CARDIFF AND VALE UHB

Patient Safety & Quality NEWSLETTER

4th Edition
Autumn 2019

WE'VE ALL MOVED...AGAIN!

The Patient Safety & Quality Team are now located at **Second Floor, Woodland House, Maes Y Coed Road, Cardiff, CF14 4HH**

The Clinical Audit Team are now located on the **First Floor, Lakeside Offices, UHW**

(Please see page 5 for new telephone numbers)

BETWEEN JUNE AND AUGUST 2019...

TOTAL NUMBER OF PATIENT SAFETY INCIDENTS REPORTED: 4423

SIs CLOSED WITH WG: 59

9 CLINICAL AUDITS PUBLISHED

NUMBER OF SERIOUS INCIDENTS REPORTED TO WG - 59

NUMBER OF NEVER EVENTS REPORTED TO WG - 1

18 PATIENT SAFETY WALKAROUNDS

1 NEW PATIENT SAFETY NOTICE ISSUED

PSN050 – Assessment and management of babies who are accidentally dropped in hospital

95% OVERALL COMPLIANCE

40 PIECES OF NEW AND UPDATED NICE GUIDANCE REVIEWED AND CONSIDERED

NICE National Institute for Health and Care Excellence

2 CORONER'S REGULATION 28 REPORTS RECEIVED

17 staff members attended Action Planning workshops

8 staff members attended RCA training

58 staff members attended Datix training

WORLD PATIENT SAFETY DAY

World Patient Safety Day 17 September 2019

On Tuesday 17th September 2019 the World Health Organisation is launching a global campaign to create awareness of patient safety and urge people to show their commitment to making healthcare safer.

The slogan for the day is "Speak up for patient safety!" You can read more about it **here**

The Patient Safety and Quality Department are launching a number of activities to mark the day including:

- The Chief Executive will give a video message for staff, patients and members of the public supported by short video sound bites from some members of staff on the theme of 'speak up for patient safety'
- The Quality, Safety and Experience Committee will acknowledge World Patient Safety Day during their meeting and a tweet will be sent to highlight this
- A public area will be illuminated orange by the statue and lakeside area on the University Hospital of Wales site to mark the occasion

CARDIFF AND VALE UHB Patient Safety & Quality Quality Clinic

- The Patient Safety and Quality Department will launch a Quality Clinic concept to support and guide staff with their quality arrangements, challenges and improvement ideas. Flyers to advertise the Quality Clinic will be hand delivered to clinical areas and the team will take the opportunity to highlight World Patient Safety Day
- A safety culture survey will be launched by the team
- A Coaching for Safety programme will also be launched
- The Patient Safety and Quality Department will launch its Twitter account @CV_UHBSafety
- The Patient Safety and Quality Department will support our Pharmacy colleagues with their stand in the Children's Hospital for Wales

QUALITY, SAFETY & EXPERIENCE COMMITTEE

The Health Board has a number of formal committees, including a Quality, Safety and Experience Committee, as part of its governance and assurance framework. The Committee meets bi-monthly and is chaired by an Independent Member of the Board and this is currently Councillor Susan Elsmore. The Committee holds its meetings in public. The papers for the Committee can be accessed via the UHB's internet page which you will find **here**.

The Clinical Boards are all required to periodically report to the Committee to outline their progress in relation to the quality, safety and experience agenda.

The Patient Safety and Quality Department encourages staff to review the Committee's information for items of interest that can be shared in your own clinical areas.

INFECTED BLOOD INQUIRY

In July, the Infected Blood Inquiry heard evidence from individuals from Wales who are infected and affected by contaminated blood. The week of hearings took place in the Royal Welsh College of Music and Drama. The testimony of the witnesses was very moving and described the devastating impact on the individuals and their families. The Health Board is cooperating fully with the Inquiry by providing information that supports the independent review. If you believe that as an employee of the Health Board, you may be able to provide evidence in relation to this Inquiry please contact Alex Scott, Head of Patient Safety and Quality Assurance on 02921 836310 or on email at **Alexandra.scott2@wales.nhs.uk.**

Infected Blood Inquiry

You can watch videos of the Inquiry hearings **on Youtube**.

NEAR MISS REPORTING

The UHB Incident, Hazard and Near Miss Reporting Policy defines a near miss as,

'an occurrence, which but for the luck or skilful management would in all probability have become an incident.'

All staff are encouraged to report near misses because they provide an opportunity to learn lessons and prevent serious incidents which have the potential to cause harm to patients. Near misses may include:

- a medication dispensing or prescribing error that is identified before administration,
- a misidentification of a patient that is identified before an intervention is performed
- a 'wrong site error' on a consent form or theatre list that is picked up during pre-operative checking processes.

Near miss incidents happen on a daily basis, but harm is avoided because the necessary steps and checks are in place. Please report them – they help us to identify root causes so that system failures can be corrected. Department managers should consider how they monitor near miss incidents. Literature suggests that a 'strong response to weak signals of failure' are one component of a high reliability organisation. How does this work in your area?

POLICY UPDATES

The Health Board's Being Open and Incident, Hazard and Near Miss Reporting policies have recently been updated. The latest versions can be found on the policies and procedures intranet page.

MENTAL CAPACITY ACT NEWS

CONSENT

We are receiving requests from departments who wish to produce procedure specific consent forms. If this is something your area is considering, you will need to:

- Take responsibility for the design of the forms and paying for them. The forms must contain all the information included in the All-Wales template forms and replicate the format (i.e. triplicate forms – English/Welsh/English). The guidance on use of the forms will need to be kept with the forms or printed on the cover of the pad of forms.
- Before the forms are printed, they must be sent to the Mental Capacity Act Manager for review.
- The customised forms must then be formally approved at the Clinical Board's Quality, Safety and Experience meeting.
- In the event of any dispute about the information on the forms, the Medical Director will arbitrate.

Please see para 7.2.7 of the **Consent Policy**

PATIENT INFORMATION LEAFLETS

Please note that EIDO produce good quality patient information leaflets about a large number of procedures, etc. The leaflets are available in Welsh, English, bilingual Welsh and English and some are available in other languages as well. NHS Wales is funding this, so please do make use of them for your patients! To find them, go to the CAV intranet and scroll down the page until you come to "EIDO Informed Consent Patient Information Leaflets"

CONSENT POLICY

A revised version of this Policy based on the All-Wales Consent Policy is currently out for consultation.

MENTAL CAPACITY ACT

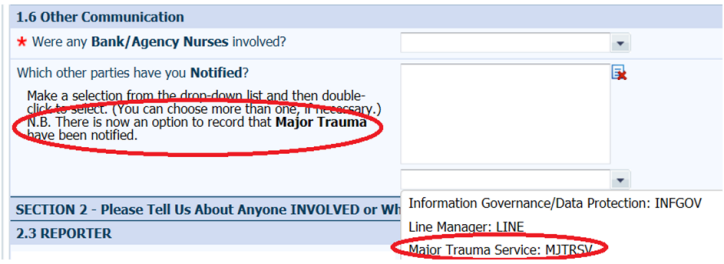
The Government has announced that the Liberty Protection Safeguards, which will replace DoLS, will come into effect in October 2020. The UHB will be considering the impact of this in due course.

COPD AND ASTHMA AUDITS

Working together with the National Asthma and COPD Audit Programme (NACAP), we are aiming to improve acute treatment of patients with Asthma and COPD by monitoring and auditing the care that has been carried out when patients are admitted with an exacerbation of these conditions. The good news is that there have been improvements in several areas since the audits began in 2016/17, including a new **Asthma Pathway** that has been developed and rolled out within the Emergency Unit! Additionally, the UHB's spirometry results are higher than average at 87.5% compared to the national average of 55.9%. But it's not all good news; recent audit figures show that UHW and UHL are below the national average for patients prescribed oxygen that may need it during their admission, the national average being 72% whereby both hospitals had a compliance of 68%. Just a reminder for those administering oxygen – please ensure the dedicated oxygen prescription on drug charts is signed and not just the NEWS chart, especially as the misuse of oxygen therapy for respiratory patients can impact significantly on patients' health.

MAJOR TRAUMA SERVICE & DATIX

The Major Trauma Service are establishing their quality, safety and governance arrangements. As part of this they need to be able to monitor incident forms relating to major trauma patients who could be located across the UHB. To help with this, a field has been added to Datix for incident reporters to flag incidents that are potentially of note for the service. You will find Major Trauma Service on the drop down menu of section 1.6 'Which other parties have you notified?'



Line managers can also select this option when they are reviewing incident forms in case the field wasn't selected at the incident reporting stage.

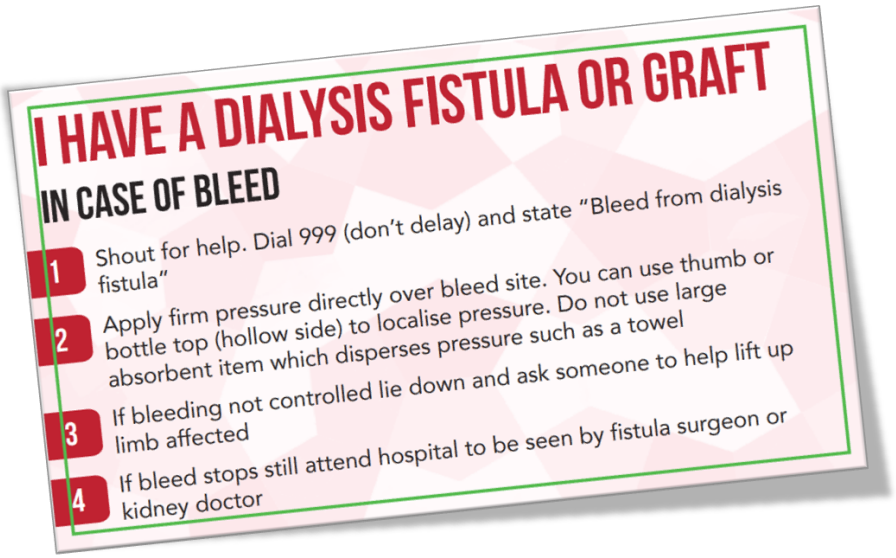
LIPS (Leading Improvement in Patient Safety) Programme is in its 6th year. In July, 66 people working in teams to deliver 11 improvement projects joined Board members in a celebration event where they shared their project successes. For more information contact joy.whitlock@wales.nhs.uk or search Twitter #cavlips

BLEEDS FROM ARTERIOVENOUS FISTULAE (AVF) OR ARTERIOVENOUS GRAFTS (AVG) - WOULD YOU KNOW WHAT TO DO?

Earlier this year, Welsh Government published **Patient Safety Notice 047**. This highlights the importance of correct management of patients with life threatening bleeds from AVFs or AVGs.

Bleeding from an AVF or AVG is a medical emergency which requires admission to hospital. Information on management is available on the **British Renal Society website**.

Patients with an AVF or AVG are given an emergency card with instructions on what to do in the event of a bleed:



Further information can be provided by the Nephrology & Transplant Directorate Vascular Access Clinical Nurse Specialists who can be contacted on extension 43398.

LEARNING OUTCOMES FOLLOWING A PROBLEM IDENTIFIED WITH AN ANALYSER IN BIOCHEMISTRY

In May 2019 the Biochemistry Laboratory identified a problem with some blood results on an analyser that had recently been installed in the UHB. This led to complex work with the manufacturer, laboratory and clinical staff to determine the extent of the problem and to ensure that patients affected were reviewed in a prompt manner. Over 2,500 test results had to be checked. Fortunately, no harm had come to patients as a result of this incident due to the diligence of the laboratory staff and clinical skill of the staff looking after the patients.

There are some key lessons that can be learnt from the incident that we'd like to share with clinical staff.

- During venepuncture, blood samples must be gently inverted to thoroughly mix blood with any preservatives or anti coagulants in the tube. This ensures that samples are of the best possible quality. Poor quality samples can result in inaccurate results and repeated tests being required.
- Clinical staff must check results of tests they've requested in a timely manner.
- If test result are unexpected, consider discussing it with the laboratory. Always consider the clinical presentation of the patient. If the clinical presentation doesn't correlate with test results it is important to understand the reasons why.

ADVICE FROM TELECOMS

The Coroner recently issued a Prevention of Future Deaths report to the UHB. This is also commonly referred to as a Regulation 28 report.

The Coroner expressed concern about referral processes between hospitals, especially for urgent referrals to tertiary services. There is a reliance on telephone communication with callers often ringing switchboard to contact clinical teams.

It would be beneficial if departments can advertise their direct dial telephone numbers on information they distribute about how to make a referral to their service. This would help to release time for switchboard operators.

If there is a need for switchboard to page a member of staff, the switchboard operator will alert the caller that they will hear a ringing tone whilst they wait for the person to respond to their pager. The ringing tone whilst waiting has previously caused some confusion with callers.

STAFF NEWS

Mathew Tomlinson has joined the Patient Safety Team as our new System Development Analyst and Database Administrator. New to the NHS, he will be supporting the administration, maintenance, and technical development of the DATIX system.

The Clinical Audit Team has also welcomed a new member of staff! **Nicole Kays** is a qualified nurse who has decided to join the world of auditing from her previous role in the Emergency Unit. Bringing along her experience, Nicole will be carrying out the National COPD and Asthma audits working alongside NACAP, with plans to expand when she has settled into her new role.

MDSOs AND THE MEDICAL DEVICES REGULATION 2017

The MHRA (Medicines and Healthcare products Regulatory Agency) and Welsh Government are currently in the process of writing guidance for health institutions and health professionals with respect to the Medical Devices Regulation 2017. In the meantime any of your queries in regards to the Medical Devices Regulation 2017 can be directed towards your Clinical Board MDSO.

What is a Clinical Board MDSO?

A Clinical Board Medical Device Safety Officer (MDSO) is a person that has been nominated by their clinical board to represent their interests at the Cardiff and Vale UHB Medical Equipment Group.

You can find an up-to-date list of each Clinical Board's MDSO on the MDSO page on the Medical Equipment Group website.

What does the Medical Devices Regulation 2017 mean for me?

The Medical Devices Regulation 2017 (Regulation (EU) 2017/745 of the European Parliament and of the Council of 5 April 2017 on medical devices) is new legislation which will come into full force on the 26 May 2020 (irrespective of Brexit!) It includes new responsibilities for health institutions and health care professionals.

For example, health institutions and health professionals will be required to implement traceability for all class III implantable devices and possibly all of our other medical devices. There are other changes to the Medical Devices Regulation 2017 and these affect us in different ways. If you modify devices or manufacture devices and are not sure how the Medical Devices Regulation 2017 affects you, contact your MDSO for guidance.

Manufacturing includes physical devices which have a medical purpose but also software (this includes Excel spreadsheets) that has a medical purpose. If you are unsure that what you are doing may be classified as a medical device you contact your MDSO.

NEW TELEPHONE NUMBERS

Carol Evans - Assistant Director Patient Safety & Quality [36331]
Juliet Evans - PA to Assistant Director Patient Safety & Quality [36323]
Maria Roberts - Head of Patient Safety & Quality [36316]
Catherine Evans - Patient Safety Facilitator [36304]
Matthew McCarthy - Patient Safety Facilitator [36305]
Suzie Cheesman - Patient Safety Facilitator [36307]
Julia Barrell - Mental Capacity Act Manager [36312]
Nicola Roderick - Clinical Governance Analyst [36309]
Mathew Tomlinson - System Development Analyst [36308]

Paul Nash - Quality & Safety Improvement Support Officer [36317]
Sharon Eley - Data Administration Officer [36315]
Alex Jones - Data Administration Officer [36314]

Joy Whitlock - Quality & Safety Improvement Manager [31311]
Alex Scott - Patient Safety & Quality Assurance Manager [36310]
Ann Jones - Patient Safety & Quality Assurance Manager [36306]

The Datix helpdesk number is now 36314