‘Passionate about patient safety’

Delhi – November 2019

Professor Sir Terence Stephenson

BSc (1st class Hons), BM, BCh, DM, FRCP, FRCPCH, SFFMLM,

Hon FRACP, Hon FRCPI, Hon FHKAP, Hon FRCS, Hon FRCGP, Hon FRCA, Hon FCAI, Hon FRCS Ed, Hon FRCOG, Hon FRCP Edin, Hon FAcadMEd

Nuffield Professor, Institute of Child Health, University College London

Consultant Paediatrician UCLH & Great Ormond Street Hospital, London

Chair of the Health Research Authority for England 2019-22

Former Chair of UK GMC 2015-18

Past-President UK Royal College of Paediatrics & Child Health 2009-12

Why is this talk so relevant to India today?

- The Indian government has moved towards proprietary standards for identification and traceability
- The need for globally harmonised standards is crucial as healthcare becomes a global industry and the world becomes a global village
- I will give some positive experiences when using them to improve patient safety
- Identification of pharmaceuticals also helps counter fraud
- GS1 standards are one leading example of globally harmonised standards

Mail Online

Bungling doctors drilled into the wrong side of a patient's HEAD as list reveals shocking mistakes cost NHS£10million in compensation every year

- One patient had her fallopian tube removed instead of her appendix
- In another medical mishap, a surgeon cut into the wrong testicle of patient
- Such incidents are described as 'never events' and cost the NHS millions
- The NHS defines these as 'wholly preventable' but harmful incidents
- According to latest figures, 345 never events have been reported this year

By SHARI MILLER FOR MAILONLINE
PUBLISHED: 16:07, 20 November 2016 | **UPDATED:** 16:16, 20 November 2016

Medical blunders: 345 so-called 'never events' have been reported to the NHS so far in 2016

A Freedom of Information Act disclosure from health watchdog NHS Improvement, also found that of the cases reported this year, 137 related to doctors operating on the wrong part of the body.

Another 83 relate to an item left by accident inside a patient.

Is the NHS safe?

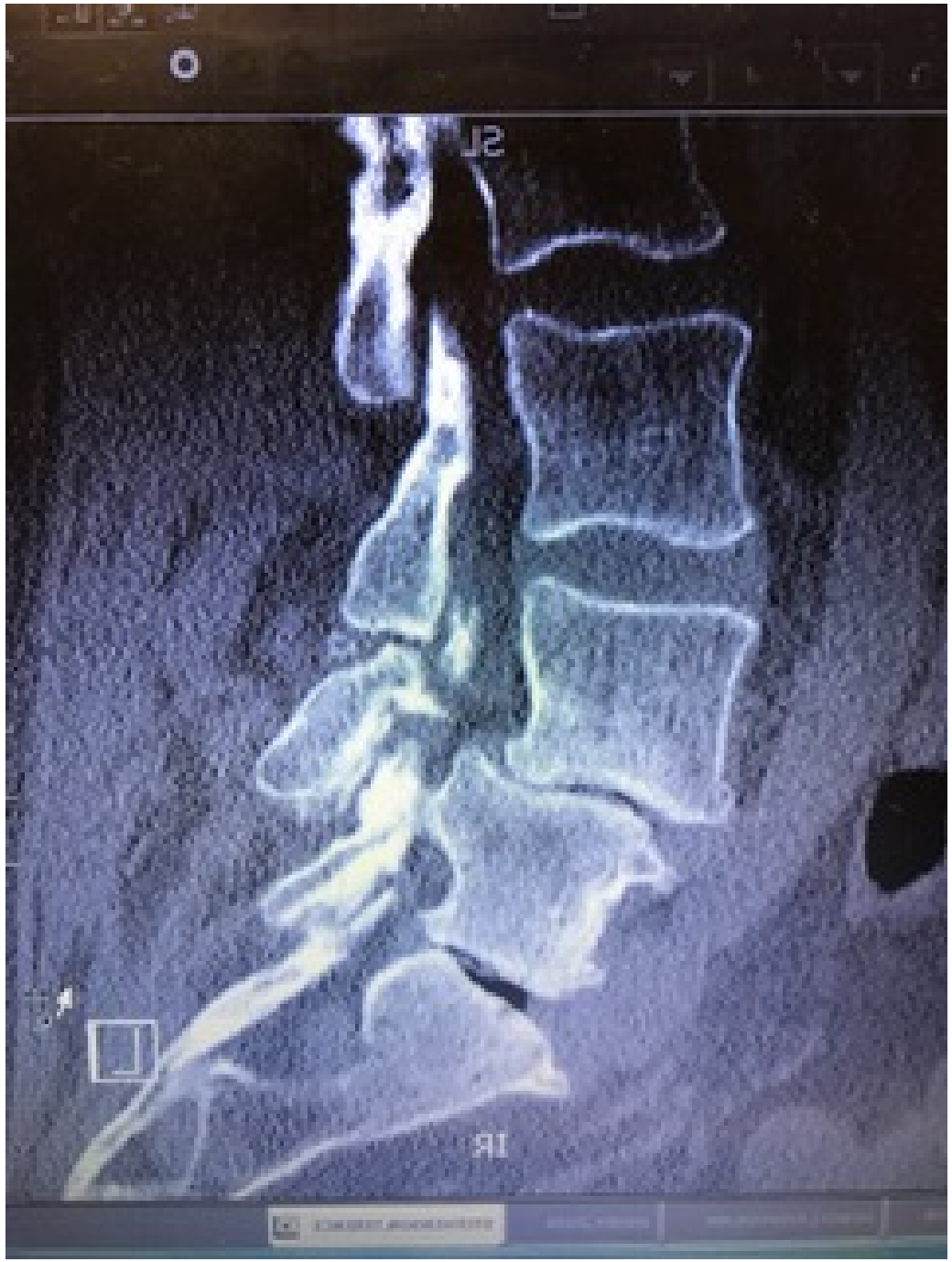
- **Of the top 20 risk factors for all deaths, adverse in-hospital healthcare events come eleventh – above alcohol, drugs, violence and road traffic accidents.**

- **In the NHS each year there are: 624 million prescriptions, 300 million GP visits, 13 million OPD visits, 5.3 million admissions, 2.9 million emergency ambulance calls, and an estimated 900,000 adverse events.**

- **Every week – two wrong site surgeries and two operations with kit wrongly left inside. NEVER EVENTS 2016/17= 400**

- **wrong site/retained foreign body/wrong implant = 79%; Medication error causing harm = 12%**

- **Adverse events (unintended injury caused by medical management rather than disease) lead to an additional three million NHS bed days. Costing at least £1 billion a year.**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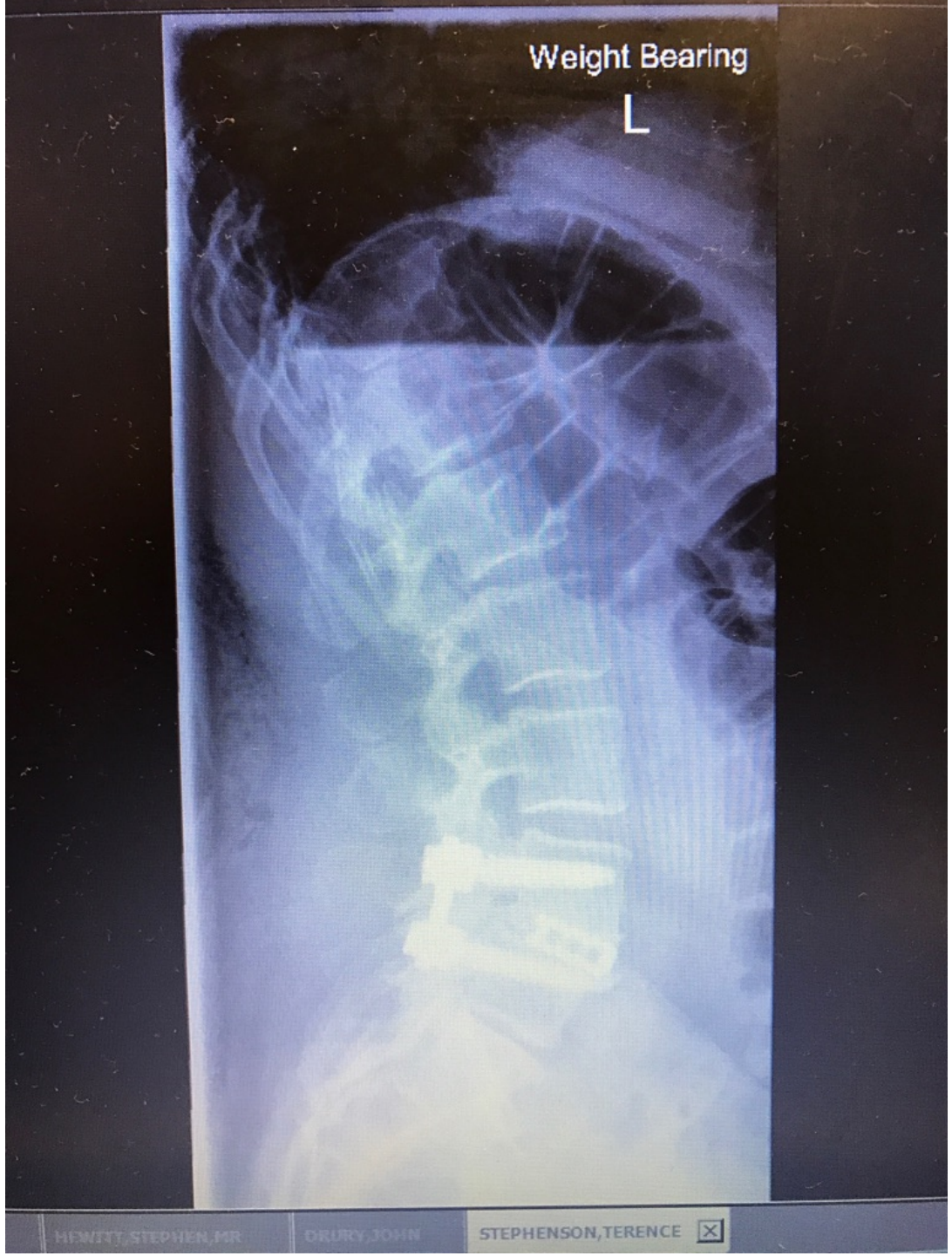
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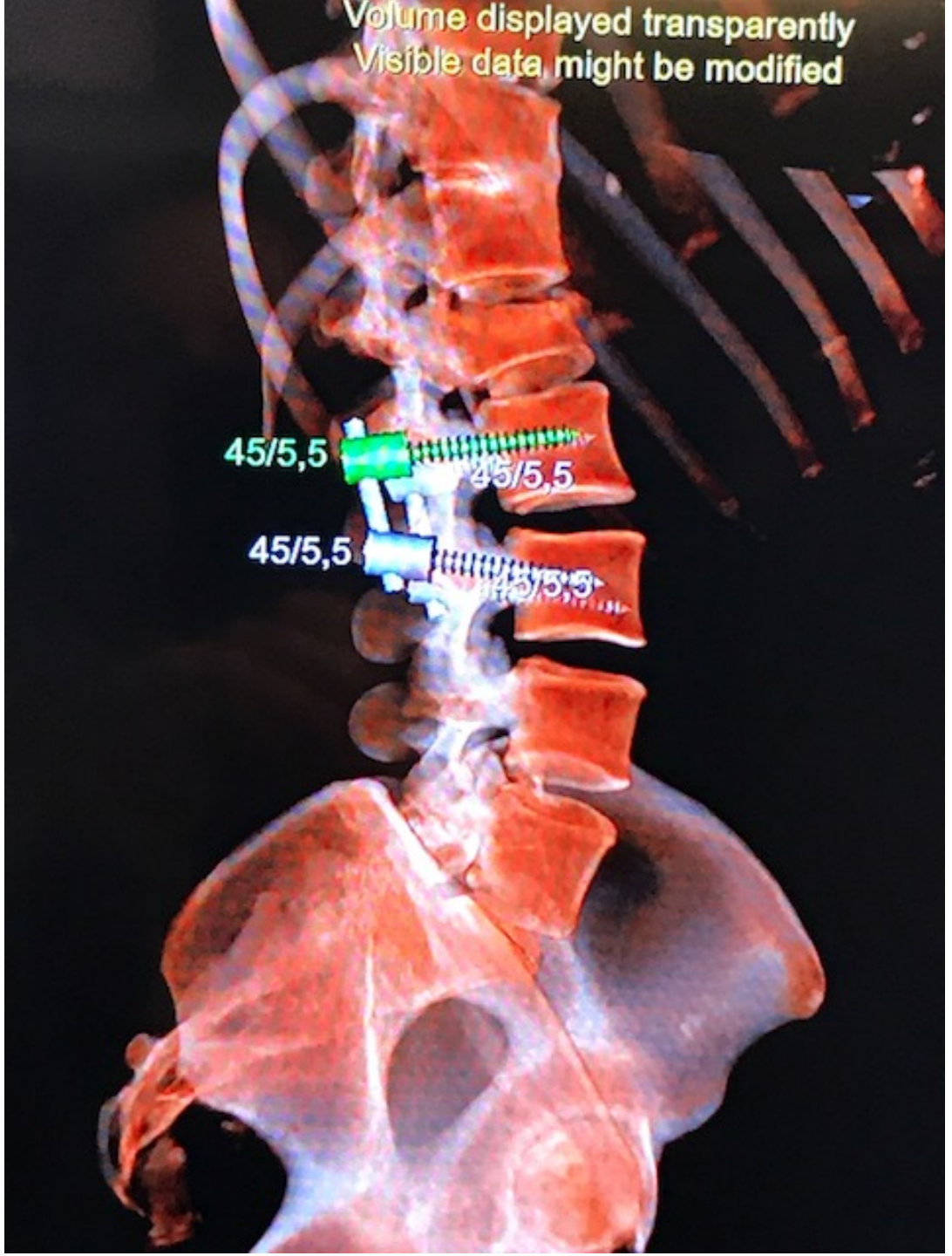
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STARBUCKS
COFFEE
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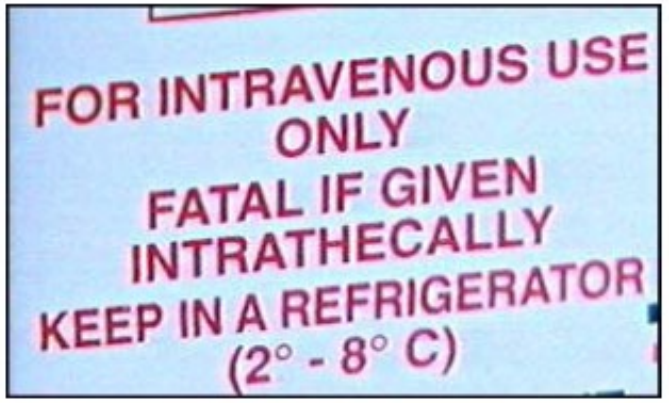
RB TAXIS


Wet hands with water
Apply enough soap to cover all hand surfaces
Rub hands palm to palm
right palm over left dorsum with interlaced fingers and vice versa
palm to palm with fingers interlaced
backs of fingers to opposing palms with fingers interlocked
rotational rubbing of left thumb clasped in right palm and vice versa
rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa
Rinse hands with water
dry thoroughly with a single use towel
use towel to turn off faucet
...and your hands are safe.

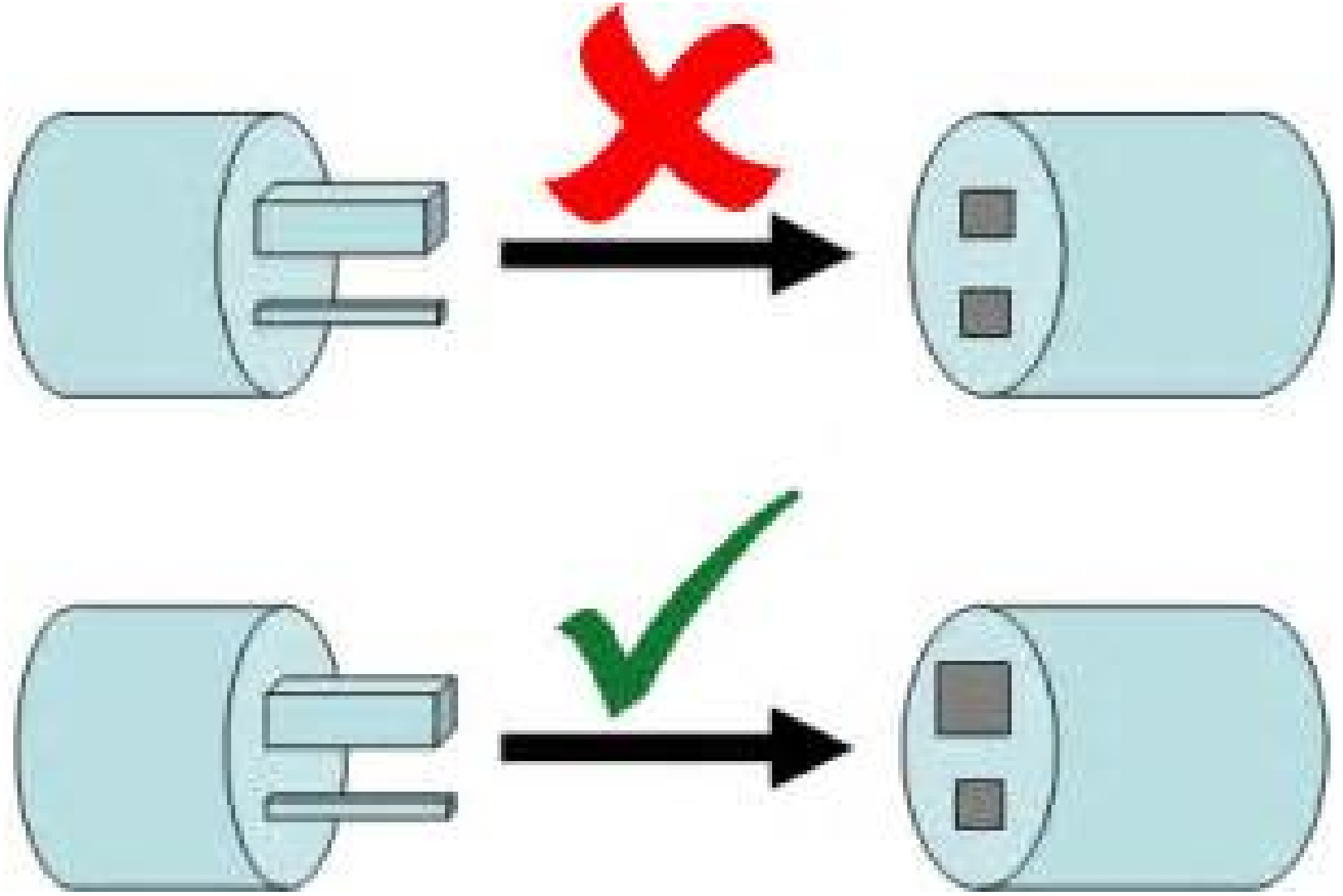
Death of Wayne Jowett (2000)



- Leukaemia patient in remission
- Queens Medical Centre Nottingham
- Cytotoxic IV vincristine given IT
- Immediate efforts to flush out drug
- Paralysis and respiratory failure
- Died 1 month later

Wayne Jowett died following an inadvertent intrathecal vincristine injection, the 23rd such incident reported worldwide (and the 14th in 15 years in the United Kingdom)

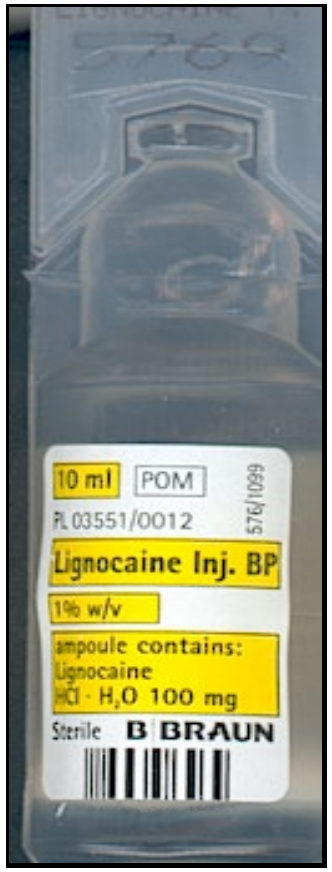
POKA-YOKE OR MISTAKE PROOFING



Advisor to the National Patient Safety Agency, 2003-2006:


2. 11. 2000

Problems with identification of intravenous infusions



Engineered solution

Our solution: WireSafe

All the equipment needed to complete the procedure is locked in the box

The guidewire acts as a ‘key’ to open the box

PROCEDURE CAN NOT BE COMPLETED UNLESS GUIDEWIRE HAS BEEN REMOVED

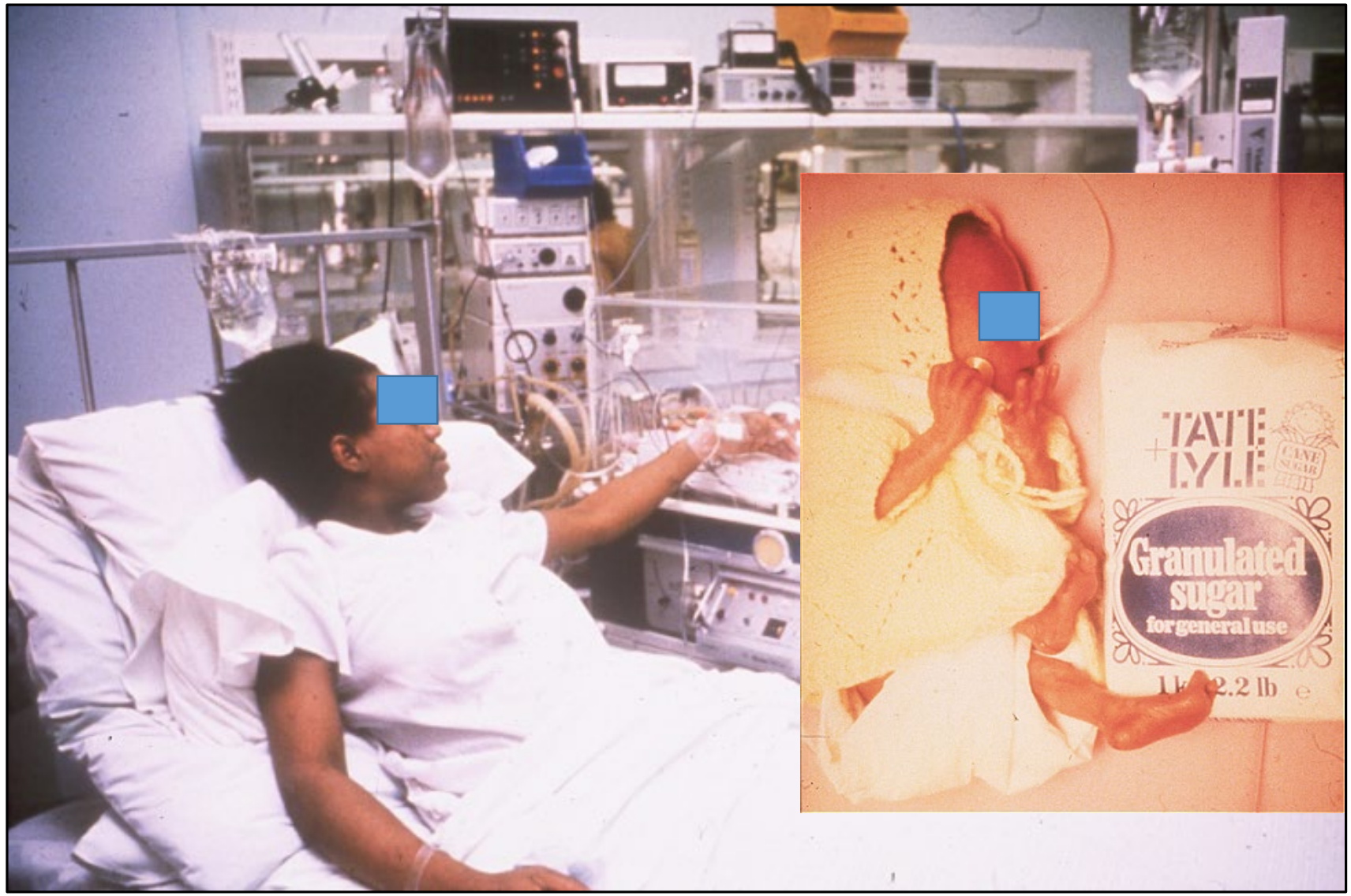
Accidental injection into the arterial line

ur solution: A one way valve
- Allows blood sampling
- Stops injection

events patient harm

otects staff making the mistake

ed on any arterial giving set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LYLE
CANE SUGAR
Granulated
sugar
for general use

BMJ

VIEWS & REVIEWS

PERSONAL VIEW

To boldly go from "computer says no" to an iNHS

It's IT, Jim, but not as we know it, says **Terence Stephenson**, with some suggestions for improvements

Terence Stephenson *professor and chair, Academy of Medical Royal Colleges, London EC1V 0DB, UK*

Captain's log. Stardate May 2013

0830-0930: Consultant led handover as per Francis.[1] The cases are projected by the trainee, Dr McCoy, on to the

1030: The nurse gives the antibiotics intravenously as prescribed but, through an easily avoidable decimal point error, the dose is only a tenth of the therapeutic dose and so is inadequate against the patient's septicaemia. Unfortunately,

Computerised prescribing with computerised decision support can decrease serious medication errors by 55% - 64%

PERSONAL VIEW

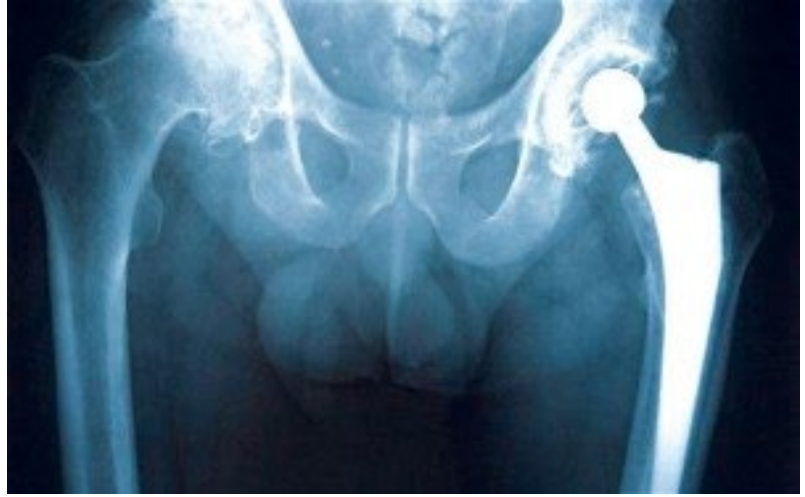
To boldly go from "computer says no" to an iNHS

It's IT, Jim, but not as we know it, reports **Terence Stephenson**

Captain's log. Stardate May 2013
0830-0930: Consultant led handover as per Francis.[1] The cases are projected by the trainee, Dr McCoy, on to the screen of the NHS Enterprise. Mr Chekov says, "Let's just take a quick look at the chest x ray." Bones has to come out of the current program, decline several on-screen queries, open a new program, and re-enter his username and password—only to be told that the x ray software won't open unless he begins again and closes the word processing program. Three minutes have elapsed, and we have 60 minutes to discuss 20 cases. We give up, noting the excellent radiologist's report but missing a valuable teaching opportunity. Thank goodness we didn't have to access anything as complicated as the tricorder or switch the phasers to stun.
0930: Consultant led ward round[2] starts on ward A. The first patient has sickle cell disease and a fever and has been seen by another NHS hospital more than a year ago.
0945: The general practitioner and St

Thank goodness we didn't have to access anything as complicated as the tricorder or switch the phasers to stun

Safety—General practices have been using e-prescribing and e-records for 30 years. Why are systems which avoid errors of calculation, drug interactions, and illegible prescribing not routine in hospitals? Drug errors are a common cause of negligence claims; as many as a quarter of all settled negligence claims are because of drug prescribing errors.[3]
"Outside-in" design—We need an end to 10 minute computer start-ups, clunking through multiple screens, and multiple passwords that have to be changed often. We need user friendly interfaces, designed with jobbing doctors in mind. Endless functionality that is rarely required is the enemy of rapid, intuitive use. Sometimes there seems to be no one who can find the zoom button on the x ray viewing software, but everyone can find it on Google Maps.
Efficient—There is a problem in paging someone, but, because you have been paged in the meantime, the phone is engaged when the person you've paged calls back.



Expert Clinical Advice – MHRA Medical Devices

Report of the independent review on MHRA access to clinical advice and engagement with the clinical community in relation to medical devices.

Professor Terence Stephenson

Barcoding allows tracking of:

- ❑ **Patient**
- ❑ **Product (UDI)**
- ❑ **Place**


Source of calcium
Vegetarian
Bottle & Cap


© Alamy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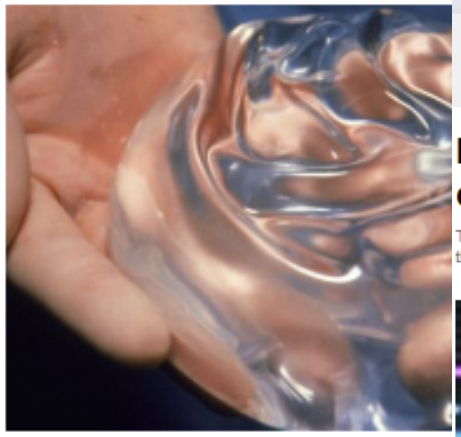
Health

Breast implants and other medical items get safety barcodes

29 December 2016 | Health



Barcodes are being printed on breast implants an
patient safety reasons.

The Department of Health initiative is to avoid future s
implant scare of 2010.

Problems arose tracing nearly 50,000 British women
faulty silicone implants.

The new system is intended to record every medicine and implant given to patients by scanning the product packet and the patient's identity wristband.

Health Secretary Jeremy Hunt said: "This can actually save lives for the NHS."

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NHS trials barcode system to reduce mistakes during treatments

The Health Secretary hopes the technology could one day help reduce the 150 avoidable deaths that happen every week in the NHS.

The barcodes would be attached to everything - including equipment, doctors and patients

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Barcoding breast implants and hip replacements 'could save NHS £1bn'

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Breast implants are being given barcodes by the NHS in an attempt to 'revolutionise' patient safety by being able to track them in case they are faulty

- The Department of Health will give every surgical item a barcode to track it
- Products are scanned alongside a patient's wristband to match them together
- It is hoped the £12 million system will help to prevent any possible human errors
- Early results from 6 pilot NHS hospitals suggest it has the potential to save lives
- And it may also help the health service save up to £1 billion over the next 7 years

BRITISH AIRWAYS
BOARDING PASS

Seq. No. 022
e-ticket - no coupon

FAST TRACK

PROF TERENCE STEPHENSON you're ready to fly

Flight	From	To	Group	S
BA1442	HEATHROW (LONDON) Terminal 5	EDINBURGH	2	

's Fund

WHEN
3 Dec 2019 at 18:30

Reducing the % – worthwhile?

If 99.9% were good enough…

- Major plane crash every 3 days
- 12 babies given to wrong parents every day
- 37,000 ATM errors every hour

Institute for Healthcare Improvement
(data relate to US population)

FINISHED FILES ARE THE RESULT OF YEARS OF SCIENTIFIC STUDY COMBINED WITH THE EXPERIENCE OF MANY YEARS

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NHS blunders cause eight deaths a day: Jeremy Hunt to speak on 'silent scandal'

- **In 2011/12, there were 326 so-called 'never events' – events so unacceptable they should never happen**
- **NHS should 'publish better safety information, such as the likelihood of emerging unscathed from each hospital across the country'**

By JAMES CHAPMAN

PUBLISHED: 01:22, 21 June 2013 | **UPDATED:** 14:29, 21 June 2013

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Eight patients die needlessly every day because of a 'silent scandal' of NHS errors, the Health Secretary said today.

Jeremy Hunt will bring back the practice of writing the names of the responsible doctor and nurse above every bed so families know 'where the buck stops'.

The NHS should also publish better safety information, such as the likelihood of emerging unscathed from each hospital across the country, he said.

In a speech at University College Hospital, London, arranged before the scandal of watchdogs hiding baby deaths broke, Mr Hunt said nearly 500,000 patients were harmed unnecessarily and 3,000 died last year.

In 2011/12, there were 326 so-called 'never events' – events so unacceptable they should never happen.

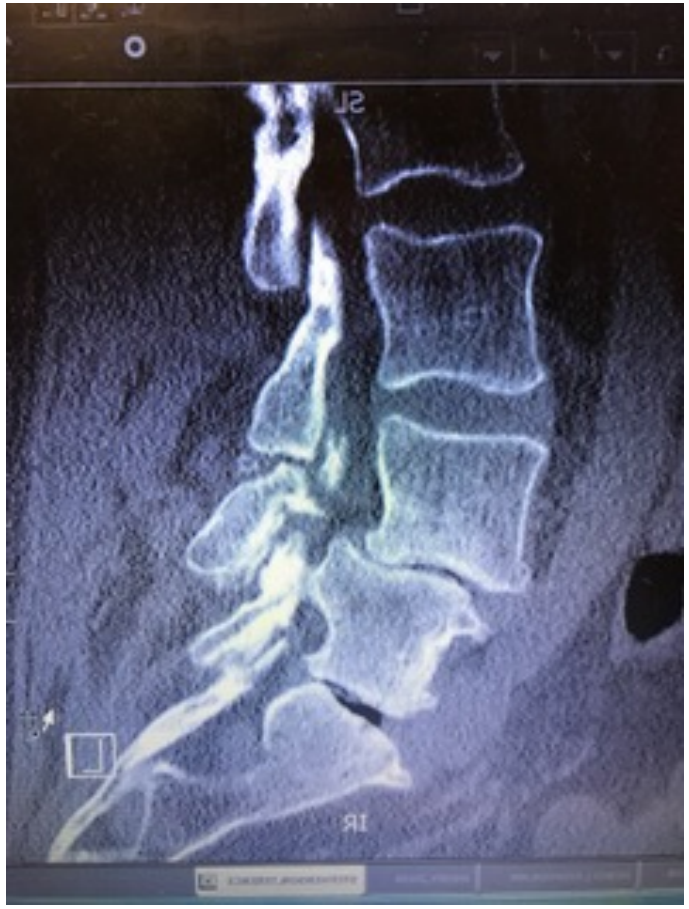
'The ones we know about include 161 people with foreign objects left in their bodies, like swabs or surgical tools; 70 people suffering wrong-site surgery, where the wrong part of the body or even the wrong patient was operated on; and 41 people given incorrect implants or prostheses,' Mr Hunt said.

'Put another way – every other day we leave a foreign object in someone's body, every week we operate on the wrong part of someone's body, and every fortnight we insert the wrong implant. This is the silent scandal of our NHS.'

© PA

Health Secretary Jeremy Hunt will bring back the practice of writing the names of the responsible doctor and nurse above every bed so families know 'where the buck stops'

Do you want to be a patient in a hospital where safety is not taken as seriously as your next airline flight?



THANK YOU