Formerly Risky Business

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Serious Incidents

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm- including those where the injury required treatment to prevent death or serious harm, abuse or Never Event. Patients and their families or carers must be involved and supported throughout the investigation process.

During 2017/18, the Trust reported 42 Serious Incidents:
Six patients fell and fractured their hip.
11 patients suffered an avoidable hospital acquired pressure ulcer.

The individual incidents are as follows:

1. Fallopian Tube incorrectly removed
2. Hypoxic Ischemic Encephalopathy (two babies)
3. Post-partum maternal death
4. Fracture of humerus during delivery
5. Failure to consider early symptoms of a TIA leading to Central Retinal Artery Occlusion
6. Perforation of Oesophagus during stenting of a non-malignant stricture
7. Failure to diagnose splenic injury in a child
8. Delay in diagnosing Sub-arachnoid haemorrhage (3 patients)
9. Failure to act on major haemorrhage post fractured neck of femur surgery leading to death
10. Delay in diagnosis of fungal encephalitis
11. Delay in diagnosis of VTE leading to death
12. Failure to prescribe insulin leading to diabetic keto – acidosis
13. Failure to prescribe anti-coagulants at the time of discharge lead to extension of PE
14. Haemorrhage leading to death following removal of ascitic drain
15. Readmission with haematemesis following discharge having been treated for an ulcer
16. Cancelled appointments, leading to delay in cancer diagnosis (three patients)
17. Never Event – guidewire in situ following chest drain insertion
18. Five year old unexpected death
19. Fall off examination table leading to head injury and death
20. Inaccurate paraprotein result leading to acute kidney injury.

Themes from these incidents include:

- Communication Failure
- System Failure
- Non-compliance with policy/ procedure/guidance
- Human error

When things go wrong in care, it is vital incidents are recorded to ensure learning can take place. By learning, we mean people working out what has gone wrong and why it has gone wrong, sharing it with all of our teams to reduce the risk of similar incidents occuring again. We also want to share and celebrate when things have gone well as we can learn just as much from this.

By Sharing How We Care each month, we want to make sure that as many staff as possible understand what has gone wrong in our hospitals and what we are doing to stop the same harms from happening again.

Remember: Serious Incidents (and never events) must be declared internally as soon as possible, via DATIX, and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation.

Serious Incidents should also be disclosed as soon as possible to the patient, their family or carers under legislation on Duty of Candour. The commissioner must be informed (via STEIS and/or verbally if required) of a Serious Incident within two working days of it being discovered. Please contact a member of the patient safety team if you are unsure of what level of harm to report.

Team work and sharing a vision

We may not be working towards putting a man on the moon, but we want all our staff at Team DBTH to know how much each role contributes towards keeping our patient safe and well cared for.

Have you seen Gina's story? This was one way we have tried to share the learning from a Serious Incident in the past, **view it here**.

Sharing how we care: Your health and wellbeing

We recognise that serious incidents can have a significant impact on staff who were involved or who may have witnessed the incident.

If you have been involved in a serious incident, you will probably want to know what happened, and what can be done to prevent the incident happening again. At DBTH, Staff involved in the investigation process will have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. You will also be provided with information about the stages of the investigation and how you will be expected to contribute to the process. At DBTH we take staff Health and Wellbeing seriously and there are a variety of services available to support you. Click on the flower icon on the intranet (or above) to see what help and support is available.
If you are a learner or trainee at DBTH then support can be gained from your LEM, mentor or educational supervisor. In addition you can contact your Education Lead or the Trust's Education Quality & Governance Manager (lisette.caygill@nhs.net) for additional pastoral support.

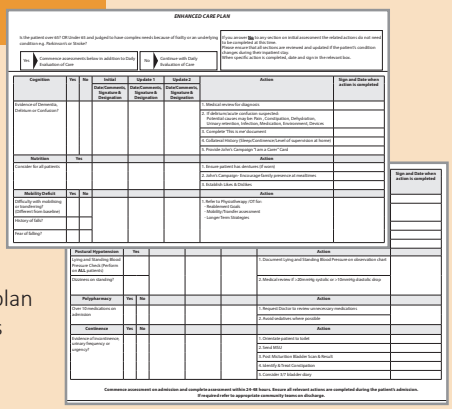
Learning from Falls

Since opening the Frailty Assessment Unit at DRI in 2014, we have seen a dramatic improvement in the numbers of patients suffering from inpatient falls, leading to a fractured hip (or neck of femur). Part of this improvement has been the spread of Person Centred Care throughout DBTH and the work of the Falls and Bone Health Group.

Dr Vicky Barradell, Consultant Geriatrician and Esther Lockwood, Falls Prevention Practitioner looked at the NICE guidance (NICE CG 161 2013) around falls prevention and developed the Enhanced Care Plan. This is to be used with all patients over the age of 65 or under 65 and judged to have complex needs because of frailty or an underlying condition e.g. Parkinsons or Stroke. If you answer YES to any section on the Enhanced Care Plan the relevant actions for that particular falls risk factor are to be completed during the patient's admission.

For example: If the patient is on 10 or more medications then request the doctor or pharmacist review the medication to identify if any of the drugs can be changed or removed to minimise the individuals risk of falls. Download our 'Five for Falls' poster.

You will be pleased to know that the new combined risk bundle is now available to order:


ENHANCED CARE PLAN

IPOC 243
WPR23085
The enhanced care plan is on page 7-8 of this document

Shared Learning from falls:
Following recent coroners inquests, where patients have fallen and subsequently died, we looked at the documentation of the care these patients received. This showed improvement was needed in:

- Ensuring daily updates on the supervision assessment for all patients requiring **AMBER**, **RED** or **PURPLE** level of supervision.
- Promptly downgrade a patients level of supervision if they no longer require the previously assessed level.
- Document and evidence all the strategies you have put in place to optimise the patients safety (e.g this is me, TIME AND SPACE).

Message of the month

Do you know we have a Pain Assessment Tool for People with Dementia or Communication Difficulties?

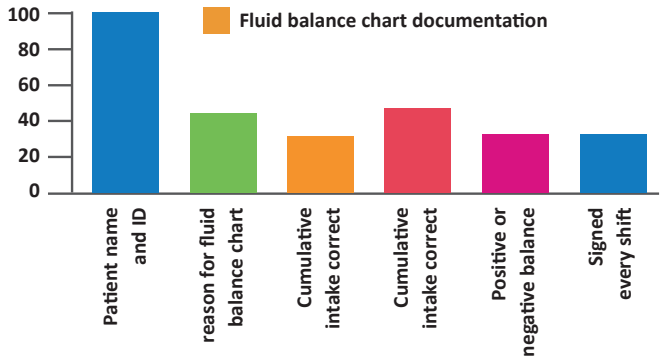
For more information or training and education, please contact Lorraine Robinson, Lead Specialist Nurse Pain Services Lorraine.robinson10@nhs.net or Beth Cotton, Lead Dementia Nurse b.cotton@nhs.net.

Acute Kidney Injury

In the September edition of the newsletter, we told you about the risks to our patients from Acute Kidney Injury.

A quality improvement project, looking at ways to improve patient hydration and improve how we monitor fluid intake and output, resulted in a new design of fluid balance chart. All wards now have this new chart.

In August 2018 a Trust-wide audit on 25 wards looked at how well all our staff were using the new fluid balance chart. It was clear from the audit results that there is still room for improvement.



From the total of 837 staff from the 25 ward areas 67% have had AKI training, but only 5.23% had attended the hydration and Fluid balance chart drop in sessions. The individual wards that had the higher audit results are those that had the most staff attend training.

Making sure that patients are adequately hydrated is one of the most important things that healthcare professionals can do to help prevent acute kidney injury (AKI). Using the fluid balance chart to monitor patients at risk is vital.

Work is now underway to look at the training and education needs for all staff on NEWS 2, Sepsis and AKI prevention. Read our new poster.

For more information on AKI you can find resources on the Think Kidneys website: https://www.thinkkidneys.nhs.uk/aki/

De-escalation Pathway

for over 65s lacking capacity

We are all capable of displaying challenging behaviour when faced with certain situations; it is a reaction to what is happening around us and a way of communicating our emotions when we may not be able to do so verbally.

There are certain groups of people who are much more likely to communicate through their behaviour such as people with dementia, learning disabilities, sensory impairment or mental health problems. But we also need to be aware of other factors. Below are some of the areas that can change a person's behaviour making it more challenging to us.

Health: Any changes to physical health, pain, medication, disabilities, tiredness, malnutrition and dehydration.

Our Staff: How we react and speak to the person, the relationship we have with them and the language we use.

Environment: Unfamiliar environments in particular will have an impact on behaviour – for example how accessible is it, comfort levels, signage (lack of), and the layout.

The Person: How they have lived their lives, and what their roles and identity has been through their lives, will impact on how they behave.

The Trust has a **De-escalation Pathway** that provides a step-by-step guide in de-escalating a person's behaviour when they lack capacity. This leads up to giving sedation as the final step in de-escalation.

When behaviour starts to change in our patients who have trouble communicating, we first need to review the person's health, and other possible contributing factors – alongside using our **de-escalation techniques.**

De-escalation basically means 'to bring down'. The objective of de-escalation is to prevent aggressive and dangerous situations from occurring and so in some situations, reduce the need for restrictive interventions.

Having a This Is Me filled-in can help provide safe provide safe, effective and fast de-escalation. It is important to know who your patient is including normal routines, what makes them sad, what makes them happy, who are the important people in their lives and much more.

Acting in an emergency

Sometimes we have to act quickly, when a person's behaviour is putting themselves or others at high risk of harm. This can be done in the person's best interests, without a documented capacity assessment. Remember to record this in the patient's notes after the event.

Some top tips to take away:

- Has the patient got a This is Me?
- Have you gone through TIME AND SPACE?
- Have you involved family/carers?
- Have you used the Trust Pain Tool for people with communication difficulties?
- Read the Patient Supervision and Engagement Policy for some Talk Down Tips.

For more information on the de-escalation pathway or for training and education, please contact Beth Cotton, Lead Dementia Nurse b.cotton@nhs.net

Seeing the problems in **Radiation Safety**

A recent review of a 6 month period (Jan to July 2018) has identified 80 ionising radiation incidents recorded on DATIX.

On review and analysis, the following was noted:

- 40% (32/80) were due to Referrer issues
- 36.25% (29/80) were due to Radiology issues
- 23.75% (19/80) were due to other factors i.e. Radiology equipment failure.

Referrers

One recent incident in the emergency department was reported after the patient was referred for multiple x-rays and then discharged without those x-rays being reviewed.

In the case of any test– good practice is that an investigation should only be undertaken if it is likely to change the clinical outcome or inform decision making .

In the case of x-rays: IRMER regulations state that it is the requester who is responsible for subjecting the patient to radiation (potential harm).

The x-rays in this case were normal, however the investigation concluded that the patient underwent unnecessary irradiation.

A case of mistaken identity

A recent incident showed one patients bloods sent off under another patients name. The bloods showed an acute drop in Hb and severe AKI stage 3. When the bloods were re-checked, they were the same as the previous day (no drop in Hb and no AKI). As a result patient underwent unnecessary physical examination (including PR exam) and multiple other venepunctures in order to recheck bloods and collect blood for group and save.

Antibiotics were also changed inappropriately as a result and investigations requested from radiology that were not required. This also meant that we did not know who the abnormal blood test belonged to and that patient could have deteriorated as a result. The ICE machines have a scanner to ensure that the patients ID band can be scanned to match the investigation request before venepuncture is performed. Staff told us that they had stopped using the machine as the batteries were not charging. IT have responded to this issue and are replacing batteries to enable staff to use the ICE machines and keep our patients safer. **If you have a machine that requires new batteries, please contact the IT service desk in the first instance. If faulty batteries are found, then replacement ones will be ordered.**

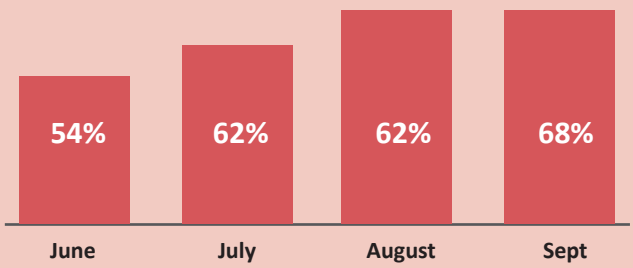
Medical Certificate of Cause of Death

Losing a loved one can be an extremely traumatic event and the level of communication and support provided to families at this time can make a considerable difference.

It is important that medical certificate of cause of death (MCCD) are available as soon as possible and that referrals to the Coroner are completed in a timely manner. Both of these activities should be completed within three days of a patient dying. A referral to the Coroner when a cause is unknown can be completed by any Doctor. It doesn't have to be by a Doctor who has seen the patient alive.

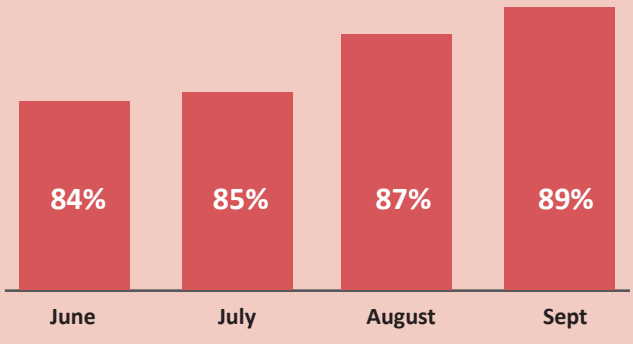
As you can see from the figures below, the internal target of issuing an MCCD within 3 days of death (when day one is the day after death and there is NO coronial involvement) is gradually improving which is having a beneficial effect on the registration of death within five days. We aim for 90% in both cases.

Completion of MCCD at DRI within 3 days



Interestingly the figure completed within four days jumps to around 80%

Registering death within 5 days



The AMU and Respiratory Unit at Doncaster have a supply of death certificates which can be issued out of hours. Please seek guidance from your consultant or medical registrar and always write your name and GMC number on the certificate.

Achieving: For the third year in a row, we have been the first nationally to vaccinate 75% of front-line staff.

Medicines Mishaps

There have been several incidents where patients on **treatment** dose dalteparin have been discharged without it being prescribed as a To Take Out (TTO) medication. This has resulted in patient harm, including development of massive PE requiring thrombolysis. Pharmacists are reminded to attach a note to the drug on JAC and add an anticoagulant note to the patient record. It is the responsibility of clinical teams to ensure that the medication has been prescribed as a TTO, the shared care proforma has been completed (if applicable) and a course length has been specified.

Learning

- Be alert to treatment dose dalteparin compared to prophylactic dalteparin on discharge
- Ensure it is added to the TTO
- Check the JAC notes for information
- Specify a course length (or lifelong)
- Ensure a shared care proforma is completed (if not already in place).

NEWS2 patient safety alert

View the patient safety alert here.

Failure to recognise or act on signs that a patient is deteriorating is a key patient safety issue. It can result in missed opportunities to provide the necessary care to give the best possible chance of survival. This video explains why the National Early Warning Score was developed; how it can be used to identify acute deterioration, including sepsis and the benefits of a standardised early warning system, https://youtu.be/ujHhqTbS1xg

We have been using the DBTH NEWS2 since August 2018 which is complamented by the SEPSIS IPOC and new fluid balance charts. The training needs analysis for all clinical staff on NEWS2, Sepsis and AKI prevention is underway.

Discharge summaries

Discharge letters are important. They help us communicate a patients plan of care while they move from the hospital back to a community setting.

It is absolutely essential that the right information is included in the patients discharge summary to make sure care is safe. Producing a good discharge summary creates a rich picture of your patient and their circumstances. Mistakes can happen when patients are transferred from one care setting to another. Please seek help from your Consultant if you are unsure about what information to include.

This short video helps to explain the value of clear and comprehensive discharge summaries. https://www.youtube.com/watch?v=0nrXU-u4itU

This newsletter was developed by: Dr Tim Noble, Deputy Medical Director. Cindy Storer, Deputy Director of Quality and Governance. Mandy Dalton, LFD lead. Beth Cotton, Lead Dementia Nurse. Dr Tracey Watson, Emergency Department Speciality Doctor. Dr Helen Meynell, Consultant Pharmacist. Marie Hardacre, Head of Nursing (Medicine). Esther Lockwood, Falls Prevention Practitioner.