

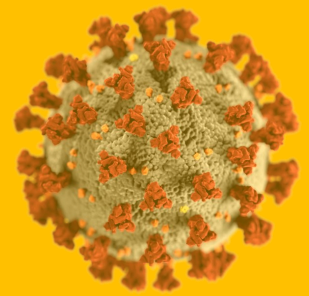


CARDIFF AND VALE UHB

# Patient Safety & Quality

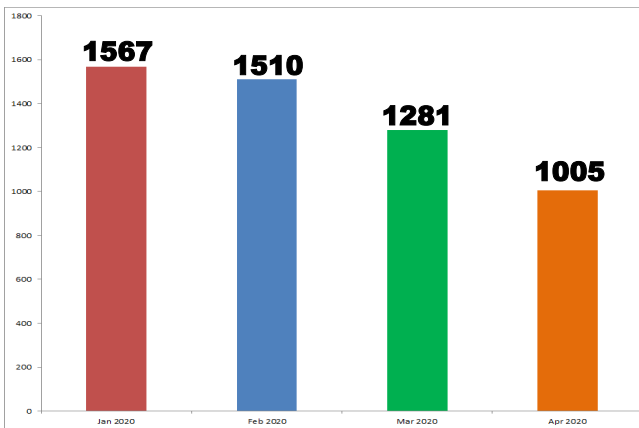


@CV\_UHBSafety



## COVID-19 NEWSLETTER

### Patient Safety Incident Reporting



The number of patient safety incidents reported since January 2020 has fallen. This is understandable in the current circumstances but please remember the importance of incident reporting. If you have any difficulties please contact the [Patient Safety Datix helpdesk](#) or [Health and Safety helpdesk](#) for assistance.

### Personal Protective Equipment Guidance

The COVID-19 pages of the UHB's intranet site includes key information for staff around **PPE**. These pages are updated regularly and contain everything staff need to know regarding training and FIT Testing, ordering PPE and donning and doffing. The Medical Education Department are supporting this work. An Occupational Health Pathway is being prepared for staff reporting health problems due to PPE. Wound Healing have prepared guidance to help staff avoid pressure damage from PPE.

- [PPE Guidance and Evidence Base](#)
- [Training and FIT Testing](#)
- [Ordering PPE](#)
- [Donning and Doffing PPE and FAQs](#)

Personal Protective Equipment (PPE)



### Human Factors

The [Clinical Human Factors Group](#) has set up a web page to help support healthcare staff and patients during the COVID pandemic. There are some interesting podcasts, checklists and top tips from frontline staff working with COVID patients. Dr Mark Stacey, Consultant Anaesthetist features on one of the podcasts. We also encourage staff to visit [our own wellbeing pages](#).

### Common Themes

To help us identify common themes, trends and issues we are asking you to let us know if the incident you are reporting is related to COVID-19. This information is shared with the Executive team weekly. Therefore a question has been added to section 1.3 of the incident form for staff to highlight if the incident relates to Coronavirus. [A help sheet is available here](#).

★ Are you reporting an issue related to **Coronavirus (Covid-19)**?

[Click here to view the Covid-19 guidance document](#)

Up until Sunday 10.05.2020, 279 incidents were highlighted.

- **16% were Uncertain patient status/potential exposure and**
  - **4% Failure to communicate patient status**

This reinforces the need for staff to be very clear about a patient's infectious state and to communicate it accurately.

- **10% were Aggressive/Inappropriate Behaviour**
- Incidents have included staff to staff and patient to staff issues. Poor behaviour contributes to a lack of safety. People may be less likely to speak up if they fear a risk of ridicule or anger from colleagues. This is not in keeping with our values and behaviours. A wealth of resources on Staff Wellbeing are available on the COVID-19 intranet page which you can access [here](#)

- **7% Unavailability of staff to treat**
- This is varied – issues included FIT testing availability and issues where existing procedures have changed due to COVID-19. The Medical Education Department are supporting training in PPE use. The COVID-19 intranet page is a must-read resource. Have you downloaded the StaffConnect app? Read about it [here](#)

- **5% Failure to follow infection control protocol**
- These incidents highlight the need for handwashing procedures; correct disposal of PPE; adhering to correct levels of PPE for different clinical areas and the importance of maintaining social distance in the workplace. Did you see the update in CEO Connects on 12th May 2020 [here](#) ?



The Patient Safety Team will hold the Quality Clinic in DHH on 15th May 2020 at 11am. Keep an eye out for us!

STAY AT HOME

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## Patient Safety Alerts

Two patient safety alerts have been recently issued by Welsh Government (WG).

### [PSA010 Interruption of high flow nasal oxygen during transfer](#)

- This alert was escalated to Clinical Engineering to oversee. Any staff who care for patients using high flow nasal oxygen should be aware of the risks highlighted within the alert.

### [PSA011 Blood control safety cannula & needle thoracostomy for tension pneumothorax](#)

- Information from Procurement indicates that this type of safety cannula is not currently used in clinical areas within the UHB, however staff should familiarise themselves with the content of the alert.

Copies of all previously issued WG patient safety alerts and notices are available on the [Safety Solutions intranet page](#).

## HIW Update

HIW took the exceptional decision to suspend all their routine announced and unannounced visits in March due to the COVID-19 outbreak. HIW do remain open for business however, and they can still be contacted either by email [HIW@gov.wales](mailto:HIW@gov.wales), or by phone 03000628163.

You can also keep up to date via their [website](#), or by following them on Facebook or Twitter.

HIW have also confirmed that they are pausing all of their work that may impact on frontline services and their staff. They will however, continue to monitor and follow up on any significant concerns regarding safety and quality of care. They are continuing to:

- Monitor intelligence relating to healthcare in Wales and use this to identify patterns and concerns
- Meet and exercise their essential statutory duties regarding the regulation of Ionising Radiation (Medical Equipment) Regulations
- Deliver the second opinion appointed doctor service, however, this service will be delivered remotely
- Work with key stakeholders and partners to ensure they can monitor the quality and safety of healthcare services in Wales

Together with our counterpart regulators of the Ionising Radiation (Medical Exposure) Regulations in England, Northern Ireland and Scotland, HIW have published a response to the developing COVID-19 epidemic. Anyone involved in the use of medical ionising radiation equipment [please read this](#).

They have made changes to the way they operate the Review Service for Mental Health in Wales during this period. [Click here](#) to read the updated guidance and amended methodology for the service.

## Reading Resources

### [COVID-19 End of life Decision Making – important information!](#)

This time of unprecedented uncertainty and change is giving rise to numerous and varied legal issues. It is anticipated that there will be increased incidences of disputes with family members about the continuation or withdrawal of life sustaining treatment. This article provides a summary of the law that applies in situations where a patient lacks capacity to make the decisions themselves. **An important read for all clinical staff.**

## MCA and DoLS

The [Coronavirus Act 2020](#) has not amended the Mental Capacity Act 2005 in any way, so the law on mental capacity, best interests and deprivation of liberty, including DoLS, must still be followed for UHB patients. The UK Government's Department of Health and Social Care (DHSC) issued [Guidance on MCA and DoLS](#) on 9<sup>th</sup> April 2020. The guidance applies until withdrawn by the DHSC.

Clinicians will need to take a proportionate approach to all cases. Any decisions must be taken specifically for each person and not for groups of people.

If the person lacks capacity to provide consent to treatment and care, the decision maker should where necessary (in the absence of an advance decision, a Deputy or Attorney with authority to make the decision in question) make a **best interests** decision under the MCA regarding the care or treatment that needs to be provided. When doing so, they should consider all relevant circumstances, and in particular:

- Whether the person is likely to regain capacity and, if so, whether the decision can wait
- Ensuring, as far as reasonably possible, the participation of the person
- Considering the person's past and present wishes and feelings; values and beliefs; and any other factors they would take into account
- The views of those with an interest in the welfare of the person, or who care for them

If you have any queries or require further information, please contact Julia Barrell, MCA Manager, either by email or by phoning 029 2183 6314.

## Death Certification & Mortality Reviews

There are emergency regulations in the COVID-19 bill related to death certification. A multi-professional Mortality Review Group (chaired by Dr Raj Krishnan, AMD) has been established to coordinate various pieces of work associated with death and the dying process. We are streamlining the process and reducing the mandatory paperwork by combining forms to prevent duplication.

The Qualified Death Certifier (QDC) is now used to report deaths from COVID-19. It is to be used to record cases in which the QDC undertakes completion of the MCCD and Cremation form 4 under the emergency regulations in the COVID-19 bill. This form will also replace the existing Mortality Review form. It should be sent to the Clinical Audit department. COVID-19 is a notifiable disease and must also be reported to Public Health Wales which can be done electronically via the Clinical Portal.

**STAY AT HOME** 

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