Patient Safety Update – 25 January 2022

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
• View the updated SALG 'stop before you block' guidance	1. The Safe Anaesthesia Liaison Group (SALG) has recently updated the 'stop before you block' (SBYB) guidance. The revised and updated guidance follows a Healthcare Safety Investigations Branch report into wrong side regional anaesthetic block in 2018. The revised guidance deconstructs the SBYB process into three explicit steps: **Preparation**, a **Stop** moment followed immediately by performance of the **Block** (**Prep, Stop, Block**). The new process is designed as a standard operating policy for national adoption
• View our identified patient safety research needs	2. We have published our 'National Patient Safety Strategic Research Needs' for 2022/2023, which particularly relate to the priorities in the NHS Patient Safety Strategy. The research needs are organised into eight themes with specific examples of the research needed for each theme: • reducing inequalities in healthcare safety • improving patient safety intelligence and understanding challenges • improving organisational patient safety culture and practice • patient safety behaviours • effective patient safety practices • patient safety impacts of alternative service delivery models • ergonomics, design and human factors • clinical risk scores (validation, implementation and outcomes).
• Be aware of the new 2022/23 CQUIN measures, particularly around deterioration	3. NHS England and NHS Improvement has launched the 2022/23 Commissioning for Quality and Innovation (CQUIN) scheme which supports improvement in the quality of services and improves patterns of care. One of the CQUIN measures (CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions) is a step towards improving care processes for deteriorating patients. To find out more about this CQUIN and access helpful implementation resources, visit the FutureNHS: National Deterioration Forum.
• Read the HSIB reports on issues around COVID-19	4. Since the beginning of the COVID-19 pandemic the Healthcare Safety Investigation Branch (HSIB) has worked to conduct investigations to help healthcare staff combat the virus. The resulting reports, cover issues including COVID-19 transmission in hospitals, early warning scores to detect deterioration, oxygen issues, treating patients using CPAP, and PPE for care workers delivering homecare. They provide useful assistance in responding to all variants of the disease, including Omicron.

• Read the latest HSIB reports	5. HSIB has recently published two new investigation reports: • Incorrect patient details on handover: Local integrated investigation pilot 2, was published 20 January 2022, focusing on the systems and procedures that are in place to help staff correctly identify patients. • Recognition of the acutely ill infant was published 9 December 2021, focusing on understanding and describing circumstances in which the acutely ill infant is not recognised and/or acted upon.
• Read the SHOT safety alert on transfusion delays and access a new range of resources	6. Serious Hazards of Transfusion (SHOT) has issued a safety alert around transfusion delays. The urgent provision of blood components and/or blood products is vital for life threatening bleeding and severe anaemia. Deaths and serious harm related to delayed transfusion continue to be reported to SHOT with the numbers increasing each year. SHOT have also recently produced a number of resources to support blood transfusion safety which include: • A new summary of SHOT reports around cell salvage • a Human Factors - Serious Hazards of Transfusion web page where multiple resources and training can be found in relation to human factors in transfusion
Send any queries on this update to patientsafety.enquiries@nhs.net	

In focus: Patient Safety Incident Response Framework (PSIRF) update

We are nearing completion of our work with early adopters who have been piloting the introductory version of the PSIRF. This work is informing the final version of the framework, which we expect to publish in Spring 2022, at which point we will ask the wider NHS to begin the transition from the current Serious Incident Framework to PSIRF.

We expect this implementation to be a gradual process and do not expect organisations to be ready to fully implement PSIRF from its launch. Organisations should not feel pressure to start to create a PSIRF Plan at this stage. The current documents on our PSIRF web page and the Patient safety investigation resources page will be revised following the completion of our work with early adopters, but are still available for information only.

To support you to prepare for PSIRF we have recently created a PSIRF area in the NHS Patient Safety workspace on the FutureNHS platform. If you are not already a FutureNHS user, you can request access to the NHS Patient Safety workspace by emailing NHSps-manager@future.nhs.uk.

Recent additions include:

- The independent evaluation report providing an overview of the findings of our work with early adopters
- A podcast providing background on PSIRF, its key features and the changes it will introduce, an overview on our work with early adopters, and information on what providers can do to prepare for PSIRF (you can also listen to the podcast directly on SoundCloud)
- Slides from the roundtable events we held in Nov-Dec 2021 to provide a brief background to PSIRF, overview of the early adopter programme, and findings from the independent evaluation of the programme. The content is directly related to the discussion in the podcast.

We will continue to update you on progress as we get closer to publication and plan to produce a range of other resources to support providers with the implementation of PSIRF and transition from the Serious Incident Framework.