

Memorandum by MRSA Action UK (PS 29)

PATIENT SAFETY

EXECUTIVE SUMMARY

1. The Charity MRSA Action UK's purpose is to relieve the distress and suffering experienced by patients who contract healthcare infections. By producing materials, to serve as an aid, our aim is to provide an advocacy and support service to families and their carers. We aim to raise the awareness of the general public in all areas relating to healthcare infections. We work alongside patient groups, regulators and government agencies to bring improvements and safer standards in the healthcare system. Patients, their families and representatives, healthcare workers and other professionals contact us on a daily basis requesting advice and seeking help.

2. We have responded on the role of human error and used our experience from dealing with patients, regulators and healthcare professionals, which demonstrate how leadership, communication and working collaboratively can help to mitigate risks.

3. We believe there needs to be much more attention paid to training in clinical practices, such as aseptic technique. Guidance and training on antibiotic prescribing and looking across the whole patient journey feature in the submission. We also believe that the under-reporting on death certificates of pathogens needs addressing, Trusts should have policies based on ONS guidelines on death certification that are subject to audit. Surgical Site infections should also be published on a quarterly basis with MRSA bacteraemias.

4. The real toll to healthcare infections and on patient safety needs to be in the public domain, this we feel will be an incentive to improve and save lives.

What the risks to patient safety are and to what extent they are avoidable?

The Role of Human Error

5. In every walk of life, there is always a chance of error. As Humans we possess an innate tendency to be imprecise—"to err is human." Human nature comprises all mental, emotional, social, physical, and biological characteristics that can define human tendencies, capabilities, and limitations. For instance, humans tend to perform very poorly under high stress and time pressure. Due to human variability, the most reliable any human being can possibly be is on the order of 99.99+ percent. Therefore error is always a factor to be reckoned with in any human activity.

6. Due to inherent fallibility, human beings are very vulnerable to external working conditions that may test their limitations, such as lighting, heat, equipment, coworkers, and procedures. Our vulnerability to such conditions increases our chances to err. This is especially true when people work within complex environments (such as hospitals or any medical facility) that contain hidden flaws and weaknesses—latent conditions that can either provoke error or weaken defenses against the consequences of error.

7. The role of human error happens at the point where medical staff touches hospital equipment—that is the place where either the physical or paper environment can be changed. The physical environment comprises of systems, buildings, wards, theatres, and other such components that function to treat or care for patients. The paper environment however consists of the design bases and other documentation used to maintain control of the physical environment's configuration. Inaccuracies in the paper environment, such as incorrect design calculations and inaccurate procedures, can lie dormant and lead to undesirable outcomes in the physical environment or even personal injury when events do not function as anticipated.

8. Not all decision-making, problem-solving, and manual actions are the result of conscious, intentional thoughts. A significant portion of mental activity occurs unconsciously. These common traps of human nature provide more reasons to be uneasy.

The Common Traps for Human Error

9. Due to the fact that consequential errors rarely occur, people tend to overestimate their ability to maintain control while they work. There is in a sense a general lack of appreciation of the limits of human capabilities. Whenever/wherever the limits of human capabilities are challenged, the likelihood of error increases. The following characteristics of the role of human error, among others, are commonly encountered whenever performing tasks in a complex work environment.

10. Stress—Effective strategies for reducing the effects of stress and improving performance include good health, skills training, procedure adherence, and teamwork.

11. Mental Strain Avoidance—Humans are naturally reluctant to engage in concentrated thinking, as it requires high levels of attention for extended periods. Thinking is a slow, laborious process that requires concerted effort. Consequently, people tend to look for familiar patterns and apply well-trying solutions to a problem. They are tempted to settle for satisfactory rather than the best solutions. Mental biases, or shortcuts, used to reduce mental effort include the following:

- assumptions—a condition taken for granted or accepted as true without verification of the facts
- habit—an unconscious pattern of behavior acquired through frequent repetition
- confirmation bias—the reluctance to abandon a current solution—to change one's mind—in light of conflicting information due to the investment of time and effort in the current solution; this bias orients the mind to "see" evidence that supports the original supposition and to ignore or rationalize away conflicting data.
- similarity bias—the tendency to recall solutions from situations that appear similar to those that have proved useful from past experience
- frequency bias—a gamble that a frequently used solution will work; giving greater weight to information that occurs more frequently or is more recent
- availability bias—the tendency to settle on solutions or courses of action that readily come to mind and appear satisfactory; more weight is placed on information that is available (even though it could be wrong). This is related to a tendency to assign a cause-effect relationship between two events because they occur almost at the same time.

Systems Failures—A Strategic Approach

12. For there to be a successful strategic approach we need to see that there is consistency throughout the whole of an organisation. This approach has to be coordinated in that there are

some 400 Trusts within the National Health Service and at the present moment this is far too fragmented for any successful strategic approach to have any reasonable chance of success. Patient care and safety have to be of the highest quality, and the safety of the patient has to take priority over all other considerations such as targets set by central Government.

13. Strategically, there should be four cornerstone programs, those being, evaluation, assistance, training, and operating experience. These would help reduce the frequency and severity of adverse events. The Anatomy of an Event model, which describes the origin and development of an event triggered by human error, illustrates two strategic focal points to reduce the frequency and severity of human performance events: initiating actions at the point of action and latent organisational weaknesses. Industrial sources at various highly successful companies support the logic of this approach. Therefore, a coherent human performance management strategy should address two primary challenges:

- Reduce the frequency of events by anticipating, preventing, and catching active errors at the event site.
- Minimize the severity of events by identifying and eliminating latent weaknesses that hinder the effectiveness of defenses against active errors and their consequences.

14. Eliminating the role of human error is more likely if front-line staff, support staff, and managers embrace the following underlying truths, or principles, that provided. Integrating these principles into management and leadership practices, staff practices, and the organisation's processes and values will help guide the development of a philosophy and strategy for eliminating human error, as well as providing guidance for the planning and conduct of work in the hospital.

- People are fallible, and even the best people make mistakes.
- Error-likely situations are predictable, manageable, and preventable.
- Individual behavior is influenced by organisational processes and values.
- People achieve high levels of performance largely because of the encouragement and reinforcement received from leaders, peers, and subordinates
- Events can be avoided through an understanding of the reasons mistakes occur and application of the lessons learned from past events (or errors).

How far the Boards of NHS bodies have established a safety culture?

15. In terms of healthcare infections there are significant regional disparities in achieving reductions in MRSA and Clostridium difficile. The perception from attending events and visiting Trusts it would appear that not all have a commitment from Board to Ward. Some staff have actually made the comment that it is still difficult to get full commitment from the top.

16. There is not a joined up approach to looking at the whole patient journey when it comes to healthcare infections. There needs to be a recognition that a resistant pathogen will go from one healthcare setting to another after a patient is discharged, and of course back to the Acute setting if the patient needs more treatment. There needs to be more of a focus on screening high risk patients, for example those who may be receiving care from Oncology post-discharge.

17. Patients being discharged to care homes may be at risk from pressure sores, therefore working with tissue viability nurses to help avoid infection is important.

18. Staff in some care homes when asking us for advice state they are worried about looking after patients who have MRSA. From the information they ask it is clear they have had little or no training on infection prevention and control.

ROLES OF THE NATIONAL PATIENT SAFETY AGENCY AND THE HEALTHCARE COMMISSION

Systems for incident reporting, risk management and safety improvement

19. We would like to see more collaboration between healthcare regulators and the National Patient Safety Agency. As part of our role on the Healthcare Commission Expert Reference Group for assessing arrangements for checking Trusts arrangements for the implementation of the Hygiene Code, there appeared to be a lack of clarity on how the two organisations can complement each others work.

20. There does appear to be some joint working emanating from the Healthcare Commission inspections of the Acute Trusts, they may for example bring to the attention of the NPSA findings relating to benchtop sterilisers, but have not been proactive in following this up to see what the NPSA will do with the information—the NPSA could for example issue medical alerts.

21. The information reported by staff and patients to the NPSA National Reporting and Learning System (NRLS) is confidential, however if there were extreme cause for concern we would like to see some form of early warning system giving to regulatory bodies such as the new Care Quality Commission.

22. For example the reporting system was still in its infancy when the Healthcare Commission investigated two outbreaks of *Clostridium difficile* in Stoke Mandeville Hospital in 2004-05 with fewer than 50 Trusts using the reporting system, so it may be difficult to draw any conclusions from reports of incidents at that time, but may merit further investigation.

23. However in the winter of 2005-06 Maidstone & Tunbridge Wells NHS Trust, and prior to this in 2004, there were significant and now well known outbreaks, and this NHS Trust was not unique in having high incidence of *Clostridium difficile*. Similarly a review of arrangements was carried out at University Hospitals of Leicester NHS Trust regarding the high number of cases of *Clostridium difficile* in 2005 and 2006.

24. In the April to March 2006 report from the NPSA NRLS there were 6,129 incidents relating to infection control in Acute / general hospitals in England. If there were a correlation with high numbers of incidents would the NPSA flag this up to the regulator, these incidents if controlled are largely avoidable and such an early warning system has the potential to save lives.

25. Patients can now also report incidents. Whilst we recognise the NRLS is a tool for learning and improving, patients and staff may feel that lessons will not be learned if incidents are not reviewed. We welcome this reporting system but we feel that investigation and root cause analysis are essential in helping to understand how lessons can be learned.

26. We actively encourage the use of this system, indeed there is a link to reporting system on MRSA Action UK's website.

27. The Joint Commission in the USA offer a Patient Safety reporting mechanism. It may be done anonymously, but contact details are needed so that complaints can be investigated and a response supplied. It may be necessary to share the complaint with the organisation in the course

of a complaint investigation. The Joint Commission policy forbids accredited organisations from taking retaliatory actions against employees for having reported quality of care concerns to The Joint Commission. We believe the NPSA should operate in the same way.

28. We note that the NRLS is now more widely used, the numbers of reported incidents relating to infection control total 12,271 for England for 2007-08, which is 2% of all reported incidents. We would hope to see some use of this information with the new regulator to flag up significant concerns and make recommendations for improvement.

29. The latest Patients Association report following a survey of patients, describes the NHS complaints system as "cumbersome, variable and takes too long." Of the patients polled, 69% said they had wanted to complain about the healthcare they had received in the last five years. For those who complained, 29% described the process as "totally pointless" and only 2% said the experience had been "very useful".—Source Press Association 21st September.

30. We also have similar experiences in opinion from our own work with patients who have had cause to use the NHS Complaints procedure.

Involving patients and learning from complaints:

31. There are common themes in the requests for information and assistance with complaints which we receive from patients and their carers:

- Insufficient information for the patient/carer to play an active role in mitigating the risk of contracting an infection
- When a patient contracts an infection, insufficient information offered on the implications and how to treat and control the infection
- Information not passed on through the patient journey from the Acute setting to the Primary Care setting
- Inadequate response to comments or complaints missing opportunities to heed lessons learned
- Failure to adhere to policies and procedures designed to mitigate risks
- Sloppy clinical techniques when inserting IV lines, cannulae and catheters

Education for health professionals

32. We believe there needs to be ongoing education for health professionals in clinical practice. Patients regularly report that attention is not paid to pristine hygiene practices when dealing with IV lines, drips, cannulae and catheters. This occurs in the Acute and Primary Care setting. We are beginning to see numbers of patients who report incidents at GP surgeries in relation to "sloppy" hand hygiene and aseptic technique. The public are becoming more aware of infection prevention, however few feel they can confidently ask a health professional to wash their hands or ask that clinical procedures are carried out effectively.

33. The Royal Colleges have a role to play not only in accrediting competency but we believe in helping to carry out audits of competency within the healthcare setting. Observation of clinical techniques should be carried out on a regular basis, this can be done by peers in the healthcare setting, however regular trained external observers will always see something that a peer may miss. The Improvement Teams who are working on the Cleaner Hospitals programme have identified the need for external review.

34. Training in antibiotic prescribing would be beneficial, there is still a tendency to prescribe broad-spectrum antibiotics before making a diagnosis of a patient's condition, elderly patients are at particular risk from *Clostridium difficile* when using broad-spectrum antibiotics.

What should be measured and assessed; and what data should be published?

35. We know that the true picture regarding MRSA is not published. Trusts are saying they have no MRSA when in fact, they have recorded no MRSA bacteraemias. The Health Protection Agency collect data on surgical site infections and we believe this data set should also be published as part of the quarterly reporting. This helps patients make informed choices about where they are most likely to go for treatment.

36. We believe that death certification needs to include the pathogens MRSA or *Clostridium difficile* where these are the cause or contributory factor to a patient's death. Patients have experienced the non-recording of this as a cause, and they know from reviewing case notes that these pathogens were a contributory factor. Evidence from the National Confidential Study following MRSA Infection published by the Health Protection Agency in 2007, demonstrated that more than half the case notes reviewed should have had either sepsis or MRSA listed as a contributory factor, and that all of the clinicians interviewed had said they were unaware of the Trusts policy on the recording of MRSA.

Derek Butler, Chair

MRSA Action UK

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