CARDIFF AND VALE UHB

Patient Safety & Quality NEWSLETTER

5th Edition
Winter 2019

'Focus on Safety, Reduce Harm, Drive Improvement'. The official Twitter account of Cardiff and Vale University Health Board Patient Safety and Quality Improvement team has been launched.

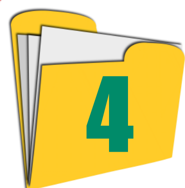
@CV_UHBSafety

Why not follow us?

BETWEEN SEPT AND NOV 2019...

TOTAL NUMBER OF PATIENT SAFETY INCIDENTS REPORTED: **4888**

SIs CLOSED WITH WG **51**



CLINICAL AUDITS PUBLISHED

NUMBER OF SERIOUS INCIDENTS REPORTED TO WG - **54**

NUMBER OF NEVER EVENTS REPORTED TO WG - **0**

11 PATIENT SAFETY WALKAROUNDS

3 INTERNAL PATIENT SAFETY NOTICES ISSUED

ISN 2019 003—Resuscitation Trolley Checks

ISN 2019 004—Security of Patient Information

ISN 2019 005—Ranitidine Supply

34 PIECES OF NEW AND UPDATED NICE GUIDANCE REVIEWED AND CONSIDERED

NICE National Institute for Health and Care Excellence

0 CORONER'S REGULATION 28 REPORTS RECEIVED

47 staff members attended RCA training

58 staff members attended Datix training

32 Staff member attended the clinical audit workshop

PATIENT MISIDENTIFICATION

How to avoid an identity crisis

What is the problem?

Patient misidentification has long been recognised as a widespread problem within healthcare organisations, not only in the UK, but also throughout the world. The identification and matching of a patient to an intended treatment or intervention are activities performed routinely in all care settings. Risks to patient safety occur when there is a mismatch between a given patient and their care (PSN026/April 2016)

Doing the right thing to the right person is a safety critical matter.

What can happen?

- Administration of the wrong drug.
- Administration of the wrong blood.
- Performance of the wrong procedure on a patient.
- Serious delays in commencing treatment on the correct patient e.g. due to mislabelling of an abnormal blood sample or tissue sample.
- Patient is given the wrong diagnosis.
- Patient receives inappropriate treatment.
- Patient is over-exposed to radiation.
- Wrong patient is brought to the operating theatre or into a consultation with a healthcare professional.

We see these issues reported through our incident reporting system.

Why does it happen?

Correct patient identification poses a challenge in healthcare because of the number of complex interventions that occur to patients, ranging from drug administration to phlebotomy to complicated invasive procedures. These interventions may occur in a variety of locations and are provided by large teams of clinical and non-clinical staff, many of whom work shifts.

Names are not unique! It is very common to have patients of the same name under our care at very one time.

There can be a lack of appreciation from staff and patients regarding the importance of patient identification.

How to avoid misidentification?

Ensure that all in-patients are wearing an identity wristband. For areas where wristbands aren't used, the Patient Identification Policy must be referred to.

Never be complacent. Misidentification probably happens to a greater or lesser degree every day within NHS organisations. Outcomes can be serious.

Always take time to satisfy yourself that you have the correct patient for whatever intervention you plan to carry out. If the patient is able to, ask them to give you their full details, including full name, date of birth and first line of address.

Do not rely on patients to always correctly identify themselves. Often patients are very ill, anxious, have cognitive impairment or language barriers.

Take extra care in the way you use addressograph labels - they feature very often in patient misidentification incidents.

COPD and Asthma

Winter has arrived, and with the biting chill we're likely to see a rise in acute Asthma and COPD admissions over the coming months. A great new COPD discharge bundle has been put together by the Respiratory Team with fantastic engagement from staff on respiratory wards. However, this is a gentle reminder for all staff to ensure the discharge bundle is fully completed prior to discharging your patients.

The COPD discharge bundle is an incredibly useful tool to make sure that all appropriate action has been taken prior to patient discharge, and has the potential to decrease failed discharges.

Good news - we have improved upon our Peak Flow (PEFR) measurements! 100% of asthma patients have documented peak flow readings during their inpatient stay – however 42.9% of those were carried out within 1 hour of the patient being admitted, which is an improvement from the 33% in September. We must strive to carry out a PEFR as soon as possible. If a patient is too unwell to perform a PEFR within 1 hour of admission, then please document this.

Clinical Audit Workshops

The workshops have been running since 2007 with several scheduled each year. They are designed to help clinicians:

- ⇒ Understand the principles of clinical audit
- ⇒ Select an appropriate audit topic
- ⇒ Develop a specific aim and objectives
- ⇒ Define criteria and standards
- ⇒ Design an audit tool
- ⇒ Understand data collation and simple analysis
- ⇒ Report audit results

We have received very positive feedback from those who have attended. If you would like to register your interest please contact Carlos Loureiro on ext 42963/ carlos.loureiro@wales.nhs.uk.

There are currently two workshops scheduled for 2020 (24th April/7th October).

Visit our Intranet to find out more.

Stay in The Know

Welsh Government have recently published their National Clinical Audit and Outcome Review Newsletter It includes useful information about :

- Recently published reports
- Update from Policy lead for Cancer, Diabetes and Respiratory
- National Clinical plan – future arrangements
- Outlier process for Wales
- Strengthening of future audit reports
- National Clinical Audit awareness week – HQIP

DATES FOR YOUR DIARY

Quality Clinic Sessions:
Thursday 23rd January 10—11am
Thursday 20th February 2—3pm
Friday 13th March 10—11am
Thursday 2nd April 12—1pm
Sessions take place in both the Peace Room (UHL) and Pathology Seminar Room (UHW)

Audit Safety & Quality Sessions:
Wednesday 12th February
Thursday 2nd April
Friday 15th May
Tuesday 16th June
More dates

Clinical Audit Workshop dates:
Wednesday 24th April
Monday 7th October
More information

Datix DIF2 (Manager) Training Sessions:
Wednesday 22nd January
Wednesday 12th February
Wednesday 4th March
Thursday 19th March
Tuesday 31st March
Please email the Datix team for further dates and to book a place.

Root Cause Analysis Training
Dates will be confirmed soon. Please contact Maria Roberts for more information

Action Planning Workshops
Tuesday 11th February
Thursday 14th May
Please email Juliet Evans for further dates and to book a place.

Mental Capacity

Two interesting cases have recently been decided by the Court –

- Gloria Esegbona and King's College Hospital NHS Foundation Trust
  - ◊ This case was about the failure of clinicians to comply with Mental Capacity Act 2005 in respect of :-
  - ◊ Medical treatment decisions
  - ◊ Change of accommodation decisions
  - ◊ Deprivation of liberty issues

The Claimant (Gloria Esegbona) was awarded approx £24k.

- The second case, Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust v TG & OG, demonstrates just how important it is when determining the patient's best interests, to consider the patient's wishes and feelings, values and beliefs and other factors that the patient would take into account if they could still take the decision themselves.

In this case, a Judge has ordered that the patient should continue to receive life-sustaining treatment, against the wishes of doctors who felt that further treatment was futile, because of what the patient would have wanted and what was important to them.

Consent

The revised Consent Policy should be published in the New Year. We plan to disseminate it widely.

A Consent to Treatment - Key Points summary of the main consent issues is now on the Consent Intranet page

Please see the LED prospectus (page 62) for details of when consent training will be held in 2020.

New Coronial Referral Guidelines

Please be aware that the Notification of Deaths Regulations 2019 have come in to force on October 1st 2019. Please refer to the information attached.

Guidance for medical practitioners (PDF)
Guide to notification of death regulations (Poster)

Medical Examiner Service for Wales

A Medical Examiner (ME) Service is being developed following several high profile cases where concerns were subsequently raised about the deaths of patients. The notable cases are those of GP Harold Shipman and the multiple deaths that occurred in Gosport War Memorial Hospital. The ME role is designed to safeguard the public; ensure deaths are referred to the Coroner where necessary; improve the quality of death certification and offer an opportunity for families to ask questions about the death of their loved one.

NHS Wales Shared Services Partnership has been asked to coordinate this service on behalf of NHS Wales.

The Medical Examiner Service will discharge its functions by scrutinising all deaths not referred directly to the Coroner. This will involve undertaking Stage 1 of the Universal Mortality Review process for around 30,000 deaths per year.

The programme to develop this service in Wales is split into 3 phases:

Phase 1: Service Design (to December 2019)

Phase 2: Acute death service build up (December 2019 to August 2020)

Phase 3: Non acute death service build up (Sep 2020 to Mar 2021).

The plan is to establish one office in each Health Board area to begin with scaling up over time so that there is a full service scrutinising 100% of deaths not referred directly to the Coroner from April 2021. Medical Examiner (ME) and Medical Examiner Officer (MEO) roles are under development. It is anticipated that the recruitment process for both roles will commence shortly.

You can read more about the service here

Inquests - witness failing to attend

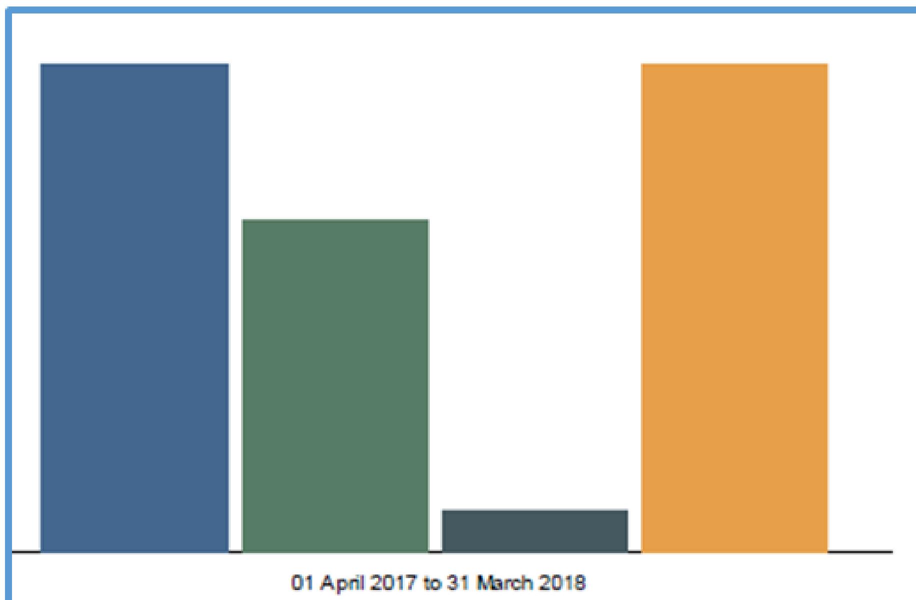
An inquest can be an acutely stressful environment. This case emphasises the importance of organisations and individuals engaging properly with the inquest process.

If you are required to attend an inquest please speak to a member of the Patient Safety Team.

Trauma Audit and Research Network

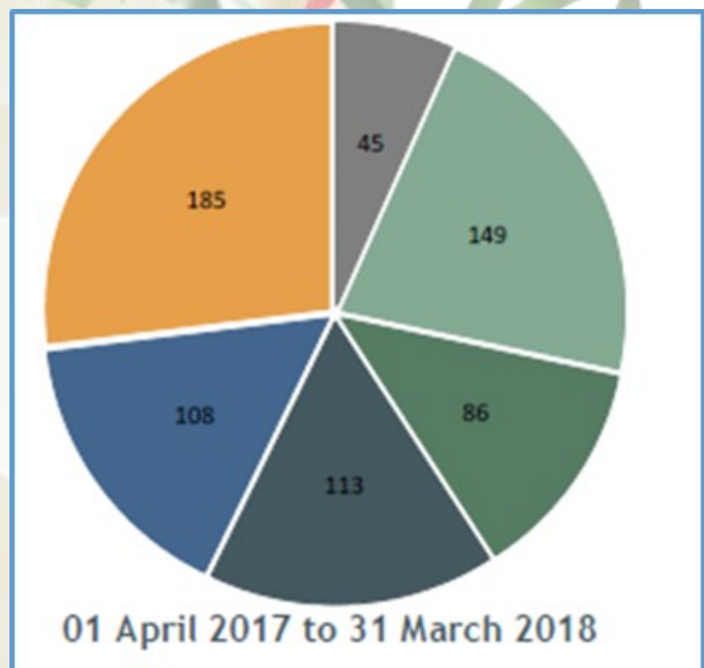
TARN

Trauma is the commonest cause of loss of life in people under the age of 40 , every year in England and Wales approximately 16,000 people die after injury. The UHB participate in the Trauma Audit and Research Network to ensure that we are able to benchmark the health board's performance in caring for this group of patients and to drive forward improvements as required. Between 1st April 2018 and 31st March 2019 48% of major trauma patients presenting at University Hospital of wales were seen by a consultant within 5 minutes of arrival. This is a 6% improvement on the previous year and is above the national average for other trauma units across in England and Wales. In additional 93% of eligible patients had a CT scan within 60 minutes.



Most Senior Doctor Seeing Patients in the Emergency Unit Within 5 Minutes of Arrival

Age of Trauma Patients Presenting at University Hospital of Wales



Annual Quality Statement 2019-20

Each year, every UHB is mandated by Welsh Government to produce an Annual Quality Statement - a public document that outlines the Health Board's quality and safety performance. We develop the Statement content in conjunction with staff, patients across the health board and the Community Health Council. Last year's copy can be accessed here.

Each chapter of the AQS is developed in line with one of the seven themes of the Health and Care Standards. The previous approach has been to use a combination of patient stories and vignettes.

We are already starting to think about preparing for our 2019-20 AQS and this year's theme will be mental health. We are particularly interested in mental health community based services, including addictions and older people's services. This is an opportunity to showcase the fantastic work that goes on in the UHB every day.

Whilst mental health is our main theme we are also keen to feature the broader range of quality services we deliver in Cardiff and Vale. If you have any ideas for content please do get in touch by emailing ann.jones11@wales.nhs.uk.

Healthcare Inspectorate Wales (HIW)

The role of HIW is to check that people receive good healthcare. They do this by regulating and inspecting NHS services and independent healthcare providers in Wales against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

Over the past 3 months Cardiff and Vale UHB have been inspected in 3 different areas - Maternity, Rehabilitation (Rookwood hospital) and Stroke rehabilitation (UHL). We are proud that whilst there were some areas for improvement identified, the inspection feedback was largely very positive in all 3 areas. This is testament to our hardworking staff and their efforts to provide the best possible care. Learning from feedback is really important, and sharing it across the across the organisation is critical. To support the sharing of learning and the spread of good practice we have developed a self - assessment tool that will be launched in December 2019. It's a simple checklist of the positive findings as well as the identified improvements from inspection. This will be a way of checking your own clinical area against the findings in other areas of the UHB. **The checklist can be viewed here.**

Health and Care Standards Corporate Assessment

Every person in Wales who uses health services or supports others to do so, whether in hospital, primary care, their community or in their own home has the right to receive excellent care as well as advice and support to maintain their health. All health boards in Wales need to demonstrate that they are doing the right thing, in the right way, in the right place, at the right time and with the right staff. The Health and Care Standards provide the framework to help teams and services demonstrate assurance to the Board that we are providing high quality care and support to Cardiff and Vale citizens. Our annual self- assessment against the 22 Standards is soon to be getting underway and will be complete by May 2020.

Once For Wales Concerns Management System

During 2019, a procurement exercise was undertaken in NHS Wales to take forwards a new Concerns Management System. The contract was awarded to RL Datix and work is underway to progress implementation of new software from April 2020.

The new software and all Wales approach promotes alignment across all Health Boards and NHS Trusts in Wales.

The new software will affect complaints management, incident reporting, Serious Incident reporting, claims management amongst other functions.

We anticipate establishing a local implementation group to complement the National Programme Board which the Patient Safety Team and Concerns Department are contributing to.

Health and Social Care (Quality and Engagement) Wales Bill

A new Bill is progressing through the Welsh Government which proposes to introduce changes to quality in health and social care in Wales.

It proposes:

- To place quality considerations at the heart of all the NHS in Wales
- Strengthen the voice of citizens across health and social services, with a new Citizen Voice Body for health and social care (replacing Community Health Councils)
- Place a duty of candour on NHS organisations, requiring them to be open and honest when things go wrong
- Strengthen the governance arrangements for NHS Trusts by introducing a formal Vice Chair role for each Trust

You can read more about it here:

National Assembly for Wales

Welsh Government

NOW RECRUITING TO COHORT 12!
APRIL—JULY 2020

For more information please follow this link.
Alternatively contact Joy Whitlock via email or telephone x36311

Wishing you a Merry Christmas and a Happy New Year!!