



CARDIFF AND VALE UHB
**Patient Safety
& Quality**



**2nd Edition
Winter 2018**

NEWSLETTER

WRISTBAND UPDATE



New patient ID wristband printers have been rolled out across the UHB during September and October, with positive feedback from staff. If you need any help or advice on the new system, please see the 'Wristbands' page on CAVWeb.

Wristbands are just one component of positive patient identification. It is vital that staff check patient ID before interventions, whether that is before giving medication, requesting tests, taking bloods or transferring patients between wards.

Misidentification leads to medication errors, incorrect diagnostics and even patients undergoing procedures not intended for them. If you need to remove a patient's wristband for a procedure or find a patient doesn't have one, it is your responsibility to replace it immediately. There are wristband printers throughout the UHB, with help sheets and a video tutorial available on CAVWeb.

WELL DONE CARDIFF & VALE

Our Medical Director Dr Graham Shortland received a letter from the Royal College of Physicians congratulating the Health Board on our case ascertainment rates for the National COPD Audit Programme's COPD Secondary Care Audit. For the period 1st April 2017 to 31st March 2018 Cardiff & Vale case ascertainment was 76% which was well above the median (43%). As a result of this performance, the Health Board has been asked to share with the Royal College of Physicians how we are achieving it so it can be shared with other organisations that are doing less well.



FALLS UPDATE

During 2018 a new simulation training resource was trialled with A4 ward at UHW as part of a LIPS project. Following positive outcomes, with evidence of improved staff knowledge and confidence in awareness and implementation of the UHB falls procedures, it is recommended that all wards adopt this form of training as part of their regular practice.

During the simulation training, small groups of staff can work through different scenarios regarding falls in a simulated ward environment on the A2/B2 corridor at UHW. There are currently 3 scenarios to go through: admitting a new patient to a ward with completion of falls risk assessments, management of a witnessed uninjured fall, and management of an unwitnessed fall. There are UHB procedures in place that cover falls risk assessment and post fall management, but evidence from the FFFAP National Audit of Inpatient Falls in 2015 and 2017, and review of root cause analyses from Serious Incidents, show that these are not consistently followed and complied with. 2019 will see the launch of the new National Audit of Inpatient Falls, which will run continuously. This will be focusing on the post-falls management of patients, which the simulation training provides excellent practice for.

Simulation training next steps:

1. Each participating ward will need to identify 1-2 staff to be their simulation training co-ordinators.
 2. Co-ordinators should then contact Melanie Cotter, Medical Education Manager on email or phone (UHL ext 25442) to arrange to attend the simulation ward for an induction and overview of how the simulations work.
- Wards can then book simulation sessions via Melanie or groups of staff to attend and complete the scenarios.

Staff from A4 ward have been completing the training and have co-ordinators who now lead the sessions for their staff. They can provide information and support to others if required.

The UHB Falls Delivery Group also endorses that all wards embed the simulation training as part of their regular practice.

Our team members can all be found on the Global email address book or alternatively call 46991 for Patient Safety queries or 42963 for Clinical Audit



CLINICAL AUDIT

Clinical Audit Annual Activity Report

All clinical audit projects undertaken within the UHB should be registered with the Clinical Audit Department. Once approved by the Department the clinical audit will be registered onto the UHB's Clinical Audit Database. A summary of the project aim and objectives are recorded on the database, as well as details of the clinicians undertaking the audit. Results are précised onto the audit record when the project is complete.

During the period 1st April 2017 – 31st March 2018 275 clinical audit projects were recorded onto the database. Of these:

- 127 projects were completed during the period
- 61 projects are still reported to be ongoing
- 21 projects were reported to have been abandoned
- 66 projects have had to be recorded on the database as incomplete. This is due to either no audit results forwarded to the Department or no response to requests for the results.

1027 patient case notes were retrieved for individual clinician clinical audit projects for the period. 375 of these (36.5%) were supplied for projects that subsequently were abandoned or incomplete.

Annual report summaries are available on the Clinical Audit intranet page and may offer ideas for topics to re-audit.

Clinical Case Note Retrieval for Clinical Audit Projects

Due to the demands of the National Clinical Audit Programme the Department has unfortunately had to halt the case note retrieval service for individual clinician based clinical audit projects. This decision has been agreed at Health System Management Board (HSMB) level and disseminated to the relevant Clinical Boards.

Whilst being a very difficult decision to have to implement, in the first 6 months of the 2018-19 financial year our Clinical Audit Assistants, Tony Robinson and Rochelle Clutterham, located, retrieved, tracked and subsequently returned 3000 patient records from and to various locations within UHW and UHL just for the national clinical audits. They would both also like to highlight the good working relationship that they have been able to build with the Clinical Coding and Medical Records Departments.

Historically, the majority of clinical audit projects have been undertaken retrospectively. In light of the above decision we would encourage, where possible, prospective data collection. Instead of perhaps reviewing a three month period from last year, consideration could be given to collecting the required clinical audit data over the coming months when the relevant patients are reviewed in clinics or on the wards. Additionally, many specialities also now have their own specific databases that may include data beneficial for clinical audit purposes.

GP INTERFACE INCIDENTS

What is an interface incident?

An interface incident is an incident which has been reported by a GP practice regarding an issue in secondary care. Commonly reported incidents include lost referrals, patient follow up concerns and problematic hospital discharges.

How are interface incidents managed?

Currently, GPs within the Cardiff and Vale area cannot report directly into the Health Board's Datix system. If GPs wish to report an incident they complete a form with the relevant details and send this through to the UHB's primary care team (interface.incidents@wales.nhs.uk) who submit the Datix incident on the GP's behalf. The team then pass the incident on to the relevant area in secondary care.

How are GP reported incidents identified?

All incidents reported via the interface process have the reporting directorate of 'Primary Care – Interface incidents'.

I have been assigned as incident manager for an interface incident, what should I do?

Interface incidents should be managed in the same way as any other incident before reviewing and closing as appropriate.

I've been sent an interface incident, but I'm not the correct person to manage it. What should I do?

If you are not the correct person within your area/department to manage the incident, you should reassign it to the correct person. The primary care team forward incidents based on the lists of incident managers available on the [Datix intranet pages](#). If you change roles, please let the Datix team know so the lists can be updated.

STAFF STORIES

As part of the *Being a Leader* programme Patient Safety Facilitator Catherine Evans has collected stories from staff who have completed Root Cause Analysis (RCA) investigations. The common themes that emerged were that undertaking RCAs are "worthwhile, enjoyable and offer an opportunity to learn about another care setting". Support was valued from colleagues for those less experienced in completing RCAs. The two main challenges faced for staff were those of time to undertake the investigation and engagement from involved staff in the process. If you have already completed RCA training and would like the opportunity to undertake an RCA, please get in touch with one of the Patient Safety Facilitators. Further RCA training dates for 2019 will be confirmed shortly on the Patient Safety Team intranet page.



LESSONS LEARNT

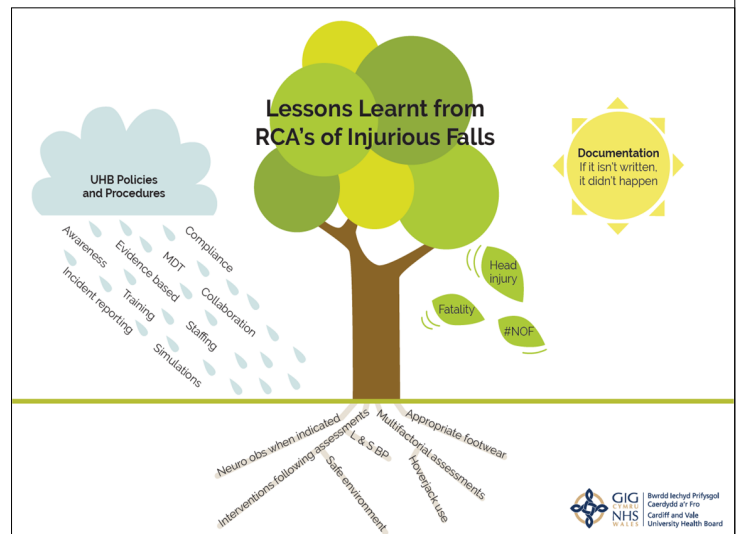
FINDINGS FROM INJURIOUS FALLS INVESTIGATIONS

Trees rely on an extensive, strong root system to sustain them and remain standing. They rely on water, warmth and light to remain healthy and grow in a suitable environment. Without the roots and appropriate environment they will lack resilience and be likely to fall.

A recent review of root cause analyses of injurious falls in the UHB found 7 common themes emerging which contributed to the falls: multifactorial assessments not fully completed and updated; interventions based on those assessments not completed; lying and stand blood pressure checks not completed; appropriate footwear not worn by patients; unsafe environments including clutter and toilet areas; hoverjacks not being used; neuro observations not completed when indicated, or only partly completed.

These 7 themes are all addressed in the UHB's evidence-based falls policies and procedures, which require staff awareness, training, compliance, collaboration between services users and the MDT, safe staffing levels, and all incidents to be reported and shared for learning. It is vital that any assessments and interventions are documented clearly in patient records; "if it isn't documented, it didn't happen".

It is important to take **preventative, proactive** steps to reduce the risk of falls, laying down the strong roots **before** any storms appear on the horizon, rather than having to react to the damage left in their wake



"A tree with strong roots can withstand the most violent storm, but the tree can't grow roots just as the storm appears on the horizon"

Dalai Lama

METHOTREXATE NEVER EVENT

In April 2018 nursing staff incorrectly administered a patient's methotrexate dose for 3 consecutive days instead of the weekly dose the patient required for his condition. The investigation identified that the prescription had been incomplete as it gave a dose and route of administration but no frequency. The incident was considered to be a Never Event and was reported to Welsh Government. You can read more about Never Events [here](#). A Root Cause Analysis investigation was completed and as a result:

- The oral methotrexate section in the Medicines Code has been updated and is available via the UHB policies and procedures pages on CAVWEB which you will find [here](#).
- For in-patients, the day of the week the methotrexate is to be administered must be written in the "special instructions box" on the drug chart.
- Nurses are reminded to NEVER administer methotrexate daily without checking with the prescriber.

HANDWRITTEN REQUEST FORMS

An incident occurred in May 2018 whereby a patient underwent an unnecessary CT scan. As the patient was unduly exposed to radiation, the UHB had to report the incident to Healthcare Inspectorate Wales. Investigation revealed that the patient had plain films and an MRI scan of her spine. There was a discussion about the need for further imaging but this was not documented in the radiology system. A further request form was written by the doctor who used abbreviations. It was subsequently interpreted incorrectly that C+T meant CT scan and it was not identified before a CT scan took place that the doctor intended the patient to have an MRI scan of their chest and thorax.

Staff are asked to ensure that the modality required is clearly indicated in the 'clinical examination required' box of the request form.

Clearly written records and request forms are important. Professional bodies require practitioners to keep clear, accurate and legible records. Remember the key principles when recording in clinical records:

- ✓ Date it
- ✓ Time it
- ✓ Sign it
- ✓ Ensure it is legible



MENTAL CAPACITY NEWS

NEW ALL-WALES CONSENT FORM 4

Welsh Government has recently issued a revised All-Wales Consent Form – *Form 4: Treatment in Best Interests*. This is an update of the 2014 form - the revised form is now more user friendly and aims to guide clinicians through each of the required steps in a more logical way.

The new form became available on **1st December 2018**.

As with the existing consent forms, the new form will be available to purchase through Oracle -

Code: AWCON4

Form Description: Treatment in best interests. Form for Patients aged 16 years and over who may lack the capacity to consent to examination or treatment

Pack Size: Pack of 50

The new form is now yellow, like the other consent forms, so should be more easily found in patient notes.

To help with familiarisation, examples of fictitious, completed forms can be found on the [Consent Intranet page](#)

In the event of any queries, etc, please contact Julia Barrell, MCA Manager (Julia.Barrell@wales.nhs.uk or by phone on 2074 3652).

HIGH COURT DECISION

A recent High Court decision means that, in future, there will be more conclusions of suicide at Coroner's court, because the standard of proof for a conclusion of 'suicide' or 'unlawful killing' in an Inquest has changed from "beyond reasonable doubt" to "on the balance of probabilities".

You can read more about it [here](#).

ITEMS OF INTEREST

The General Medical Council published a revised handbook on effective clinical governance for doctors in November 2018. You can find the handbook [here](#).

Many of you will be familiar with the work of Martin Bromiley OBE who is Founder and current Chair of the Clinical Human Factors Group Charity. Martin's late wife died as a result of errors during an operation. It became clear to Martin that it was issues related to human factors and not technical ability which led to his wife's death. Martin is a Captain for a major UK airline; he saw a stark contrast in how healthcare responded to the incident to his experience in aviation. You can read more about the Clinical Human Factors Group [here](#). We will provide more information on Human Factors in future newsletters.

THE PATIENT SAFETY & QUALITY TEAM WISHES EVERYONE A MERRY CHRISTMAS AND HAPPY NEW YEAR!



HM CORONER AND INQUESTS - ADVICE FOR STAFF

The law says that the Coroner must open an Inquest into a death if there is reasonable cause to suspect that the death was due to anything other than natural causes or occurred in state detention. There are particular circumstances when deaths must be reported to the Coroner, for example, the death was violent or unnatural (e.g. self harm or overdose); the cause of death is unknown; the death could be due to an occupational disease; the death occurred during an operation or was in any way related to an anaesthetic or occurred within 24 hours of admission to hospital. This list is not exhaustive and the Coroner's office should be contacted for further advice if you are unsure.

An Inquest is a public, fact finding inquiry to establish who the deceased was; when and where they died and how they came about their death. Inquests cannot deal with issues of blame or criminal/civil liability. An Inquest may be held with a jury in particular circumstances. The family and/or UHB may be legally represented at an Inquest. At the end of an Inquest when all evidence has been heard, the Coroner will confirm the cause of death and reach a conclusion as to how the deceased person died. The Coroner has the legal power and duty to write a Preventing Future Deaths Report under Regulation 28 of the Coroner's Rules. The report is sent to people or organisations who are in a position to take action. They must reply to the Coroner within 56 days to explain what action they intend to take. Regulation 28 reports and responses may be published on the Chief Coroner's website and they will be shared with family members and Interested Persons. You will find the website [here](#).

It is of crucial importance that staff also inform the Patient Safety Team if they have informed the Coroner of the death of a patient within the UHB and the Coroner is opening an investigation or Inquest.

Staff may be required to provide a written statement for the Coroner during his investigation. If you are asked to provide a statement, please inform the Patient Safety Team so that support and guidance can be provided. Statement writing guidance is available [here](#).

The Coroner may require staff to attend the Inquest to give oral evidence. The Patient Safety Team can provide guidance and support.

Between April 2017 and March 2018, 63 inquests involving the UHB took place that the Patient Safety Team were aware of. In the same timeframe, the Coroner wrote 3 Regulation 28 reports to the UHB.

Key themes that emerge for the UHB from recent Regulation 28 reports relate to neurological observations following patient falls and various medication safety issues including safe storage and prescribing.

