Improving patient safety: achievements and future developments

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PATIENT SAFETY
Working together

The publication of the Francis report has prioritised safety at all levels of the healthcare system.[1] *Infant* journal and BAPM are committed to supporting this agenda through regular safety publications. This review of the past twelve months sets out to reflect on some of the strategic achievements in the NHS in relation to neonatal care; appraising achievements and challenges and perhaps considering where effort might be better spent in the coming year.

January 2014 saw the launch of the National Patient Safety Alerting System (NPSAS, **FIGURE 1**).[2] To date, 19 alerts have been issued most of which have relevance for maternity and neonatal care. Two alerts have direct relevance to newborn infants and include highlighting the risk of inadvertent cutting of in-line or closed suction catheters and considering Legionnaires' disease in the differential diagnosis of severe respiratory infection or sepsis in any neonate who had a water birth (**FIGURE 2**). More information on these alerts is available on the patient safety section of the NHS England website (www.england.nhs.uk/ourwork/patientsafety).

In February the *Surgical Never Events Taskforce Report*[3] (**FIGURE 1**) was published, focusing on standardising operating procedures, education and training and harmonising activity to support a safer environment, both within and outside the operating theatre environment. This includes surgical procedures carried out on neonates in the NICU environment in cases where an infant is too ill to be moved. April saw the beginning of monthly publishing of 'never events' data as part of the NHS commitment to being open and transparent.

FIGURE 1 The *National Patient Safety Alerting System* and the *Surgical Never Events Taskforce Report*.

The Secretary of State for Health launched the 'Sign up to Safety' campaign[4] in June (**FIGURE 3**) with healthcare providers who sign up to the campaign committing to reducing harm and saving lives within their own organisations in the next three years. Publishing of patient safety data by hospital on the new 'my hospital' section of the NHS Choices website also commenced in June and by September, 15 patient safety collaboratives had launched. The collaboratives, coordinated by NHS England and NHS Improving Quality, aim to provide safety improvements across all healthcare settings, tackling the leading causes of avoidable harm to patients. Led by England's 15 Academic Health Sciences Networks, the collaboratives will empower patients and staff to work collaboratively at a local level to identify safety priorities and develop solutions.[5] These will then be implemented and tested locally prior to national dissemination.

October saw the launch of new patient safety thermometers, point-of-care survey instruments that provide a 'temperature check' on harm.[6] Haelo, commissioned by NHS England to develop the patient safety thermometers, is investigating the feasibility of developing a bespoke neonatal safety thermometer. Discussions are still in the early stages and clinicians are currently being asked to put forward indicators for consideration for inclusion in a neonatal thermometer.

A partnership between NHS England and the Health Foundation to develop and deliver the Patient Safety Fellows initiative, commenced in December. This initiative seeks to connect and support

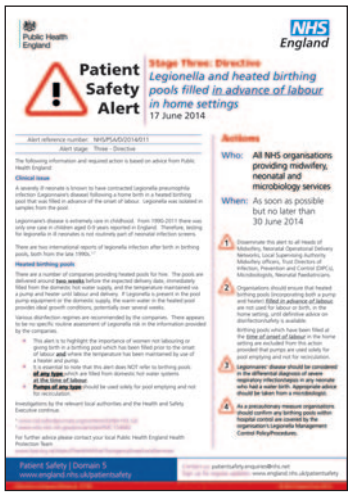

FIGURE 2 The Legionnaires' disease alert, issued in June.

FIGURE 3 Sign up to Safety, launched in June 2014.

people with expertise in safety and quality improvement across the UK, working with organisations connected to those at the forefront of safety, including Academic Health Science Networks (AHSNs), the Royal Colleges, health charities and research networks as well as regional improvement organisations.[7] The programme aims to recruit 5,000 safety fellows in five years to support these improvements.

Work on understanding reasons for term admissions to neonatal units has been carried out throughout the year as part of the NHS England Patient Safety Domain's response to indicator 5.5 of the NHS Outcomes Framework. NHS England commissioned the Neonatal Data Analysis Unit (NDAU) to undertake an analysis of the primary reasons for admission and the work programme has focused on the top five reasons for admission, identified as:

1. respiratory
2. hypoglycaemia
3. infection
4. jaundice
5. asphyxia.

A stakeholder event was held in early November and was pivotal in exposing the enormity and complexity of this work programme. Evident from discussions is the need for local audit of term admissions to understand the local issues; however, investment needs to be made across the system in order to tackle some of the higher level aspects relating to data, resources and measurement.

A parallel work stream, also led by the safety team is focusing on avoidable deterioration with a particular focus on children, including newborn infants. The work is delivered by a wide network of experts through monthly webinars, an online repository of shared resources on the Patient Safety First Deterioration website[8] and face-to-face meetings. Projects seek to 'curate' rather than 'create' resources for the recognition and response to deterioration for staff as well as safer care film resources for parents.

These reflections do not begin to capture the depth or wealth of work which is undertaken on a daily basis in maternity and neonatal units across the country. To continue the ethos of sharing and learning, *Infant* would love to hear of any safety and improvement work your unit has carried out, which could be shared through the journal in the coming year.

Acknowledgement

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References

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For more information on patient safety, visit the NHS England website
www.england.nhs.uk/ourwork/patientsafety

Join us to help improve patient safety

In collaboration with BAPM, *Infant* journal is keen to help improve patient safety and raise awareness of issues affecting neonatal patients, their families and staff by devoting a specific section to patient safety in each edition of the journal. Anyone can submit an article so if you have ideas for highlighting safety aspects to improve care, please do let us know.

- Have you implemented an initiative locally which has demonstrable benefits for improving safety?
- Are you developing a new initiative which might benefit from a wider application?
- Do you have experience in any human factors-related improvement that you'd be able to share?

If you would like to submit a patient safety article to *Infant*, please email lisa@infantgrapevine.co.uk

If you have any incidents for national learning, please contact BAPM by emailing bapm@rcpch.ac.uk