NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

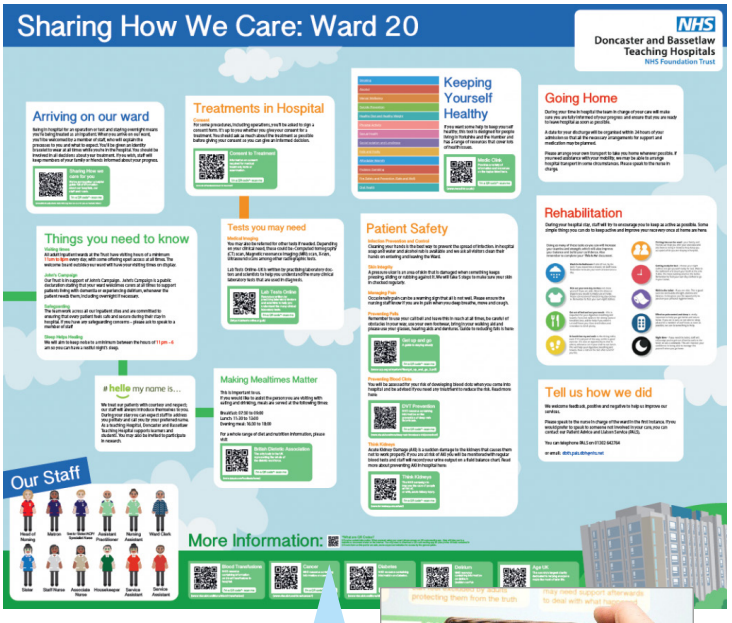
Sharing how we care

Sharing How We Care for You

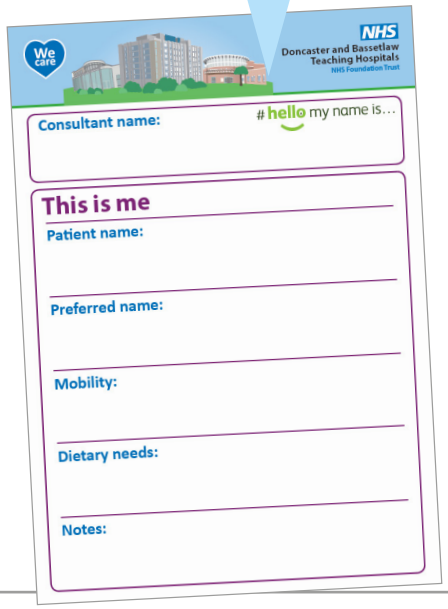
To improve communication for patients, relatives and carers, this summer we completed the Sharing How We Care for You trilogy. This includes all the new work we have been undertaking such as the standardised visiting times, Sleep Helps Healing (Shh) and Making Mealtimes Matter.

Part one was the co-creation and co-development of new bedside information. Stored at the bedside and available electronically, this folder has key information to help improve patient safety and patient experience for patients, their relatives, carers and friends.

You can read more about the folders here.



Part two was to refresh the bedside information boards. This simple yet essential patient safety board enables all staff to see what the person they are looking after, or communicating with, needs. The notes can be added for patients with learning disability, autism, dementia.



Part three was to adapt and develop the welcome boards already in use outside the Department of Critical Care (DCC) and Intensive Care (ITU) and personalise them for our inpatient wards. All adult ward boards are completed and being placed into position. Work on the children's and maternity areas will be next with department areas commencing in the autumn.

Learning from **Never Events**

Never Events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations.

For the full list of never events, click here.

We have reported three Never Events throughout 2019.

These are:

Wrong site spinal injection

Reported on 23 January 2019

Patient A was seen in our Orthopaedic service with right leg and back pain. An MRI scan showed lumbar disc prolapse. She was listed for a right side foraminal injection at L3/L4 level to relieve her symptoms.

She attended theatre for her procedure as planned and all aspects of the WHO check list were completed. Following the time out, under X-ray guidance, the doctor injected the left side instead of the intended right side.

From the investigation, it was clear that all members of staff had adhered to the WHO safer surgery checklist. The skin was marked prior to surgery by the surgeon on the right side as intended. However, when the drapes were applied, the mark was obscured as it was placed higher up the back than the L3/L4 level. This meant that the doctor was reliant on their memory to ensure that the correct side was injected. Unfortunately, the doctor had a lapse in concentration and the wrong side was injected. Theatre staff did not notice this was happening until the injection had already been given.

The main learning here is that **the surgical site should be marked in a place that remains visible once drapes are applied**. In this case, there was low harm as the patient received a misplaced injection that was necessary and may still be effective despite the different location. There is no indication that this incident will have a detrimental long term effect.

Wrong site laser eye surgery

Reported on 15 April 2019

Patient B is an 85 year old man who had previous cataract surgery in both eyes, had advanced bilateral glaucoma and a right central vein occlusion. He had no sight in his left eye.

In order to try and improve the sight in his right eye, a course of laser treatment was planned. When he attended the ophthalmologist reviewed him and his notes. The patients daughter was with him as he suffered from dementia and could be unsettled at times.

There was a checking process in place in eye clinic in which uses a sticker to prompting review and documentation of the site of the intended procedure. This reminder is signed by the ophthalmologist and the nurse present, giving a two person check and less room for error. Unfortunately this process was not followed on this occasion. Due to human error the laser treatment was given to the left eye rather than the right eye. There was no harm in this case as there was no sight in the left eye anyway.

The learning here is that **processes are in place to minimise the risk of untoward incidents and they should be followed consistently.** It would help to ensure these processes are emphasised during the induction of new members of staff to the department.

Learning from **Never Events**

The wrong site stent

Reported on 6 June 2019

Patient C was admitted as an emergency with severe pain in the left groin and loin with vomiting and fever. A CT scan revealed a dilated, obstructed left ureter with a 6mm stone and dilated left kidney.

She was taken to theatre for a cystoscopy and left ureteric stenting. The procedure was deemed to be successful and uneventful at the time of surgery and she was discharged and listed for removal of the stent.

When the patient attended a few weeks later for removal of the stent, it was found to be in the right ureter instead of the left.

On investigation, there were a number of contributory factors. One was that the infection and inflammation was extensive such that the ureteric orifices were difficult to visualise. The ureter was inflamed and distorted and the instrument could not be passed easily. The urologist was reliant on the X-ray imaging to identify whether the stent was in the correct ureter. The images on the machine had been flipped left to right.

Earlier in the procedure, the radiographer and one of the surgical team had an exchange with some heated words. The radiographer had thought they heard the surgeon ask for the image to be flipped over on the imaging machine. Normally the radiographer would ask the surgeon to ensure they had heard this request correctly. Because the Radiographer felt unwelcome, they did not feel confident to speak up and check. The surgeon did not ask for the images to be flipped and so worked on the assumption that the images were the right way round, therefore inserting the stent into the right ureter and not the left.

The most significant learning in this case, is that **just a small change in team dynamics brought about by a difference of opinion can lead to errors being made**. There was no harm to the patient in this case but this could have been a different story.

What is the learning for DBTH

A working group was established in June 2019 and two sub groups are progressing development of the learning packages (to be e-learning based), accompanying videos and annual declaration for the theatre environment and non- theatre environment. A theatre video is planned and a department based video is planned to follow. Both the learning package and annual declaration are expected to be in place by the end of November 2019.

This will enable teams to have a clear understanding of the principles included in and their roles and responsibilities in relation to safer surgery, including WHO checklist and recommendations within NatSSIPs. The learning package will include a video example of good practice and explanation around the processes linked to WHO check list and NatSSIP's. The annual self-declaration will help to inform us of our local education needs and identify areas of focus for the education and development teams.

In parallel to this is the development of the same process for non-theatre environments where invasive procedures are undertaken. The learning package will be based upon applying NatSSIPs to these non-theatre areas and include video examples applicable to a variety of settings including endoscopy, urology out patients, ophthalmology out patients, interventional radiology, dental clinics and pain clinics (amongst others). The process will also include an annual declaration which will inform us of education and development needs and will be utilised for current staff and new starters in these specific areas.

In addition to this work the Trust is currently working in partnership with Blue Spier the provider of our theatre management system. This will move towards an electronic theatre checklist process, enhancing processes, minimising patient safety risks and embedding best practice within the theatre environment.

For more information, contact: Kirsty.clarke4@nhs.net

What checks should have been in place?

The Surgical Safety Checklist is a simple tool designed to improve communication and teamwork by bringing together the surgeons, anaesthesia providers and nurses involved in care to confirm that critical safety measures are performed before, during and after an operation. January 2019 marked ten years of this checklist in England and around the world.

Launched by the World Health Organization (WHO) in June 2008, with substantial input from UK clinicians, the checklist was mandated for use in the NHS in January 2009. It is now in standard use across the UK as well as worldwide.

Not all the never events occur in an operating theatre, so a new National Safety Standards for Invasive Procedures (NatSSIPs) was published in September 2015.

The DBTH NatSIPPS guide is available here.

Triangulation of patient safety data

It is important to remember that, on the whole, NHS healthcare is generally very good and most people don't experience any difficulties. When patients make a claim, it can be an expensive, stressful and potentially a lengthy process. It is also likely that during the process of making a claim patients will have to go over what happened several times, which can be very upsetting and traumatic.

The process of taking legal action is only about claiming compensation, the court can't discipline healthcare practitioners, force a hospital or individual healthcare practitioner to change how they work or make a healthcare practitioner say sorry.

Before making a claim, patients are encouraged to use the NHS complaints procedure in order to find out more about what happened. This helps many patients to make a more informed decision if they are unsure about what to do.

NHS Resolution commissioned The Behavioural Insights Team (BIT) to research the factors which lead patients to consider a claim for compensation when something goes wrong in their healthcare. **You can read about it here**.

The findings were that:

- Reactions of NHS staff following an incident were generally considered unsatisfactory by claimants, in terms of providing adequate and appropriate explanation and apology for events.
- The majority of the research participants were not satisfied by the NHS complaints' handling process, in terms of communication (both verbal and written) and feeling that a meaningful outcome had been achieved.

Complaints process

Overall, complainants who claimed were not satisfied by the complaints handling process. Themes included not being kept up to date, not responding to timescales, procrastination and incorrect information. In relation to the complaints process, particular themes emerged from the interviews around poorly written communications, a lack of sharing meaningful outcomes and poor handling of meetings.

Several of the interviewees reported that better complaint handling may have prevented them from going on to make a claim. These include:

- Saying sorry (read the NHS R guide to saying sorry here)
- Correcting mistakes relating to the individual's case
- Correcting mistakes in the system to assure the individual that the same incident would not recur in the future.
- A better apology and explanation following investigation.

What is happening at DBTH?

The numbers of complaints, concerns and advice comments, questions registered with the Trust is below:

In June 2019, we sent out 50 patient surveys to complainants who had their complaint closed within the last six months (Jan-Jun 2019). The results are:

84% of complainants felt it has been easy to raise their complaint.

58% felt they were kept updated about what was happening to their complaint.

59% felt the complaint addressed the points raised in the complaint.

34% were satisfied with the outcome of the complaint.

We are now triangulating themes from patient experience with incidents, claims and inquests.

Serious Incidents 2018/19

The Trust Serious Incidents for 2017/18 were in this edition of SHWC.
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Inquests

Between April 2018 and March 2019, there were a total of 80 Inquests.
Between January 2014 and March 2019 we received 10 Coroner's Regulation 28 Reports (Prevention of Future Death Reports – PFDR). See this edition of SHWC from April 2019.

Claims

Between Jan 2017 – Dec 2018
226 Clinical Negligence Claims were made against DBTH.
See the December 2018 edition for more information on claims.

Themes from **Triangulation**

What are the themes from triangulating this data?

When we look at the themes from complaints, incidents, inquests, PFDR and claims, as well as where we need to meet Care Quality Commission (CQC) fundamental standards, the top themes for us to focus improved quality are:

Communication
we need to improve how we communicate with patients and families.

Diagnosis
make sure this is understood (or as is the case with some patients, if no diagnosis – why?)

Discharge process
to ensure that handing patients over to primary care goes as seamlessly as possible.

Handover process
ensuring clinicians handover essential information to ensure continuity of care.

Documentation and record keeping
is a clear and accurate record of the patients care.

Escalation of deteriorating patients
is done promptly and in line with NEWS2 guidance.

Medicines management
prescribing and administration of medication is done as safely as possible.

Informed Consent
the patient is fully aware of the risks of the procedure.

Following new policy and guidance
(e.g supervision for falls).

We will keep you informed on what work we will be doing in future editions of SHWC.

Inpatient Quality Accreditation Tool (iQAT)

In May 2019 – the new inpatient Quality Accreditation Tool (iQAT) was launched with the new Nursing Assessment and Accreditation System (NAAS).

You can access the NAAS document here.

Please click here to access the iQAT.

The results of the iQAT and NAAS are collated each month into the Hard Truths Quality Metrics. This is all the information on planned versus actual staffing levels as well as the quality indicators. The Hard Truths Quality Metrics is shared with the Clinical Governance Committee, Quality and Effectiveness Committee and the Clinical Commissioning Group (CCG) as well as all ward managers, matrons and Associate Directors of Nursing.

Department Quality Accreditation Tool (dQAT)

On World Patient Safety Day 2019, DBTH launched the first department Quality Accreditation Tool (dQAT) to ensure that the department areas were working to the same clinical standards as the inpatient areas. This would include using an adapted version of the inpatient tool called Department Accreditation and Assessment Tool (DAAS) and will be collated each quarter.

Download the DAAS Tool here.

Click here to access the dQAT.

Headlines from the August Quality Metrics (iQAT)

Access the full quality matrix here

Accreditation Performance (Quarter 1)

Positives

Nutrition
17 Wards have achieved Green RAG rating for Quarter one of the Nutrition accreditation, by completing all of the expected requirements.

6 wards achieved Amber for their Quarter one RAG as they had not had link nurse attendance, but had completed all other aspects of the accreditation.

Falls
There were 21 wards that achieved Green for their first RAG rating, and 2 wards Amber.

Infection Prevention & Control
13 wards achieved a Blue for Quarter one of IPC accreditation, these areas were fully compliant with all expectations of the accreditation with high scores for each domain.

25 wards achieved Green overall again performing well in all aspects of the accreditation.

Concerns

Nutrition
There are 6 wards that have a RAG rating of Red for Quarter one of the nutrition accreditation.

4 of these wards have not commenced work towards their Nutrition Accreditation.

11 wards were not represented at the first nutritional link nurse meeting.

Falls
There are 6 wards that have a RAG rating of Red for Quarter one of the falls accreditation. Main themes for development were completion of monthly falls documentation audits, and attendance of the falls champion training.

Infection Prevention and Control
There were 2 wards that have a RAG rating of Amber for Quarter one of the IPC accreditation. With the remainder of wards achieving green or blue.

There were 2 wards that have a RAG rating of Amber for Quarter one of the IPC accreditation. With the remainder of wards achieving green or blue.

Main themes for development were hand hygiene compliance, with 9 areas being RAG rated Red in this domain.

Overall Quality outcome (July 2019)

Positives

10 wards achieved blue for August 2019 on the Quality Metrics.

25 wards achieved green overall

These wards have achieved;

- No Serious Incidents
- No falls with moderate or severe harm
- No hospital acquired PU above cat 2 or reportable to STEIS
- Have not had any complaints or concerns
- Have achieved blue or green in all Q1 accreditation performance.

Concerns

5 wards were overall amber for quality. The themes from the amber ward are:

- Accreditation performance
- Results of Observation Audit
- Low FFT response rates
- Safety thermometer results
- Falls with severe harm
- C-Difficile with no lapses in care identified
- Pressure ulcers > Category 2
- Pressure ulcers reported to STEIS
- Drug delay and omission results.

Main themes for development were hand hygiene compliance, with 9 areas being RAG rated Red in this domain.

Nursing Assessment and Accreditation System (NAAS)

Positives

All the wards expected to have completed NAAS have achieved this.
23 wards achieved Amber as their overall result, 13 wards achieving Green, there were no Red wards.

This assessment is to be completed as a minimum of quarterly and July was the first assessment of this process. Some wards that were amber on their first assessments have reassessed before the expected time frame and have become green overall.

Positive themes from the NAAS completion were:

- Wards felt confident in the End of Life care they deliver.
- Their environments were safe for patients, staff and visitors
- Observations are completed correctly and deterioration is communicated to relevant people.

Concerns

The main themes of learning from the results of these assessments are:

- Pain Link Nurse – Pain will become a new accreditation from April 2020, therefore at present there isn't any link nurse meetings the ward staff need to attend. The majority of wards have now allocated a pain link nurse in preparation.
- Pain Score 2 or 3 is acted upon – A few areas have answered with N/A this may be due to not having any patients on the ward experiencing these levels of pain at the time off the assessment, However it is suggested that staff are asked their understanding of this process if this is the case. This will then enable the wards to answer this question with a yes/no and identify any areas for learning.
- RCA required for acquired Category 2 and above pressure ulcers – All Pressure Ulcers require a DATIX and these are then investigated in order to close, this is sufficient for Category 2 pressure Ulcers, any HAPU above a category 2 follows the full RCA process as advised by SIT.

Thanks this month go to: Cindy Storer, Miriam Boyack, Rebecca McCombe, Kirsty Clarke, Ben Cutler (for his design on the welcome boards), Liam Wilson and Bonny Stevenson.