SAFETY PROMPTS WITHIN MNSI INVESTIGATION REPORTS

MNSI BRIEFING

Content Tags: *#Safety #SafetyPrompts*

Date: *7 November 2024*

Author: *Zoe Munson*

Introduction

On 1 April 2024, we introduced changes to our investigation reports and processes. These changes were implemented to reinforce a culture of excellence, to allow the greatest opportunity to share the learning from investigations and to promote safe maternity care for the benefit of families, trusts and national bodies.

Many trusts are now starting to receive the new style investigation reports. This briefing document outlines the role of safety prompts and how to use them

What is a safety prompt?

When the findings of a safety prompt have been agreed, the investigation report may contain safety prompts and / or recommendations.

Safety prompts describe a set of questions / prompts that help to improve safety at a local level where there has been insufficient evidence to support a safety recommendation, or because the issue fell outside the direct scope of the investigation.

When is a safety prompt made?

A safety prompt is made when safety concerns are identified that warrant further consideration, but the investigation does not have sufficient understanding or evidence to make a recommendation. Safety scientist Sidney Dekker (2015), introduced the idea that we gain a better understanding of safety through different perspectives or 'windows'. An MSNI investigation offers the chance to look through such a window. The creation of safety prompts allows trusts to consider the risks

SAFETY PROMPTS WITHIN MNSI INVESTIGATION REPORTS

identified and be at the centre of creating solutions, providing additional opportunities for learning and development.

Practically, a safety prompt will always begin with what the investigation has learnt. It will be written to influence the internal environment, tasks, tools and technology, people or organisation. The prompt will pose several questions for a trust to consider, keeping in mind that the report will be based on what MNSI has learnt during the investigation and may not reflect the entire service.

What happens when the report is shared with a trust?

When the draft report is shared, a trust is sent a factual accuracy form, allowing them to comment on the draft report, including the wording of safety prompts, and identify any factual inaccuracies. We do not ask trusts to formally agree or answer a safety prompt. The purpose is for the prompts to guide further discussions to inform their action plans.

MNSI definitions of recommendations and safety prompts

Findings, safety recommendations and safety prompts

This report contains **findings** from our analysis of the evidence gathered during our investigation. The report may also contain **safety recommendations** and **safety prompts.**

Safety recommendations are made to an NHS organisation when the evidence indicates a change is needed to make care safer.

Safety prompts describe an action that may help to improve safety at a local level and where there was insufficient evidence to support a safety recommendation, or because the issue fell outside the direct scope of the investigation.

Not all reports will contain **safety recommendations or safety prompts**. On these occasions, maternity services are encouraged to use the findings within the report to promote and support learning.

SAFETY PROMPTS WITHIN MNSI INVESTIGATION REPORTS

Examples of MNSI safety prompts:

1. An investigation learnt that not all mothers were aware that they are required to accept push notifications on their mobile telephones, in order to receive written information via the Trust's electronic patient record system.
    - Do all community midwives know their role in informing mothers regarding accepting push notifications?
    - How is it confirmed during the antenatal period that a mother is receiving written information via the electronic patent record system?

2. An investigation found that navigating local guidance was challenging, with different maternity guidelines across the Trust's sites
    - Has the Trust gathered feedback from staff about the ease of accessing site specific guidance and how they navigate these guidelines?
    - What are the barriers to developing Trust wide, standardised guidance?

Case study: Somerset NHS Foundation Trust

Somerset NHS Foundation Trust have recently received a new style report including a safety prompt. See how they actioned the prompt to improve patient safety.

During the investigation we learned that the Trust's guidance was not explicit in advising clinicians of the process for arranging prescriptions for aspirin for mothers during pregnancy.

As this was identify as a potential patient safety issue the MNSI investigation report gave the below safety prompt questions to support the Trust in making positive changes to their processes and practice:

- Do all community midwives know the process for arranging an aspirin prescription in pregnancy?
- Has the Trust reviewed and aligned the guidance for aspirin requirement in pregnancy?

SAFETY PROMPTS WITHIN MNSI INVESTIGATION REPORTS

In response to the safety prompt Somerset NHS Foundation Trust:

- ✓ Reassessed the prescription of aspirin so midwives can prescribe it if women are identified as needing it during the booking appointment.
- ✓ Developed a new process to ensure stock of aspirin is kept in the community hubs, so this can be given at the time of the risk assessment.

Somerset NHS Foundation Trust said:

"We have received our first report in the new format style and have found the reports less repetitive and easier to read. In particular, we have found the questions in the safety prompts really useful when creating smart actions, the questions have instigated some really meaningful conversations about areas for improvement within our team".