Patients First
Together, putting patients first

Board of Directors: **11.01.18**
Agenda Item: **Bo.1.18.15**

Combined Learning
Quarters 1 and 2 2017/18

Presented by:	Donna Thompson Director of Governance and Corporate Affairs/ Deputy Chief Executive	**Author:**	Tanya Claridge Assistant Director of Governance and Risk on behalf of the Learning and Surveillance Hub
Previously considered by:	Quality Committee		

Key points	**Purpose:**
1. This paper provides an overview of the work of and outcomes from the organisational learning response system	To note and gain assurance

Executive Summary:

During the latter part of 2016/17 the Trust identified the need for a knowledge management framework to support learning from 'precursor events' (which can be complaints, incidents, claims, inquests, mortality reviews, tacit knowledge and experience of staff etc.). As a result an organisational learning response system was developed, and has been presented in a specific paper to this Committee. This paper provides an overview of the learning generated through the system, its precursor 'incident', the learning itself and the modality used to disseminate it across the Trust. Due to the implementation of the system within year, this report covers Quarters 1 and 22017/18.

Much of the work of the Trust during Quarter 2 was focused on the safe implementation of the Electronic Patient Record. There is a huge amount of organisational learning that has been generated from the implementation and go live processes. This learning is subject to a separate review and presentation within the organisation and provides useful focus especially in relation to staff enagement and leadership.

Financial implications:
Yes – Income & Expenditure

Regulatory relevance:

Monitor:	Risk Assessment Framework
	Quality Governance Framework
	Code of Governance

Equality Impact / Implications:	**Is there likely to be any impact on any of the protected characteristics?** (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights) Yes ☐ No ☒ If yes, what is the mitigation against this?

Other:	

Strategic Objective: *Reference to Strategic Objective(s) this paper relates to*	To provide outstanding care for patients
	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To be a continually learning organisation
	To collaborate effectively with local and regional partners

1. Introduction

This report has been prepared to provide a tangible output from the Trust's organisation learning response system during 2017/18. The system is designed to process information from multiple sources, identify opportunities for learning from 'precursor incidents' identified within the information processed, develop an agreed modality for that learning to be shared, share the learning and test and assure the effectiveness of the methods used.

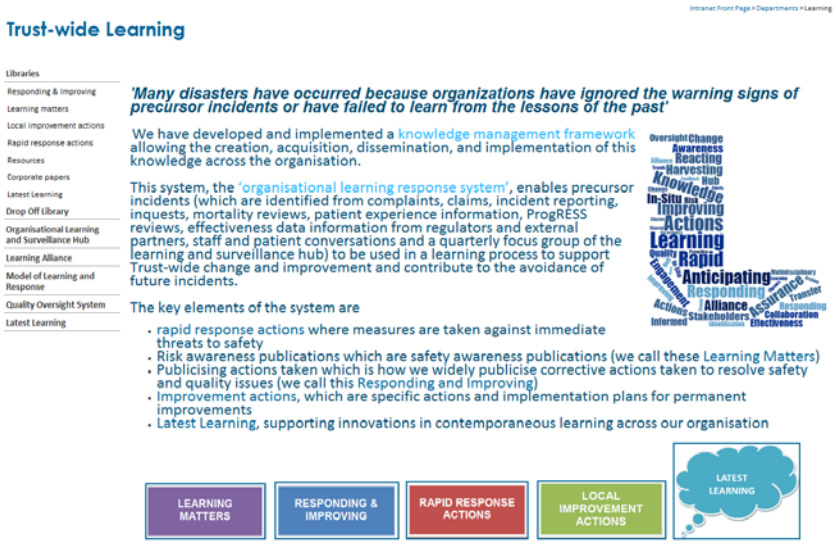
The report does not purport to include all organisational learning across the Trust during the specified time period for a number of reasons:

- One of the principles of the learning and response system is the absolute recognition that most organisational learning is informal, and the system should serve to strengthen that learning, not try to measure it.
- The learning and response system is new and evolving.
- It is designed to provide a pen portrait of learning, other learning is routinely described in reports and papers presented throughout the Trust.

For the purposes of this report learning and learning outcomes are presented in relation to the risk associated with the precursor event that was identified within the system.
1: precursor events where there was significant concern
2: precursor events where there was concern
3: precursor events where there were opportunities for change and improvement
4: precursor events where good practice in learning was identified

To support the assurance examples of how learning was disseminated or actioned are provided. These examples take the form of alerts, safety information dissemination, information about action taken and descriptions of local improvement actions. To improve the rigour of this report as the organisational learning and response system is strengthens and gains momentum different strategies will be used to identify key elements of organisational learning.

The Trust now has a dedicated intranet site for Learning, http://nww.bradfordhospitals.int/departments/Learning/Pages/Learning-Home-Page.aspx



1. **Precursor event: Significant Concern**

Learning question	Source	Mechanism	Action	Learning outcome
How do we inform all relevant staff of the immediate learning from an incident relating to a medication error?	There was a serious incident and a significant profile of no harm incidents relating to medication incidents	Incident performance management group, trend analysis	This issue was escalated to QuOC as a significant concern	A rapid response alert was published (see Appendix 1) and a programme of work initiated with the Medicines Safety Group to address the identification of high impact learning relating to medicines incidents.
How do we identify and implement immediate learning from a Never Event that involved the insertion of a wrong strength intra-ocular lens?	Never event	QuOC	An immediate focus group with staff involved was convened by the Medical Director	A range of immediate actions were identified as a result and improvements and safety solutions were put into place with an immediate effect.
How do we ensure that the pathways for the management of screening samples through the new pathology service are effective?	Serious incident	QuOC	Sample walkthrough and risk assessment	It is key that governance and administration processes are fully mapped out and understood when services change.
How do we inform all relevant staff of the immediate steps they need to take to prevent a bogus health care professional entering our wards and seeking drugs?	There was a serious incident involving the a bogus health care professional accessing our wards and potentially stealing drugs	QuOC	This issue was escalated to QuOC as a significant concern	A rapid response alert was published (see Appendix 1) and a dissemination process using face to face contact with key staff across the Trust.
How do we ensure that all obstetric clinical staff are aware of the criteria for referral to an obstetric consultant?	Serious Incident	QuOC	This issue was escalated to QuOC as a significant concern	A rapid response alert was published (see Appendix 1) and a dissemination process using face to face contact with key staff across the Trust.

2. Precursor event: Concern

Learning Question	Source	Mechanism	Action	Outcome
How can we re-inforce the requirement to respond appropriately to changing NEWS scores?	A consideration during an incident investigation that NEWS was conceptually linked with sepsis and that other causes for deterioration were not considered	IPMG L&SH NPSAS Alert Daily Huddle QuOC	Escalated to QuOC	A Learning Matters publication was issued to support the work of the Deteriorating Patient Collaborative focusing on NEWS as a tool to identify deterioration. See Appendix 2.
Do we really understand the data about falls that we are reviewing? Are we reviewing it and understanding themes and trends appropriately?	Review of falls data identified that there had been 300 falls across 2 wards (29 and 30) during a 1 year period.	QuOC	Escalated for management and review to the Patient Safety Sub Committee	Weekly reports to be provided to QuOC for information, a deep dive was undertaken and changes to reporting are being made to support the contextualisation of falls data.
Are we sure, despite a previous ProgRESS review, that staff fully understand Deprivation of Liberty Safeguards (DoLS) and know where to find advice and guidance?	Concerns raised by safeguarding leads and in the context of an investigation into an incident	Daily huddle IPMG	Explored at L&S	A Learning Matters publication was issued to support the knowledge base of our staff. See Appendix 2.
Are we sufficiently focused on the safe handover between our service and primary care?	Complaint Discharge incidents (with no or low harm)	IPMG L&SH	Explored at L&SH	A Learning Matters publication was issued to raise awareness of the incident and the importance of high quality handover information at discharge. See Appendix 2. A ProgRESS review has been commissioned to explore the handover between our services and primary care and identify opportunities for change and improvement.
Is the current approach to the governance associated with, assessment of risk and prevention of Venous Thrombo-embolism effective?	Compliance with NICE Guidance Performance data Serious incident Incident	Clinical Audit & Effectiveness Patient Safety Committees QuoC IPMG Daily Huddles	Second order change required through establishment of Inquiry Group	Inquiry group meeting during July 2017. Approach to be reviewed and high level action plan to be developed. The current situation has been risk assessed and the need for second order change agreed.

Learning Question	Source	Mechanism	Action	Outcome
Are needlestick protocols followed consistently in AED?	CQC raised concern	Assurance team	Assurance review	During March 2017 there were 10 A&E attendances coded as needle stick injuries. 6 related to injuries sustained from a needle. 4 related to contamination from bodily fluids. 100% of the cases reviewed followed the correct procedure. Where the injury related to BTHFT employee a referral to Occupational Health was completed and a Datix. Staff members were questioned on their awareness of the procedures for patients presenting with needle stick injuries. 100% of staff could describe the correct procedure to follow. 100% of staff were confident that all patients presenting with a needle stick injury have blood taken.
Are patients with malaria identified and treated in a timely way in our AED?	Cluster of incidents	IMPG	Internal investigation	Education and reminders required (and subsequently enacted) in relation to asking patients about any history of travel to support diagnostic testing and early treatment.
How can we re-inforce the importance of our Duty of Candour?	An identified breach in our Duty of Candour	IPMG L&SH NPSAS Alert Daily Huddle QuOC	Escalated to QuOC	A Learning Matters publication was issued (see Appendix 2) to support the implementation of our revised Duty of Candour Policy, together with a trust-wide awareness campaign
Is the current approach to the governance associated with, assessment of risk and prevention of Venous Thrombo-embolism effective?	Compliance with NICE Guidance Performance data Serious incident Incident	Clinical Audit & Effectiveness Patient Safety Committees QuoC IPMG Daily Huddles	Second order change required through establishment of Inquiry Group	Inquiry group meeting during July 2017. Approach to be reviewed and high level action plan to be developed. The current situation has been risk assessed and the need for second order change agreed. This learning continues and a learning matters is planned, together with a call to action during October 2017.
Is our stroke service safe and effective?	National audit outcome Incidents Performance data	Clinical Audit and Effectiveness Patient Safety QuOC	Escalated to QuOC	A summit process has been initiated and will be conducted during October 2017.

Learning Question	Source	Mechanism	Action	Outcome
Do the governance and quality and safety processes within our renal service assure the safe and effective deliveryof care?	Serious incident investigation	Risk management team	QuOC	Service level action plan developed in response to concerns identified with executive oversight

3. Precursor Event: Opportunities for change and improvement

Learning question	Source	Mechanism	Action	Outcome
Are our action plans that are developed after Serious Incidents and Complaints effective?	Serious Incident and Complaint Investigations	IPMG QuOC Commissioners CQC	Quarterly report to Quality and Safety Committee and CCG Newsletter publication to describe impact of changes made trust wide	Assurance reviews of the effectiveness of action plans developed after serious incidents have occurred are routinely undertaken and identify how effectively the organisation has responded to the recommendations made. Quarterly "Responding and Improving" publication produced and disseminated through corporate communications and divisional governance (Appendix 3).
Does the wording in the Access Policy result in patients with a suspected cancer being referred back to primary care rather than directly to an appropriate consultant?	Incident	QuOC	Review of Access Policy wording through TOG	The wording in the policy is nationally mandated, so a locally developed supportive information pack will be developed through the Medical Directors Office.
Are our action plans that are developed after Serious Incidents and Complaints effective?	Serious Incident and Complaint Investigations	IPMG QuOC Commissioners CQC	Quarterly report to Q&S Committee and CCG Newsletter publication to describe impact of changes made trust wide	Assurance reviews of the effectiveness of action plans developed after serious incidents have occurred are routinely undertaken and identify how effectively the organisation has responded to the recommendations made. Quarterly "Responding and Improving" publication produced and disseminated through corporate communications and divisional governance (Appendix 3)

4. Precursor events: Good learning practice

Description	Mechanism	Learning and Surveillance Hub assessment
The Standardised Structured Judgement Review (SJR) process used in mortality reviews enables a comprehensive and consistent approach to the clinical review of cases where a serious incident or incident is suspected.	A pilot process will be commenced with between the Medical Directors Office and the Risk Management Team.	Consistency to support decision making is key, this may also support preparation for inquests and claim management.
The Standardised Structured Judgement review (SJR) process used in mortality reviews enables a comprehensive and consistent approach to the clinical review of cases where a serious incident or incident is suspected	A succecssful pilot process has been completed between the Medical Directors Office and the Risk Management Team	Consistency to support decision making is key, this may also support preparation for inquests and claim management.

Appendix 1: Rapid Response Action

Bradford Teaching Hospitals NHS
NHS Foundation Trust

RAPID RESPONSE ACTION

Medicines Management

A patient has come to harm after their anticoagulation medication was omitted in error.

The investigation is in its early stages but it appears likely that poor communication, a lack of recognition of the importance of the medication and a lack of attention to detail in relation to the timing of the administration of medicines were contributory factors.

In addition we are seeing a range of other medication related incidents across the Trust where the harm to patients is prevented

With immediate effect, and pending the outcome of the investigation, **it is essential** that all staff responsible for medicines management within the Trust, its prescribing, preparation, dispensing and administration **review** the Trust's Medicines Management Policy. **Staff are all reminded of their personal responsibility for the safe management of medicines, and should escalate any concerns related to their responsibility to their manager immediately.**

http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP24%202017%20Medicines%20Policy.pdf

Bradford Teaching Hospitals NHS
NHS Foundation Trust

RAPID RESPONSE ACTION

Bogus Health Care Professional

Situation

An unknown person has been entering our wards (by either 'tailgating' or buzzing). They have claimed to be a Pharmacist and have asked for and gained access to treatment rooms and obtained the codes for drug cupboards. The person is reported as

- being female, white, mid to late 40's, medium height, slim build with bleached blond hair (worn in a ponytail) with dark roots and well spoken
- wearing a blue lanyard with a card appearing to be ID
- carrying 'official looking' pharmacy documentation
- being well versed in hospital policies and procedures

Background

Attempts were made by the same person to access wards on the BRI site over the weekend. There have also been a report from Calderdale that someone with a similar description has tried to access wards there .

Assessment

We believe that the person is acting illegally and is seeking drugs. The person appears authentic. There is a significant risk that this person, or an accomplice, may attempt to access our wards and areas where we store drugs again. There is a risk that they may change their method, for instance, pretend to be a different type of health care professional or appearance.

Recommendations

- All staff to ensure that no-one can enter any of our wards or departments without a legitimate reason for being there.

  -Check all ID badges, compare them to your own if in doubt

  -Don't let anyone 'tailgate' as you enter wards and departments

- All staff to be extra vigilant and to report any security concerns to the Security Team on extension 2130 and also inform the Matron for your area and your manager.

Bradford Teaching Hospitals NHS
NHS Foundation Trust

RAPID RESPONSE ACTION

Criteria for discussion with an Obstetric Consultant

Antenatal Outpatient/Inpatient

- Failed computerized CTG or concerns about any antenatal CTG
- Decisions for IOL (except postmaturity)
- Any abnormal Doppler/growth restriction/abnormal growth velocity
- Two or more episodes or reduced fetal movements
- New or known fetal anomaly
- Transverse/oblique/unstable lie
- Any new serious medical condition, change or deteriation
- Gestational hypertention/Pre-eclampsia – and the plan for delivery
- Abnormal antibodies
- Consultant to have reviewed each antenatal inpatient
- Consultant to review discharge plan for preterm SROM, twins and non-cephalic presentation at term

Intrapartum:

- Intrapartum or Obstetric Emergencies
- Severe PET
- Septic or deteriorating patient
- Haemorrhage
- Maternal collapse
- VBAC Induction & augmentation
- Any patient requiring obstetric theatre
- Vaginal breech delivery twin delivery
- Prior to 3rd fetal blood sample

Post-natal:

- 2nd Postnatal attendance to MAC
- PN Readmissions (maternal

This list is not exhaustive. Please discuss any uncertainty regarding plans of care

Appendix 2: Learning matters

NEWS - National Early Warning Score - *What you need to know*

NHS
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PREVENTING INCIDENTS

A cluster of incidents have been logged regarding failure to respond appropriately to **NEWS** scores. An audit of patient records found scores were not always calculated correctly and opportunities to escalate care are being missed.

The **NEWS** trigger system is aligned to a scale for managing clinical risk. It is our surveillance system for all patients; for tracking their clinical condition, alerting the clinical team to any medical deterioration and triggering a timely clinical response.

NEWS is based on a simple scoring system. A score is allocated to physiological measurements undertaken when patients present to, or are being monitored in hospital.

NEWS supports and drives an improvement in safety and clinical outcomes by standardising the assessment and scoring of simple physiological parameters.

The **NEWS** scoring system enables a more timely response to the assessment and planning of care and for optimising organisational delivery of safe, equitable, quality care for all acutely unwell, critically ill and recovering patients.

NEWS

KEY LESSONS

- All patients should have NEWS recorded within 1 hour of admission / assessment area / transfer to a ward and as part of every reassessment
- All patients require a minimum of 12 hourly NEWS unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient (NICE 2016)
- If individual **NEWS is 3 in one parameter or total NEWS is 5 and above**, or the patient is being prescribed antibiotics then the sepsis screening tool **MUST** be used to evaluate for severe sepsis
- If no response from the parent team within the timescales specified in the NEWS guidelines, **immediately** escalate to a more senior doctor within the team
- NEWS should be monitored in a timely manner
- Patients must be managed in areas appropriate to their clinical needs
- A patient's clinical condition should always override the calculated score from NEWS when considering the need to escalate the level of care
- NEWS has not been validated in pregnancy; it should be used with caution in pregnant women admitted to general wards within the Trust.

Learning Matters - 05 NEWS May 2017

Deprivation of Liberty Safeguards (DoLS)

NHS
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NHS Foundation Trust

MAIN POINTS TO REMEMBER

The Acid Test (all three points must be met to make an application):-

- ✓ The person must lack mental capacity
- ✓ The person must be under complete control and supervision
- ✓ The person is not free to leave (whether they are trying to is irrelevant).

An application can't be made if:-

- ✗ The person has mental capacity
- ✗ The person's predominant issue is a deterioration of a pre existing mental disorder
- ✗ If the person is already subject to the Mental Health Act.

If you are unclear as to whether an application is appropriate contact your Matron or the Safeguarding team (4076)

'IF IN DOUBT, CHECK IT OUT'

Do

- ✓ Ensure a capacity assessment has been completed
- ✓ Inform your Matron / site coordinator
- ✓ Keep a copy of the application in the patients notes.

Don't

- ✗ Forget to fax the paperwork to the DoLS admin team (01274 431161) and the Hospital Safeguarding Adults team (4176)
- ✗ Forget to inform Safeguarding Adults if the patient:-
  - Regains capacity
  - Moves ward
  - Is discharged
  - Dies.

PLEASE NOTE

HM Coroners no longer requires an inquest into the death of every person who was subject to an authorisation. An inquest is still required if the cause of death was unnatural /violent or if concerns regarding care contributed to the death.

Learning Matters - 06 DoLS Jun 2017

SAFE DISCHARGE (nutrition) - *What you need to know*

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Failure to communicate nutritional care plan to primary care

A patient was identified by the ward dietitian to have experienced significant unplanned weight loss. The dietitian advised that a nutrition care plan and regular monitoring was required and this was documented in the medical notes. However, this was not included in the patients discharge summary which was sent to the primary care team. This lack of effective handover has led to a serious complaint.

Key lessons from this incident are:

- The discharge summary to the primary care team must include assessments and recommendations from other members of the multi-disciplinary team .
- Medical staff with responsibility for producing discharge summaries must be aware of the minimum dataset required.

'IF IN DOUBT, CHECK IT OUT'

What can you do?

- Nursing and medical staff must ensure all patients who they consider to be at risk of malnutrition or they know have lost weight are referred to the dietitians.
- Nursing staff must ensure that advice given by the dietitian is followed and that the nursing assessment and care plan documentation is kept up to date.
- Medical staff must ensure discharge summaries include a summary of any assessments or recommendations from other members of the multi-disciplinary team.
- Ensure that the minimum data required for an adequate discharge summary is part of the induction process for new members of the medical and nursing teams.

The impact of the Electronic Patient Record

The Electronic Patient Record will have a section for the dietitian to record their findings for patients whom they have assessed during admission along with any recommendations to the primary care team.

Information can be sourced from:

- Nutrition Policy: BTHFT Intranet site
- The ward dietitians.

Learning Matters - 07 Safe Discharge (nutrition) Jun 2017

A breach in our Duty of Candour
What you need to know

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

What happened…

A critically ill infant was brought to our Accident & Emergency Department (AED), and later died following their transfer to Leeds General Infirmary. It was identified that there were opportunities during the infant's antenatal and postnatal care provided by us, and during his admission to our AED, that could have led to an earlier detection and treatment of the presenting condition. The circumstances surrounding the death of the infant were investigated as a Serious Incident.

- We did not provide the infant's parents with any apology or clinical explanation until several months after their death.
- We did not provide an appropriate clinical single point of contact for the family, leaving them navigating a complex system involving multiple Trusts and the Sudden Unexpected Death in Childhood (SUDIC) process, unsupported and trying to get answers.

This has led to an understandable breakdown in the trust that the infant's family has in our organisation and has compounded the grief that they are experiencing.

'Be wise, Be open, Be honest'

Key Lessons

- We have a duty to be open and honest with our patients and their families when things go wrong, whether the harm is identified when they are still in our care, or after they have left our care.
- Where the care of a patient who is harmed is delivered across multiple specialities it is essential that a formal documented decision is made in relation to the responsibility for the first Duty of Candour disclosure. This decision should be supported by the relevant Divisional Head of Nursing if required.
- It is essential that we agree future disclosures and support with the patient or their family and document and monitor this as part of any incident investigation process.
- We should continue to strive to improve the time that it takes us to investigate incidents.
- We should continually review the effectiveness of how we engage with patients and families during investigations.

Learning Matters #08Duty of Candour

Appendix 3: Responding and Improving

Issue 2 June 2017

Bradford Teaching Hospitals NHS
NHS Foundation Trust

RESPONDING & IMPROVING

Invasive procedures edition

Responding and Improving

When a serious incident occurs we need to make sure that it cannot happen again.

During the investigation a number of recommendations are usually identified, some are very specific to the incident, some have implications across the Trust.

We work hard to respond to recommendations . We also work hard to make sure any of the actions we take are effective and we have made sustainable improvement, meaning that we have confidence that the incident should not happen again.

Post Angioplasty Management

In September 2015 a patient died during a CT angiogram. The root cause of this incident was a lack of appreciation of the risk of bleeding in a post angioplasty patient on heparin with hypotension.

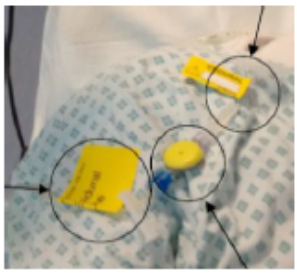
Contributory factors included presence of a hard tender lump over an arterial puncture site in an anticoagulated patient, in combination with a systolic blood pressure of below 70 should have prompted an urgent senior review, the instructed dose of heparin for prescription on the chart is a fixed dose and not weight related, there was an assumption that the trainee doctor had sufficient knowledge and skill to review the patient post angioplasty.

The key lessons learned from this incident are the importance of excluding bleeding being the cause of a raised NEWS post angioplasty in an anticoagulated patient, and of the importance of a clear mechanism for the management of patients requiring heparin.

Mitigating actions taken included finalising the revised IV Heparin chart, awareness raising of the incident and that medical records MUST be updated following review/interventions with patients.

The assurance review resulted in confidence. The IV heparin chart was disseminated to wards week commencing 27/03/2017 and featured in the latest news global email on 05/04/2017.
An assurance review of ward awareness took place w/c 03/04/17. 87% of wards were aware the new charts.

Never Event—Epidural catheter wrongly connected



In April 2016 the Trust reported a Never Event following an epidural catheter being inadvertently connected to the intravenous cannula . The root cause of the incident was human error.

Contributory factors included reduced staffing levels and skills within the recovery area and regular interruptions throughout the day .

The key lesson learned from this incident is that the interchangeability of the Luer connection system, whilst clinically useful, can aid the administration of drugs via the incorrect route. Clinical caution is required when setting up different infusions via different routes in the same patient, to avoid potentially harmful drug errors.

Mitigating actions taken included production of illustrative instructions for connection, revising the Epidural Analgesia guideline and the Acute Pain Management Chart to include the requirement for the epidural catheter to be connected by an anaesthetist and checked by a nurse / ODP. These revisions are included within the local anaesthesia induction.

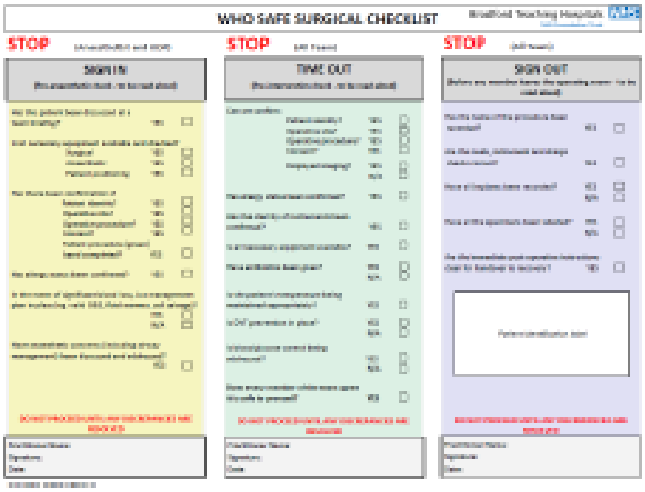
Never Event—wrong tooth extraction

In July 2016 the Trust reported a never event following the removal of a wrong tooth of a child. The root cause of the incident was the failure to recognise and take into account the child's unerupted teeth during the intraoperative count.

Contributory factors included a missed opportunity to make reference to the x-ray immediately prior to or during the intraoperative count , there were missed opportunities to highlight the unerupted teeth both during the pre-operative time out and intra-operatively, during the second count both operating surgeons could not visualise the teeth.

The key lessons learned were the importance of operating surgeons thoroughly reviewing a patient's medical records and x-rays prior to performing procedures and during tooth extraction surgery both surgeons visualise the teeth fully during both counts. Cross reference must be made to the x-ray images displayed in theatre and any anomalies in the normal presentation of the teeth are highlighted

Both of these lessons have been emphasised within the amended SOP for Dentoalveolar Surgery. The WHO surgical checklist has been revised and implemented. The checklist includes a check of operative site. The completed actions have given the Trust an assurance rating of confidence that this incident should not occur again.



5 Steps to safer surgery

Following their inspection in 2016 the CQC issued the Trust with a compliance action to ensure staff working in surgery comply with the five steps safer surgery process and that the WHO surgical checklist is consistently implemented.

A great deal of progress has been made against the action plan. The WHO checklist has been refined and improved based on staff feedback and scenario based training has taken place.

NPSA alert NatSSIPs National Safety

In 2015 NHS England published National Safety Standards for Invasive Procedures (NatSSIPs). NatSSIPs sets national measurable standards for all invasive procedures. It aims to Standardise safety principles, Educate—for team safety and Harmonise across all areas.

The LocSSIPs Implementation Group has revised the out of date Safe Procedures Policy to ensure it meets NatSSIPs. The Policy aims to establish a Bradford Way of working with the introduction of BradSSIPs. A handbook has also been developed which summarises the safety standards for readers.

The next stage will be for Divisions to establish working groups to identify and standardise all relevant SOPs/guidelines or policies to harmonise with NatSSIPs/BradSSIPs.

BradSSIPs

A copy of the revised policy and handbook will be published on the Intranet.

Responding and Improving is developed by the Learning and Surveillance hub. For more information please contact Diane Matthews on extension 6643 or by email Diane.Matthews@BTHFT.NHS.uk

Issue 3 September 2017

Bradford Teaching Hospitals NHS
NHS Foundation Trust

RESPONDING & IMPROVING

Focus on the Accident & Emergency Department

Responding and Improving

When a serious incident occurs we need to make sure that it cannot happen again.

During the investigation a number of recommendations are usually identified, some are very specific to the incident, some have implications across the Trust.

We work hard to respond to recommendations . We also work hard to make sure any of the actions we take are effective and we have made sustainable improvement, meaning that we have confidence that the incident should not happen again.

Discharge of a vulnerable patient

In May 2016 an elderly gentleman was pronounced dead at his home by paramedics. The gentleman had attended our AED two days previously and was discharged at 03.00 am. A post mortem identified the cause of death as a Pulmonary infarction, Pulmonary thromboembolism & DVT.

The Trust wanted assurance that the systems and processes in place for the assessment and discharge of patients from the Accident and Emergency Department (AED) were sufficient and followed.

Immediate steps were taken to reduce the risk of such an error recurring:
The Clinical Lead for AED shared and discussed the case with all AED Consultants and senior nursing staff when the incident was identified and information regarding the discharge of elderly patients at night was included in both nursing and medical handover for two weeks following the incident.

Action was taken to share the report within AED and ensure all medical staff were aware of the high risk groups which require senior sign off. A ProgRESS review of the discharge of vulnerable patients took place.
We were confident that staff were aware of the high risk groups requiring senior sign off and 100% of staff asked were happy with escalation process for senior review.
The full report can be read here.

Child non-accidental injury

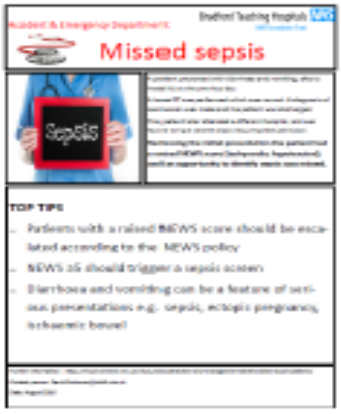
In 2015 there was a missed opportunity to safeguard a child when they first attended the AED. A child had been brought to AED by ambulance and during this visit a student nurse noticed a bruise on the child's wrist, the child was discharged home later. Three days later the child attended the AED with injuries consistent with non-accidental injury.

Lessons learnt from the review were the importance of clear, unambiguous guidance about the requirements for senior review before a child is discharged from the AED; during assessment the doctor must take into account the information documented within the AED record as part of their assessment.

A number of actions were taken to prevent reoccurrence of this type of incident. These included the paediatric AED card being amended to include 'unexplained bruising' in a non-mobile child as a possible non accidental injury ; a department procedure was implemented that all patients under 1 years old requires senior review before discharge and education and training took place with all AED staff.

We reviewed the effectiveness of the actions taken and we are confident that they have been completed, and that the speciality has learned from the incident.

Missed Sepsis



A patient presented to AED with diarrhoea and vomiting, after a head injury the previous day. A head CT was performed which was normal. A diagnosis of concussion was made and the patient was discharged. The patient later attended a different hospital, and was found to have severe sepsis requiring ICU admission.

Reviewing the initial presentation found that the patient had a raised NEWS score (tachycardia, hypotension), and an opportunity to identify sepsis was missed.

The department produced a lesson learnt bulletin for all staff outlining the incident and sharing top tips for the identification and management of Sepsis.

The department now has a sepsis trolley that is used for every patient with sepsis, dedicated nurses with an interest in sepsis and have strengthened the relationships with ICU to ensure they have briefings during and following each case to improve processes.

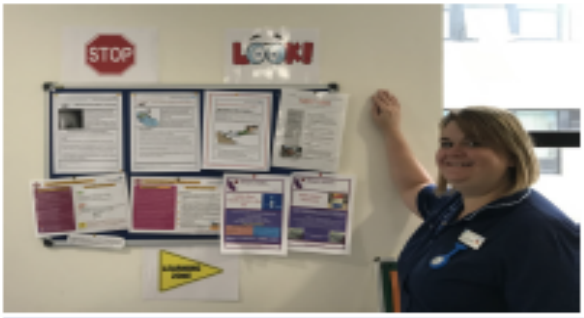
Learning in AED

At the end of 2016 there was a real drive to refocus AED on safety and quality to improve the management of deterioration and response to incidents.

The department have made some significant and innovative changes in their practices with the implementation of multidisciplinary in-situ simulation and immediate review and action following incidents.

The department now undertake monthly in-situ simulation with a multi-professional team and share the findings with all staff via a one page newsletter displayed in staff areas.

The department actively review themes and trends of incidents and introduce step changes or involve partners to improve outcomes. Following an increase in violence and aggression incidents the department are working closely with security to ensure staff and patients are safe.



Responding and Improving is developed by the Learning and Surveillance hub. For more information please contact Diane Matthews on extension 6643 or by email Diane.Matthews@BTHFT.NHS.uk