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NATIONAL REPORTING AND LEARNING IS CRUCIAL FOR BETTER PATIENT SAFETY

The National Patient Safety Agency will be rolling out the new National Reporting and Learning System for National Health Service-funded health care in England and Wales during the next year. In the first of four articles, Wendy Harris, senior pharmacist at the NPSA, reviews the evidence on reporting and reflects on the role pharmacists can play

The National Patient Safety Agency was set up following the publication of two reports on patient safety in the National Health Service: "An organisation with a memory" and its follow-up, "Building a safer NHS for patients". The reports highlighted research which suggested that around 10 per cent of patients admitted to United Kingdom acute hospitals experience some kind of incident that might threaten their safety, and that up to half of these could have been prevented. Findings in the United States, Australia, New Zealand and Denmark have suggested similar error rates. The reports noted, however, that in the UK as well as in many other countries, little systematic learning resulted from incidents or failures in health care.

The international evidence tells us that in complex health care systems things can, will and do go wrong. "An organisation with a memory" concluded that the best way of reducing error rates is to target the underlying systems failures, rather than to take action against individual members of staff, since most incidents result from weaknesses in systems and processes rather than the acts of individuals. This thinking reflects the work of Dr Lucian Leape from the Harvard School of Public Health, who has demonstrated that professionals will make errors in imperfect systems however hard they try not to, and that punishing people for their mistakes does not reduce error rates.

Both these conclusions have informed our development of the National Reporting and Learning System (NRLS). The new system — the first of its kind in the world — will co-ordinate the reporting of patient safety incidents nationally and, more importantly, improve the ability of the NHS to learn from an analysis of these incidents.

Of the 850,000 incidents that are likely to occur annually in hospitals in the UK, around one-quarter involve medication errors so it is vitally important that pharmacists working both in hospitals and the community are involved in patient safety incident monitoring and analysis. Although most of the research to date has focused on incidents in acute care, many of the underlying contributory factors relate to all health care settings.

LOCAL SCHEMES

The safe medication practice team at the NPSA has visited a number of organisations that are already doing good work locally. This includes an anonymous paper-based reporting system for prescribing and dispensing events called Sharing Actions Following Events Reporting (SAFER), which was set up by a community pharmacist in Gwent and receives about 30 reports a month from 130 pharmacies. At the Royal Liverpool and Broadgreen University Hospital Trust, the pharmacy department found significant continued on-ward preparation of potassium infusions using potassium chloride ampoules, despite all of the published risks. In the autumn of 2001, the hospital ordered the withdrawal of potassium ampoules from all clinical areas and issued a policy statement that promoted the safe intravenous administration of potassium to correct hypokalaemia. The NPSA has since issued an alert on this subject.

The NRLS has been designed to build on this local activity and the system has been developed to be compatible with all the major commercial local risk management systems used in most NHS organisations. This means that incident information that was previously only collected locally can be gathered to track national trends in a seamless way. The system depends on two main features for its operation:

- An NPSA dataset — a standard national framework used to gather patient safety incident information and ensure optimum learning
- An electronic reporting form transmitted via NHSnet, Health of Wales Information Service or the internet, for organisations without a commercial local risk management system, or for those staff who only wish to report independently of their organisation

The NPSA expects that hospital-based pharmacists will report through their local NHS system while independent community pharmacists will use the electronic reporting form. The national and regional multiple pharmacy groups that already report incidents internally are expected to link up with the NRLS via corporate systems in the head office. Whatever reporting method is used, the dataset has been developed by the NPSA to include specific and targeted questions on medication errors. Pharmacists will be asked whether the incident occurred at the prescription, preparation or administration stage, and if the problem involved, for example, the wrong patient, drug, dose or formulation and any details of associated issues such as labelling and packaging.

As part of its commitment to maintaining the anonymity of staff and patients, the NPSA will store all information from the NRLS anonymously and will not investigate individual incidents. The system will retain the names of NHS organisations that report directly however, and this will therefore apply to hospital-based pharmacists reporting through their local NHS system. This will enable the NPSA to offer those organisations feedback on particular developments in reported incident rates.

ANALYSIS OF TRENDS

The analysis of NRLS data will focus on the key themes and trends that emerge, such as certain drugs, processes and procedures that occur more frequently than others and how they shed light on systemic failures in patient care. The information will then be fed back to the NPSA safe medication practice team, who will identify cross-cutting issues and inform the development and prioritisation of practical national solutions.

The NPSA is still evaluating possible reporting routes for community pharmacists and the exact procedures to be followed. It is currently examining the options in a working group involving representatives from all the pharmacy groups and organisations, as well as IT suppliers to community pharmacies. The final decision will be dependent on both the new pharmacy contract and on developments in IT in the community setting. The NPSA is pleased to have been involved in the discussions between the Pharmaceutical Services Negotiating Committee, the Department of Health, and the NHS Confederation, which firmly established patient safety incident reporting as part of the wider clinical governance agenda.

In their role of verifying patient prescriptions and reviewing doctors' instructions to patients, pharmacists have always been the traditional guardians of patient safety in the field of medication. The NRLS must harness pharmacists' expertise and gather the high quality data they can provide to track incidents and developments in medication error successfully.

Pharmacists, therefore, have a vital role to play in both reporting the incidents that require the attention of the NPSA, and in helping it to work on solutions. The NRLS data will help to inform the direction and focus of future research in patient safety, and the NPSA remains committed to involving the pharmacy profession in the issues it targets and the solutions it develops.