



! The Trust's 'Risky Business'

Welcome to the first edition of 'Risky Business' your new monthly bulletin produced by the Patient Safety, Experience and Legal Team.

This bulletin is for you, it is intended to share the lessons learned from patient safety incidents, complaints, claims and inquests but we would also like to hear from you to share your learning.

'Risky Business' will be produced every month so look out for it across the Trust and become involved by working with the team to ensure DBTH is a safe Trust in which patients have a very positive experience.

The team have undergone a re-structure and patient experience, patient safety and legal services has been brought together under the direction of Louise Povey, Head of Patient Safety & Experience.

Louise is keen for the department to be proactive and engaging with patients/families and Care Groups across the Trust.

"It is important that as a Trust we learn from serious incidents, complaints, claims and inquests and also patients and their families.

"I am very keen that as a department we support the Care Groups in providing patients and their families with a positive patient experience."

! Get involved and reporting

Each month the team will share key lessons learned. Look out for the key message of the month in our 'Risky Business.' News of events will be advertised that are available for you to attend and learn.

We can only learn and share if the incidents are reported in the first instance, please report incidents/near misses.

If you need any help or support then please contact Tracy Evans-Phillips Datix System Analyst and Admin (details can be found on the Phone Directory).

Tell me and I'll forget. Show me and I may remember. Involve me and I learn.

- Benjamin Franklin

The team

Head of Patient Safety & Experience

Louise Povey: 642277

Legal Services Manager

Michele Corbett: 642167

Patient Experience Team Leader

Joanne Blockley: 642768

System Analyst and Admin (Datix)

Tracy Evans-Phillips: 642275

Patient Safety Leads

Debbie Swift: 642274

Mark Race: 642273

Linda McLoughlin: 642719

Maggie Gregory: 642719

Emma-Louise Drabble: 642395

Risk Management Co-ordinator

Dianne Crozier: 642276

Legal Services Admin

Angela Giblin: 642272

Patient Safety Facilitator

Rachel Roberts: 642272

Patient Safety and Legal Admin

Julie Scarborough: 642272

Andrea Berry: 642272

Patient Experience Officers

Gary Metcalfe: 642766

Jenny Olma: 642765

Patient Experience Admin

Sarah Maye: 642764

Elaine Green: 642764

Deborah Cummins: 642764

Amy Farrington: 642764

Duty of Candour being open with patients

WE CARE at DBTH and always like to ensure we are open and honest and offer an apology to all patients and/or families when an incident occurs. The Duty of Candour Regulation came into force for all NHS Trusts in November 2014. It includes actions that must be taken when patients are involved in a patient safety incident that leads to moderate harm, serious harm or death or prolonged physical harm.

Key Principles:

- Timely reporting when an incident has occurred resulting in moderate harm, severe harm or death
- A verbal apology with an explanation that an investigation will be undertaken.
- A first letter to be sent within 10 days to confirm the initial discussion
- A second letter of apology on conclusion of investigations, explaining the findings and actions undertaken to reduce the risk of recurrence.

Why is it important: It supports We Care, the values of DBTH, providing patient-centred and accountable care. It shows that we are open and honest about the care we provide and we are willing to learn when things go wrong.

What you can do:

- 1) Discuss with patients and/or families when any patient safety incident has occurred, explaining what happened and offering a sincere apology.
- 2) Write to the patient and/or family providing an apology when the incident has led to moderate harm, severe harm or death with an explanation of what happened and the plan for the investigation
- 3) Support the patient and/or family as required following the incident and during the subsequent investigation.
- 4) Write to the patient on conclusion of the investigation and provide a further apology with a summary of the findings
- 5) Report all patient safety incidents using the Datix-web incident report form, adding appropriate documentation.
- 6) Review incident reports with your colleagues and seek advice about the level of harm. If required; make sure the apology field is completed on Datix, to confirm the apology has been offered.
- 7) Monitor all incidents where Duty of Candour applies to ensure the full process is followed and evidence on Datix.

