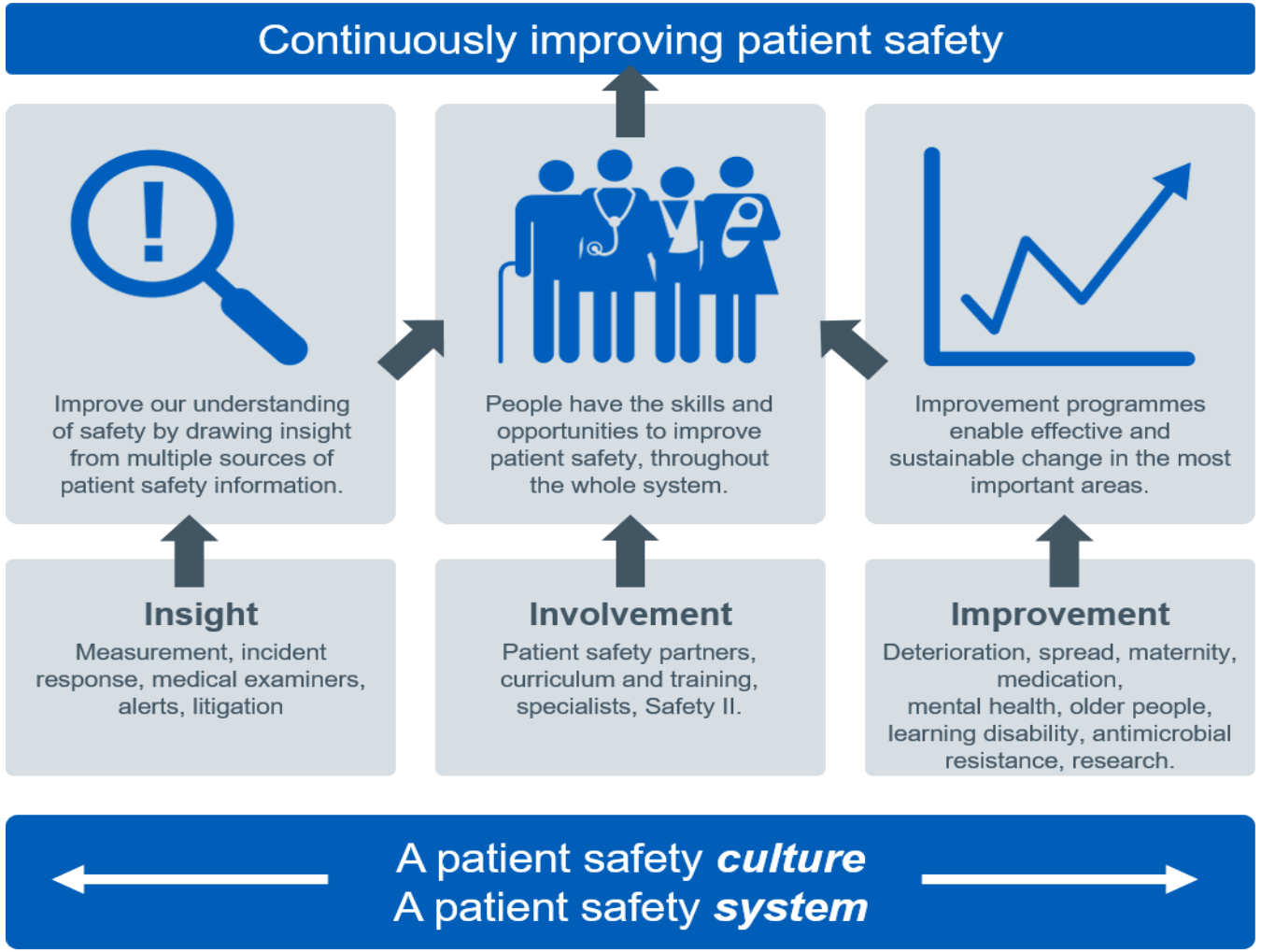
NHS England

Medicines Safety

The NHS Patient Safety Strategy



Patient Safety Strategy:
https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

Patient Safety Syllabus:
https://www.hee.nhs.uk/our-work/patient-safety

Level 1 and Level 2:

https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/

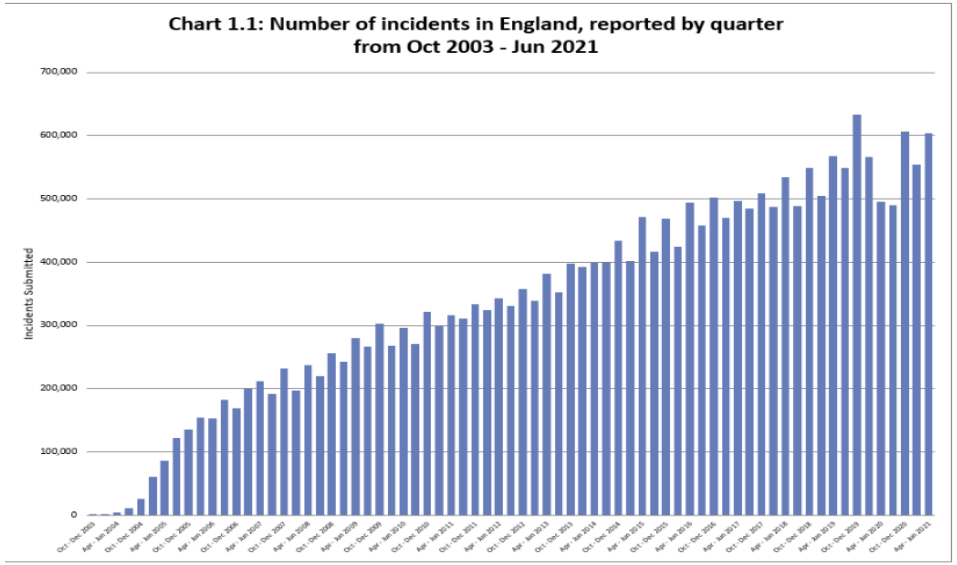
A Just Culture Guide:
https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

National Reporting & Learning

21 million
Incident reports on National Reporting & Learning System

Upgrading to
“learning from Patient Safety Events service”

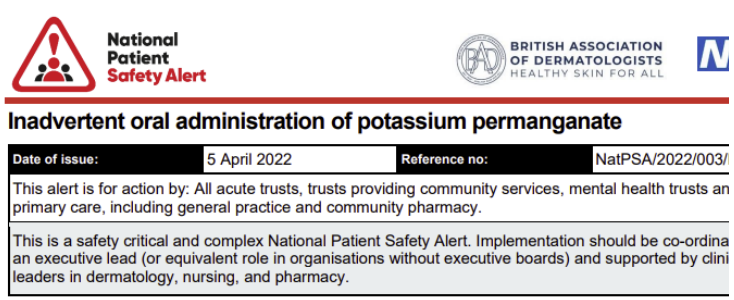
Data shared publicly & on request



NHS England » National patient safety incident reports up to June 2021

National Response to Medicines Safety Data

- Data drives improvements across the whole of England
- Data used to design national improvement programmes
- Review of data identifies new and under-recognised patient safety issues,
- This allows us to issues advice and guidance:
  - By working with partner organisations eg professional bodies/regulatory agencies https://www.england.nhs.uk/patient-safety/using-patient-safety-events-data-to-keep-patients-safe/how-we-acted-on-patient-safety-issues-you-recorded/clinical-specialty/
  - By issuing a National Patient Safety Alert containing mandatory actions https://www.england.nhs.uk/patient-safety/patient-safety-alerts/



National Patient Safety Alert

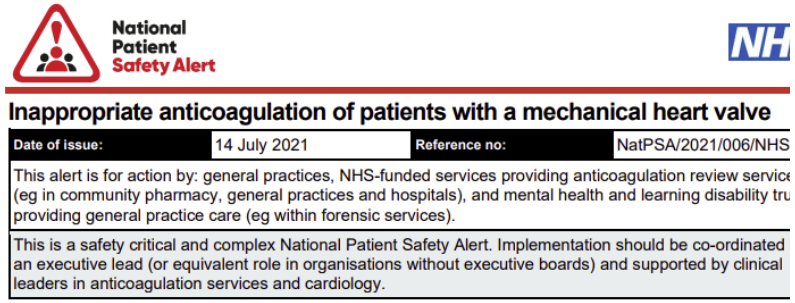
BRITISH ASSOCIATION OF DERMATOLOGISTS HEALTHY SKIN FOR ALL

Inadvertent oral administration of potassium permanganate

Date of issue:	5 April 2022	Reference no:	NatPSA/2022/003/

This alert is for action by: All acute trusts, trusts providing community services, mental health trusts an primary care, including general practice and community pharmacy.

This is a safety critical and complex National Patient Safety Alert. Implementation should be co-ordina an executive lead (or equivalent role in organisations without executive boards) and supported by clini leaders in dermatology, nursing, and pharmacy.



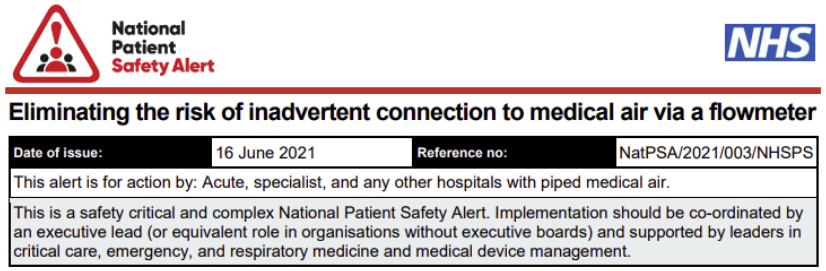
National Patient Safety Alert

Inappropriate anticoagulation of patients with a mechanical heart valve

Date of issue:	14 July 2021	Reference no:	NatPSA/2021/006/NHS

This alert is for action by: general practices, NHS-funded services providing anticoagulation review servic (eg in community pharmacy, general practices and hospitals), and mental health and learning disability tru providing general practice care (eg within forensic services).

This is a safety critical and complex National Patient Safety Alert. Implementation should be co-ordinated an executive lead (or equivalent role in organisations without executive boards) and supported by clinical leaders in anticoagulation services and cardiology.



National Patient Safety Alert

NHS

Eliminating the risk of inadvertent connection to medical air via a flowmeter

Date of issue:	16 June 2021	Reference no:	NatPSA/2021/003/NHSPS

This alert is for action by: Acute, specialist, and any other hospitals with piped medical air.

This is a safety critical and complex National Patient Safety Alert. Implementation should be co-ordinated by an executive lead (or equivalent role in organisations without executive boards) and supported by leaders in critical care, emergency, and respiratory medicine and medical device management.

National Improvement Programme

Reduce severe avoidable medication-related harm by 50% by 2024

- Optimise leadership in medicines safety
  - Empower the Medication Safety Officer workforce
  - Capitalise on Patient Safety Incident Response Framework
- Optimise Safer Systems
  - Optimise safety in transfers of care
  - Maintain the Enduring Standards from past alerts
  - Reduce harm from medicines used in care homes
- Safer use of high risk medicines
  - Reduce harm from opioids used in chronic pain
  - Perfect dosing of Direct Oral Anticoagulants
  - Reduce harm from valproate taken in pregnancy
  - Reduce traumatising rapid tranquilisation
  - Reduce gastrotoxic polypharmacy

Measuring Impact

303 lives saved

With fewer opioids used in chronic pain

16,920 readmissions avoided by Discharge Medicines Service

54% reductions in interruptions in Care Home medication rounds

Over 1000 fewer people at risk of overdose from Methotrexate

31% reduction in number of women of childbearing age prescribed valproate

48 fewer babies suffering cerebral palsy

31% reduction in prescribing of high dose opioids

90 fewer major bleeds from co-prescription of anticoagulants and anti-inflammatories

85% of Trusts implementing electronic medication software reducing errors by 30%

25% reduction in traumatising rapid tranquilisations

16,986 fewer patients at risk of gastric bleed

2 million visits a month to Medicines A-Z web-pages

Further Information

- For further information contact: patientsafety.enquiries@nhs.net
- Follow @PtSafetyNHS