NEWS RELEASE

EMBARGO: 10am on Thursday 11 April 2019
Issued by the Healthcare Safety Investigation Branch (HSIB)

HSIB investigation tackles national complexity of medicine safety

A report published today by the Healthcare Safety Investigation Branch (HSIB) emphasises that complex and fragmented medicine safety processes are putting patients across the country at risk.

The report puts forward a number of recommendations aimed at driving national improvement to reduce potentially fatal medication errors. This follows an investigation launched after HSIB were made aware of a nine-year old child wrongly administered an oral liquid drug into a vein during a planned renal biopsy. The child stayed in the hospital for monitoring and discharged with no adverse effects a day later.

HSIB's investigation identified that there are a number of professional and regulatory bodies involved in the implementation of system wide safety standards and guidance, dissemination of safety messages and professional training. It concluded that the current system is confusing with a lack of clarity over roles and responsibility. It also acknowledges the influence of human factors on medication administration and the range of cognitive demands placed on staff during critical stages of the process.

The report sets out four recommendations:

- Three are addressed to **NHS Improvement**. These are focused on the work of the National Patient Safety Committee (NAPSAC) to review alerts, improving skills and knowledge in risk analysis and hazard identification (to feed into the wider National Patient Safety Strategy) and a formal evaluation of the banding, time and resource given to the Medication Safety Officer (MSO) role.
- One is addressed to the **Royal of College of Physicians (RCP)** to work with other royal colleges and bodies to standardise professional development and postgraduate learning in medicine safety.

Keith Conradi, Chief Investigator said: "This investigation highlighted how challenging it is to make improvements at a national level, due to the complex nature of safety processes and

the number of human interactions needed to prevent errors from occurring. By applying a human factors perspective, working with subject matter experts and engaging with national bodies, a clear picture emerged of where the pressure points are for healthcare staff carrying out invasive procedures in busy working environments.

“The case we looked at for the investigation demonstrated that whatever the level of harm, medication errors have a devastating impact on all those involved – patients, families and staff.

“We recognise all the good work already undertaken but there is more to be done. The recommendations set out in the report are focused on ensuring consistency in standards and training. We trust this collaborative and cohesive work at a national level will improve medicine safety processes across the system.”

The report also makes seven safety observations and highlights seven safety actions already undertaken including the launch of the National Medicines Safety Programme led by NHS Improvement in response to the launch of the third global patient safety challenge by the World Health Organization (WHO).

The report is now available on the HSIB website and responses to the recommendations will be published.

ENDS
Notes to Editors

Recommendations, observations and safety actions in full

Safety recommendations

- **NHS Improvement**, through the National Patient Safety Alert Committee, set standards for all issuers of patient safety alerts which make clear that alert issuers should assess for unintended consequences of the actions in the alert, the effectiveness of barriers created by these actions, and provide appropriate advice for providers on implementation, include ongoing monitoring.
- **NHS Improvement** support the development of necessary knowledge, skills and capacity for the effective operationalisation of hazard identification and risk analysis at a national, regional and local level, as an integral part of the national Patient Safety Strategy.

- **Royal College of Physicians**, in collaboration with the Royal Pharmaceutical Society, British Pharmacological Society, Royal College of General Practitioners, Royal College of Paediatrics and Child Health, NHS Improvement, the professional bodies for the professions regulated by the Health and Care Professions Council, Royal College of Nursing and Royal College of Midwives, provide leadership in recommending the postgraduate learning needs and activities to standardise professional development in medicines safety processes.
- **NHS Improvement** undertake a formal evaluation of banding, time and resource given to the Medication Safety Officer role across England and publish its findings and mandate minimum resources and standards.

Safety observations

- It is recommended that staff with a responsibility for medicines safety, for example Medicines Management and Chief Pharmacists, Clinical Governance Leads, Heads of Medicines Optimisation and Medication Safety Officers are familiar with the contents of the existing National Institute for Health and Care Excellence clinical guidance on medicines optimisation and can demonstrate how they have implemented the quality standard on medicines optimisation [QS120] and quality statement 3, 'Learning from medicines-related patient safety incidents'.
- It would be beneficial to define a national standard for independent two-person checking when preparing high-risk medication for administration to minimise medication errors associated with high-risk medications.
- Availability of oral/enteral syringes in all clinical areas (in accordance with the requirements contained in the National Patient Safety Agency's Patient Safety Alert 19) is inconsistent. A national audit tool may be helpful to organisations.
- Colouring of high-risk and/or oral liquid medications (such as midazolam) may have a justifiable role in improving safety as it will offer a signal to differentiate oral from parenteral preparations.
- It would be beneficial if potential interventions designed to reduce wrong route administration medication errors were subjected to human factors testing, review, evaluation and modification prior to being introduced at scale; this includes standards, processes, and the design of medication and administration devices.
- SCRIPT is an eLearning programme to improve safety and competency among healthcare professionals around prescribing, therapeutics and medicines management. It would be beneficial to roll out SCRIPT as a mandatory requirement for all prescribers.

- There is an opportunity with the new General Medical Council Medical Licensing Assessment to mandate additional therapeutic practical skills for example, the practical aspects of medicines administration, as part of the Clinical Practical Skills Assessment.

Safety Actions carried out and/or in progress

- The Trust where the reference event occurred removed an inaccurate notice affixed to the inside of a controlled drugs cupboard and reviewed its storage arrangements.
- In January 2019 the Specialist Pharmacy Service published its Medicines Governance Do Once Programme, which includes a plan to develop national templates for medicines-related policies for adaptation and adoption within NHS organisations and other publicly funded commissioned services.
- The Royal Pharmaceutical Society has produced and published professional guidance on the administration of medicines for use by all healthcare professionals.
- NHS Improvement is working towards a formal launch of the National Medicines Safety Programme in April 2019.
- The reference event site has acted upon the requirement for a Local Safety Standard for Invasive Procedures (LocSSIP): '…a Local Safety Standard (LocSSIP) should be developed for all invasive procedures including renal biopsies and any other procedures that include sedation. Including minimum staffing/skillmix required'.
- HSIB, supported by a teaching hospital, has produced a reconstruction of events and a simulation of what happened during the reference event along with a supplementary teaching aid to increase awareness of this type of error.
- The reference event site has developed a safe sedation guideline for under 19s and reviewed the integrated care pathway for children undergoing a procedure requiring sedation.

About HSIB

The formation of HSIB is a world-first and represents a landmark moment for the NHS in England. HSIB's purpose is to help improve safety in the healthcare system by developing recommendations and sharing lessons from investigations. HSIB will improve patient safety through effective and independent investigations that do not apportion blame or liability.

More details can be found www.hsib.org.uk

Media contacts

Please contact media@hsib.org.uk or phone 07710 114191 or 07453283931 for interviews and other queries.