

Patient Safety Update (24-11) – 26 November 2024

Patient safety update from the NHS National Patient Safety Team

This update pulls together key information that you or your clinical governance/patient safety leads might need to know but could otherwise miss. It is not intended for general circulation within your organisations.

| Key messages | Information for safety leaders |
|--|---|
| <p>Read the updated guidance for recording responses to patient safety incidents during the transition to LFPSE and PSIRF</p> | <p>StEIS will remain operational whilst providers transition to Version 6 of the LFPSE taxonomy which incorporates the PSIRF response fields. You can read the Updated Guidance: Recording responses to patient safety incidents during the transition to LFPSE and PSIRF here.</p> |
| <p>NHS England & CQC Joint statement on definitions and recording guidance</p> | <p>NHS England and the Care Quality Commission (CQC) recognise the need for clarity regarding the definitions of various levels of harm associated with patient safety incidents within both CQC regulations and NHS England's guidance on recording incidents. NHS England and the CQC have provided a Joint statement on definitions and recording guidance - NHS Patient Safety - FutureNHS Collaboration Platform.</p> |
| <p>Reminder to publish patient safety incident response plans</p> | <p>A requirement of the Patient Safety Incident Response Framework (PSIRF) is the production of an organisation patient safety incident response plan. Please could we remind everyone that patient safety incident response plans should be published on the organisations webpage so that they can be accessed easily by patients, families and the public.</p> |
| <p>Be aware of new NICE guideline on adrenal insufficiency: identification and management</p> | <p>Listen to the NICE talks podcast where a consultant endocrinologist, and an endocrine clinical nurse specialist, discuss the recently published NICE guidance and its benefits. The guidance covers identification and management including emergency treatment kits for adrenal crisis. Further practical resources can be found on the Society for Endocrinology website.</p> |
| <p>Utilising ePRaSE to optimise trust's prescribing systems to reduce harm and improve patient safety.</p> | <p>ePRaSE is an NHS England commissioned web-based tool intended to help NHS hospital sites assess and evaluate their electronic prescribing systems to support optimisation and reduce harm caused by adverse medication prescribing events and ultimately improving patient safety.</p> <p>The 2024 version of ePRaSE will be available until 21 December 2024 and all trusts are encouraged to sign up and test their electronic prescribing system. Your trust will receive an individual report on completion of the assessment that will allow optimisation of your system. In addition, anonymised user data is used to identify thematic learning and best practice across the NHS that can be shared with system suppliers and trusts to further drive optimisation and ultimately further improve patient safety. Full information can be found at https://eprase.info - to sign up visit eprase.nhs.uk.</p> |

| | |
|---|---|
| <p>Increase your understanding on the safe use of electronic patient records</p> | <p>The NHS England clinical safety team is holding a small number of master classes master class which are designed to deepen your understanding of critical patient safety practices, and the vital role of Electronic Patient Records (EPRs) in modern healthcare. The 1st master class will be on 5th December.</p> <p>The master class is relevant for clinicians, clinical safety officers and non-clinical professional and offers valuable insights into safety protocols that are shaping the future of healthcare. By focusing on the latest standards and technologies, individuals will learn how to better protect patients and improve the quality of care through secure and efficient record-keeping practices.</p> |
| <p>Read the latest HSSIB reports</p> | <p>Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings was published in October 2024. This investigation report is one of a series of HSSIB investigations focussed on mental health inpatient settings and focussed on the workforce and workplace conditions in acute mental health inpatient settings that deliver care to adults.</p> |
| <p>Get involved in the Red Tape Challenge</p> | <p>The 'Red Tape Challenge', was launched by the Secretary of State for Health and Care, Wes Streeting, and NHS England Chief Executive, Amanda Pritchard, in October.</p> <p>NHS England wants to hear from teams across the NHS about what's working well, what's working less well and what tangible actions could help improve bureaucracy and reduce unnecessary workload. Views can be shared by completing this short survey. Further feedback and examples of good practice can also be shared by emailing: england.redtapechallenge2024@nhs.net. The deadline for submitting views and ideas is 16 December 2024.</p> <p>Feedback will be used to implement immediate, operational improvements – with information around longer-term, transformational change fed into wider engagement as part of the 10 Year Health Plan.</p> |

In focus: Implementing Martha's Rule

Initial data is really encouraging, indicating already the impact of the [Martha's Rule programme](#), with national metrics collection now underway. Early feedback from pilot sites is indicating patient care has changed in response to patient and staff calls as part of the initiative. Data submissions for October and November achieved impressive participation rates of 95% and 93%, respectively, reflecting strong engagement across sites. Ongoing learning and improvement work is being supported by Patient Safety Collaboratives with pilot sites. To further assist with implementation efforts, we will be hosting two upcoming webinars.

Friday, 29 November 2024, 14:00 – 15:00

This session will feature work from the National Worry and Concern Improvement Collaborative, conducted in partnership with the NHS Race and Health Observatory. The webinar will focus on identifying and addressing ethnic inequalities in healthcare, particularly regarding how patients, families, and carers voice their worries and concerns about acute illness or deterioration. Findings and recommendations for improvement and practical change will be shared.

Wednesday, 4 December 2024, 10:00 – 12:00

This webinar will provide insights into how pilot sites are implementing Martha's Rule in paediatric settings across tertiary and District General Hospitals. Attendees will hear reflections on challenges, barriers, and best practices from experienced professionals.