Welcome to Newsline

It has been an exciting and busy start to 2005 for the NPSA. We have already announced two patient safety alerts and a patient safety information notice. The patient safety alerts tackle the issues of misplaced nasogastric tubes and the safety of surgical patients. The patient safety information notice highlights the safety issues for patients with specialist breathing requirements.

In 2004 careful consideration was given to deciding how our work should be prioritised and then to embedding the processes for doing this. From 1 April we will be ready to take on the additional responsibilities assigned to us following the Department of Health’s Arm’s Length Bodies review.

2005 marks a period of substantial growth in the NPSA’s capacity to develop and implement solutions that increase patient safety. We look forward to updating you on our progress in Newsline.

If you have any comments about Newsline, please email stella.zegge@npsa.nhs.uk

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Implementing the Arm’s Length Bodies review

The NPSA’s role within the NHS is to be strengthened as it prepares to take on a number of new responsibilities.

The Agency is to expand its remit following the publication of Reconfiguring the Department of Health’s Arm’s Length Bodies in July 2004. The changes will allow the Agency to broaden its focus on improving patient safety in the NHS.

From 1 April this year, the NPSA will assume responsibility for:
• the National Clinical Assessment Authority, which will become the NPSA’s National Clinical Assessment Service (NCAS), providing a service to NHS employers where there are concerns over the performance of individual doctors and dentists;
• the Central Office for Research Ethics Committees (COREC) which safeguards the rights, dignity and welfare of people participating in NHS research;
• the Better Hospital Food Programme;
• cleanliness in the NHS;
• the safety of hospital design;
• contracts with the confidential enquiries into maternal and child health (CEMACH), patient outcome and death (NCEPOD) and suicide and homicide by people with mental illness (NCISH), which are to move from the National Institute for Clinical Excellence (NICE) to the NPSA.

In addition to these new areas of opportunity, the NPSA will continue to work towards improving safety by helping the NHS to learn when things go wrong, introducing preventative measures nationwide, and encouraging a culture of safety and openness so that incidents and concerns are not overlooked but acknowledged, investigated and learnt from.

As described in An Implementation Framework for Reconfiguring the Department of Health’s Arm’s Length Bodies (published in December 2004), these changes see the NPSA’s future role as to “co-ordinate system-wide patient safety functions: reporting, analysing and learning from adverse incidents and ‘near misses’ involving NHS service users; supporting NHS employers who are concerned about the performance of individual doctors and dentists; taking the national operational lead on hospital food, aspects of hospital design and in supporting local research ethics committees.”

The NPSA’s Joint Chief Executive, Susan Williams, said: “The change heralded by the Arm’s Length Bodies review offers the NPSA a much greater opportunity to ensure that safety is the health service’s number one priority. It also recognises the fact that the responsibility for safety is not one person’s or one organisation’s but is for everyone and affects all aspects of care.”

Contact numbers and addresses will, for the time being, remain the same for all the organisations involved.

The full Arm’s Length Bodies documents can be found at www.dh.gov.uk
**Improving emergency care for laryngectomy patients**

The NPSA is working to improve the safety of patients who have had a laryngectomy or a long-term tracheostomy. These patients may be at risk when receiving emergency care if staff are not aware of how to manage their special breathing needs.

This is an issue that was first raised by the National Association for Laryngectomy Clubs (NALC), whose preferred term for these patients is ‘neck breathers’. Patients who are neck breathers cannot breathe through their mouths and receive air through a hole in their neck (a stoma).

The NPSA carried out a survey of NALC members that showed that in some cases when neck breathers received emergency care, oxygen was given accidentally via the nose and mouth. In other cases, although the emergency oxygen was given correctly via the stoma, mucous plugs blocking the airway were not removed.

The NPSA issued a patient safety information notice on 7 March to NHS organisations, including accident and emergency departments and ambulance trusts, which highlights the problems and provides advice on how they can improve the safety of these patients.

The advice includes ensuring that airway management for neck breathers is included in resuscitation training courses for all ambulance staff and hospital staff working in accident and emergency departments, or other areas where neck breathers are likely to require emergency care.

Dr Tom Clarke, Chair of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), said: “As the organisation responsible for clinical guidance of the UK ambulance services, JRCALC fully supports this useful advice which will further help to ensure the delivery of the highest standards of care to this special group of patients.”

The full patient safety information notice is available on the NPSA website at [www.npsa.nhs.uk/advice](http://www.npsa.nhs.uk/advice).

**Oral methotrexate consultation outcome**

Oral methotrexate is normally taken for the treatment of moderate to severe rheumatoid arthritis and severe psoriasis. It is an important and effective medication if taken at the right frequency, in the right dose and with appropriate monitoring.

However, after consultation with health professionals, patient groups, software suppliers and the pharmaceutical industry, the NPSA issued a patient safety alert in July 2004 to help make the administration of the drug safer.

The alert provided the core information to be communicated to patients. The NPSA is now working with the British Society for Rheumatology and the British Association of Dermatology to review and revise the patient information materials regarding oral methotrexate. The revised materials will be used in conjunction with any guidance and information that is already in use. It is anticipated that clinical staff will need to adapt the documents for local preference, style and approach.

The NPSA aims to provide a model with the appropriate balance between warning of the potential risks and communicating the benefits of the drug.

Further announcements are expected after summer 2005.

The patient safety alert can be found on the NPSA website at [www.npsa.nhs.uk/advice](http://www.npsa.nhs.uk/advice).

**Uptake hits 99 per cent**

Following a tremendous response to our call for implementers for the [CleanYourHands](http://www.cleanyourhands.org.uk) campaign, we are pleased to announce that 99 per cent of hospitals across England and 100 per cent in Wales, are now partner sites.

The campaign focuses on increasing hand hygiene compliance by involving staff and patients, and is supported by a range of resources and materials for local use, including posters, badges, stickers and patient information.

To date, hospitals in the first three of the campaign’s five phases have completed the preparation stage and are now ‘live’, with all staff groups engaged and materials supplied and displayed on every ward. Each month, wards will receive a new poster to help maintain interest and awareness, and to reinforce the key messages of the campaign.

Phases four and five are due to go live between April and June. In the meantime, as part of ongoing evaluation, we will be holding a workshop with representatives from the early implementers who will share feedback, highlight practical issues and identify where there may be room for improvement in the future. For further information about the campaign, including news from our partner sites, visit [www.npsa.nhs.uk/cleanyourhands](http://www.npsa.nhs.uk/cleanyourhands).

**Design for patient safety**

A project aimed at enhancing patient safety by improving the design of pre-packaged and bulk medicines is being undertaken by a graduate of the Royal College of Art, and is co-sponsored by the NPSA.

Thea Swayne, who graduated last summer with an MA in Communication Art and Design, is spending a year researching, designing and producing a prototype for superior medicine packaging. The NPSA design brief resulted from the joint Department of Health and Design Council report, Design for Patient Safety (October 2003), which drew attention to the role of design in preventing errors in the health service.

Thea aims to design medicine packs that will be easier for pharmacists and patients to handle, and make it harder for patients to take incorrect dosages.

The NPSA’s Design Manager, Colum Menzies Lowe, said: “It is great to see the worlds of design and patient safety coming together in a project where design is being applied as a problem-solving process, with the user in mind, and not as an aesthetic veneer applied to a finished product.”
**Action to protect surgical patients**

The NPSA and the Royal College of Surgeons of England (RCS) have joined forces to help improve the safety of patients undergoing surgery.

A patient safety alert has been issued to the NHS promoting ‘correct site surgery’. The recommendations, launched on 2 March, encourage a consistent approach to marking patients for surgery. Previously, across the NHS, there has been no single, standard method for marking a surgical site, which increases the likelihood of confusion and error.

The alert includes advice for surgical teams on where, how and when the patient should be marked; who should mark the patient; and who should be actively involved in the process. It also provides staff with a checklist to help them ensure the vital steps that are required to protect the patient, are taken.

The NPSA’s Medical Director, Professor Sir John Lilleyman, said: “Mistakes during surgery can have devastating emotional and physical consequences for patients and their families. For the staff involved too, incidents can be distressing, while members of their clinical teams and the wider organisation can become demoralised and disaffected. Implementing these new recommendations will help surgical teams make patient care safer.”

Mr Hugh Phillips, President of the RCS, said: “We urge all surgical teams to adopt these guidelines. As the professional body committed to promoting and advancing the highest standards of surgical care for patients, the RCS has been working closely with the NPSA to ensure that the guidance is practical for our members and surgical teams across the NHS. The aim of the guidance is to promote best practice to help improve patient safety.”

The NPSA are delighted that having worked closely with a number of key organisations, the following bodies have agreed to endorse the correct site surgery patient safety alert:

- Royal College of Ophthalmologists
- Royal College of Obstetricians and Gynaecologists
- Royal College of Nursing (RCN) Perioperative and Surgical Nursing Forum
- National Association of Theatre Nurses
- National Association of Assistants in Surgical Practice (NAASP)
- Association of Operating Department Practitioners (AODP)
- Independent Healthcare Forum (IHF)

The patient safety alert can be found on the NPSA website at [www.npsa.nhs.uk/advice](http://www.npsa.nhs.uk/advice)

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**Matching patients and their care**

New developments in technology provide unparalleled opportunities for increasing patient safety by ensuring that patients get the right treatment.

However, a report published by the NPSA highlights the scope for improving manual and technology-based systems for identifying and matching patients and their care.

Mismatched care can include confusing one patient with another or mismatching medication, blood or pathology samples. Where mismatching happens in surgery, the patient may have the wrong part of their body operated on or removed.

The report, *Right patient – right care*, points to significant opportunities to enhance patient safety. The NPSA has worked with the National Programme for IT (NPfIT) to develop the use of new technologies in the health service such as barcodes, radio frequency tagging and biometrics. These technologies are already being piloted in clinical set-ups.

A general practice surgery in South London is using fingerprint technology to allow patients access to their electronic records. They are issued a PIN and can look at their records, alert the surgery about changes to their personal details and print off leaflets about specific medical conditions.

A trial using radio frequency tagging is being conducted at Birmingham Heartlands Hospital. This allows the patient’s position within the hospital to be tracked so their medical notes can be made available on the nearest hand-held computer.

The NPSA report also sets out the findings of research by the Human Reliability Associates of Dalton (commissioned by the NPSA) on manual checking processes. The research found that bedside identity checking appears to be a major source of matching errors.

The NPSA’s Head of Safer Practice, Chris Ranger, said: “It is vital that the health service works with the technology manufacturers to develop solutions that are tailor-made for health service settings. But our work has also shown that improving manual checking procedures is a priority to prevent errors that can lead to serious risk of harm to patients. We will be monitoring developments in this field and promoting exchanges between interested parties.”

The NPSA will continue to monitor developments in this field and to identify potential ways to ensure that the right patient gets the right care.

The report is available from the NPSA website at [www.npsa.nhs.uk/health/publications](http://www.npsa.nhs.uk/health/publications)
Reducing harm caused by misplaced feeding tubes

The NPSA has issued advice to the NHS on how to correctly check the position of nasogastric feeding tubes.

Thousands of nasogastric feeding tubes are inserted daily without incident into patients who have swallowing or feeding difficulties. However, there is a small risk that tubes can be mistakenly inserted into the lung rather than the stomach. Although misplacement can be recognised at an early stage, studies have shown that conventional methods used to check the placement of nasogastric feeding tubes can be inaccurate.

The NPSA is aware of 11 deaths and one case of serious harm due to misplaced nasogastric feeding tubes between December 2002 and December 2004.

A patient safety alert has been issued which recommends the methods that should be used to confirm correct placement of feeding tubes and asks NHS acute trusts, primary care organisations and local health boards in England and Wales to immediately review their local guidelines for this procedure.

The following are the recommended tests to check the correct position of nasogastric feeding tubes:

- measuring the pH of aspirating using pH indicator strips;
- radiography is recommended but should not be used routinely. Fully radio-opaque tubes with markings to enable measurement, identification and documentation of their external lengths should be used.
- The alert highlighted a series of tests that should not be used. These include the ‘whoosh’ test (auscultation of air insufflated through the feeding tube); testing the acidity/alkalinity of aspirate using litmus paper; and monitoring bubbling at the end of the tube.
- The alert also advises trusts to carry out individual risk assessments prior to nasogastric tube feeding; review and agree local action required; and report misplacement incidents via their local risk management reporting systems.

The University of Birmingham Patient Safety Research Programme has been commissioned to further assess the existing testing methods, including specific work on the neonatal population. A revision to the alert may therefore be made in light of this research.

The full patient safety alert is available on the NPSA website at www.npsa.nhs.uk/advice

Healthcare Commission partnership

Following publication of the national standards for safety in the NHS, the NPSA is now working with the Healthcare Commission to develop assessment criteria.

Working in partnership with other national healthcare organisations has always been an important commitment for the NPSA and working with the Healthcare Commission is now more important than ever.

The draft national standards for the NHS in England were published in February 2004 and safety was identified as the first of seven domains. Following extensive consultation, the commission was charged with developing assessment criteria for each of the domains.

Over the last year, the NPSA has worked with the commission’s safety team. Our aim has been to influence its considerations on how the safety performances of NHS organisations are assessed. The safety message to the NHS needs to be consistent, whether it is from the NPSA in relation to improving patient safety, or from the commission in relation to the inspection of services.

The commission has established an Expert Reference Group on the safety domain. The group is looking at producing criteria to support the implementation of the standards. Elisabeth Davies, the NPSAs Head of Policy, Planning and Partnerships, is the NPSA’s representative in the group.

These standards and subsequent criteria only apply to England. The NPSA is working closely with the Welsh Assembly Government and Healthcare Inspectorate Wales to develop and implement the standards that have been drawn up by the Welsh Standards Board. The NPSA has also responded to the draft Standards for Healthcare Governance, produced by NHS Quality Improvement Scotland, and is working closely with colleagues in Northern Ireland on related issues.

Coming soon…

Seven steps to patient safety for primary care

Following the success of the Seven steps to patient safety - the full reference guide and summary documents, the NPSA will shortly be launching a version tailored for primary care staff.

Whilst the original Seven steps was relevant for all care settings, the NPSA has responded to feedback from primary care organisations and is developing a guide that specifically acknowledges and addresses the different challenges that the primary care sector faces.

The document, Seven steps to patient safety for primary care, offers practical guidance and tools, in seven key areas of patient safety, to help primary care organisations and teams safeguard the patients they care for.

We hope it will prove useful for all staff providing primary care as well as staff responsible for clinical governance and risk management. The guide is equally applicable to managed and independent contractor staff. It provides a three to five year plan with achievable goals for creating, in the medium-term, a patient safety-conscious organisation.

Advance notice

The Royal College of Psychiatrists’ Research Unit, in collaboration with the NPSA, is organising a one-day conference entitled ‘Patient Safety in Mental Health Services’ on Wednesday 6 July 2005 in London.

For further information, please contact Emma George, Communications/Marketing Manager on 020 7227 0825 or email egeorge@rcru.rcpsych.ac.uk