Bradford Teaching Hospitals
NHS Foundation Trust

Keeping our patients safe during the pandemic

Karen Dawber, Chief Nurse

Council of Governors' meeting - April 2021

Together, putting patients first

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Getting the basics right…….

- Daily dynamic patient safety tool.
- Improving the service – Quality Improvement (QI), learning from incidents, complaints, compliments in a timely way.
- Enhancing the patient experiences – Different ways of doing things.
- Demonstrating kindness.
- Senior nurse inspection.
- Presentation/sharing learning.
- Team work and engagement.
- Quality of Care group (QuoC).
- Quality oversight tool.
- Clinical Reference Group (CRG).

Quality of Care
1. Oversight

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Alert | Advise | Assure

Daily Huddle

410 incidents reported during this two week period. 26 incidents discussed at Safety Huddle, with 10 being raised at IPMG. The updated run chart for low harm/no harm incidents is available for information. There are no incidents for escalation to QuOC.

Moderate Harm and above Incidents

All patient safety incidents where harm was moderate and above are reviewed through the daily huddle and IPMG/falls/pressure ulcer groups. There were 5 incidents graded as moderate harm during this two week period. 4 were discussed at IPMG, none of which require escalation to QuOC.

COVID

Incidents are routinely reviewed at the daily risk huddle and in the context of silver command. Any escalations are made to the COVID huddle weekly and dealt with through IPC processes. There were 4 incidents that required discussion at IPMG during this two week period. Two require discussion at QuOC with regard to declaration as SIs:
QuOC0523 (WR108322) – COVID Outbreak
QuOC0524 (WR108323) – Hospital onset COVID deaths (14 patients)

Themes, trends, specific issues

Themes, trends and specific issues are identified through daily huddle and raised through IPMG and QuOC as necessary.
The Quality Team have picked up a theme around bleeds to the brain and is currently undertaking some work to better understand these.

Regulators

Reporting of incidents to external agencies are monitored through the Non-Clinical Risk Team. There was 1 incident reported to IR(ME)R during this period related to an over exposure to radiation.
The HSE have contacted the Trust regarding the staff COVID death. This has been officially signed off with no further action for the Trust.

Serious Incidents

There are 10 ongoing Serious Incident investigations currently. 1 SI closed – 2020/12772 Failure to follow decontamination protocol.

Patient Experience

There were 16 complaints received during this two week period, 15 low risk and 1 moderate risk.

Claims

T/MH/KHAH/I – alleged delay in diagnosis and treatment of Strep B. Conference took place on 07.04.2021 – all experts and Trust clinicians in agreement that Breach of Duty and Causation indefensible. NHSR suggested full admissions and apology from Trust.

Inquests

No Inquests Heard
Three Inquests are Formally Listed:
Vascular Surgery (26 April)
Emergency Medicine (24 May)
General Medicine (7 June)
Two further inquests pending listing.

Rapid Response and Learning

WYAAT has shared an Early Learning SBAR – Wrong Implant and this is available for information.

Surveillance

No services are currently under surveillance.

Quality Summits

No current Quality Summits.

Mortality

FOI 20533 – SJRs completed since January 2020 and how many related to COVID.
JC and LE attending Improvement Academy Mortality Masterclass on 25/04/2021.

Risks

The Strategic Risk Report presented at Exec Team Meeting in March is available for information.

Learning

The Spring Edition of the BTHFT Mental Health Bitesize Newsletter is available for information.

Improvement

HSIB Report – Maternal Death (WR101965). Report and Maternity Response.

Clinical Outcomes

High Priority Audit Programme – to be presented at the Quality Academy for sign off (31 March). Engagement plan started with National Audit Leads to support the restart of the programme in April.

Alerts

JC is preparing an SBAR Report for presentation at ETM in relation to the NatPSA_2021_001_MHRA Supply disruption of sterile infusion sets and connectors manufactured by Becton Dickinson (BD).
There were no CAS Alerts received during this period. Existing alerts can be viewed by following the link below:
https://www.cas.mhra.gov.uk/Home.aspx

National Patient Safety Improvement Programme (NPSIP)

Beverley Slater from the Improvement Academy presented at the Quality Academy on 31.03.2021.

QOS Development

The National Pilots have restarted, expectation is that evaluation of the pilots will commence in July 2021. Trust SI policy will be reviewed in the interim. Judith Connor has registered as a Patient Safety Specialist with NHS England.

2. Dynamic Quality and Safety Tool

- Daily completion and escalation.
- Weekly review.
- Areas covered include -

  Safe staffing/skill mix.
  PPE compliance
  Infection, Prevention and Control measures – Cleaning, hand hygiene.
  Fit testing.
  Incidents/near misses.
  Patient medical reviews, safety huddles.
  Documentation – Risk assessments and care plans.
  Red flags – Delays in pain relief, care.
  Communication.
  End of Life care.

3. Clinical Reference Group (CRG)

- Daily completion and escalation.
- Clinical decision making group.
- Gold and Silver meetings to raise, discuss, plan and approve decisions related to patient safety, experience and care.
- Established and maintained throughout the pandemic, still in place.
- Areas.

4. Patient Experience

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Person centred care - Focus on learning disabilities.

Meeting fundamental needs - *Red bag pathway*.

- Wards accommodating changing patient needs in terms of the Trust Covid status.

Staff and communication

- Use of clear face masks and communication aids.
- *Thinking of You* email account.
- Relatives' line receives approximately 1200 calls a week.
- *Family View.*
- Chaplaincy team has increased their onsite presence and working hours to support both staff and patients.
- Safe visiting SOP.

Patient discharge from hospital .

What have we learnt?

Are we confident that our care and services were safe in the past?

Are we confident that our care is safe today?

Are we confident that our systems and processes are reliable?

How can we improve?

Are we confident that we will be safe in the future? Do we respond effectively to safety issues?