

Jim Livingstone
Director of Safety, Quality and Standards



Department of
**Health, Social Services
and Public Safety**

www.dhsspsni.gov.uk

AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

Castle Buildings
Upper Newtownards Road
**BELFAST
BT4 3SQ**

Tel: 028 90522788

Fax: 028 90520725

Email

jim.livingstone@dhsspsni.gov.uk

Circular HSC (SQSD) 44/2008

Date: 1 October 2008

For action:

SABS Liaison Officers:

- to acknowledge receipt by 3 October 2008
- to indicate action underway by 24 October 2008
- to confirm completion by 31 March 2009

Chief Executives of HSC Trusts

Chief Executives HSS Boards

For information:

Medical Directors HSC Trusts (for cascade to all relevant staff)

Medical Director NIAS

Directors of Nursing HSS Boards/HSC Trusts

Directors of Public Health in HSS Boards

NI Medicines Governance Team

Regulation and Quality Improvement Authority (for cascade to relevant regulated establishments and independent hospitals, clinics and hospices)

HSC Chief Executive

Chief Executives NIMDTA, NICPPET, NIPEC

General Manager, Safety Forum

Dear Colleague,

Re: National Patient Safety Agency: Rapid Response Report 3: Risks of chest drain insertion

Status: For immediate action (for completion by 31 March 2009)

The NPSA has received reports of 12 deaths relating to chest drain insertion and 15 cases of serious harm between January 2005 and March 2008. A substantial number of less severe incidents have been reported highlighting poor management of inserted chest drains. Many more are likely to be unreported.

Following NPSA advice, Medical Directors of HSC Trusts should ensure:

- Chest drains are only inserted by staff with relevant competencies and adequate supervision;
- Ultrasound guidance is strongly advised when inserting a drain for fluid;

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Chief Medical Officer Group



INVESTOR IN PEOPLE


- Clinical guidelines are followed and staff made aware of the risks, reflecting the questions above;
- Identify a lead for training of all staff involved in chest drain insertion;
- Written evidence of consent is obtained from patients before the procedure, wherever possible (and in accordance with the DHSSPS Good Practice in Consent guidance: www.dhsspsni.gov.uk/public_health_consent); and
- Local incident data relating to chest drains is reviewed and staff encouraged to report further incidents.

This Rapid Response Report issued on 15 May 2008 is available on:
<http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/rapidrr/risks-of-chest-drain-insertion/>

You will wish to bring the contents of this document to the attention of staff, particularly those involved in governance and risk management within your organisation who need to be aware of this safer practice notice in order to assist in complying with the *Quality Standards for Health & Social Care* –

- Criterion 5.3.1(f)(iii) (obtaining informed consent);
- Criterion 5.3.2 (preventing, detecting, communicating and learning from adverse incidents and near misses);
- Criterion 5.3.3(d) (ensuring that clinical interventions are carried out under appropriate supervision and by appropriately qualified staff); and
- Criterion 5.3.3(f) (implementing evidence based practice through the use of guidance from the NPSA).

Yours sincerely



DR JIM LIVINGSTONE
Director Safety, Quality and Standards