NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Learning from Serious Incidents

Our ambition at DBTH is to be the safest Trust in England, Outstanding in all that we do.

Responding appropriately when things go wrong in healthcare is a key part of the way that we can continually improve the safety of the services we provide to our patients. We know that healthcare systems and processes can sometimes have weaknesses that can, in thankfully none-to-often circumstances, lead to errors occurring and, tragically, these errors sometimes have serious consequences for our patients, staff and the reputation of a Trust.

Serious incidents in health care are events where the potential for learning is so great, or the consequences for patients, families and carers, staff or organisations are so significant that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again.

Throughout 2018/19, the Trust reported 54 Serious Incidents (five were de-logged). Of the subsequent 49 incidents: six patients fell and suffered avoidable, severe harm (hip fracture or head injury) and 13 patients suffered a severe, avoidable hospital acquired pressure ulcer.

The incidents relating to care are:

1. Tacrolimus toxicity contributed to the need for haemodialysis
2. Failure to perform Salpingectomy and remove an Ectopic Pregnancy
3. Return to theatre, Postpartum haemorrhage >1500ml
4. Baby born in unexpected poor condition ; HIE grade 1
5. Poor wound management of a post-surgical spinal infection
6. Possible delay leading to HIE grade 1
7. Maternal death
8. Cluster of Patients experiencing a delay getting treatment causing op thalmological deterioration
9. Missed polyp during a virtual CT colonoscopy
10. Not referred for follow up following Endoscopy
11. Intrauterine Death at 38+4
12. A delayed/misreported of a right hip x-ray developing metallosis
13. Management of Orbital Cellulitis
14. Post liver biopsy haemorrhage
15. Missed opportunity to biopsy a breast lump

The incidents relating to live investigations and others are:

16. Never Event- wrong site spinal injection
17. IUD at 26+2
18. Jaundice baby
19. PE caused by stopping Rivaroxaban
20. Wrong route administration of local anaesthesi
21. Facial scaring following forceps (no causal factors – known complication)
22. Delayed diagnosis of Lymphoma (unusual presentation)
23. Missed diagnosis of malignant melanoma (interpretation error)
24. TAH bladder injury (no causal factors)
25. Cerebral bleed after administration of antiplatelet drug (no causal factors- known side effect)
26. Unexpected HIE at birth (no causal factors)
27. IUD at 40+2 (no causal factors)
28. Treatment delay CRVO – Ophthalmology
29. Unsafe discharge of baby (HSIB investigation)
30. Bowel perforation following drainage of haematoma

What are we doing to be the Safest Trust in England? Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience. The NHS Patient Safety Strategy (Safer Culture, Safer Systems, Safer Patients) was launched in July 2019.

The aim of this new strategy is to build on two foundations. Patient safety culture and patient safety systems. You can read it here: https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf

We care **Kindness** counts

To work safely, people need to be able to talk to each other freely and without judgment.

To some extent this is a profoundly simple solution; engaging in conversations where people are willing and able to share their ideas, opinions and experiences, and people are willing and able to listen carefully to one another. For this to be possible, we need to create an environment where people can feel respected for their views and the diversity they bring to a conversation no matter who they are.

There are certain values and behaviours that need to be embodied by all of us for this to happen:

- Kindness – THE most important thing
- Respect
- Humility
- Positivity
- Encouragement
- Curiosity

Even though a lot can feel out of our hands in the busy world we live and work in, we do have complete control over how we talk to each other and whether we embody these behaviours and values. We can choose to talk to each other in a way that helps people experience, for that moment, the kinder attitudes, values and behaviours that are necessary for the right culture to grow and flourish.

It is these kinds of conversations that can create connections, develop relationships, and provide opportunities to learn Dr Suzette Woodward, Director of the Sign up to Safety campaign that ran from 2014 to 2019, describes the equally important individual behaviours of kindness and civility that support patient safety. It is summarised in this infographic that you can download can print off in your area:

Prepare for the CQC: Attend the Friday Lunchtime Lecture.

Just culture

Don't ask who is responsible ask what is responsible

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated

NHS improvement have developed a Just Culture guide to support conversations between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

This guide updates and replaces the incident decision tree (IDT) developed by the National Patient Safety Agency (NPSA) around the work of James Reason, an expert in human error and its drivers.

The Just Culture Guide is now part of the new Serious Incident policy. You can read about it by clicking the link on the right, or heading to https://extranet.dbth.nhs.uk/wp-content/uploads/2019/08/AJustcultureGuide.pdf. You can watch the video to learn about the Just Culture Guide by heading to https://youtu.be/zje765OEggs.

Click to **download**.

Making **families** count

Making Families Count helps health and care providers learn and improve by improving engagement with families.

Watch online

Our vision at DBTH is that lessons are learnt and services transformed by Making Families Count, through placing the family front and centre during health and social care investigations. With the new patient safety strategy – we will be recruiting patient safety partners, who have experienced harm as a consequence of healthcare provided in the NHS: https://www.makingfamiliescount.org.uk/films/

Training for **investigators**

In January 2019, we began a programme of investigation training for clinical governance leads, associate directors of nursing, matrons, education leads and the patient safety team.

60 members of staff attended the training delivered by Consequence UK. The aim of this was to improve how we incorporate the Just Culture guide and improve confidence in our investigations. You can watch a discussion with previous course attendees here https://www.youtube.com/watch?v=TYoMEv4IPiY

Next steps – we are developing our own DBTH investigation training for any member of staff needing these skills. Would you like more confidence to investigate? Watch this space for more information.

Saying "**sorry**"

Saying sorry meaningfully when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them.

Saying sorry is: always the right thing to do not an admission of liability acknowledges that something could have gone better the first step to learning from what happened and preventing it recurring.

When? As soon as possible after you become aware something has gone wrong you should seek out the patient and or their family and say sorry and acknowledge what has happened and tell them that you will find out more. Reassure them that you will keep them informed.

Who? Everyone can say sorry, but you may need to be supported to do so. You may need the backing of more senior people and staff may need training but it should not stop you from simply saying sorry.

Don't say *I'm sorry you feel like that*
We're sorry if you're offended
I'm sorry you took it that way
We're sorry

Do say *I'm sorry X happened*
We're truly sorry for the distress caused
I'm sorry, we have learned that...

"We have never, and will never, refuse cover on a claim because an apology has been given." Helen Vernon, Chief Executive, NHS Resolution, https://resolution.nhs.uk/wp-content/uploads/2018/09/NHS-Resolution-Saying-Sorry.pdf.

You can read our new Duty of Candour leaflet here https://www.dbth.nhs.uk/document/corprisk14/. Please make sure you ward or department has this version to give to patients and families.

Mental Capacity Act

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

Someone can lack capacity to make some decisions (for example, to decide on complex financial issues) but still have the capacity to make other decisions (for example, to decide what items to buy at the local shop).

A recent audit of the new ReSPECT document found the MCA part documented as the patient not having capacity. When the team spoke to the patient – he had recovered full capacity.

If you are unsure about mental capacity and the ReSPECT process see FAQ https://www.respectprocess.org.uk/faqs.php

Patients who have the ReSPECT process followed must be involved fully. Many people want to have the support of family, friends or carers in the discussion, and some may choose to have a family member or friend advise them on what choices to make.

Where the person does not have capacity to take part in the ReSPECT process and if there is no legal proxy to represent the person, the clinical team must consult family or friends about a person's situation and previously expressed views or wishes, in order to make recommendations that are in that person's best interests (in England & Wales).

However, the responsibility for making those recommendations rests with the senior responsible clinician. The family should not be given the impression that they are being asked to make them.

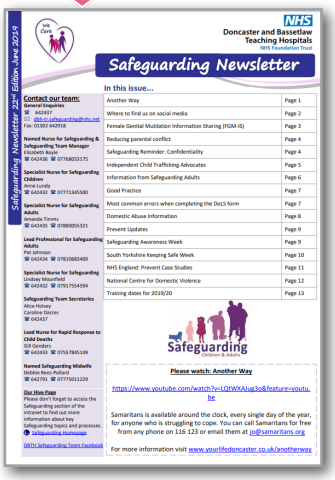
The 5 principles of the MCA have been developed onto a handy prompt for staff - you can click the image to download it or head to https://extranet.dbth.nhs.uk/wp-content/uploads/2019/08/mca-5-principles-poster.pdf

Click to **download**.

This one year anniversary edition of Sharing How We Care was made possible by:

Cindy Storer, Rebecca McCombe, Liam Wilson and Bonny Stevenson.

Safeguarding at DBTH


Safeguarding Newsletter 22nd Edition June 2019

NHS Doncaster and Bassetlaw Teaching Hospitals

Safeguarding Newsletter

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Safeguarding Children & Adults

Please watch: Another Way

https://www.youtube.com/watch?v=LQtWXAJqa3o&feature=youtu.be

Samaritans is available around the clock, every single day of the year, for anyone who is struggling to cope. You can call Samaritans for free from any phone on 116 123 or email them at jo@samaritans.org

For more information visit www.yourlifedoncaster.co.uk/anotherway

Safeguarding means protecting a patients health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility.

Those most in need of protection include:

- Children and young people
- Adults at risk, such as those receiving care in their own home, people with physical, sensory and mental impairments, and those with learning disabilities.

Everyone at DBTH has a responsibility to safeguard children and adults at risk of abuse or neglect in our hospitals.

For more information, you can read the DBTH Safeguarding newsletter here: https://extranet.dbth.nhs.uk/safeguarding/safeguarding-newsletter/