New report focuses on design and implementation of patient safety alerts

A report released today highlights that, despite ongoing work, NHS trusts may face barriers when responding to national patient safety alerts.

The Healthcare Safety Investigation Branch (HSIB) has focused on how patient safety alerts are designed and how advice is given to providers to implement them. This follows an investigation on safety risk of connecting patients to the piped medical air supply instead of the oxygen supply in hospitals. HSIB identified a case where this happened to an 85-year old woman whilst she was receiving treatment following a fall at home.

Since being classified as a Never Event in February 2018, 32 cases of unintentional connection to air instead of oxygen have been reported (1 February 2018 to 30 June 2018). NHS Improvement had recognised this risk and issued a patient safety alert in 2016, asking trusts to reduce the risk of oxygen tubing being connected to airflow meters and setting out actions and barriers that could be put in place.

The investigation found that trusts may have misinterpreted the direction of the alert and that the central alerting system doesn't capture the detail of actions taken by providers in response to alerts.

As a result, a recommendation has been made to the National Patient Safety Alert Committee (NAPSAC):

1. The National Patient Safety Alert Committee should set standards for all issuers of patient safety alerts that require an assessment for unintended consequences, the effectiveness of barriers in the alert, and the advice the alert issuers give providers on implementation and ongoing monitoring.

Dr Kevin Stewart, Medical Director at HSIB, said: "Our investigation highlighted that despite the work that has gone into this, we are still seeing the same issues. In this particular case, as well as finding that there is a lack of clarity over the need for piped medical air in hospitals, financing and resourcing might also be a systemic barrier for trusts.

“Although the patient in this case wasn’t harmed, there could have been a very different outcome. Rather than equipment design, we felt that it would be more effective for our recommendation to feed into the work being done by the National Patient Safety Alert Committee.”

The report is now available on the HSIB website and the response to the recommendation will be published.

ENDS

Notes to editors

Never Events are serious incidents that the national Serious Incident Framework define *as ‘entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.’*

Recommendations, observations and safety actions

Safety recommendations

The National Patient Safety Alert Committee should set standards for all issuers of patient safety alerts that require an assessment for unintended consequences, the effectiveness of barriers in the alert, and the advice the alert issuers give providers on implementation and ongoing monitoring.

Safety observations

The Central Alerting System gives providers the opportunity to supply information on actual actions taken alongside recording that actions have been completed. However, the functionality could be developed to require providers to give further detail and this would allow a more effective way of nationally reviewing this information.

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 at www.hsib.org.uk

Media contacts

Please contact media@hsib.org.uk or phone 07710 114191 or 07850 881947 for interviews and other queries.