We care

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Patient Safety and Experience

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.

We also know that involving patients, carers and their families in making decisions about their care can lead to better outcomes and a better overall experience. To help our ambition to be the safest Trust in England, Outstanding in all we do, we want to prioritise learning from;

- Incident investigations and complaints
- Patients and their experiences
- Good practice within DBTH and others
- Inquests and Claims
- Clinical audit

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).

In October, we shared with you the key themes from pulling together this data, which is shared in the image below. These 9 key themes will help us focus on what our patients are currently telling us needs to improve to make them safer and improve their experience while they are in our care.

12 ways of Sharing How We Care

This Christmas, we brought together some of the Trust's singing superstars and heros of health care, to celebrate the work we have done over the past year. Using the theme of Sharing How We Care, we created an alternative version of the 12 days of Christmas, along with the children at Hall Cross Academy.

We know that you all work incredibly hard in the Trust to all keep our patients safe and well looked after, so would also like to say a big thank you for your continued help and support and wish you a Happy Christmas!

Watch our special Christmas message here:

Learning from an inquest in another area

An inquest in another area

The Coroner at Barnsley heard a case in January 2018 where a patient had suffered a fatal anaphylactic reaction after eating at a local restaurant. The patient was served a korma containing almond powder but the powder contained both almonds and peanuts. The restaurant was not aware of this, as they had decanted the powder into another container and not checked the ingredients. There was no allergy information on the menus or displayed in the restaurants.

At the inquest, evidence was heard that there had been a similar incident at the same restaurant in 2014 where a curry containing nuts was given to a customer who had requested a nut free curry. They subsequently had an anaphylactic reaction and attended the local emergency department.

The inquest in 2018 revealed that there were no processes in place for hospitals to notify trading standards in cases of non-fatal anaphylactic reactions. This would have alerted trading standards to visit the premises and consider appropriate action.

Since then, Barnsley hospital have developed a proforma to notify trading standards of all attendances in the ED for non-fatal anaphylaxis. They have kindly shared this proforma with us and this has gone through the relevant governance groups for approval for patients across DBTH.

Access the Food Allergy Reporting Form here

Learning from Massive Haemorrhage Protocol (MHP)

A Serious Incident (SI) in December 2017, later resulted in a Prevention of Future Deaths Notice (PFDR or regulation 28) from the Coroner. Issuing the Trust with a PFDR means the Coroner is concerned there is a risk of future deaths, unless action is taken.

In December 2017, a patient was admitted to hospital after a fall in his garden. He was brought to Bassetlaw Hospital and diagnosed with a fractured hip. He was then transferred to DRI for surgery.

He attended theatre the following day and underwent internal fixation of the left hip under general anaesthetic with nerve block. Post operatively, he had a reduced urine output and for a 17 hour period, did not pass any urine at all. His dressings were frequently changed as they were leaking.

Observations continued to demonstrate a low blood pressure with the old early warning system in use. Although there was some evidence of the nursing staff escalating the rising early warning score to medical colleagues, there was no evidence of a review taking place.

On the first day post op he had blood tests showing haemoglobin was 51 with an acute kidney injury stage 2. There was a delay of 3 hours and 45 minutes before the first unit of blood was administered with poor documentation in the notes for the ceiling of care.

The following day, he had a cardiac arrest and died.

What is the learning?

The learning from this incident has been in-depth and has involved many changes across the whole Trust.

1. Massive Haemorrhage Protocol (MHP)

The MHP flowchart has been updated and should be displayed in clinical areas. Click here to print your copy.

Early recognition and intervention of the Massive Haemorrhage Protocol is essential for the patient's survival. The immediate priorities are to control bleeding (surgery and interventional radiology) and maintain vital organ perfusion by transfusing blood and other fluids through a wide-bore intravenous catheter.

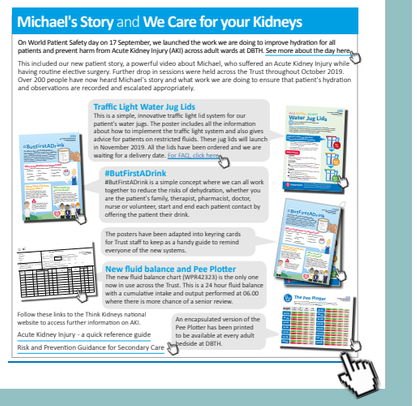
All communication from activating the MHP must be made using the MHP mobile number DRI: 07775013348. Bassetlaw: 07970423121 and not the bleep. This ensures direct communication between the clinical area and blood bank. Please be aware that out of hours only one member of staff is on shift to cover Blood bank, Haematology and Coagulation (and also chemistry at BH). When the MHP mobile rings it takes priority over any bleep to ensure an immediate response.

For more information on the massive haemorrhage protocol, please contact Emma Richards, Transfusion Practitioner at emma.richards21@nhs.net

2. Acute Kidney Injury (AKI) and Fluid Balance

Following this incident, the Trust identified that the existing fluid balance chart was not fit for purpose and had a cumulative intake and output calculated at midnight. This meant that any patient with a significant deficit in their urine output at midnight would be waiting until the morning (potentially up to 9 hours) for a senior clinical review. As such a Trust wide piece of work on having one standard fluid balance chart was commenced, resulting in the new chart launched on world patient safety day on 17 September 2019.

This is also complimented by the work we shared with you to help prevent or reduce incidents of AKI with #ButFirstADrink and the new water jug lids.



3. Implementation of NEWS 2

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 intervention to give the best possible chance of improved outcomes.

The revised NEWS2, published by the Royal College of Physicians, was introduced in September 2018 and we immediately saw improvements in how patient observations were recorded, calculated and escalated.

This short film featuring Professor Bryan Williams (one of the founders of NEWS), looks at why it was developed; what the changes are to NEWS2; how it can be used to identify sepsis.

Click here to watch the video.

4. Electronic observations

The introduction of electronic observations to record NEWS 2 has reduced the need for the nursing staff to manually calculate the score. Although started at BH, this will be rolled out across all the wards in the Trust. Evaluation has demonstrated that using electronic observations saves about a minute and a half per set of observations compared to pen and paper. In the 6 week period between 8 October – 20 November; 33, 271 observations were taken and recorded. This has released an average of 49,506 minutes or 831 hours of nursing time to spend with patients.

5. Sepsis alerts and Fluid balance

The Sepsis module is now live at BH and uses NEWS 2, plus suspicion or evidence of infection to alert clinicians to the possibility of sepsis. The Fluid balance module is planned for introduction in April 2020. We will keep you updated as the digital transformation continues.

6. Respect

ReSPECT

The ReSPECT process was introduced in April 2019 and helps to provide professionals responding to an emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. The ReSPECT plan is created through conversations between a person and their health professionals. The plan is recorded on a form and includes their personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that they would want, that would not help, or that they would not want.

We need to Talk about Dying was an infographic developed by the medics on twitter, campaigning for peaceful EoL care and patient dignity. This is intended to encourage clinicians to have the conversation with patients around their wishes when they are at the end of their lives.

Learning from CQUIN

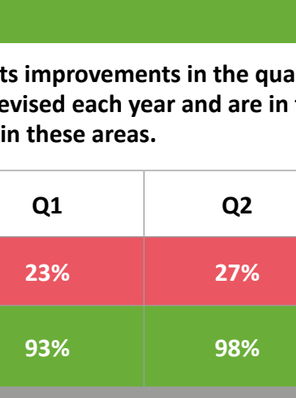
The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care. These are revised each year and are in the table below; where the table is Red – this means that we need to improve in these areas.

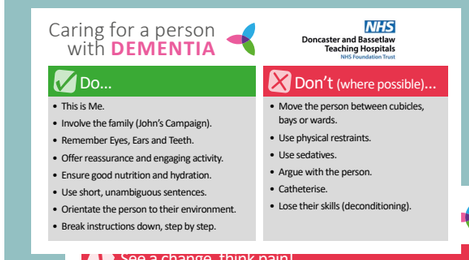
CQUIN Indicator	Q1	Q2
Antimicrobial Resistance – Lower Urinary Tract Infections in older people (overall pass %)	**23%**	**27%**
Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery (overall pass %)	**93%**	**98%**
Staff Flu Vaccinations (not measured until Q4)		
Alcohol and Tobacco - Screening	**91.41%**	**92.5%**
Alcohol and Tobacco – Tobacco Brief Advice	86.6%	**98%**
Alcohol and Tobacco – Alcohol Brief Advice	59.3%	74%
Three high impact actions to prevent Hospital Falls (overall pass %)	**20%**	27%
SDEC – Pulmonary Embolus	**100%**	57%
SDEC – Tachycardia with Atrial Fibrillation	**100%**	Awaiting data
SDEC – Community Acquired Pneumonia	**85.7%**	74%

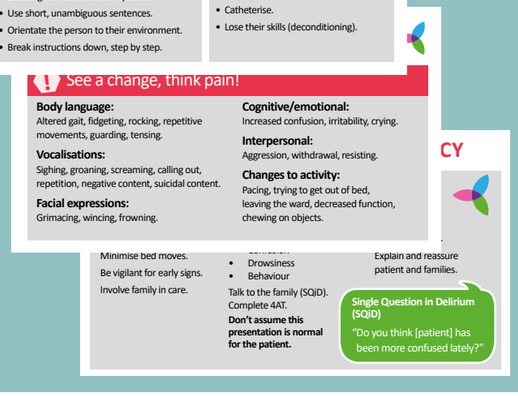
What is the learning to improve CQUINS?

Asymptomatic bacteriuria (ASB)

is the presence of bacteria
in urine without typical signs or symptoms of UTI. Treating ASB with unnecessary antibiotics can lead to harm in 1 out of 3 elderly patients. Our colleagues in Infection Prevention and Control have produced a helpful poster for clinical areas where staff may dipstick urine.







Lying and Standing Blood Pressure

The Royal College of Physicians the lying and standing blood pressure measurement guide has been designed to assist clinical teams in standardising their approach to falls prevention in hospitals.

A drop in blood pressure (BP) on standing (orthostatic hypotension – OH) is a common occurrence in acutely unwell hospitalised patients and is a risk factor for falls. For more information, click here.

Learning from Insulin prescribing

A recent incident occurred in a day unit, where a patient was prescribed insulin. The drug card was handwritten written as 6 UNITS. The nurse mistakenly drew up and administered 60 units. The error was realised instantly and appropriate action taken with no harm to the patient. This could have been a Never Event, had the prescription used abbreviations (e.g U instead of UNITS).

What is the learning?

Always double check prescriptions for the correct dose and check with the patient (they usually know exactly how much insulin they take).

Message of the month Information Governance

We recently had Peer review visit for our Chemotherapy service. The reviewers identified Information governance serious risks on the ward:

1. Computers with patient identifiable information were left open and unlocked leaving access to sensitive patient information by any individual on the ward.

2. Medical notes trolleys were also left unlocked, open and unattended in the corridors on the ward.

Can you please ensure that all computers with identifiable patient details are locked and not left unattended. Patient case notes and results that have identifiable data and information should be locked properly and securely stored.

Learning from Good Practice

Nationally an increasing number of people with Diabetes are requiring lower limb amputations through the complications of this long term condition. An individual who has Chronic Kidney Disease and Diabetes has a much higher risk of developing diabetic neuropathy, an active foot ulcer and in many cases leading to a lower limb amputation.

Rebecca Stevenson, Staff Nurse on the Renal Unit at DRI performed a literature search to highlight studies which showed a reduction in the number of lower limb amputations, when implementing monthly diabetic foot checks during the 4 hour session of dialysis three times a week.

Rebecca arranged for training from the podiatry department to implement diabetic foot checks on patients receiving dialysis. The results were then audited and identified new foot problems with 15 patients not able to recall when they last had a foot check within the community.

There were 31 individual new foot problems identified in 6 months with 4 active diabetic foot ulcers and 12 identified with poor sensation to their feet. All problems were referred onto podiatry for follow up on dialysis or in the community for treatment. 17 patients were referred in total to podiatry from a group of 27 patients. This proved the monthly foot checks were effective in the early detection of diabetic foot conditions in this high risk group resulting in early assessment and early treatment instigated.

The impact of preventing even one patient from having a lower limb amputation allows improved quality of life, whether avoiding amputation altogether or delaying the problems from starting for a number of years and also reducing pain. These checks make more effective use of the time on dialysis and ensure holistic nursing care with a shared care philosophy. This meets the needs across different specialities especially when these conditions are so closely linked.

There are now ongoing discussions with Mexborough and Bassetlaw satellite dialysis units to extend these foot checks to all three units and improve care for all haemodialysis patients. There is also scope for further auditing of the findings and hopefully nursing research within this area in the future. It does demonstrate that a simple idea can make a great deal of difference to people's lives.

For more information, please contact Rebecca Stevenson at rebecca.stevenson3@nhs.net

Safeguarding

A member of ED staff made a referral for a patient who presented after being assaulted by her partner. As well as ensuring the patient had the correct support in place, ED staff made a safeguarding referral for the children in the household who were witnessing Domestic Abuse. We received positive feedback from the social worker who praised the staff and expressed her thanks that the information provided and the subsequent joined up working between ourselves, ambulance service and the police provided her with a fuller understanding of the present situation.

Access the Domestic Abuse section on the Hive here.

For more information, the safeguarding newsletter can be accessed here.

Learning from Compliments posted on NHS.UK

Labour Ward

We can not express in words our gratitude towards the Midwife at Labour Ward. She saved our Sons Life during CTG. She noticed in time that there is something wrong with our Babys pulse. She was extremely Professional, gentle and caring. After the emergency C Section she was more a Family member than a Midwife. She cried with us, supporting, saying kind words, and sharing tears of joy as well. Your heart melts when you meet this kind of Persons. They are more than a human, acting like Watch Angels. Can not recommend enough this Hospital! Superb staff in every single department!

Day Surgery and Theatres

I attend Doncaster day surgery for my gall bladder surgery, I can say this was one of the best experiences I have had from the NHS! From meeting the staff in the day unit to my consultant they were all fantastic! A special mention to the young ODP and his student who helped put me to sleep, you was a true god send! He came in smiling and joking, treated me like I was a member of his family! Thank you! Thank you to you all, who ever said the Nhs is failing needs to see these people in action!

Thanks this month go to: Cindy Storer, Acting Deputy Director of Nursing & Midwifery; Tim Noble, Consultant Physician and Deputy Medical Director; Juan Ballesteros, Emergency Medicine Consultant; Mr O. O. Olubowale, Consultant Oncoplastic Breast Surgeon and Breast MDT Lead, Trust Cancer Lead; Emma Richards, Transfusion Practitioner; Rebecca Stevenson, Staff Nurse Ward 32; Esther Lockwood, Falls prevention Practitioner; Catrina Drury, Head of Audit and Effectiveness; Elizabeth Boyle, Named Nurse for Safeguarding Children and Safeguarding team leader.