You're invited to our **SHWC Conference 2020**

We are pleased to let you know that our third DBTH Sharing How We Care Conference has been arranged for 2 April 2020 at the Hilton Garden Inn, Doncaster.

Speakers include Dr Suzette Woodward who is a national expert in patient safety and talks about a more positive approach to learning how things normally happen in order to understand why they may have failed. Her talk will acknowledge how complex healthcare is, but also how we need to encourage kindness and civility.

Following her work on the sign up to safety campaign, she helped to develop this info-graphic, which has been shared in previous editions of this newsletter.

There will be a series of breakout sessions to choose in the morning and then back together for a Mindful of Happiness by our own Mr Ravi Karwa.

Dr Graham Cooper, recently appointed regional medical examiner for North East and Yorkshire will speak about the introduction of the system of medical examiners (ME) in England and Wales. This role is aimed to deliver a more comprehensive system of assurances for all non-coronial deaths and provide an opportunity to develop a system that addresses concerns about avoidable hospital deaths. More information about the national medical examiner system can be found here: https://improvement.nhs.uk/resources/establishing-medical-examiner-system-nhs/

We will be closing the day by launching our new Healthy Hospitals Team! Due to generous funding from Yorkshire Cancer Research, and by working together as an Integrated Care System across South Yorkshire and Bassetlaw, DBTH will be having a dedicated inpatient team to work across all sites to support our patients. The team will be starting by offering an inpatient smoking cessation service and will move onto other health promotion initiatives as part of the NHS Long Term Plan. Read the summary here: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/the-nhs-long-term-plan-summary.pdf


Event timetable

Sharing how we care CONFERENCE 2020

Event location:

Garden Suite North Side · Garden Suite South Side · The Old Weighing Room · The Trophy Room

8.30am **Registration** Tea and Coffee and opportunity to visit corporate stalls

9.15am **Welcome and housekeeping**

9.20am **The Patient Safety Vision for DBTH** Richard Parker OBE, Chief Executive DBTH

9.30am **Safety II - Rethinking Patient Safety** External Keynote Speaker Dr Suzette Woodward

10.30am **Break** Tea and Coffee and opportunity to visit corporate stalls

11.00am **Breakout Sessions**

- **Leadership & Staff Engagement 'Our journey to Outstanding'** Jayne Collingwood, Head of Leadership
- **Maternity Transformation 'The DBTH journey so far'** Lois Mellor, Head of Midwifery
- **Speak up to make a difference** Paula Hill, Freedom to Speak Up Guardian

11.45am **Lunch** Tea and Coffee and opportunity to visit corporate stalls. Free hand massages from Doncaster College students

12.30am **A 'MINDFUL' of Happiness** Mr Ravi Karwa, Gastroenterology Associate Specialist

1.00pm **The new role of the Medical Examiner and Learning from Deaths** External Speaker Mr Graham Cooper, North East and Yorkshire Lead Medical Examiner (Cardiothoracic Surgeon)

2.00pm **Healthcare Safety Investigation Branch 'Our journey so far'** Improving Patient Safety through effective and independent investigations that don't apportion blame or liability. External Speaker Julie Shaw, Maternity Investigations Team Leader (Midlands & East Central (North)), Healthcare Safety Investigation Branch

2.45pm **Break** Tea and Coffee and opportunity to visit corporate stalls

3.15pm **Digital Transformation @DBTH** The impact of eObservations Dr Lee Cuffe, Critical Care Consultant

3.45pm **Launch of the Healthy Hospitals Team** and the role of prevention in health care Kay Wroe, Healthy Hospitals Programme Manager

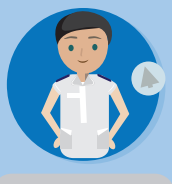
4.15pm **Thank You and Close** David Purdue, Director of Nursing, Midwifery & AHPs

Click the image above to view the agenda for the day.


Click here for the **SHWC 2020 site**

Reserve your tickets

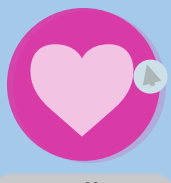
Please click on your respective Division to book tickets. If you don't belong to a Division, please select the one which states 'All Directorates'. If you are booking for yourself and colleagues, press register and select the 'group' option.


Medicine


Cancer & Surgery


Clinical Specialities


Women's & Children


All Directorates

? Not sure which division you belong to? Click here to find out.

INCIVILITY

THE FACTS

WHAT HAPPENS WHEN SOMEONE IS RUDE?

80% of recipients lose time worrying about the rudeness

38% reduce the quality of their work

48% reduce their time at work

25% take it out on service users

Less effective clinicians provide poorer care

WITNESSES

20% decrease in performance

50% decrease in willingness to help others

SERVICE USERS

75% less enthusiasm for the organisation

Incivility affects more than just the recipient
IT AFFECTS EVERYONE

CIVILITY SAVES LIVES

The price of incivility. Porath C, Pearson C. Harv Bus Rev. 2013 Jan-Feb;91(1-2):114-21, 146.

What is **civility?**

Almost all excellence in healthcare is dependent on teams, and teams work best when all members feel safe and have a voice. The civility saves lives website has been developed by healthcare professionals aiming to raise awareness of the power of civility in medicine. Read more about it here: https://www.civilitysaveslives.com/

Rudeness is defined by the interpretation of the recipient, regardless of intent. There is a growing body of new science that finds Civility between team members creates that sense of safety and is a key ingredient of great teams. The evidence also shows that Incivility robs teams of their potential.

Please watch this powerful 15 minute video by Chris Turner helps to explain how rudeness in teams can turn deadly:

Message of the **month**

Last month we shared the work we are doing to prevent Hospital Acquired Pressure Ulcers (HAPU).

One of the recurring themes of patients acquiring HAPU was the availability of dynamic air mattresses. We are pleased to let you know that, in addition to the 226 static mattresses, 458 chairs and 34 trolley mattresses, we are now ordering in 150 dynamic air mattresses to support our patients who need this equipment. All equipment, once not needed should be returned to the medical equipment library, so they can ensure they are meeting requests for new equipment.

Please ensure you speak to your ward manager, matron or associate director of nursing if you have any concerns about equipment being available.

Learning from Serious Incidents (1/2)

The following Serious Incidents have been investigated by our Patient Safety Team and the subsequent reports closed by our local clinical commissioning group (CCG). To ensure learning across the whole Trust, we are sharing a summary of the incidents and learning.

Patient A: In September 2014, patient A was diagnosed and treated for an unprovoked Pulmonary Embolism (PE). A CT scan of the abdomen and pelvis was done at the time to rule out the possibility of a tumour. In May 2019, this patient was scanned again following a complaint of left sided scrotal swelling. This revealed a large mass in the lower pole of the left kidney. The kidneys would have been included in CT scan done in 2014. There was no mention in this CT report of any kidney abnormality, however when reviewed in retrospect; this imaging did show an abnormality in the left kidney.

What is the learning?

Patient A had an undiagnosed 36mm abnormality in his left kidney in 2014. Following a CT scan in 2019, Patient A was diagnosed with a left renal tumour of approximately 100mm in size. The abnormality in the lower pole of the left kidney was present on scan in 2014; however it was not identified and reported by the radiologist at this time. The patient probably would have been recommended to have the same surgical intervention if he had been diagnosed in 2014. However, the risk of recurrent disease in the future may be increased due to the delay in diagnosis.

The outcome of the investigation has not identified any specific issues that require further recommendations and actions. There is a known rate of interpretation errors of imaging tests in all units and the investigation concluded that this individual case came under this category. Systems and processes were reviewed to minimise these errors.

Patient B: In 2014 Patient B was referred into the Dermatology Department. She had a history of Psoriasis Vulgaris and Psoriatic Arthritis. On initial review by the Dermatologist, a small lesion on the rim of her right nostril was noted and she was booked for biopsy. Within a month, the biopsy was taken and after histological examination, it was confirmed to be basal cell carcinoma (BCC).

The biopsy results were received and reviewed by the Consultant in a timely manner. The process within Dermatology was that when the paper copy of the report was received, the secretaries would annotate the patient's next appointment using a code. When the Consultant reviewed the paper copy and noted that the patient had an appointment within a short period of time, an assumption was made that the code related to the follow up with a Consultant, where Patient B would get her results.

The investigation found that the code was actually related to a nurse led day treatment for Patient B's routine Psoriasis treatment and therefore, the patient was not informed of the results of the biopsy and neither were follow up arrangements made.

In 2019, during a routine Psoriasis treatment appointment, Patient B pointed out the area to the nurse as it had been bleeding recently and would not heal. At this point the nurse looked back at the notes and results and realised that the patient had never received the diagnosis of basal cell carcinoma and that treatment had not been offered. Unfortunately due to this error, Patient B has had to undergo more invasive surgery and has been left with a deformity on her face.

What is the learning?

Each Dermatology Consultant now has an individual record of all significant samples that have been sent for histology and are individually responsible for reviewing those results and acting on them. In addition the secretaries will write 'longhand' whether the next appointment is nurse led or doctor led. The Consultant will annotate on the paper result whether a nurse led or doctor led appointment is required.

Learning from Serious Incidents (2/2)

Patient C: Patient C was admitted to hospital as an emergency with obstructive jaundice and possible underlying malignancy. While undergoing investigations, he had an unexpected collapse and despite no ReSPECT document present or formal documentation of the decision to resuscitate made, the staff didn't call for help, attempt resuscitation or call 2222.

What is the learning?

The investigation concluded that the cause of death was unpredictable and sadly was not likely to be recoverable even with attempts at resuscitation. The nurse looking after the patient had assumed the ReSPECT decision not to resuscitate was in place as discussions around palliative care had taken place.

Although attempts at CPR were ultimately not appropriate in this case, the Trust policy is clear that an emergency call 2222 should have been made and resuscitation commenced.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. Had this decision been made in advance of the emergency, it would have ensured the staff had made the correct decision not to attempt futile resuscitation.

How do we improve palliative and end of life care?

To give advice, support and guidance to staff, patients and families, the Palliative care team are available on 07760 990613 at Doncaster or 07760 990543 at Bassetlaw. This is a seven day service 09.00 – 17.00. Out of Hours, the Palliative Care Consultant is available through switchboard.

The End of Life team at are available on 07768 965979 at Doncaster and 07769 578856 at Bassetlaw. This service is available for all inpatient areas, seven days a week 09.00 – 18.00.

For more information, please contact karen.lanaghan@nhs.net or visit the end of life page on the intranet: https://extranet.dbth.nhs.uk/end-of-life-care/

Outpatient appointments intended but not booked

The Healthcare Safety Investigation Branch (HSIB) conduct independent investigations of patient safety concerns in NHS-funded care across England.

The safety recommendations aim to improve healthcare systems and processes in order to reduce risk and improve safety.

HSIB have identified a safety risk involving outpatient follow –up appointment's which are intended but not booked after an inpatient stay. We will be following the case closely to ensure any learning can be shared at DBTH. You can read more about the case here:

https://www.hsib.org.uk/investigations-cases/outpatient-appointments-intended-not-booked-after-inpatient-stays/

Stop all fax use

after **31 March**

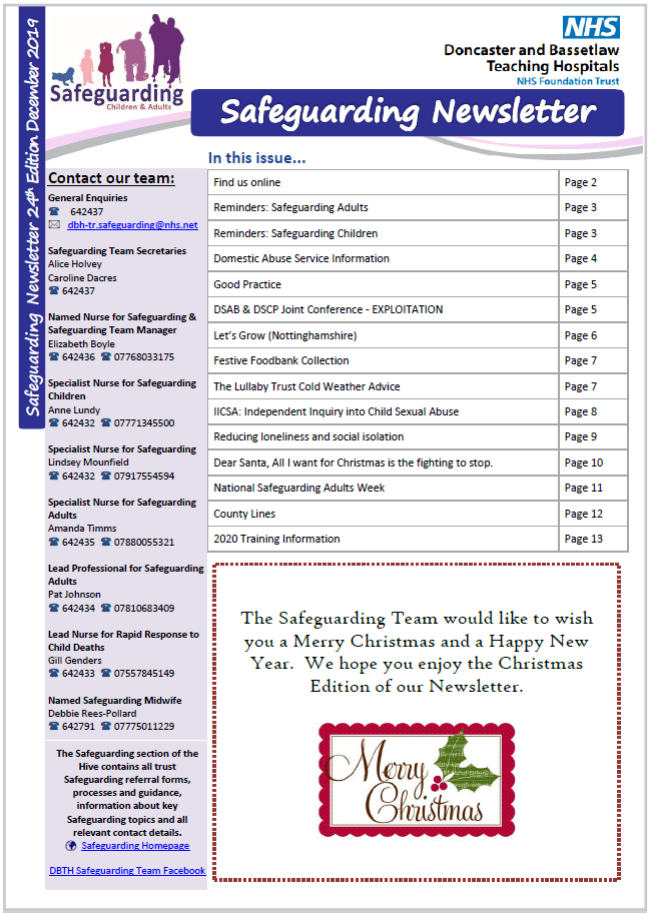
Learning from Safeguarding

A patient disclosed to the nurse looking after her that her family were asking for money from her all the time. While not openly stealing, she felt intimidated by her family and gave them the money they asked for. The patient didn't want to go home as she was scared of her family.

The nurse assessing the patient suggested that she phone the police, which she did, supported by the hospital social worker. The police investigated this case and someone was arrested and taken into custody.

Another patient, admitted as an emergency, lacked capacity to consent to treatment. At this point, surgery was a potential treatment option for this patient. The treating clinicians waited for a few days until the initial treatments had been effective, and revisited the discussion about surgery with the patient.

The patient had regained capacity and was able make the decision. The patient opted for conservative treatment and was able to rationale the decision and her reasons for it. This good practice identified the capacity assessment through good documentation and allowed time for the patient to regain capacity to make an informed choice about their treatment options.


Safeguarding Newsletter 24th Edition December 2019

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Safeguarding Children & Adults

Safeguarding Newsletter

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Contact our team:

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Specialist Nurse for Safeguarding Adults
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Lead Professional for Safeguarding Adults
Pat Johnson
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Lead Nurse for Rapid Response to Child Deaths
Gill Genders
642433 07557845149

Named Safeguarding Midwife
Debbie Rees-Pollard
642791 07775011229

The Safeguarding section of the Hive contains all trust Safeguarding referral forms, processes and guidance, information about key Safeguarding topics and all relevant contact details.
Safeguarding Homepage

DBTH Safeguarding Team Facebook

The Safeguarding Team would like to wish you a Merry Christmas and a Happy New Year. We hope you enjoy the Christmas Edition of our Newsletter.

Merry Christmas

Click the image above to view the latest Safeguarding newsletter.

For more information on safeguarding, visit the page on the Hive https://extranet.dbth.nhs.uk/safeguarding/

Safe Staffing at the Trust


Sharing how we care

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Nursing and Midwifery Workforce and Safe Care

January 2020

We know that the nature of patient needs and ward activity is changing. Inpatients tend to be more ill than they used to be, many with complex needs often arising from multiple long-term conditions. At the same time, all hospitals in the NHS face the challenges of a shortage and high turnover of registered nurses and midwives.

Planning the Teams

Making decisions about optimal ward staffing is complex. Most inpatient areas have their establishment, skill mix and hands per shift planned on the average acuity and dependency of patients. This means that at times of increased patient activity, acuity and dependency, these areas can seem busy places with not enough staff.

Leadership

While planning the shape of the team is critical, managing wards well is not just a numbers game. Managers need time and training to manage staff and to use roster planning tools well. Evidence is emerging that patient experience is affected by staff wellbeing and local ward culture. Teamwork, clear role design and good local leadership all contribute to positive ward environments.

Click the image above to view the latest Workforce and Safe Care newsletter.

At the Trust, we want you to deliver safe care for patients, as well as achieving the best clinical outcomes from treatments or operations. To do this, we work hard behind the scenes to ensure we have maximised the available resource to provide safe staffing.

To share this work, we have created a new newsletter for nurses and midwives, which will be produced twice a year, in line with the times we run the Safer Nursing Care Tool (January and June).

You can read the newsletter and download the relevant posters for your areas here:

https://extranet.dbth.nhs.uk/safety-quality/wp-content/uploads/2020/01/Nursing-and-Midwifery-Workforce-and-Safe-Care-SHWC-Jan-2020.pdf

Celebrating **Quality Improvement in Maternity**

On Monday 27 January, an event was held to celebrate the varied quality improvement events across maternity services at DBTH

The teams all presented short summaries of the work they had done, starting by getting their teams together to focus in identifying the unnecessary frustrations they faced on a regular basis. Patients were asked what they thought about the services they used and helped to raise money to support small but important improvements.

Everyone in the team was able to have their say in the improvement process and contributed ideas, from the support workers, to the admin staff, the midwives and the consultants, right through to the senior management team.

The collaboration has been remarkable and made a huge difference to the clinical areas, with all staff commenting that they can perform their jobs to a much higher standard.

Congratulations and well done to the whole team!

For more information on Quality Improvement or to get help for an idea you have had in your area, you can look for ideas on this page https://extranet.dbth.nhs.uk/quality-improvement-qi/qi-overview/