Learning from Serious Adverse Incidents

BELFAST HSC TRUST

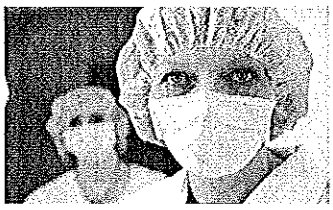
Corporate Governance

September 2011

Key messages

- ENSURING QUALITY AND SAFETY IS TOP PRIORITY
- LESSONS LEARNED CAN BE DEFINED AS KEY SAFETY AND PRACTICE ISSUES
- IT IS EVERYONES RESPONSIBILITY TO APPLY LESSONS RELEVANT TO THEIR AREA.

Lessons - changing practice, improving safety



You can make a difference

Ensuring quality and safety for service users, staff and others is a top priority for Belfast HSCT. When incidents happen, it is important that lessons are learned across the Trust and beyond to prevent the same incidents occurring elsewhere.

Lessons learned can be defined as key safety and practice issues which may not have directly contributed to the incidents but are significant and will be useful learning for others.

The following pages bring to your attention lessons learned from Serious Adverse Incidents (SAI's) and other incidents reported in our Trust, that have learning relevance across the Trust. It is important that you are aware of these and ensure they are applied to your areas where relevant to do so. Lessons should be embedded through changes in practice, processes or systems.

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Medical Devices are implicated in 400 UK deaths annually

The National Patient Safety Agency (NPSA) have indicated that around 400 deaths occur annually in the NHS which have involved a medical device.

Follow up of incidents allows identification of learning to reduce the risk of similar events occurring. Here is some learning that could help you work with medical devices safely.

Lesson – Know the relevant guidance

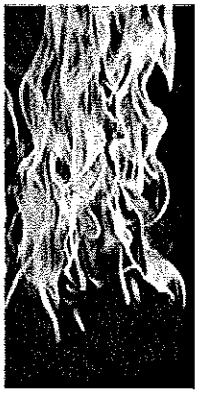
It is essential that all clinical staff familarise themselves with our current Trust policy and procedures entitled 'Management of Medical Devices Procedures & Guidelines' (September 2009). This includes essential guidance regarding the correct procedure for trial and/or procurement when introducing new medical devices. This guidance is also essential in relation to off-label use or modification of medical devices.

Lesson – Ensure you are competent

Staff must ensure they understand and are competent to use medical devices . For example incorrect shut down of an electronic device could result in loss of a warning message critical for alerting staff that there is a problem. Managers must ensure that staff using medical devices have received appropriate training in their use and facilitate attendance at generic medical device management training available on an ongoing basis. Corporate Governance hope to make an e learning package available in the next few months.

Lesson - Record keeping

SAI investigations continue to highlight some weakness in record keeping including records regarding management of medical devices. Nurses must follow the NMC guidance on record keeping (July 2009).



All staff must attend fire safety training

Fire Safety

Common lessons have been identified from recent SAI's in relation to fire in hospital settings.

Lesson 1: Designated smoking areas do not eliminate risk of fire in wards

Patients who wish to smoke in outside designated smoking areas must be risk assessed.

If patients are refusing to adhere to the no smoking policy then this should be discussed with the Consultant/Senior Manager.

Lesson 2: Know your evacuation procedures in event of fire

All staff must attend fire safety training annually.

A contingency plan should be in place for re-locating patients if required.

All staff should ensure their areas are clear of clutter to ensure safe evacuation in event of fire.

Thumbs Up on Monday?

You may not have to check your work area smoke alarm but there are regular checks you must do e.g.

Do your alarm systems work? - Ensure all your alarm buzzer systems are regularly checked in your area.

Also, check any window restrictors and Nurse Call breakaway cords.

Managing Serious Adverse Incidents

"THE MORE SERIOUS THE INCIDENT THE MORE URGENTLY IT SHOULD BE ESCALATED AND REPORTED"

A Serious Adverse Incident (SAI) is defined as meeting at least one of the following (summarised) criteria:-

- Serious injury, or unexpected/unexplained death

- Unexpected serious risk to service user, staff or public

- Unexpected or significant threat to provide service and/or maintain business continuity

- Serious assault by a service user

- Serious incidents of public interest or concern involving theft, fraud, information breaches and data losses

Lesson: When a SAI occurs, know the "who, when and how" of reporting the incident

The more serious the incident the more urgently it should be escalated and reported.

The Trust Incident reporting policy and relevant procedures are available on the Intranet under Medical Director's directorate.

Staff must be clear on who they contact when they feel a HSCB reportable SAI has occurred.

Staff should also be clear on the procedures they must follow after the death of a patient/client as a result of an adverse incident, particularly out of hours.

Procedures agreed locally should be in line with the Trust Adverse Incident & Management policy and Procedures for Reporting & Managing Incidents.

Remember your duty of care

Child Welfare

Lesson: Remember your duty of care

Staff should ensure that they relay any information relating to concerns for the welfare of a child obtained through the course of their work in line with their duty of care.

Healthcare Acquired Infections

Lesson: Use available 'physical barriers' to prevent the spread of infection

Staff should ensure strict adherence to PPE in line with Infection Prevention & Control Management Arrangements policy.

Remember to keep side room doors closed when there are patients with infections being nursed in them.

Policy Management

Lesson: All Policies & procedures must be relevant and up to date

All policies, procedures, guidelines (including associated posters/notices) currently being used should be reviewed and updated as required. These should then be made available to all relevant staff.

Any previous policies should be archived.

Trust Policies intranet webpage:- http://intranet.belfasttrust.local/Pages/Policies.aspx

Prevent overdosing of injectable medicines

Lesson 1: Know the medication you are administering

IV medication infusions must be checked by 2 members of staff.

NMC Standards of Medicines Management 2010 must be followed, in particular, staff must not administer medication drawn into a syringe or container by another practitioner when not in their presence.

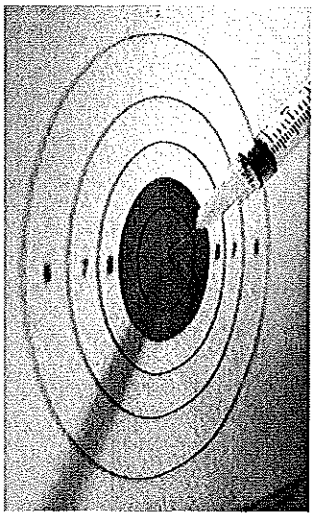
Staff must also know the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications.

Lesson 2: If in any doubt seek advice

Trust medicines management policies and procedures incorporate standards and good practices to ensure safe administering of medicines.

Your pharmacy colleagues will also be happy to give advice.

Local medicine management policies and procedures should be explicitly clear on providing guidance to ensure that infused medicines are safely prescribed either on the medicines Kardex or are referenced on the medicines Kardex and prescribed on the fluid balance prescription sheet.



Lesson 3: Write accurately and legibly

For all written documentation the prescriber must ensure accuracy and legibility, e.g. taking close attention of where decimal places are being used and ensuring dosage units are clear and unambiguous.

Lesson 4: Ensure you are trained and training is up to date

Staff should liaise with their manager to ensure their training is up to date on the prescribing and administration of injectable medicines.

Ward Managers should ensure they have up to date protocols and procedures for the prescribing, preparing and administering injectable medicines in all clinical areas.

All Trust Staff employed in acute settings must adhere to the Medicines Code (Feb 2011). This document defines the polices and procedures to be followed for prescribing administration, dispensing monitoring, ordering and storage of medicines.

WARD MANAGERS SHOULD ENSURE THEY HAVE UP TO DATE PROTOCOLS AND PROCEDURES FOR THE PRESCRIBING, PREPARING AND ADMINISTERING INJECTABLE MEDICINES IN ALL CLINICAL AREAS

Locum Induction

Lesson: Appropriate induction is vital for all staff including locums

All locum appointments should have a formal induction programme, which must be signed off by both the locum and the relevant manager.

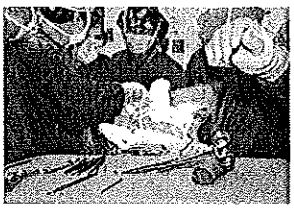
Consideration should be given to the introduction of a peer review or mentoring period for locum appointments, as determined by the relevant specialty.

Surgical Pause

An operating theatre is a complex and high risk environment.

Lesson: Everyone must know their own role and everyone else's role

The WHO checklist and surgical pause must be embedded in all operating departments without exception and used as a communication tool.



Improve the safety of surgery by reducing deaths and complications

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Admission to Mental Health Services

Lesson: Risk screen all Mental Health admissions

All patients admitted to mental health services must have a Risk Screening Tool completed.

Should further risks be identified a comprehensive Risk Assessment should be completed.

Are you effectively managing incidents?

Think about the most recent error or clinical incident that you came across in your work

Was it something that had happened before?

How would you know if it had happened before?

What did you do about this error or incident?

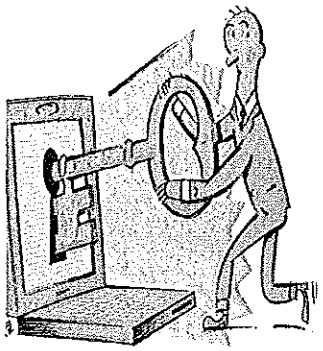
Do you know what action has been taken?

Do you know if the action has been effective?

Discuss with your colleagues/team how you deal with errors and incidents in your work area.

On the move? - Secure your data

Personal data: Ensure you secure!



Lesson 1: Know the policy

Staff vacating premises must ensure they follow their responsibilities outlined in the Trust Decommissioning Interim Policy (Policies section of Intranet).

Lesson 2: Ensure all files sent in transit arrive

When departments are moving, files to be transported by private companies should be listed and signed over before moving and a check done on receipt at the other end that no files have been lost in transit. Ref: Policy for the Safeguarding, Movement & Transportation of Patient/Client/Staff/Trust Records, Files and other Media between Facilities (available soon).

Lesson 3: Your portable IT equipment must be encrypted

Staff are reminded of the importance of ensuring that IT equipment which is their responsibility must be encrypted.

Lesson 4: Double check that the electronic recipient is correct

When emailing, using predictive recipient function on outlook can increase risk of non-HPSS recipients being sent data in error. Always double check or preferably use the outlook address book instead.

When faxing, double check the number is correct and that you have entered it correctly.

When printing, double check that the printer selected is the one you expect the document to be printed at.