

			Review therapeutic protocols to ensure that guidance on use of midazolam is clear and that the risks, particularly for the elderly or frail, are fully assessed. Ensure that all healthcare practitioners involved directly or participating in sedation techniques have the necessary knowledge, skills and competences required. Ensure that stocks of flumazenil are available where midazolam is used and that the use of flumazenil is regularly audited as a marker of excessive dosing of midazolam. Ensure that sedation is covered by organisational policy and that overall responsibility is assigned to a senior clinician which, in most cases, will be an anaesthetist								
Reducing risk of harm from oral bowel cleansing solutions	19/02/2009	Executive director	A clinical assessment is undertaken by the clinician authorising the surgery or investigative procedure (including GPs using the direct access route) to ensure that there is no contraindication (e.g. clinical condition such as diverticulitis) or risks (e.g. concurrent medication such as diuretics) from the use of a bowel cleansing solution. Use of a bowel cleansing solution is authorised by the clinician at the same time as the surgery or investigative procedure. This may be done by using the same form. The clinician requesting the surgery or procedure and authorising the use of a bowel cleansing solution is responsible for ensuring that an explanation on the safe use of the product is provided to the patient or carer.	07/09/2009	On-going	On-going	On-going	Complete	On-going	On-going	Complete

			A safe system exists that involves an authorised clinical professional in the supply of the medicine and written information (including named contact) for each patient. See implementation checklist in supporting information for more details on this.								
Mitigating surgical risk in patients undergoing hip arthroplasty for fractures of the proximal femur	11/03/2009	Clinical Directors of surgery	Report to the NPSA and MHRA every peri-operative harm or patient death for total hip replacement and hemiarthroplasty, stating use of cemented or uncemented prosthesis and share the results of local investigations with the NPSA. Review local guidelines and audit current activity against best practice including submitting data to the NHFD, and reduce risks as follows: Patient Assessment Anaesthetic technique Surgical technique	14/09/2009	On-going	Complete	Complete	Complete	On-going	On-going	N/A
Female urinary catheters causing trauma to adult males	30/04/2009	Chief Executives	This Rapid Response Report is immediately distributed to all staff who insert urinary catheters in teenage or adult male patients, and to community pharmacists who dispense urinary catheters. Current supply systems for female length catheters are reviewed, with the aim of limiting access where appropriate (for example, an acute hospital supplying female length catheters only via a specialist ward or specialist nurses rather than routinely stocking them on every ward). Where female length catheters are stocked in any setting where teenage or adult males are also treated, a warning notice is displayed close to the stock of female length catheters	01/09/2009	On-going	Complete	On-going	Complete	Complete	On-going	Complete

			Where female length catheters are stocked in any setting where teenage or adult males are also treated, wherever possible additional clear warning labels are attached to each catheter before these are distributed to individual clinical areas or community staff bases The content of local competency based training for urinary catheter insertion is reviewed to ensure it includes selection of catheters of the correct length.								
Preventing harm to children from parents with mental health needs	28/05/2009	Chief Executives	All assessment, CPA monitoring, review, and discharge planning documentation and procedures should prompt staff to consider if the service user is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user. If the service user has or may resume contact with children, this should trigger an assessment of whether there are any actual or potential risks to the children, including delusional beliefs involving them, and drawing on as many sources of information as possible, including compliance with treatment. Referrals should be made to children's social care services under local safeguarding procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met.	27/11/2009	Complete	Complete	80% Complete	Complete	Complete	On-going	Complete

			Staff working in mental health services should be given clear guidance on how to make such referrals, including information sharing,the role of their organisation's designated lead for child protection, and what to do when a concern becomes apparent outside normal office hours. A consultant psychiatrist should be directly involved in all clinical decision making for services users who may pose a risk to children. Safeguarding training that includes the risks posed to children from parents with delusional beliefs involving their children or who might harm their children as part of a suicide plan is an essential requirement for all staff. Attendance, knowledge, and competency levels should be regularly audited, and any lapses urgently acted on.								
Preventing delay to follow up for patients with glaucoma	11/06/2009	Directors of ophthalmology services/ service managers	Make NICE guidelines on glaucoma available to all relevant staff and develop an action plan to implement the recommendations Review levels of hospital initiated cancellation of appointments for patients with established or suspected glaucoma through clinical governance forums. Review patient 'did not attend' rates in order to identify and audit high risk non-attending patients	10/12/2009	On-going	On-going	On-going	On-going	On-going	On-going	On-going

			Identify the number of patients currently awaiting follow up and confirm there is sufficient capacity within the local health community to meet this number in terms of outpatient appointments and any specialist investigations e.g. visual field and optic disc imaging. Develop a system whereby patients can be 'flagged' on the booking/ appointment system to indicate the clinical priority given to the appointment and monitor activity to ensure compliance with NICE follow-up intervals. Make information on glaucoma available to patients and ensure that there is a straight forward process for patients to reschedule appointments where necessary.								
Minimising risks of suprapubic catheter insertion (adults only)	29/07/2009	Medical Directors	1.Information about the risk of this procedure is immediately distributed to all staff who may insert or request the insertion of a suprapubic catheter (a sample briefing sheet for clinical staff is given in supporting information www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr/suprapubic-catheter). 2.A named lead for training is identified and a training plan developed. 3.Local guidelines/policies are reviewed or developed in the light of this report and forthcoming BAUS standards. 4.Ultrasound is used wherever possible to visualise the bladder and guide the insertion of the catheter. There should be ultrasound machines available in the relevant areas and staff trained in their use.	29/04/2010	On-going	Complete	On-going	On-going	On-going	On-going	Complete

			5.Local incident data relating to suprapubic catheterisation is reviewed, appropriate action is taken and staff are encouraged to report further incidents and to take part in the BAUS national clinical audit.								
Oxygen safety in hospitals	29/09/2009	All Hospitals	1. This Rapid Response Report (RRR) and the NPSA briefing sheets (visit www.nrls.npsa.nhs.uk/alerts) highlighting actions to minimise risks of oxygen therapy are immediately made available to all relevant staff. 2. The use of oxygen cylinders is minimised and, where necessary, a business case for increased piped oxygen provision is developed in accordance with HTM 02-01 Part A. 3. Where the use of oxygen cylinders is unavoidable (i.e. transfer and emergency situations or for mental health trusts), robust systems are in place to ensure reliable and adequate supplies, including checking and stocktaking of cylinders. 4. The risks of confusing oxygen and medical compressed air are assessed and action plans developed (e.g. removing the medical air flow meter from the wall outlet when not in regular use). 5. Oxygen is prescribed in all situations in accordance with BTS guidelines (but note these do not cover critical care or children under 16 years). In an emergency, oxygen should always be given immediately and documented later. 6. Pulse oximetry is available in all locations where oxygen is used. 7. A multidisciplinary group (such as a Medical Gas Committee) is responsible for reviewing oxygen-related incidents, developing a local oxygen policy and a training programme.	29/03/2010	On-going	On-going	On-going	On-going	On-going	On-going	80% Complete
Reducing risks of tourniquets	09/12/2009	All organisations	1. Guidelines include the removal of digital tourniquets as part of the swab counting procedure and specify the need to record the	09/06/2010	Complete	Complete	On-going	Complete	On-going	On-going	Complete

left on after finger and toe surgery			length of time a tourniquet is in place. 2. CE marked digital tourniquets which are labelled and/or brightly coloured should be used, in accordance with manufacturers' instructions. Surgical gloves should not be used as tourniquets. 3. The WHO Surgical Safety Checklist is reviewed locally to consider adding tourniquet removal at 'Sign Out' stage. 4. The NPSA clinical briefing sheet is used to raise awareness of risks using digital tourniquets and safer practice recommendations (www.nrls.npsa.nhs.uk/tourniquets).								
Vaccine cold storage	21/01/2010		1. Ensure that all departments and providers (including independent contractors) holding vaccine stocks are aware of relevant policy on safe storage (for example, as given in Appendices 1 and 2 of the supporting information). Local policies should include having a designated person and deputy/ies responsible for receipt and storage of vaccines. 2. Have procedures in place to assure themselves that all relevant departments and providers adhere to relevant policy for vaccine cold chain storage. This includes reviewing refrigerator temperature readings in a manner that will identify if vaccines have been stored outside of manufacturers' recommended temperature ranges before they are administered to patients. 3. Have procedures in place for remedial action where vaccines are stored outside manufacturers' recommended temperature ranges, and ensure departments and providers are aware of these. Actions may include initial reference to the UKMi fridge database with subsequent advice sought from NHS medicines information services or the vaccine manufacturer.	21/07/2010	On-going	On-going	Complete	Complete	On-going	On-going	Complete
Reducing harm from omitted and delayed medicines in hospital	24/02/2010		1. identify a list of critical medicines where timeliness of administration is crucial. This list should include anti-infectives, anticoagulants, insulin, resuscitation medicines and medicines for Parkinson's disease, and other medicines identified locally; 2. ensure medicine management procedures include guidance on the importance of prescribing, supplying and administering critical medicines, timeliness issues and what to do when a medicine has been omitted or delayed; 3. review and, where necessary, make changes to systems for the supply of urgent medicines within and out-of-hours to minimise risks; 4. review incident reports regularly and carry out an	24/02/2011	On-going	On-going	On-going	Complete	On-going	On-going	80% Complete

			annual audit of omitted and delayed critical medicines. Ensure that system improvements to reduce harms from omitted and delayed medicines are made. This information should be included in the organisations annual medication safety report; 5. make all staff aware (by wide distribution of this RRR) that omission or delay of critical medicines, for inpatients or on discharge from hospital, are patient safety incidents and should be reported.								
Early detection of complications after gastrostomy	31/03/2010		All NHS organisations providing care in the period up to 72 hours (three days) post-gastrostomy should: 1. Distribute this RRR to relevant clinical staff, including nursing and medical staff in acute hospitals and GPs, community nurses and out-of-hours services in primary care. All NHS organisations with departments inserting gastrostomies should ensure that: 2. Local protocols specify the observations to be taken in the immediate recovery period (for example, the frequency and duration of observations of blood pressure, pulse, respiration and pain score, alongside checks of the stoma site for bleeding, leakage of gastric contents or tube displacement). 3. They mark the patient's medical and nursing notes with a high-visibility warning that if there is pain on feeding, prolonged or severe pain post-procedure, or fresh bleeding, or external leakage of gastric contents, stop feed/medication delivery immediately, obtain senior advice urgently and consider CT scan, contrast study or surgical review*. 4. They add the equivalent warning to the preliminary discharge information that is communicated to the patient's GP and community nurses or care home nurses on discharge. 5. Where patients are discharged within 72 hours (three days) of gastrostomy insertion: a) systems are in place to ensure senior review before discharge (see supporting information); b) patients and their carers are warned that the signs listed above are danger signs that need urgent attention (verbally and through using the labels provided with this RRR, or an equivalent high visibility warning on local patient information) and are given an appropriate local contact number for urgent aftercare advice that is available overnight and at weekends; c) the staff answering this contact number understand that the signs listed above are symptoms that need an urgent response, and have local protocols to guide them on what actions to take.	30/09/2010	Complete	Complete	On-going	On-going	On-going	Complete	Complete
Checking	28/04/2010		1. Local preoperative assessment policies should be	28/10/2010	On-going	On-	On-going	On-going	Complete	On-	Complete

pregnancy before surgery			reviewed to ensure that pregnancy status is checked within the immediate preoperative period in accordance with NICE guidelines. 2. The check should be recorded on preoperative documentation used by staff performing final clinical and identity checks before surgical intervention.				going				going	
			3. Organisations should demonstrate robust reporting of incidents where pregnancy checks have not happened and any associated actions that may come from this (which may include local audit).									
Reducing the risk of retained swabs after vaginal birth and perineal suturing	26/05/2010	**All NHS organisations**		1. have written procedures in place for swab counts at all births (including perineal suturing);	26/11/2010	On-going	Complete	On-going	Complete	Complete	On-going	Complete
				2.audit swab count practices in their maternity services								
				3. provide education and training about the counting procedure for all midwifery, obstetric and support staff								
				4. Ensure that lead professionals (midwives and obstetricians) are aware of their responsibility for documenting the completed swab count in the women's health record								
				5. In conjunction with the supplies department , risk assess sterile delivery and perineal suture packs and consider using x-ray detectable swabs								
				6.Ensure staff report incidents of swabs retained after vaginal births and perineal suturing as patient safety incidents								
				7.cascade the clinical briefing sheet to relevant staff to raise awareness of the risks of swabs being unintentionally retained following vaginal births and perineal suturing	16/12/2010							

Safer Administration of Insulin	16/06/2010	**All NHS organisations and the Independent sector**		1. All regular and single insulin (bolus) doses are measured and administered using an insulin syringe or commercial insulin pen device. Intravenous syringes must never be used for insulin administration		On-going	Complete	On-going	Complete	On-going	On-going	On-going
				2. The term 'units' is used in all contexts. Abbreviations, such as 'U' or 'IU', are never used.								
				3. All clinical areas and community staff treating patients with insulin have adequate supplies of insulin syringes and subcutaneous needles, which staff can obtain at all times.								
				4. An insulin syringe must always be used to measure and prepare insulin for an intravenous infusion. Insulin infusions are administered in 50ml intravenous syringes or larger infusion bags. Consideration should be given to the supply and use of ready to administer infusion products e.g. prefilled syringes of fast acting insulin 50 units in 50ml sodium chloride 0.9%.								
				5. A training programme should be put in place for all healthcare staff (including medical staff) expected to prescribe, prepare and administer insulin. An e-learning programme is available from: www.diabetes.nhs.uk/safe_use_of_insulin								
				6. Policies and procedures for the preparation and administration of insulin and insulin infusions in clinical areas are reviewed to ensure compliance with the above.								

Reducing Treatment dose errors with low molecular weight heparins	30/07/2010	All NHS organisations and the Independent sector		1. A patient's weight is used as the basis for calculating the required treatment dose of LMWH. The weight must be accurately recorded in kilograms (kg) in the inpatient medication chart (when in use) and clinical record. Patients should be weighed at the start of therapy and, where applicable, during treatment.	28/01/2011	On-going	On-going	On-going	Complete	On-going	On-going	Complete
				2. Renal function is considered when prescribing treatment doses of LMWHs. The renal function test should not delay initiation of the first dose but every effort must be made to base subsequent dosing on these results.								
				3. Dose calculation tools are available for a range of body weights, specific clinical indications and LMWH products, and that consideration is given to rationalising the range of LMWH products used in the organisation.								
				4. Essential information such as dose, weight, renal function, indication and duration of treatment is communicated at transfers of care (e.g. by discharge letters) and used to ensure that future doses are safe.								
				5. Dosing checks based on patient information are made by healthcare professionals who review, dispense or administer LMWHs when this information is readily available to them.								
				6. System improvements should be demonstrated through the collection and review of data, such as incident reports, clinical pharmacy interventions, audit or other relevant outcome measures.								

Prevention of over infusion of intravenous fluid* and medicines in neonates	26/08/2010	All NHS organisations that provide Neonatal services		Departments providing neonatal services should:1. Ensure that a local neonatal intravenous administration policy is available that specifies: a. When using a syringe pump to administer intravenous fluids or medicines to neonates, a bag of fluid should not be left connected to the syringe.* b. All clamps on intravenous administration sets must be closed before removing the administration set from the infusion pump, or switching the pump off. This is required regardless of whether the administration set has an anti-free flow device. c. The frequency and responsibility for monitoring: i. the intravenous infusion device ii. the infusion administration equipment iii. the patient receiving intravenous infusion	28/02/2011	On-going	On-going	On-going	Complete	On-going	On-going	N/A
				2. The above points should all be included in local standards for education, training, assessment and subject to audit to ensure clinical practice is in accordance with the local policy.								
Laparoscopic surgery: Failure to recognise post-operative deterioration	23/09/2010	**All organisations where laparoscopic surgery is carried out in the NHS and Independent sector . For information to primary**		Organisations must ensure that: 1. Local protocols • specify the observations required in the immediate post operative period to help staff recognise and act upon signs of deterioration; • define discharge criteria, including senior medical review, if the patient does not meet these criteria; • define facilities for ongoing care when discharge would be unsafe.	24/03/2011	On-going	On-going	On-going	Complete	On-going	On-going	Complete

		care organisations											
				2. When a patient is discharged, systems are in place to ensure • patients and carers are given o a copy of their discharge summary; o verbal and written advice about signs of deterioration and when to seek medical advice; o the contact numbers to access urgent medical advice for at least the first 24 hours. • staff responsible for answering these contact numbers have access to local protocols for action; • a copy of the discharge letter is sent to the patient's GP within 24 hours (Department of Health. Guidance on the NHS Standard Contract for Acute Services. 2010/11. Available at: www.dh.gov.uk.)									

The transfusion of blood and blood components in an emergency	21/10/2010	NHS organisations and Independent Sector (Acute)		1. The hospital transfusion committee reviews the local protocols and practices for requesting and obtaining blood in an emergency (including out of hours), ensuring that they include all the actions required by clinical teams, laboratories and support services, e.g. portering and transport staff/drivers and any specific actions pertinent to sites without an on-site transfusion laboratory.		On-going	On-going	On-going	On-going	On-going	On-going	Complete
				2. Local protocols enable the release of blood and blood components without the initial approval of a haematologist although they should be advised of the situation at the earliest opportunity.								
				3. Staff (clinical, laboratory and support staff) know where to find the massive blood loss protocol in all relevant clinical and laboratory areas and are familiar with it, supported by training and regular drills.								
				4. The blood transfusion laboratory staff are informed of patients with a massive haemorrhage at the earliest opportunity.								
				5. Clinical teams dealing with patients with massive haemorrhage nominate a specific member of the team to co-ordinate communication with the laboratory staff and support services for the duration of the incident.								

				6. There is a clear and well understood trigger phrase to activate the massive blood loss protocol, for example “I want to trigger the massive blood loss protocol [and state location e.g. delivery suite]” and all subsequent communications between clinical areas and laboratory staff should be preceded by the use of a locally agreed trigger phrase such as “This call relates to the massive blood loss protocol [and location]”.								
				7. All incidents where there are delays or problems in the provision of blood in an emergency are reported and investigated locally, and reported to the NPSA and the Serious Hazards of Transfusion (SHOT) scheme (www.shotuk.org).								
				8. Each event triggering the massive blood loss protocol is recorded and reviewed by the hospital transfusion committee to ensure local protocols are applied appropriately and effectively.								

Safer Practice Notices - strongly advises implementing particular recommendations or solutions											
	Date issued	Action for	Action	Action by	**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**
Improving infusion device safety	20-May-04	NHS Trusts Clinical Governance leads Heads of clinical/medical engineering departments	To reduce the risk of patient safety incidents involving infusion devices, NHS acute trusts in England and Wales are advised to take the following steps within the NHS financial year 2004/05: 1. Review how purchasing decisions are made; 2. Evaluate the necessity for an infusion device before it is purchased; 3. Reduce the range of infusion device types in use and , within each type, have agreed default configurations; 4. Investigate the benefits of a centralised equipment library	Within NHS financial year 2004/05.	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Ensuring safer practice with Repevax and Revaxis vaccines	29-Apr-05	NHS Trusts and LHBs	Take the following steps immediately:	Action plan to be agreed and actions started by 13 May 05.	Complete	Complete	Complete	Complete	Complete	Complete	Complete

		Directors of Public Health and Chief Pharmacists	1. Ensure procedures are in place to check the correct vaccine has been selected for the individual patient concerned on each and every administration. 2. Raise awareness of the proposed changes to the packaging with all staff involved in childhood immunisations. This may include displaying pictures of the product packaging in all locations where the vaccine is stored or used. To reduce the chances of staff selecting the wrong vaccine, where possible staff should use up stocks in the original packaging style first. 3. Review procedures for risk assessment and management of new vaccine products introduced locally, and strengthen procedures where necessary. 4. Continue to report any patient safety incidents.	All actions to be completed by 10 June 05						
Safer Patient Identification	22-Nov-05	Directors of Nursing in England and Wales	By May 2006, NHS organisations providing acute services in England and Wales should have either: · Implemented the NPSA's recommendations, stating that all inpatients should wear wristbands that identify them and match them to their care. Formally risk assessed alternatives should be made for patients for whom this is not possible or practical such as pre-term babies, patients with some skin conditions and those with learning disabilities. Arrangements should also be made for implementing and monitoring this advice; or	May-06	On-going	Complete	Complete	On-going	On-going	Complete	Complete

			· Other formally risk-assessed arrangements. Monitoring should show that these arrangements are as effective as those set out in this notice.								
High dose ampoules of diamorphine and morphine	25/05/2006		• Risk assess and have procedures for safely prescribing, labelling, supplying, storing, preparing and administering diamorphine and morphine injections. Review therapeutic guidelines for the use of diamorphine and morphine injectable products for patients requiring acute care, including post-administration observation of patients who have not previously received doses of opiates. Update information concerning the safe use of diamorphine and morphine injectable products as part of an ongoing programme of training for healthcare staff on medication practice. Ensure that naloxone injection, an antidote to opiate-induced respiratory depression, is available in all clinical locations where diamorphine and morphine injections are stored or administered.	Action underway: 31 July 06 Action complete: 31 October 06	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Right Patient right Blood	09-Nov-06		Agreed to and started to implement an action plan for competency-based training and assessment for all staff involved in blood transfusions.	01/05/2007	On-going	On-going	On-going	Complete	On-going	Complete	Complete

			Ensured that the compatibility form (or equivalent) and patient notes are not used as part of the final check at the patient's side. They should comply with their blood transfusion policy which stipulates that the final identity check must be done next to the patient by matching the blood pack with the patient's wristband (or identity band/photo identification card). Systematically examined their local blood transfusion procedures, using formal risk assessment processes, and appraised the feasibility and relevance of using:·Bar codes or other electronic identification and tracking systems for patients, samples and blood products; ·Photo identification cards for patients who undergo regular blood transfusions; · a labelling system of matching samples and blood transfusion to the patient concerned.								
Colour coding hospital cleaning materials and equipment	10-Jan-07		All NHS organisations providing inpatient services should: · Make a policy decision to adopt the National Colour Coding Scheme where existing practice differs; · Develop an action plan for introducing the National Colour Coding Scheme;	Action underway by: 31 March 07 Action to be completed by:	Complete	Complete	Complete	Complete	Complete	Complete	Complete

			· Raise awareness of any revised practice amongst healthcare staff	31-Mar-08							
Early indentification of failure to act on radiological imaging reports	05-Feb-07		The NPSA is recommending that all healthcare organisations providing or commissioning radiological imaging services should: 1 ensure that the radiological imaging reports of all patients are communicated to, and received by, the appropriate registered health professional and, where necessary, action is taken in a manner appropriate to their clinical urgency; ensure registered health professionals design 'safety net' procedures for their specialty; make it clear to patients how and when they should expect to receive the results of a diagnostic test; review relevant policies and procedures in line with the safer practice recommendations outlined in this safer practice notice by June 2007.	06-Mar-08	Complete	On-going	On-going	On-going	On-going	complete	On-going

Using Bedrails safely and effectively	26-Feb-07		To improve the appropriate use of bedrails, the NPSA is advising NHS organisations providing adult inpatient care to take the following actions 1 produce a policy on bedrails based on the draft policy provided or ensure their policy on bedrails covers the key areas required within this safer practice notice; 2 ensure ongoing training programmes are in place for staff who make decisions about bedrails, attach or maintain bedrails, or care for patients using bedrails; 3 develop an effective implementation plan to bring their new or revised policy on bedrails to the attention of all relevant staff; 4 develop plans to audit and evaluate the impact of their new or revised policy on bedrails, including taking baseline measures before the implementation of their new or revised policy on bedrails where appropriate	28/08/2007	Complete	Complete	On-going	Complete	Complete	Complete	Complete
Standardising wristbands improves patient safety	03-Jul-07		Only use patient wristbands that meet the NPSA's design requirements. See www.npsa.nhs.uk	18/07/2008	Complete	Complete	Complete	On-going	Ongoing	On-going	Complete

			Only include the following core patient identifiers on wristbands: • last name; • first name; • date of birth; • NHS Number (if the NHS Number is not immediately available, a temporary number should be used until it is); • first line of address (this only applies to Wales, where this is required by a Welsh Health Circular). If any additional identifiers are thought to be necessary, these should be formally risk assessed. Develop clear and consistent processes, set out in trust protocols, specifying which staff can produce, apply and check patient wristbands, how they should do it and what information sources they should use. Only use a white wristband with black text. If you wish to have a system for identifying a known risk (for example, an allergy or where a patient does not want to receive blood or blood products), the wristband should be red with patient identifiers in black text on a white panel on the wristband.								
Risk to patient safety of not using the NHS Number as the national identifier for all patients	24-Jun-09		1. Use the NHS Number as the national patient identifier; OR the NHS Number as the national patient identifier in conjunction with a local hospital numbering system (NB where local hospital numbers are used they must be used alongside and not instead of the NHS Number).	18-Sep-09	On-going	Complete	On-going	Ongoing	Ongoing	Ongoing	Complete

			2. Use the NHS Number (and its barcoded equivalent) in/on all correspondence, notes, patient wristbands and patient care systems to support accuracy in identifying patients and linking records. 3. Put processes in place to ensure that patients can know their own NHS Number and are encouraged to make a note of it (for example through patient literature that explains the NHS Number, its uses and advantage! s, and how patients can use it to increase safety). 4. Primary care organisations that have stopped issuing medical record cards should reinstate this practice and use it as a means of informing patients about their NHS Number and encouraging them to use it where appropriate.								
Reducing the risk of retained throat packs after surgery	28/04/2009	Clinical risk managers responsible for anaesthesia and surgery	should ensure that local policies and procedures are adapted to state that: • The decision to use a throat pack should be justified by the anaesthetist or surgeon for each patient as appropriate. This person should assume responsibility for ensuring the chosen safety procedures are undertaken; • At least one visually-based and one documentary-based procedure is applied whenever a throat pack is deemed necessary; • All staff are fully informed on the locally chosen procedures.	14/10/2009	Complete	Complete	On-going	Complete	On-going	On-going	Complete

Patient Safety Alerts - requires prompt action to address high risk safety problems											
	Date issued	Action for	Action required	Action by	**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-Jul-02	NHS Trusts Chief Pharmacists and Pharmaceutical Advisers	Initial action by 31 Oct 02 in the following areas: 1. Storage and handling of potassium chloride concentrate and other strong potassium solutions 2. Preparation of dilute solutions containing potassium 3. Prescription of solutions containing potassium 4. Checking use of strong potassium solutions in clinical areas Action by June 03: 5. Risks associated with above areas should be highlighted in patient safety induction training for all staff involved in the medication process. Also in specific training in intravenous drug preparation and administration. Includes induction schemes for locum staff.	Initial action by 31 Oct 02. Training action by June 03.	80% Complete	Complete	Complete	Complete	Complete	Complete	Complete
Standardising crash call numbers	24-Feb-04	NHS Trusts with acute services Chief Executives Directors of Finance	· Trusts with acute services to standardise crash call numbers to 2222. Trusts which have not standardised should:	March 05 - the NPSA will review progress.	Complete	Complete	Complete	Complete	Complete	Complete	Complete

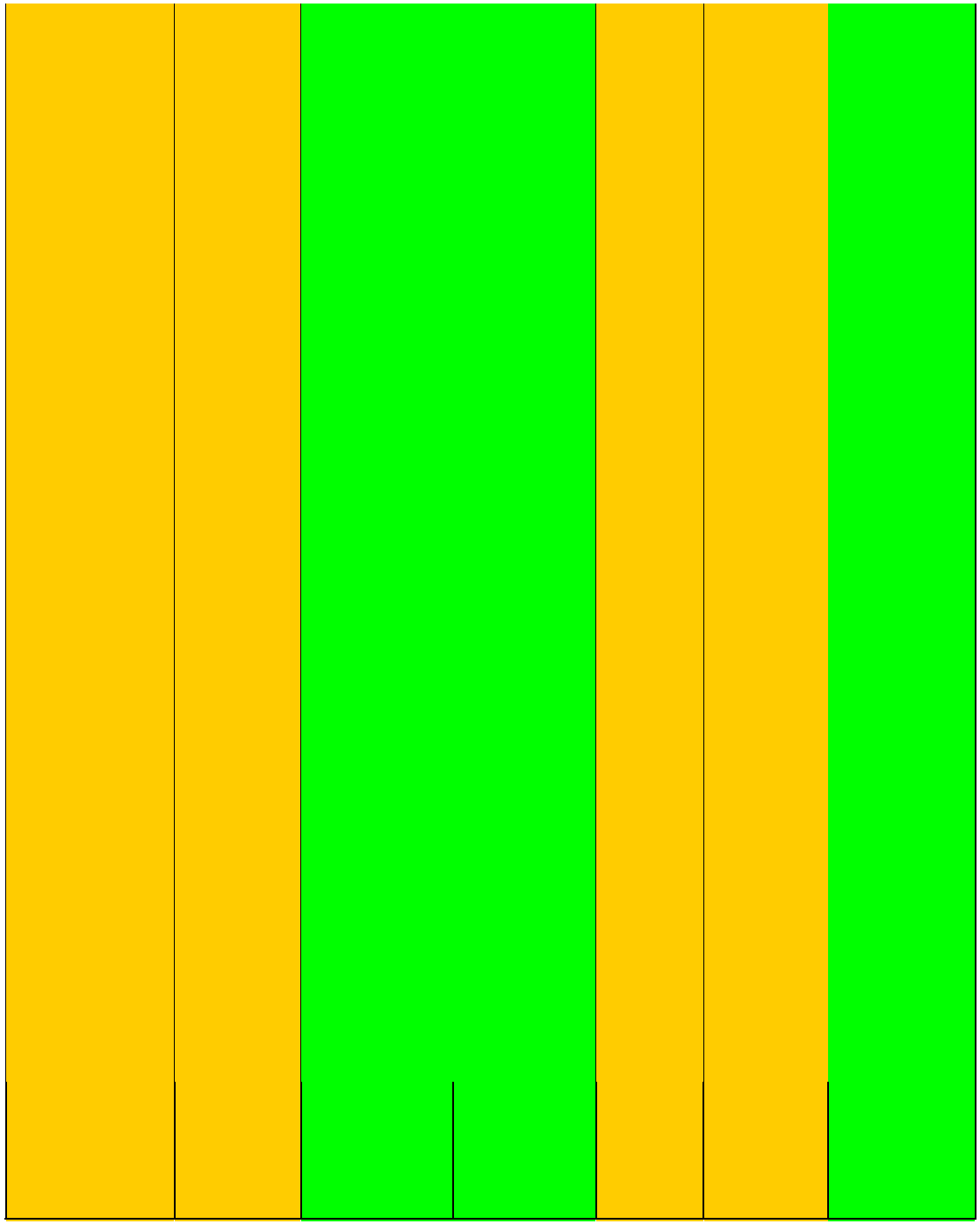
		(director responsible for telecoms)	· Plan a date for conversion if feasible, or; · Where conversion costs are prohibitive, identify opportunities in the future to convert to 2222 as part of planned switchboard changes. Technical advice available from Health Solutions Wales.									
Reducing the harm caused by oral methotrexate	29-Jul-04	NHS Trusts and LHBs Medical Directors	Take the following steps by March 05: 1. Agree local action required Agree appropriate local risk reduction actions through your Drugs/Medicines and Therapeutic Committee. 2. Provide patient information before and during treatment Recommended core content for a pre-treatment information leaflet provided before treatment starts and a patient-held monitoring and dosage record during treatment is attached to the alert. 3. Update prescribing and dispensing software programmes All prescribing and dispensing software programmes in primary and secondary care locations must be updated with the latest software which includes methotrexate alerts and prompts. 4. Review purchasing	Review of actions implemented in March 2005	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete

			Purchasers of 2.5mg and 10mg tablets should ensure that the tablets are visually distinguishable by shape, and that packaging contains the cautionary wording required by the MHRA								
Clean hands help to save lives	02-Sep-04	NHS Trusts Board leads for infection control	To reduce infection rates and prepare for the 'cleanyourhands' campaign, NHS Trusts should: 1. Install alcohol-based hand rub at the point of care across their organisation by April 05. 2. Assess and manage the risks associated with the use and storage of alcohol-based hand rub.	Review of implementation of action points in May 05.	On-going	Complete	Complete	Complete	Complete	Complete	Complete
Reducing the harm caused by the misplacement of nasogastric feeding tubes	21-Feb-05	NHS Trusts and LHBs Directors of Nursing	Take the following steps immediately: 1. Provide staff, carers and patients in the community, with information on correct and incorrect testing methods: · Measuring the pH of aspirate using pH indicator strips/paper is recommended; · Radiography is recommended but should not be used 'routinely'. Local policies are recommended for particular groups of patients eg those in intensive care units and neonates. Fully radio-opaque tubes with markings to enable accurate measurement, identification and documentation of their position	Action plan to be agreed and actions started by 8 March 05. All actions to be completed by 1 Sept 05.	Complete	Complete	On-going	Complete	Complete	Complete	Complete

			should be used; · DO NOT use the 'whoosh' test – this practice must cease immediately; · DO NOT test acidity/alkalinity of aspirate using blue litmus paper; · DO NOT interpret absence of respiratory distress as an indicator of correct positioning. 2. Carry out individual risk assessment prior to nasogastric tube feeding 3. Review and agree local action required 4. Report misplacement incidents via their local risk management reporting systems.								
Correct site surgery	02-Mar-05	NHS Trusts Medical Directors	By 16 March 05 NHS organisations providing acute care should have action underway to: · Use the national CSS pre-operative marking recommendations or a robust local alternative; · use the pre-operative marking verification checklist to ensure marking recommendations are carried out or a robust local alternative; · review existing pre-operative checklists or integrated care plans against these recommendations;	Action plan to be agreed and actions started by 16 March 05. All actions to be completed by 16 March 06.	On-going	Complete	Complete	Complete	Complete	Complete	Complete

			· raise awareness of any changes made locally with healthcare staff, and provide them with the appropriate information and support.								
Reducing the harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units.	18-Sep-05	NHS Trusts Nursing Directors	1. Give staff, and carers of babies in the community, the following information on correct and incorrect testing methods (see www.npsa.nhs.uk/advice). · Neonatal units and carers change to using pH indicator strips or paper, following competency based training and education, by 01 January 2006; · Radiography should not be used 'routinely' but can be used if the baby is being x-rayed for another reason. Tubes with markings should be used for all babies to enable accurate measurement of depth and length and the position of the tube documented; · DO NOT use the auscultation method ('whoosh' test) to determine tube position; · DO NOT interpret the absence of respiratory distress as an indicator of correct positioning; · DO NOT test correct positioning by monitoring for bubbling at the end of the tube; · DO NOT use the appearance of feeding tube aspirate as a primary method to rule out misplacement. 2. Carry out an individual risk assessment prior to gastric tube feeding. 3. Review and agree local action required.		On-going	Complete	Complete	Complete	Complete	Complete	N/A
Improving compliance with oral methotrexate guidelines	01/06/2006		1. Ensure all actions described in the NPSA's previous patient safety alert (03) are completed. Carry out local self-assessments to check compliance with patient safety alert with the three checklists on p2,3 and 4 of this alert.	Action plan to be agreed and actions started by 30 June 2006.	Complete	Complete	Complete	Complete	Complete	Complete	Complete

			2. Give patients who are taking oral methotrexate the core patient information leaflet and monitoring document.	Actions from patient safety alert (03) to be completed 30 September 2006								
				Audit of local actions and safe practice checklist to be compelted by 31 January 2007.								
Actions that can make anticoagulant therapy safer	28/03/2007	All organisations	1 Ensure all staff caring for patients on anticoagulant therapy have the necessary work competences. Any gaps in competence must be addressed through training to ensure that all staff may undertake their duties safely.	13/03/2008	On-going	On-going	Complete	Complete	On-going	On-going	Complete	
			2 Review and, where necessary, update written procedures and clinical protocols for anticoagulant services to ensure they reflect safe practice, and that staff are trained in these procedures.									
			3 Audit anticoagulant services using BSH/NPSA safety indicators as part of the annual medicines management audit programme. The audit results should inform local actions to improve the safe use of anticoagulants, and should be communicated to clinical governance, and drugs and therapeutics committees (or equivalent). This information should be used by commissioners and external organisations as part of the commissioning and performance management process.									

			4 Ensure that patients prescribed anticoagulants receive appropriate verbal and written information at the start of therapy, at hospital discharge, on the first anticoagulant clinic appointment, and when necessary throughout the course of their treatment. The BSH and the NPSA have updated the patient-held information (yellow) booklet. 5 Promote safe practice with prescribers and pharmacists to check that patients' blood clotting (International Normalised Ratio, INR) is being monitored regularly and that the INR level is safe before issuing or dispensing repeat prescriptions for oral anticoagulants. 6 Promote safe practice for prescribers co-prescribing one or more clinically significant interacting medicines for patients already on oral anticoagulants; to make arrangements for additional INR blood tests, and to inform the anticoagulant service that an interacting medicine has been prescribed. Ensure that those dispensing clinically significant interacting medicines for these patients check that these additional safety precautions have been taken. 7 Ensure that dental practitioners manage patients on anticoagulants according to evidence-based therapeutic guidelines. In most cases, dental treatment should proceed as normal and oral anticoagulant treatment should not be stopped or the dosage decreased inappropriately. 8 Amend local policies to standardise the range of anticoagulant products used, incorporating characteristics identified by patients as promoting safer use.		

			9 Promote the use of written safe practice procedures for the administration of anticoagulants in social care settings. It is safe practice for all dose changes to be confirmed in writing by the prescriber. A risk assessment should be undertaken on the use of Monitored Dosage Systems for anticoagulants for individual patients. The general use of Monitored Dosage Systems for anticoagulants should be minimised as dosage changes using these systems are more difficult.								
Epidural injections and infusions	28/03/2007	All Organisations	1 Clearly label infusion bags and syringes for epidural therapy (whether purchased commercially, manufactured by the hospital pharmacy or prepared in clinical areas) with 'For Epidural Use Only' in a large font. Make judicious use of colour and design to differentiate these products from those for administration by intravenous and other routes. 2 Minimise the likelihood of confusion between different types and strengths of epidural injections and infusions: a Rationalise the range of epidural injections and infusions available, and introduce procedures for preparing and administering these products. Undertake an annual audit to ensure epidural practices adhere to the agreed range of products and procedures. b Maximise the use of ready-to-administer epidural infusions to help reduce the need for complex calculations and preparations. 3 Reduce the risk of the wrong medicine being selected by storing epidural infusions in separate cupboards or refrigerators from those holding intravenous and other types of infusions.	31/12/2007	On-going	Complete	On-going	Complete	On-going	Complete	N/A

			4 Use clearly labelled epidural administration sets and catheters that distinguish them from those used for intravenous and other routes. 5 Use infusion pumps and syringe driver devices for epidural infusions that are easily distinguishable from those used for intravenous and other types of infusion. 6 Ensure all staff involved in epidural therapy have received adequate training, and have the necessary work competences to undertake their duties safely.								
Reducing the risk of hyponatraemia when administering intravenous infusions to children	28/03/2007	All Organisations	1 Remove sodium chloride 0.18% with glucose 4% intravenous infusions from stock and general use in areas that treat children. Suitable alternatives must be available. Restrict availability of these intravenous infusions to critical care and specialist wards such as renal, liver and cardiac units. 2 Produce and disseminate clinical guidelines for the fluid management of paediatric patients. These should give clear recommendations for fluid selection, and clinical and laboratory monitoring. 3 Provide adequate training and supervision for all staff involved in the prescribing, administering and monitoring of intravenous infusions for children. 4 Reinforce safer practice by reviewing and improving the design of existing intravenous fluid prescriptions and fluid balance charts for children. 5 Promote the reporting of hospital-acquired hyponatraemia incidents via local risk management reporting systems. Implement an audit programme to ensure NPSA recommendations and local procedures are being adhered to.	30/09/2007	On-going	Complete	On-going	Complete	On-going	On-going	N/A
Promoting safer use of injectable medicines	28/03/2007	All Organisations	1 Undertake a risk assessment of injectable medicine procedures and products in all clinical areas to identify high risks, and develop an action plan to minimise them.	31/03/2008	On-going	On-going	On-going	On-going	On-going	On-going	Complete

			2 Ensure there are up-to-date protocols and procedures for prescribing, preparing and administering injectable medicines in all clinical areas. 3 Ensure essential technical information on injectable medicines is available and accessible to healthcare staff in clinical areas at the point of use. 4 Implement a 'purchasing for safety' policy to promote procurement of injectable medicines with inherent safety features. 5 Provide training for, and supervision of, all healthcare staff involved in prescribing, administering and monitoring injectable medicines. 6 As part of the annual medicines management audit programme, healthcare organisations should include an audit of medication practice with injectable medicines.								
Promoting safer measurement and administration of liquid medicines via oral and other enteral routes	28/03/2007	All Organisations	1 Design, supply and use of oral/enteral syringes • only use labelled oral/enteral syringes that cannot be connected to intravenous catheters or ports to measure and administer oral liquid medicines; • do not use intravenous syringes to measure and administer oral liquid medicines; • make sure stocks of oral/enteral syringes are available in all clinical areas that may need to measure and administer oral liquid medicines in a syringe; • when patients or carers need to administer oral liquid medicines with a syringe, supply them with oral or enteral syringes.	31/03/2008	On-going	Complete	On-going	Complete	Complete	Complete	Complete

			2 Design, supply and use of enteral feeding systems • enteral feeding systems should not contain ports that can be connected to intravenous syringes or that have end connectors that can be connected to intravenous or other parenteral lines; • enteral feeding systems should be labelled to indicate the route of administration; • three-way taps and syringe tip adaptors should not be used in enteral feeding systems because connection design safeguards can be bypassed. 3 Organisational procedures, training and audit • medicines and enteral feeding policies and procedures should identify and manage the risk of administering oral liquid medicines by the wrong route; • these procedures should be part of the organisation's training and competency assessment programmes; • annual medicines management audits should include a review of the measurement and administration of oral liquid medicines to ensure compliance with local policies and procedures.								
Clean hands saves lives	02/09/2008		All providers of NHS care in England and Wales will: > Undertake an audit to review current risk management strategies including: • the placement, accessibility and suitability of all hand hygiene products, including handwash basins and handrub dispensers, to ensure healthcare staff are able to undertake hand hygiene at the point of care • all hand hygiene policies, processes and programmes to ensure they prioritise hand hygiene at the point of care Develop and implement an action plan to address the issues identified in the audit.	31/03/2009	On-going	On-going	Complete	Complete	Complete	Complete	Complete

WHO Surgical Safety Checklist	26/01/2009	CE	1) Ensure an executive and a clinical lead are identified in order to implement the surgical safety checklist within the organisation. 2) Ensure the checklist is completed for every patient undergoing a surgical procedure (including local anaesthesia). 3) Ensure that the use of the checklist is entered in the clinical notes or electronic record by a registered member of the team, for example,surgeon, Anaesthetist, Nurse, ODP.	01/02/2010	On-going	Complete	Complete	Complete	Complete	On-going	Complete
Being Open	19/11/2009	CE	1) Local policy: Review and strengthen local policies to ensure they are aligned with the Being open framework and embedded with your risk anagement and clinical governance processes. 2) Leadership: Make a board-level public commitment to implementing the principles of Being open. 3) Responsibilities: Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance. 4) Training and support: Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support. 5) Visibility: Raise awareness and understanding of the Being open principles and your local policy among staff, patients and the public, making information visible to all. 6) Supporting patients: Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the Being open process.	23/11/2010	On-going	On-going	On-going	On-going	On-going	On-going	On-going

Safer spinal (intrathecal), epidural and regional devices – Part A	24/11/2009	Nominated Executive Director	• all spinal (intrathecal) bolus doses and lumbar puncture samples are performed using syringes, needles and other devices with safer onnectors that will not connect with intravenous Luer connectors; • medical device and pharmaceutical manufacturers supply devices with safer connectors well before the required implementation date, to enable clinical evaluation and changes in the supply chain to occur; • new orders for non-compliant devices should not be requested six months before the required implementation date to enable time for clinical evaluation and changes in the supply chain.	01/04/2011	On-going	On-going	On-going	On-going	On-going	On-going	N/A
Safer lithium therapy	01/12/2009	All Organisations	1. patients prescribed lithium are monitored in accordance with NICE guidance; 2. there are reliable systems to ensure blood test results are communicated between laboratories and prescribers; 3. at the start of lithium therapy and throughout their treatment patients receive appropriate ongoing verbal and written information and a record book to track lithium blood levels and relevant clinical tests*; 4. prescribers and pharmacists check that blood tests are monitored regularly and that it is safe to issue a repeat prescription and/or dispense the prescribed lithium; 5. systems are in place to identify and deal with medicines that might adversely interact with lithium therapy.	31/12/2010	On-going	80% Complete	Ongoing	Complete	On-going	On-going	On-going
Safer use of intravenous gentamicin for neonates	09/02/2010		1. A local neonatal gentamicin protocol is available. 2. Local policies and procedures are developed or revised to state that intravenous gentamicin should be administered to neonates using a care	09/02/2011	On-going	Complete	On-going	Complete	On-going	On-going	N/A

			bundle incorporating four elements: • When prescribing gentamicin the 24 hour clock format should be used and unused time slots in the prescription administration record should be blocked out to prevent wrong time dosing. • Interruptions during the preparation and administration of gentamicin should be minimised by the wearing of a disposable coloured apron by staff. • A double checking prompt (included with this Alert) should be used during the preparation and administration of gentamicin. • The prescribed dose of gentamicin should be given within one hour of the prescribed time. 3. Neonatal units are encouraged to implement this care bundle using small cycles of change with a sample group of patients. 4. Neonatal units' compliance with the care bundle should be measured daily for each patient in the sample group until full compliance for all patients receiving gentamicin is achieved. 5. All staff involved in the prescribing and administration of intravenous gentamicin are provided with training relating to its use.								