NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

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.

***Sharing* how we care** is about how we make our Trust values the golden thread of everything we do, how we share where we have gone wrong so we can make improvements together and learn how to minimise harm for the next patient.

Insight: Measurement, incident response, medical examiners, alerts, litigation

Improve our understanding of safety by drawing insight from multiple sources of patient safety information

Learning from **Serious Incidents**

The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

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, why it has gone wrong and sharing it with all of our teams to reduce the risk of similar incidents occurring again.

Remember: Serious Incidents (and never events) must be declared internally as soon as possible. Please contact a member of the patient safety team if you are unsure of what level of harm to report.

In 2019/20 we reported 57 Serious Incidents:

- Four patients falling and suffering a fractured hip where there was significant learning for the clinical area.
- 28 patients suffering a category 3 hospital acquired pressure ulcer where there were significant learning for the clinical area (HAPU category three are no longer a serious incident as from April 2020).

Learning from **Serious Incidents**

25 Serious Incidents for care related issues:

1. Wrong Eye treatment **Never Event**
2. Wrong Site Ureteric stenting **Never Event**
3. Missed opportunities to escalate and recognise patient was unwell – CDS
4. Ophthalmology Treatment delay
5. Resuscitation not commenced when found collapsed
6. Missed renal tumour diagnosis – treatment delay
7. Follow up in wrong clinic – Dermatology diagnosis
8. Treatment delay medical imaging – Vascular patient, fem-pop bypass. Missed review
9. Missed diagnosis on x-ray – treatment delay
10. Endoscopy screening for Barrett's surveillance - delayed treatment LTFU
11. Accidental arterial cannulation – CVC
12. Lobular cancer delayed diagnosis
13. Missed slipped SUFE – treatment and diagnosis delay
14. Death from hospital acquired C-Diff
15. Missed report of chest x-ray – treatment and diagnosis delay
16. Missed AAA surveillance scan
17. Wrong strength lens fitted to correct eye **Never Event**
18. Ophthalmology treatment delay
19. Insulin administered from Pen device **Never Event**
20. Intra-Uterine Fetal Death

HSIB investigations

21. HIE grade 2
22. HIE

Three further incidents were reported and investigated but delogged by the CCG. These were: Aortic Dissection, Wrong Eye injection, Ischaemic Leukoncephalomalacia.

Themes from these incidents include the following:

Thinking Errors:

Action is carried out, as planned, using conscious thought processes, but wrong course of action is taken: 'do the wrong thing believing it to be right'.

Rule Based Mistakes:

If behaviour is based on remembered rules and procedures, mistake occurs due to mis-application of a good rule or application of a bad rule.

Knowledge Based Mistakes:

Individual has no rules or routines available to handle an unusual situation: resorts to first principles and experience to solve problem.

Action Errors:

Associated with familiar tasks that require little conscious attention. These 'skill-based' errors occur if attention is diverted, even momentarily. Resulting action is not intended: 'not doing what you meant to do'.

Skill Based Errors:

Fall into one of two categories either 'slips' or 'lapses in concentration.'

How will the Serious Incident framework change to the Patient Safety Incident Response Framework?

To support us to further improve patient safety, we are preparing for the introduction of a new Patient Safety Incident Response Framework (PSIRF), outlining how we should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

The PSIRF is a key part of the NHS Patient Safety Strategy published in July 2019. It supports the strategy's aim to help the NHS to improve its understanding of safety by drawing insight from patient safety incidents.

Until instructed to change to the PSIRF (likely from Spring 2022), we must continue to use the existing Serious Incident Framework.

Update from the Medical Examiner

The medical examiner system is a point of contact for bereaved families to raise concerns about the care provided to the death of a loved one.

The purpose of the medical examiner is to provide greater scrutiny of non-coronial deaths, ensure the appropriate direction of deaths to the coroner, improve the quality of death certification and improve the quality of mortality data and ensure these are discussed with the next of kin/informant, establishing if they have any concerns about the care that could have led to the patient's death.

Unfortunately having not identified any SIs in quarter two, the Medical Examiner team have highlighted around 4 potential Serious Incidents (SI) in quarter three (Q3). These were passed onto the SI panel for discussion and further investigation.

The incidents in Q3 include two patients who suffered severe harm after an inpatient falls (fractured NOF and intracranial haemorrhage). One patient had an unexpected cardiac arrest while being treated for Covid-19 and was not prescribed prophylactic treatment for VTE and another patient had a complication from surgery, which started with the brand name of medicine being documented in the medication history, rather than the generic name, missing an opportunity to recognise the patient was on anticoagulants.

What is the immediate learning?

While overall the numbers of patients falling in our hospitals has reduced since 2014, the numbers of patients suffering severe harm as a result of their fall has been increasing since 2019. The effect of a fall on a patient and their family can be devastating, resulting in death or a life changing injury and can be avoided if we work together as a multidisciplinary team. We shared all the learning from Falls in the March newsletter all of which is still relevant learning.

We have also introduced a new 'Learning from Falls' panel, to improve learning in real time. Clinicians from the MDT involved in the care of the patient at the time of the fall are welcome to attend and contribute.

One new theme has been escalation through the Hospital @ Night team and for the assessment of the patient to be immediate following a fall with head injury. On one occasion, the job was not assessed as urgent, leading to a delay in the patients review, when they needed urgent referral to neurosurgery.

Triangulated themes for the learning from falls:

Asked about any history of falls	81% (22/27)
Assessed for the presence or absence of delirium or a documented diagnosis of delirium	63% (19/26)
A record of level of mobility	100% (29/29)
Measurement of lying and standing blood pressure	9% (2/22)
Assessment for medications that increase the risk of falls	12% (3/25)
Night sedation or other sedative medication administered since admission	7% (2/29)
Is safe footwear on patient's feet?	83% (15/18)
Is call bell in sight and in reach of patient?	84% (21/25)
Is the immediate environment free of clutter?	84% (21/25)
Is the appropriate walking aid in reach?	75% (6/8)

A patient had an unexpected cardiac arrest and screening from the medical examiners team highlighted the absence of VTE prophylaxis. For all inpatients being treated for Covid-19 – VTE prevention NICE guidance is as follows: https://www.nice.org.uk/guidance/ng186/ resources the headlines from this are to assess bleeding risk using a risk assessment tool and start pharmacological VTE prophylaxis with low molecular weight heparin (LMWH) unless contraindicated.

Another patient attending pre-operative assessment prior to elective hip replacement was identified as being on the medication Eliquis (brand name) but this doesn't appear to have been recognised as the anticoagulant apixaban (generic name). The patient was subsequently not told to stop taking the Eliquis, which was a contributory factor leading to the post-operative death. This was identified by the medical examiners team and passed onto the SI panel for further investigation.

When taking a drug history from the patient, the generic name (name of the active ingredient in the medicine) should always be used and not just the brand name (the name created by the pharmaceutical company).

Involvement :

Patient safety partners, curriculum and training, specialists, Safety II

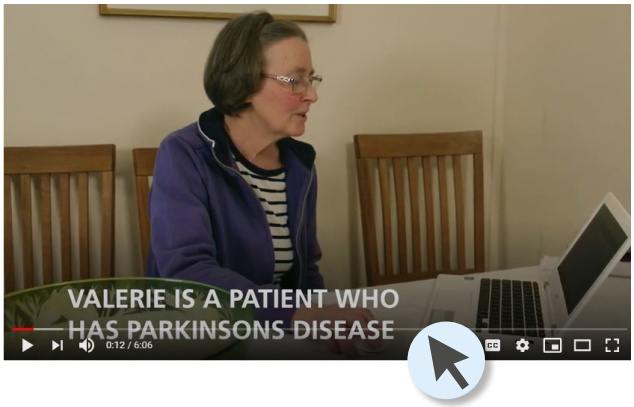
People have the skill and opportunities to improve the patient safety, throughout the whole system.

NHS improvement have developed a series of patient story videos to be used as training resources for NHS organisations to demonstrate the impact the initial response to a patient safety incident and subsequent investigation has on the patient.

Valerie's story

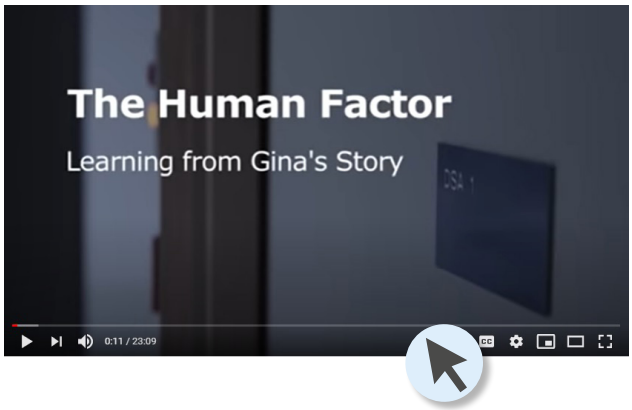
Valerie, a patient with Parkinson's disease, talks about her experience following an incident where she was mixed up with another patient and given the wrong medication.

At DBTH, we have produced a series of patient stories, which can also be used as training resources in your wards and departments.



Gina's Story (2014)

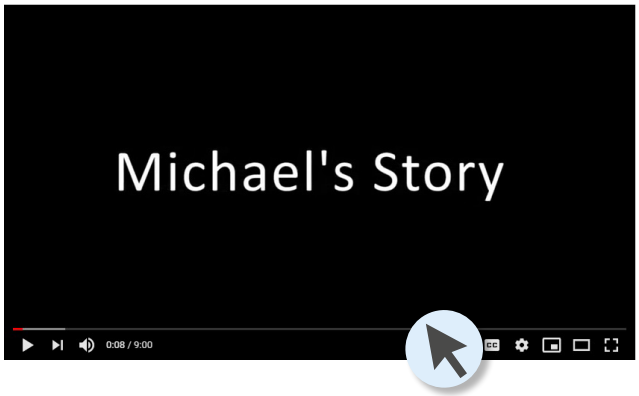
Gina was attending hospital for a routine procedure, where the standard practice (at the time) for preparing IV medications allowed the wrong medicine to be administered, leading to a life changing injury for Gina.



Michael's Story (2019)

Michael was having an elective knee operation at a local private hospital, where inadequate peri-operative management and monitoring of his fluid balance led to a life changing Acute Kidney Injury. Working closely with Michael and his family, we have been able to share his story and have implemented several changes to try and improve hydration for our patients, These include a new fluid balance chart (which will be incorporated into the new eObservations system), the Traffic Light Water Jugs Lids and #ButFirstADrink.

Information on the improvement work to prevent AKI was shared with you all in SHWC Nov 2019, click here to access it.



Saying Sorry and Duty of Candour

If a patient suffers harm in our care, saying sorry meaningfully is vital for everyone involved in the incident, including the patient, their family and carers. This leaflet is part of the work NHS Resolution have completed on the Duty of Candour to guide clinicians on what they should and can say. If a patient has fallen and suffered harm, the incident should be reported and an apology offered to the patient and their family as soon as possible. Download the Saying Sorry leaflet from NHS Resolution here.

Observing the Duty of Candour (DoC) requirements is a legal duty for all healthcare providers. The patient and family information leaflet on duty of candour can be accessed here and should be given to the patient who has suffered moderate or severe harm.

More information can be found on our website here.

Improvement :

Deterioration, spread, maternity, medication, mental health, older people, learning disability, antimicrobial resistance, research

Improvement programmes enable effective and sustainable change in the most important areas.

DBTH Digital Transformation programme

Preventing deterioration

eObservations, provided by Nervecentre, is an extension of Hospital@ introduced to the Trust in early 2019, and helps in the recording and distribution of tasks within wards and departments between health professionals. Similar to the former system, observations are logged centrally on the system, with an accompanying patient record and related notes and alerts visible to trained users. The system will also work out the frequency of required observations, helping clinicians to make the most of their time.

A recap of 2020

- **Hospital@** – Rolled out @ Bassetlaw, DRI & Montagu
- **eObs** – Rolled out @ Bassetlaw: 6 adult wards; Doncaster: Frailty & Medicine divisions

Continuing in January 2021...

Nervecentre upgrade to 6.1 will allow us to deploy:

- **Clinical assessments**
- **Care plans**

New DBTH strategies launched

Learning Disability Strategy

We recognise patients with a learning disability have far greater health needs than the general population. Patients with learning disabilities are more likely to die younger, have greater health inequalities and poor access to care provision which can lead to premature deaths.

In June 2018, NHS Improvement launched the National Learning Disability Improvement Standards for NHS Trusts. These were designed with people with a learning disability, carers, family members and healthcare professionals to drive rapid improvement of patient experience and equity of care.

The new LD strategy, approved at the BoD in October 2020, aims to provide all staff and services an approach to planning effective care pathways from admission to discharge and is aligned to the standards in the National Learning Disability Improvement Standards.

The link to the strategy can be found here.

Mental Health Strategy

The Mental Health Strategy intentions were developed following the week long system perfect completed on the 2nd of April 2019. The week was run supported by numerous social media and communication campaigns to address the needs of patients with mental health, learning difficulties and those with a dependency issue, who present to DBTH.

The full strategy can be found here.

Infection Prevention and Control working with the community

Like the rest of our teams, Our Infection, Prevention and Control teams have worked incredibly hard during the Covid-19 pandemic. One new development was for some of our IPC nurses to work across care home localities in Doncaster. This was to help, advise and support staff, residents and families in those homes. This incredible work also to helped to reduce further outbreaks and unnecessary admission to hospital. NHS I picked up the work and published on their website.

Click here to access the NHS I website.

Sharing **How We Care** shortlisted for another National Patient Safety Award!

Our approach to shared learning has been shortlisted for another national patient safety award. This time for Patient Safety Innovation of the Year with the Health Service Journal. Thank you to everyone who continues to read, support and contribute towards patient safety at DBTH NHS FT

Thanks this month go to: Cindy Storer, Dr Ruth Medlock, Dr Tim Noble, Simon Brown, David Purdue, Miriam Boyack, Nikki Severein-Kirk and Bonny Stevenson