

Learning From the First Implementation of Hospital SOPS in National Health Service (NHS) Trusts Across England and Wales



Kate Beaumont

Head of NHS and Patient Engagement

National Patient Safety Agency

Catherine.beaumont@npsa.nhs.uk

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Session: SOPS International User Activities
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The National Patient Safety Agency

We lead and contribute to improved, safe patient care by **informing**, **supporting** and **influencing** organisations and people working in the health sector.

Step 1

Build a safety culture that is open and fair

Step 2

Lead and support your staff

Step 5

Involve and communicate with your patients

Step 4

Develop your reporting culture

Step 3

Proactively manage your risks

Step 6

Learn and share your safety lessons

Step 7

Develop safer practices to reduce harm

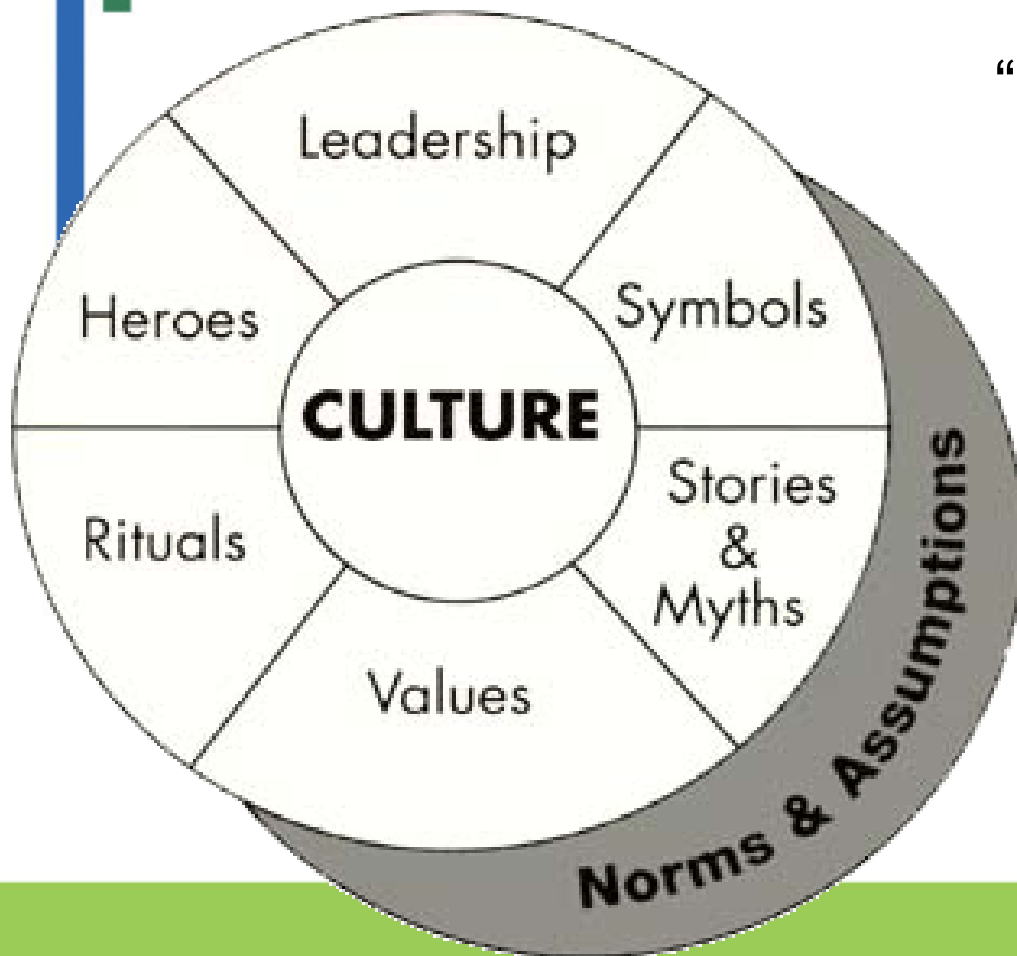
Step 1 Build your safety culture

Very simply, a safety culture, is the 'way we make sure everything we do is as safe as possible'. It needs to be...

- Open and fair
- Reliable and resilient
- Vigilant and proactive



Culture



“the total of inherited ideas, beliefs, values and knowledge which constitute the shared basis of social action”

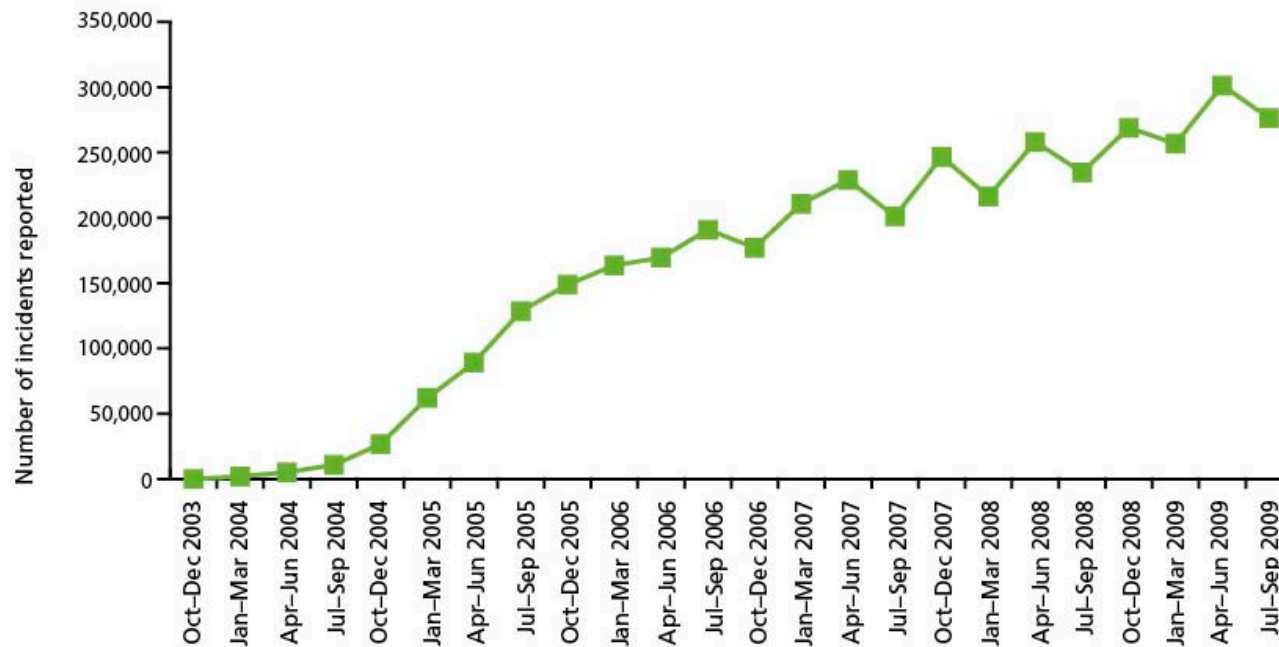
Collins Concise English Dictionary



“If we don’t know where the problems are, then we can’t fix them. That is why we are so pleased that more and more staff are reporting safety concerns. This shows that there is a much greater awareness of patient safety amongst NHS staff.”

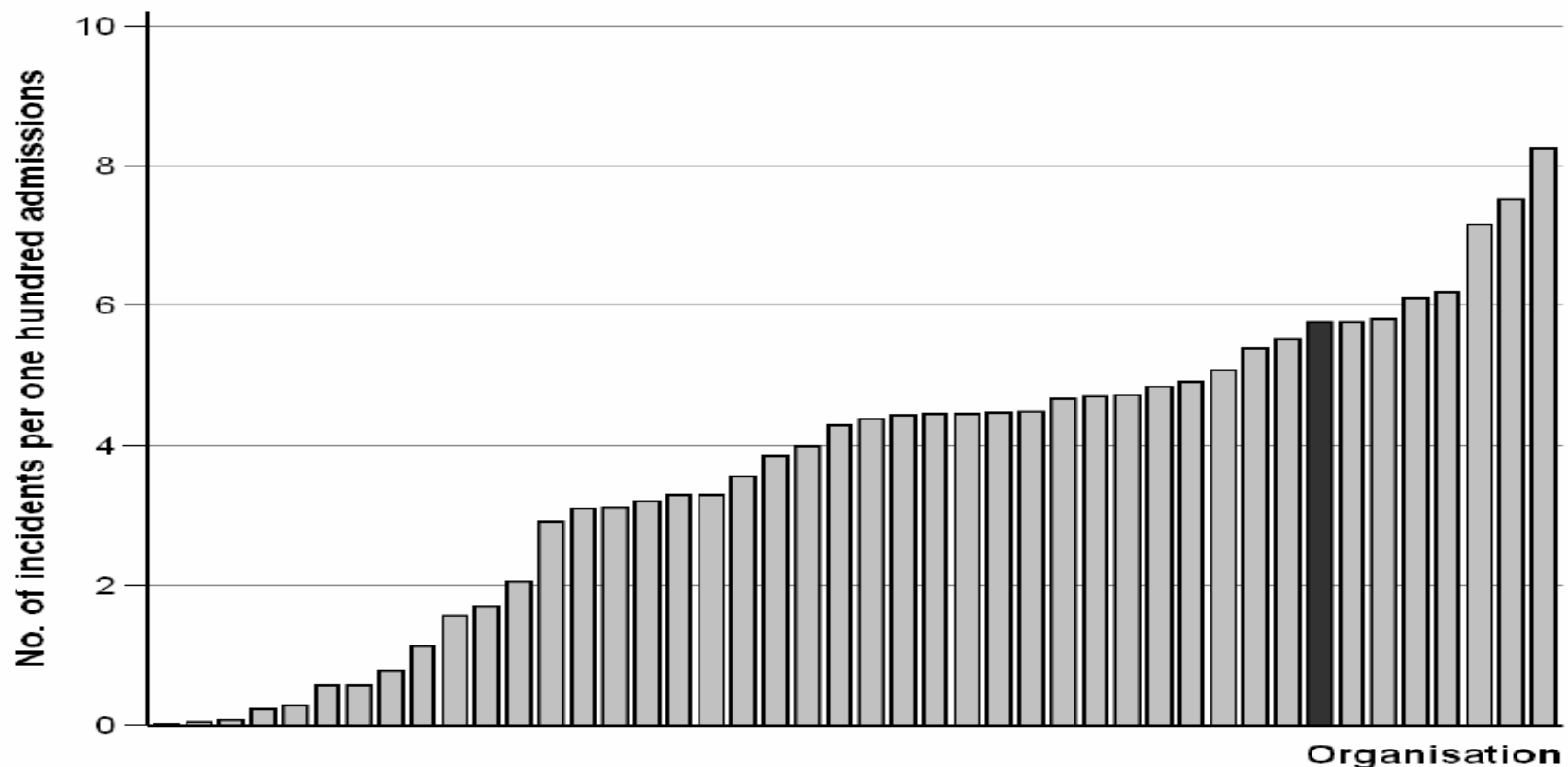
Martin Fletcher, Chief Executive, NPSA, to December 2009

Number of incidents reported in England, October 2003 to September 2009



Which is the safer hospital?

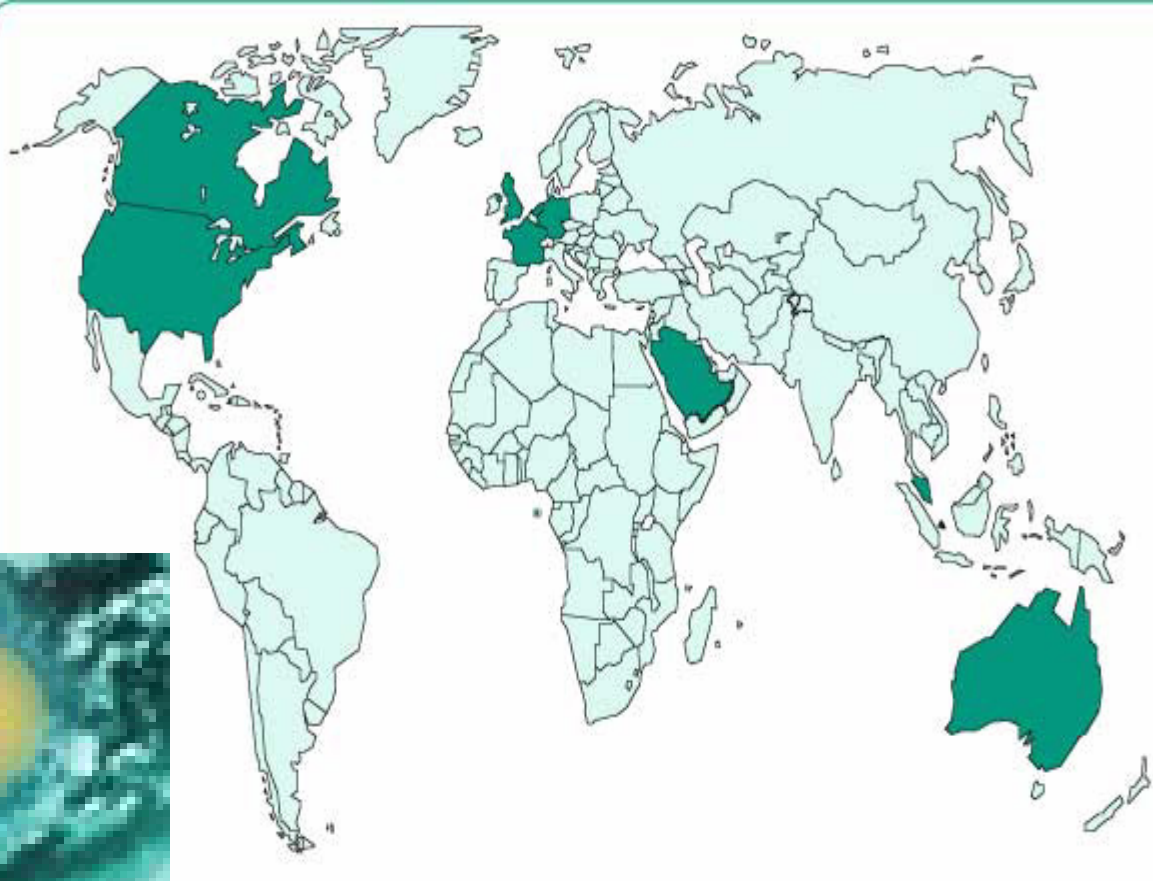
Figure 2: Incident rate per one hundred admissions



Source: patient safety incident reports successfully submitted to the NRLS where the incident occurred during the period 1 October 2006 to 31 March 2007

‘NHS Peterborough has excellent safety culture....’

‘The first externally published report by the National Patient Safety Agency (NPSA) shows NHS Peterborough has an excellent culture of reporting incidents, showing its commitment to patient safety.’



Putting Patient Safety First

<u>Country</u>	<u>Lead Technical Agency</u>
<u>Australia</u> 	Australian Commission on Safety and Quality in Health Care (LTA website)
<u>Canada</u> 	Canadian Patient Safety Institute (LTA website)
<u>France</u> 	French National Authority for Health (LTA website)
<u>Germany</u> 	German Agency for Quality in Medicine (LTA website) German Coalition for Patient Safety (LTA website)
<u>The Netherlands</u> 	Dutch Institute for Healthcare Improvement - CBO (LTA website)
<u>Saudi Arabia</u> 	Ministry of Health, Kingdom of Saudi Arabia
<u>Singapore</u> 	Ministry of Health, Singapore (LTA website)
<u>United Kingdom</u> 	National Patient Safety Agency (LTA website)
<u>United States</u> 	Agency for Healthcare Research and Quality (LTA website) American College of Surgeons (LTA website)

High 5s Mission Statement

To facilitate implementation and evaluation of standardized patient safety solutions within a global learning community to achieve measurable, significant and sustained reductions in highly important patient safety problems.

Main objective of High 5s Project

To achieve a measurable, significant and sustained reductions in highly prevalent patient safety problems over a five year period.

‘A number of other issues were identified as important in supporting implementation of solutions, **in particular the strength of the safety culture** within an organisation. Implementing new techniques without also addressing an existing culture can undermine the effectiveness and sustainability of the new techniques. Purposeful attempts to change culture often fail, so patient safety tools can also be used as **a catalyst for cultural change**’.

Action on Patient Safety (High 5s) Planning Meeting
WHO Headquarters, Geneva, Switzerland
Joint Commission International, Ferney-Voltaire, France
29-30 September 2006

The Standard Operating Protocols (SOPs)

- Correct procedure at correct body site (USA)
- Assuring medication accuracy at transfers in care (Canada)
- Prevention of high concentration injectable medication errors (UK – NPSA)

Description of patient safety problem

Concentrated injectable medicines have been involved in medication incidents resulting in death or serious harm. These have been frequently caused by:

- Mis-selection of the wrong product due to look-a-like labelling and packaging, where concentrated injectable medicines are mis-selected for other injectable medicines

- Dose and rate of administration errors

- This may involve incorrect calculation, measurement and dilution.

Concentrated injectable medicines included

- Concentrated potassium chloride solution
- Sodium heparin >1,000 units/ml
- Injectable morphine preparations
- Other concentrated injectable medicines in addition to those listed above may be included e.g. Insulin/Diamorphine (*but measurement data will not be required to be submitted*)

PATIENT SAFETY ALERT

PROBLEM:

Research in UK and elsewhere has identified a risk to patients from errors occurring during intravenous administration of potassium solutions.

Potassium chloride concentrate solution can be fatal if given inappropriately.

ACTION FOR NHS BY 31 OCTOBER 2002:

This alert sets out action, including initial action 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

For the attention of:

Chief Executives of NHS Trusts and Primary Care Trusts

For action by:

Chief Pharmacists and pharmaceutical advisers in NHS Trusts and Primary Care Trusts

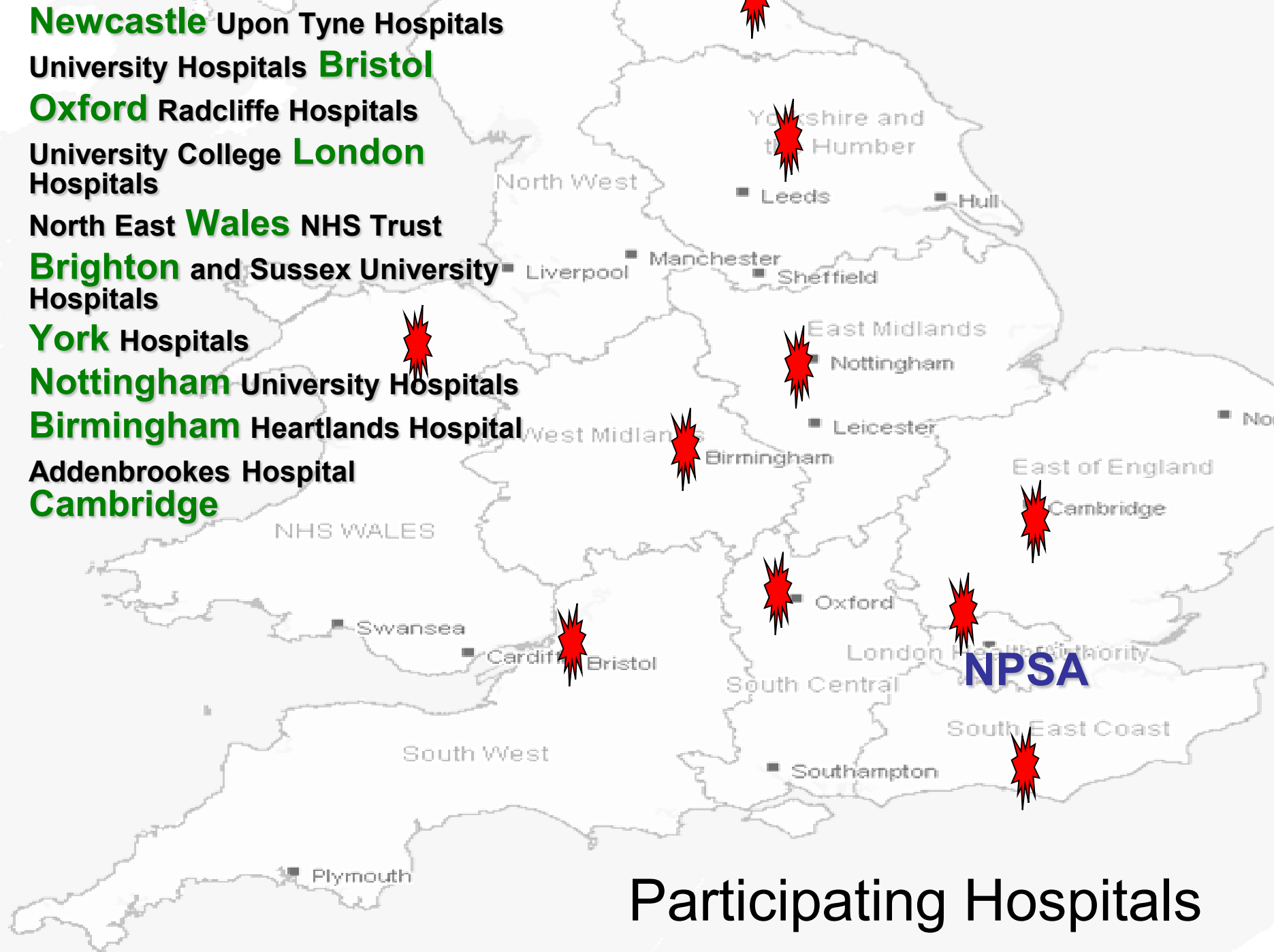
For information to:

Regional Directors of Health and Social Care
Chief Executives of Strategic Health Authorities
Directors of Public Health: Regional, StHA, PCT
Medical Directors
Directors of Nursing
Risk Managers
Lead Consultants/Clinical Directors – critical care areas
Communications Leads
Patient Advice and Liaison Service (PALS)



Date: 23 July 2002

- **Newcastle** Upon Tyne Hospitals
- University Hospitals **Bristol**
- **Oxford** Radcliffe Hospitals
- University College **London** Hospitals
- North East **Wales** NHS Trust
- **Brighton** and Sussex University Hospitals
- **York** Hospitals
- **Nottingham** University Hospitals
- **Birmingham** Heartlands Hospital
- Addenbrookes Hospital **Cambridge**



Participating Hospitals

Benefits to participating trusts

- National recognition as one of group of exemplar patient safety organisations
- Participation in international patient safety community of practice
- Participation in international safety culture evaluation for whole organisation (or part of if preferred) with analysis and report provided
- Improved patient care and patient safety through using systematic processes for implementation of best practice
- Support with implementation of existing NPSA national guidance
- Refresher RCA training if desired

Culture survey hypotheses

- A culture of safety facilitates the introduction of protocols (SOPs)
- The more mature the safety culture the greater ease of implementation of SOPs

Stated culture survey purpose

- To assess whether the culture of an institution impacts on the degree of success in implementing specific Standard Operating Protocols,

Not

- to assess the effect of the SOP on the safety culture.

- Together with other components of the evaluation plan, the results of the culture survey may help to explain variations in the successful implementation of Standard Operating Protocols.
- Results of the culture survey will permit specific examination of the relationship between a culture of safety (or lack thereof) and levels of success in implementation of standard operating protocols.

Manchester Patient Safety Framework (MaPSaF)

MaPSaF can be used;

- To facilitate reflection on patient safety culture
- To stimulate discussion about the strengths and weaknesses of the patient safety culture
- To reveal any differences in perception between staff groups
- To help understand how a more mature safety culture might look
- To help evaluate any specific intervention needed to change the patient safety culture
- It can be applied at organisational or team level
- But not individually

Issues

Changes to the survey from US to UK –

- Hospital specialties/departments/wards
- Role types
- Getting the survey done!

Paper or web?

- access to the web
- cost/numbers of paper

https://www.surveymonkey.com/s.aspx?sm=HX86dyYhO4CFxvsD4vqfVg_3d_3d

Paper surveys requested by hospital leads

- Bristol 10,000
- Cambridge 30
- Heart of England 8,000
- Nottingham 500
- Newcastle (20 online)
- York 500
- Wales 100
- UCLH 8,000
- Oxford 10,000
- Manchester ?
- Brighton and Sussex ?

= 37,130

Paper surveys received by Westat at 13th March 2010

• <u>Brighton & Sussex University Hospital NHS Trust</u> -	11
• <u>Cambridge University Hospitals NHS Foundation Trust</u> -	60 ?
• <u>Heart of England NHS Foundation Trust</u> -	101
• <u>North Wales NHS Trust (Central Area)</u> - <u>Nottingham University Hospitals NHS Trust</u> -	38
• <u>Oxford Radcliffe Hospitals NHS Trust</u> -	800 ?
• <u>The Newcastle upon Tyne Hospitals NHS Foundation Trust</u> -	0
• <u>University College London Hospitals NHS Foundation Trust</u> -	0
• <u>University Hospitals Bristol NHS Foundation Trust</u> -	0
• <u>York Hospitals NHS Foundation Trust</u> -	0
	=1330

Matching Michigan

- 80% of intensive care units (ICUs) in England are participating in Matching Michigan.
- This is a patient safety project based on a model developed in the United States which, over 18 months, saved around 1,500 patient lives.
- It took place at ICUs in Michigan and introduced measures that reduced central venous catheter (CVC) associated bloodstream infections.

A key component of Matching Michigan is SOPS

First reports

- Six Trusts (8 hospitals) have reports completed so far
- Three Trusts had >100 respondents
- Two Trusts had >300 respondents

Main areas of positive response

- Hospital management provides a work climate that promotes patient safety
- Actions of hospital management show patient safety is a top priority
- Staff are actively doing things to improve patient safety

Main areas of negative response

- Non punitive response to error
- Handoffs and transitions
- Staffing

Does large scale survey of patient safety culture provide indicators for success?

I'll come back to you in 5 years!

Thank you for listening.

Catherine.beaumont@npsa.nhs.uk