# Patient safety COVID-19 update – 10 July 2020

Patient safety COVID-19 update from the NHS National Patient Safety Team

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

| Key messages | Information for safety leaders |
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| • Ensure your organisation uses the Surgical Safety Checklist as surgical services are re-instated | 1. The Surgical Safety Checklist is a simple tool for perioperative teams to use to confirm that critical safety measures are performed before, during and after surgical procedures.<br><br>As surgical services are re-instated more staff may be working in unfamiliar teams and new environments, and using more PPE. This can challenge good team communication and makes the sharing of safety critical information and undertaking safety checks even more essential. The team brief before each session and use of the checklist for each patient is now even more important to reduce the risk of surgical error. |
| • Ensure risk assessments are undertaken for at-risk staff groups | 2. A letter from Prerana Issar, Dr Nikki Kanani and Amanda Pritchard (25 June 2020) reminded healthcare organisations of their requirement to risk assess all staff in at-risk groups within four weeks.<br><br>Organisations are asked to publish the following metrics, until fully compliant:<br><br>• number of staff risk assessments completed and as a percentage of whole workforce<br>• number of black, Asian and minority ethnic (BAME) staff risk assessments completed, and as a percentage of total risk assessments completed and of whole workforce<br>• percentage of staff risk assessments completed by staff group<br>• additional mitigation over and above the individual risk assessments in settings where infection rates are highest. |
| • Let us know about new ways of working | 3. We know that COVID-19 has meant organisations needed quickly to introduce many new ways of working and that some have particularly benefitted patient safety.<br><br>Let us know via patientsafety.enquiries@nhs.net if you would like to highlight any new ways of working that have been good for patient safety and should be shared more widely. We may share your examples including through, for example, the Patient Safety Collaboratives, service improvement programmes or future patient safety specialist networks. |

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| • Be aware of new role for medical examiners | 4. Directions published by DHSC on 2 July 2020 mean medical examiners at acute trusts will be made available to scrutinise the |

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| | deaths of health and social care workers from COVID-19 in their trusts, as well as in trusts without medical examiners or in non-hospital settings, such as at home.<br><br>The process is described in a letter from the Secretary of State for Health and Social Care, with further detail given in a letter on 7 July 2020 from the National Medical Director, National Director of Patient Safety and National Medical Examiner.<br><br>In cases where medical examiners find coroners have opened investigations, medical examiner scrutiny will end. Regional medical examiners will contact NHS organisations if they need to take action, and provide further information and support. |
| • Review the latest letter on stepping back up key reporting and management functions | 5. Amanda Pritchard wrote to system leaders on 6 July setting out next steps on resuming some important reporting and management functions. These include reporting activities that relate to quality of care, including safety. National clinical audit and outcome review programme providers will soon begin work to identify key data items for collection from national clinical audits and outcome review programmes. |
| Send any queries or feedback on this update to patientsafety.enquiries@nhs.net | |

## In focus: Be aware of new or under-recognised issues to add to ligature risk assessments in mental health units

**Information for safety leaders in mental health units:**

Publishing information on methods of self-harm is unsafe as it can give people ideas about how to harm themselves. In units designated for the care of people with mental health needs, prevention of self-harm ultimately relies on improving the therapeutic environment, not a focus on environmental safety alone. However, to help improve environmental risk assessments in mental health units, directors of nursing are routinely notified via the National Mental Health and Learning Disability Nurse Directors' Forum of new or under-recognised methods of self-harm identified through the review of reported incidents or other routes. Forum members also frequently share risks identified in their own organisations, including detail that can help colleagues assess whether they have similar equipment or fittings.

Although all mental health and learning disability trusts in England are represented on the forum, patient safety leads may want to ensure clear local systems are in place in their trust to communicate forum notifications to those colleagues working to improve local risk assessment policies and practice, whilst ensuring those communications are carefully protected and not accessible on any publicly accessible websites nor printed or displayed anywhere that patients might see them.