Patient Safety Webinar Quarter 1 2023

3 August 2023

Welcome. Thank you for joining us today.

We are just setting up. Please do mute yourselves while joining or during presentations. (We may mute you on entry – this is not an audio fault, and you can of course unmute yourself any time).

Please introduce yourself in the Chat Box by full name and organisation and please make use of it throughout for Q&A.

Time	Item	Presenter(s)
13:00	Welcome and Introductions	Julia Russell, Senior Clinical and Quality Improvement Manager, Hospice UK
13.05	Case Study on Clinical Audit	Joe Potts Clinical Lead and Head of Inpatient Services Douglas Macmillan Hospice, Stoke on Trent.
13.30	Evaluation of last year	Julia Russell
13:35	Curriculum Setting	Julia Russell
14.00	Q1 Patient Safety Data	Julia Russell and Stuart Duncan
14:25	AOB and Close	Julia Russell

Joe Potts,
Clinical Lead & Head of Inpatient Services
Douglas Macmillan Hospice

Clinical Audit

Using a digital tool to support quality improvement

Joe Potts

Head of Quality & Innovation

Douglas Macmillan Hospice

Background

Hospice in Stoke on Trent caring for Children & Adults

Two hospice sites & 21 retail shops

Care for around 3000 patients & families per year

440 staff & 700 volunteers

Background

Services include

- **Inpatient Unit (26 beds)**
- **Wellbeing Team – outreach, wellbeing clinics, lymphoedema, physio, comp therapy, SPARCS, bereavement etc.**
- **Community Team – PCNS led, 24/7 Advice line,**
- **Hospice @ Home**
- **Children's hospice**
- **Young Adult Unit**
- **Dementia Services**
- **Support services etc.**

Audit

Audit and the use of data in healthcare has a long history but has often failed to bring about the expected improvements. Many settings have not fully embedded audit in clinical practice

(Paton, Ranmal, Dudley, et al.,2015).

Case for change

Handwashing Audits

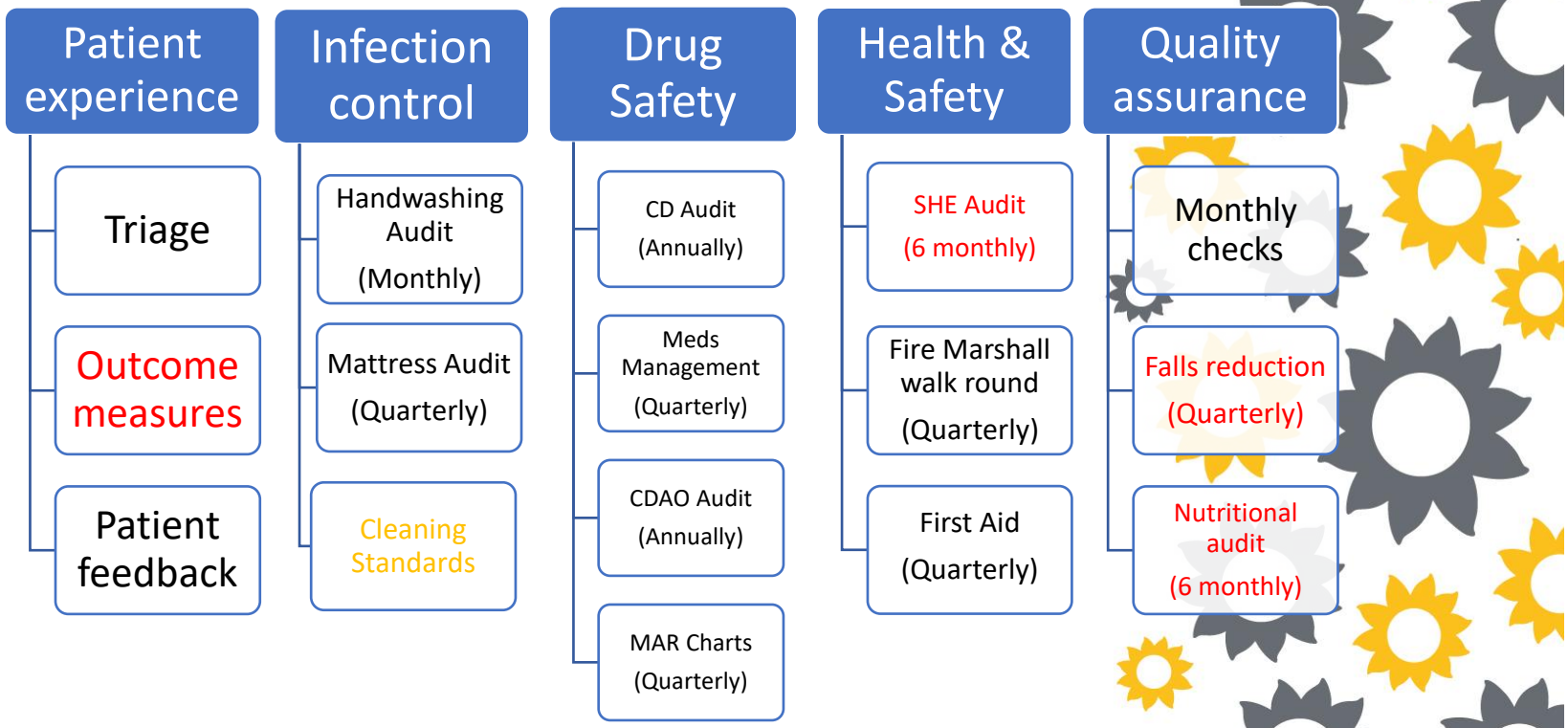
- Audits completed on paper
- Left in pigeon hole for Quality & Compliance Manager
- Data collated over period of weeks to months
- Limited feedback due to workload
- Actions required not captured

Case for change

Controlled Drugs Audit

- Audits completed on Excel
- Data collected using multiple methods
- Manual calculations for results % etc.
- Delay in feedback to prescribers/ IPU
- Actions completed 3-6 months after audit

Audit Schedule



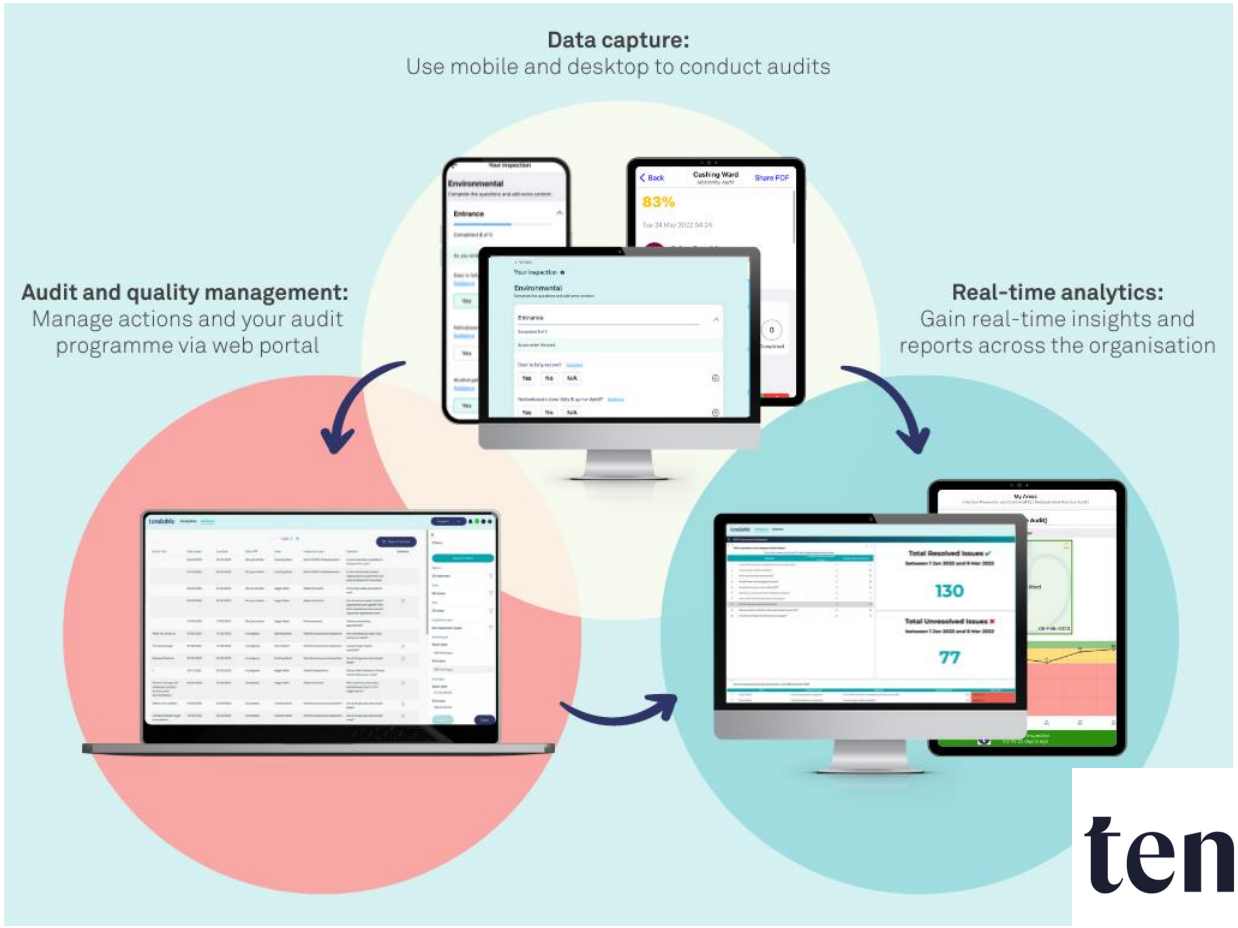
Options

Continue with current process

Utilise existing software to support (well known hospice risk/incident management system)

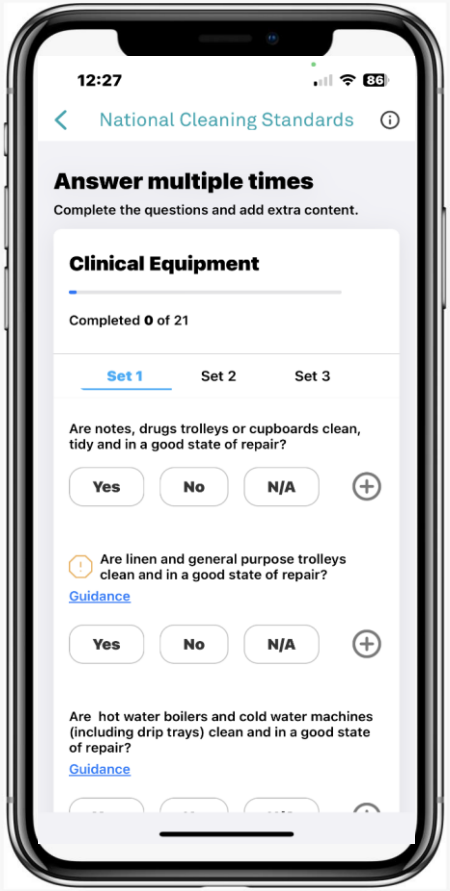
Look for supplier (Tendable)

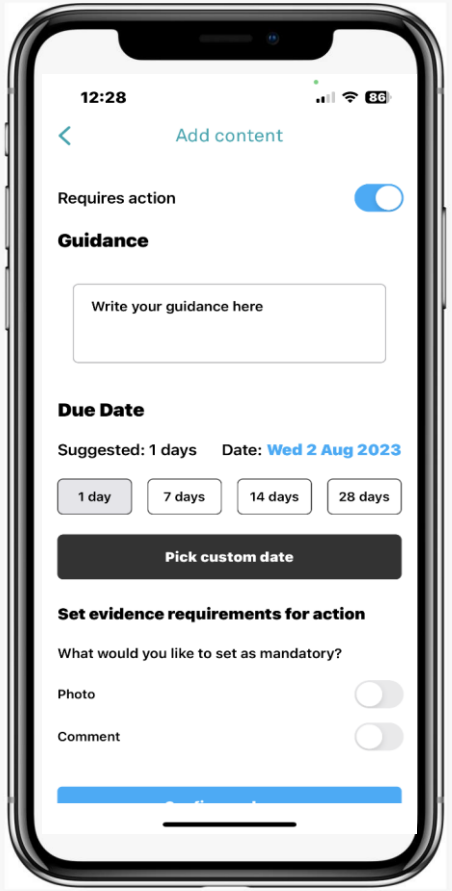
Solution

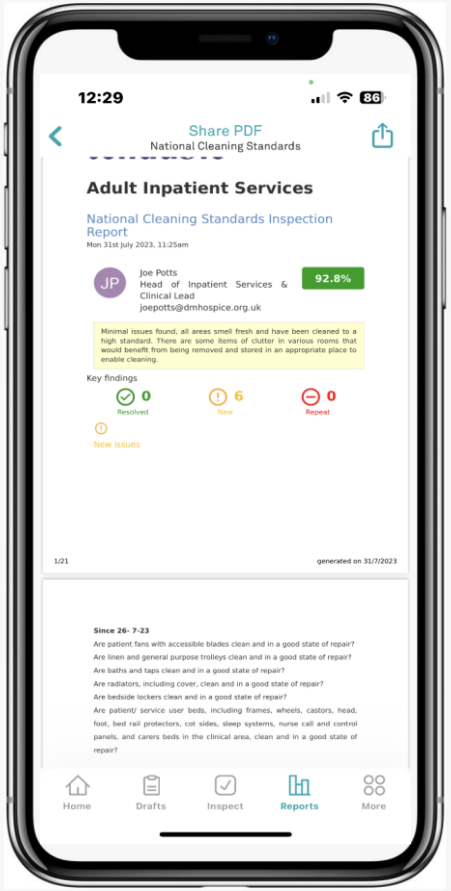


tendable

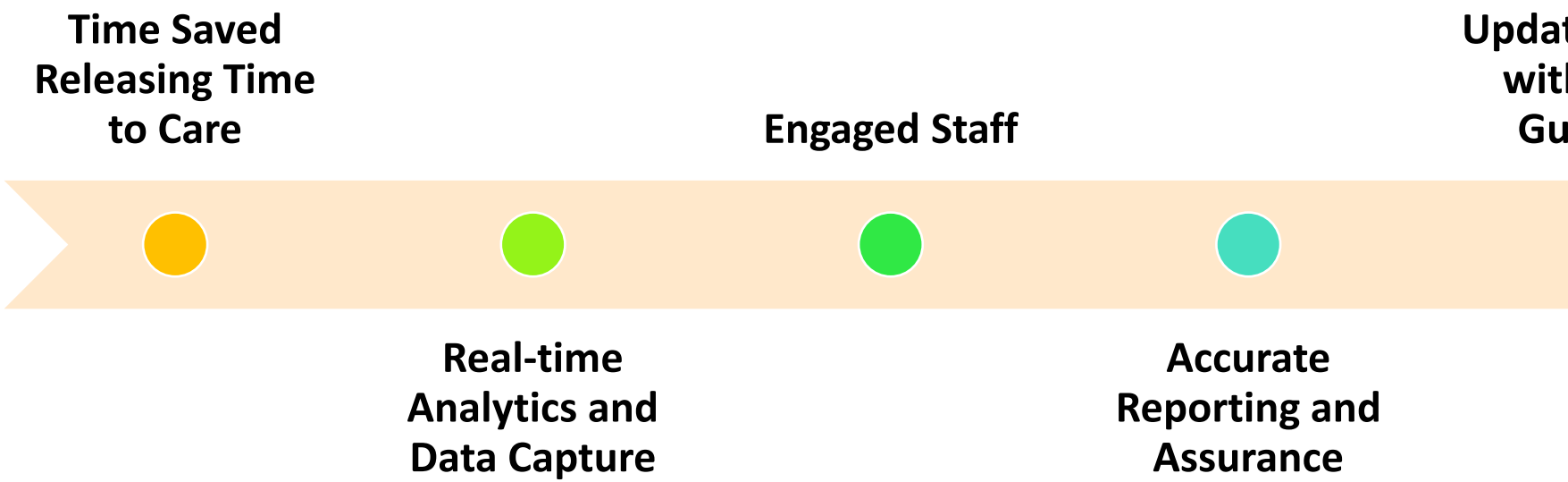
Example


12:27
National Cleaning Standards
Answer multiple times
Complete the questions and add extra content.
Clinical Equipment
Completed 0 of 21
Set 1
Set 2
Set 3
Are notes, drugs trolleys or cupboards clean, tidy and in a good state of repair?
Yes
No
N/A
Are linen and general purpose trolleys clean and in a good state of repair?
Guidance
Yes
No
N/A
Are hot water boilers and cold water machines (including drip trays) clean and in a good state of repair?
Guidance


12:28
Add content
Requires action
Guidance
Write your guidance here
Due Date
Suggested: 1 days
Date: Wed 2 Aug 2023
1 day
7 days
14 days
28 days
Pick custom date
Set evidence requirements for action
What would you like to set as mandatory?
Photo
Comment


12:29
Share PDF
National Cleaning Standards
Adult Inpatient Services
National Cleaning Standards Inspection Report
Mon 31st July 2023, 11:25am
Joe Potts
Head of Inpatient Services & Clinical Lead
joepotts@dmhospice.org.uk
92.8%
Minimal issues found, all areas smell fresh and have been cleaned to a high standard. There are some items of clutter in various rooms that would benefit from being removed and stored in an appropriate place to enable cleaning.
Key findings
0 Resolved
6 New
0 Repeat
New issues
1/21
generated on 31/7/2023
Since 26-7-23
Are patient fans with accessible blades clean and in a good state of repair?
Are linen and general purpose trolleys clean and in a good state of repair?
Are baths and taps clean and in a good state of repair?
Are radiators, including cover, clean and in a good state of repair?
Are bedside lockers clean and in a good state of repair?
Are patient/ service user beds, including frames, wheels, castors, head, foot, bed rail protectors, cot sides, sleep systems, nurse call and control panels, and carers beds in the clinical area, clean and in a good state of repair?
Home
Drafts
Inspect
Reports
More

Outcomes


Time Saved Releasing Time to Care
Real-time Analytics and Data Capture
Engaged Staff
Accurate Reporting and Assurance
Updat
with
Gu

Questions

Joe Potts

Head of Quality & Innovation

Douglas Macmillan Hospice

joepotts@dmhospice.org.uk

@NurseJoe87 – Twitter/ X

tendable

https://www.tendable.com/contact-us

Debra Renwick

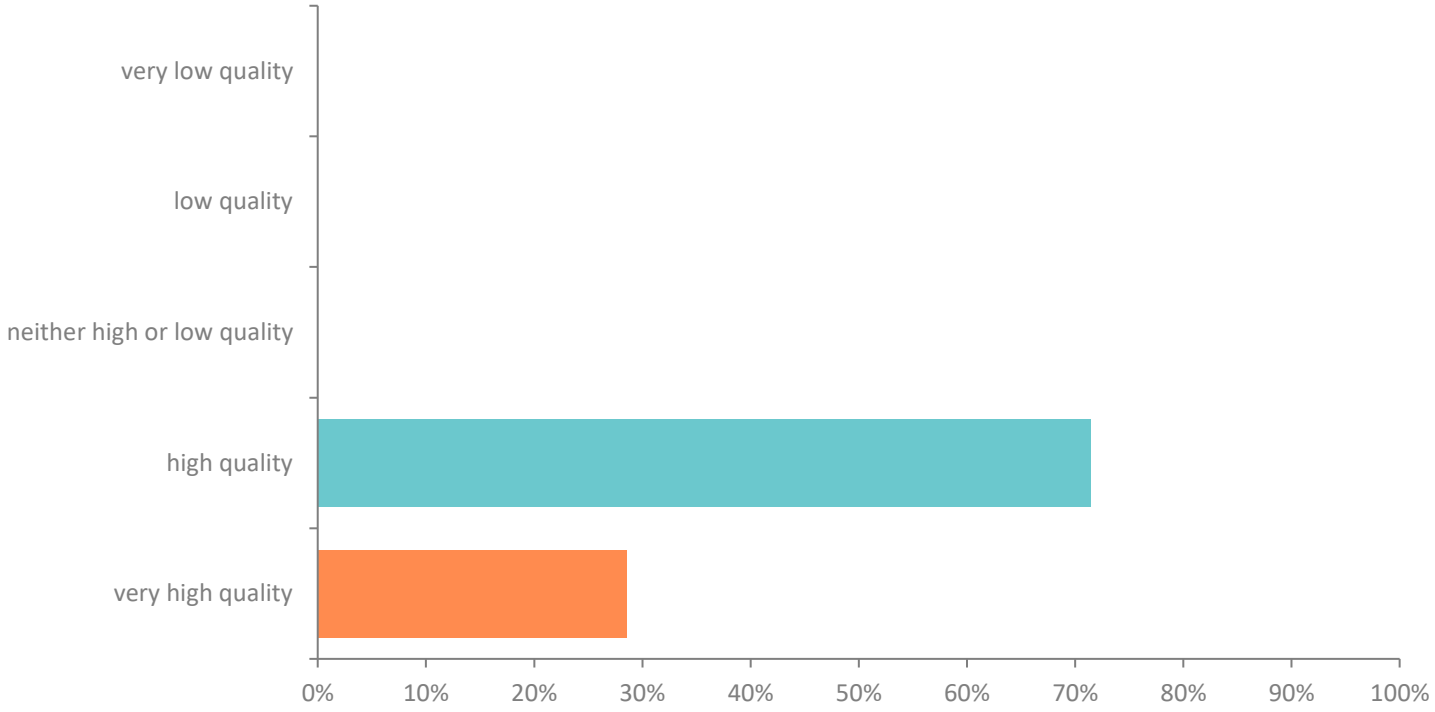
Partnerships Manager

debra.renwick@tendable.com

Patient Safety Webinar Evaluation Survey (end of year 2022/23)

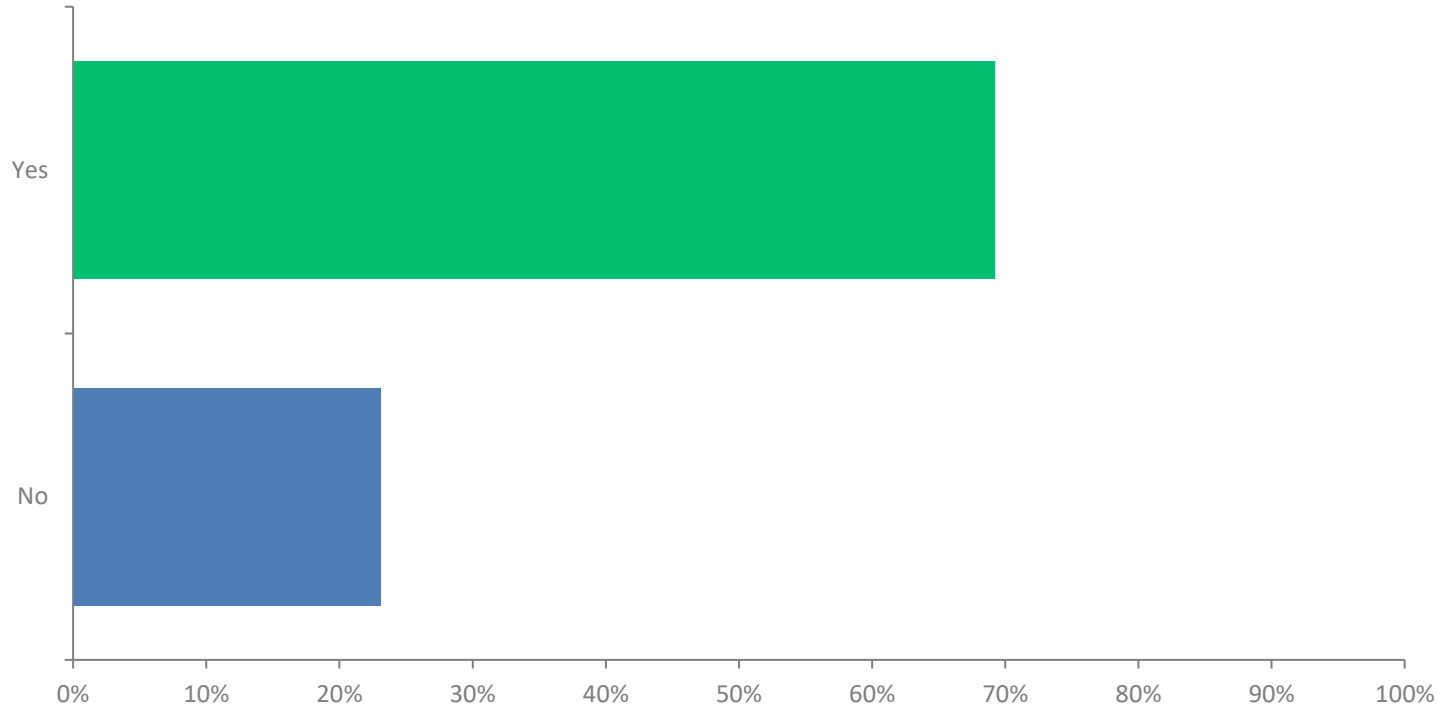
Q1: How would you rate the quality of the webinars you have attended?

- **Answered: 14 Skipped: 1**



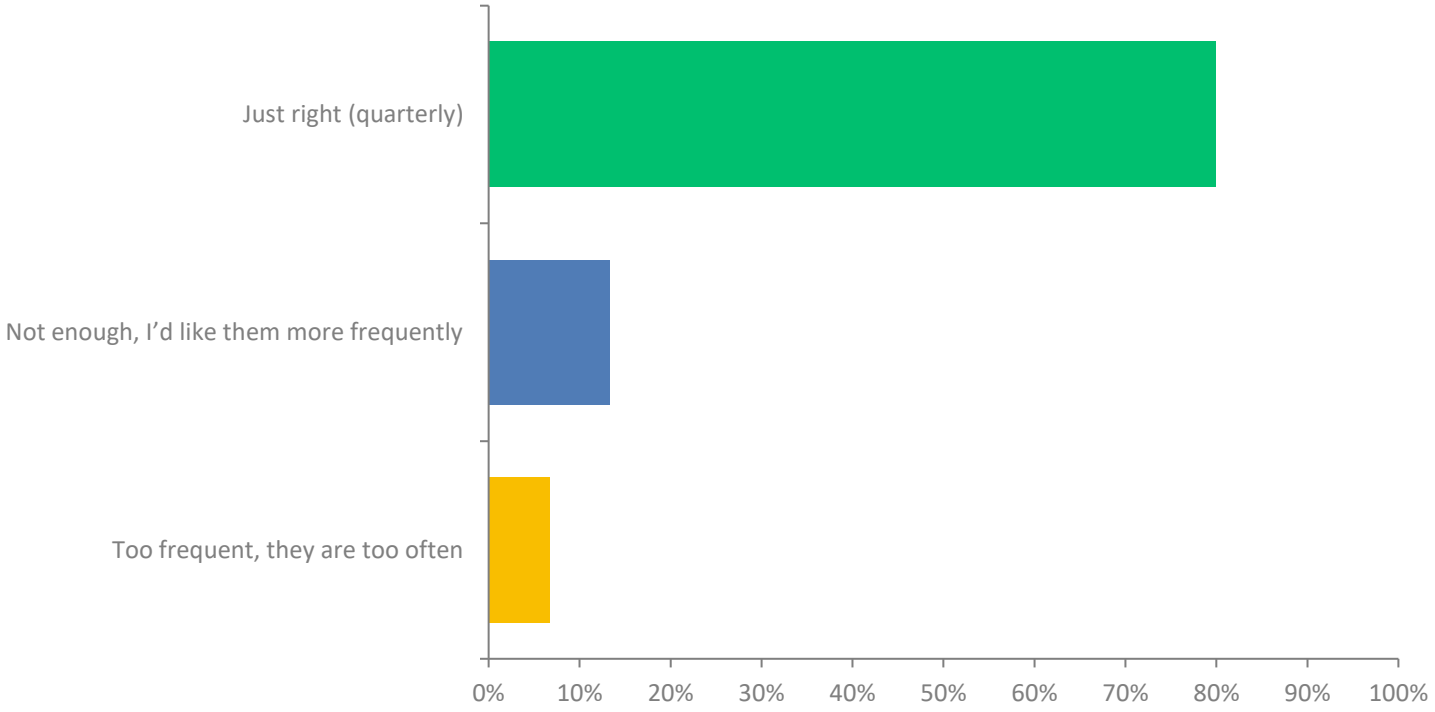
Q2: Have you learned something new in the webinars that has made a difference to your practice?

- **Answered: 12 Skipped: 3**



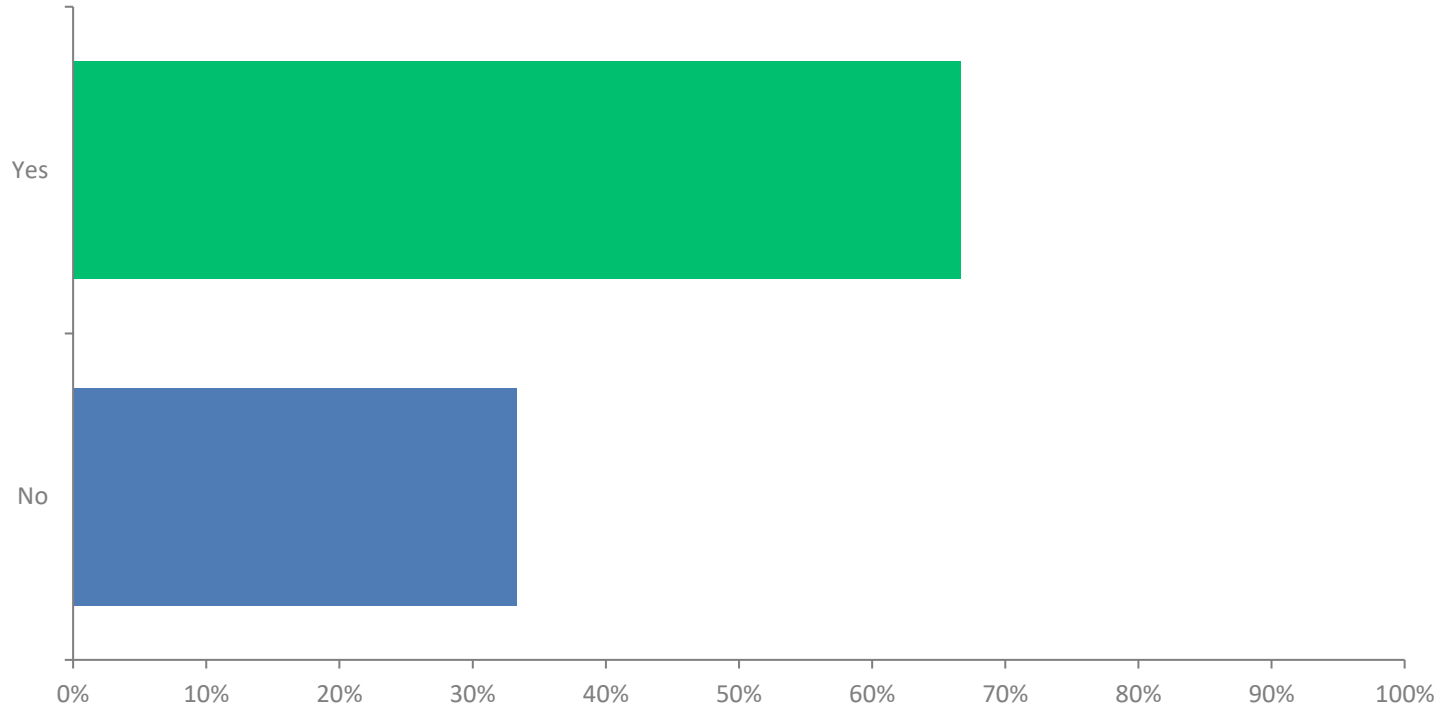
Q3: Is the frequency of the webinars...

- **Answered: 15 Skipped: 0**



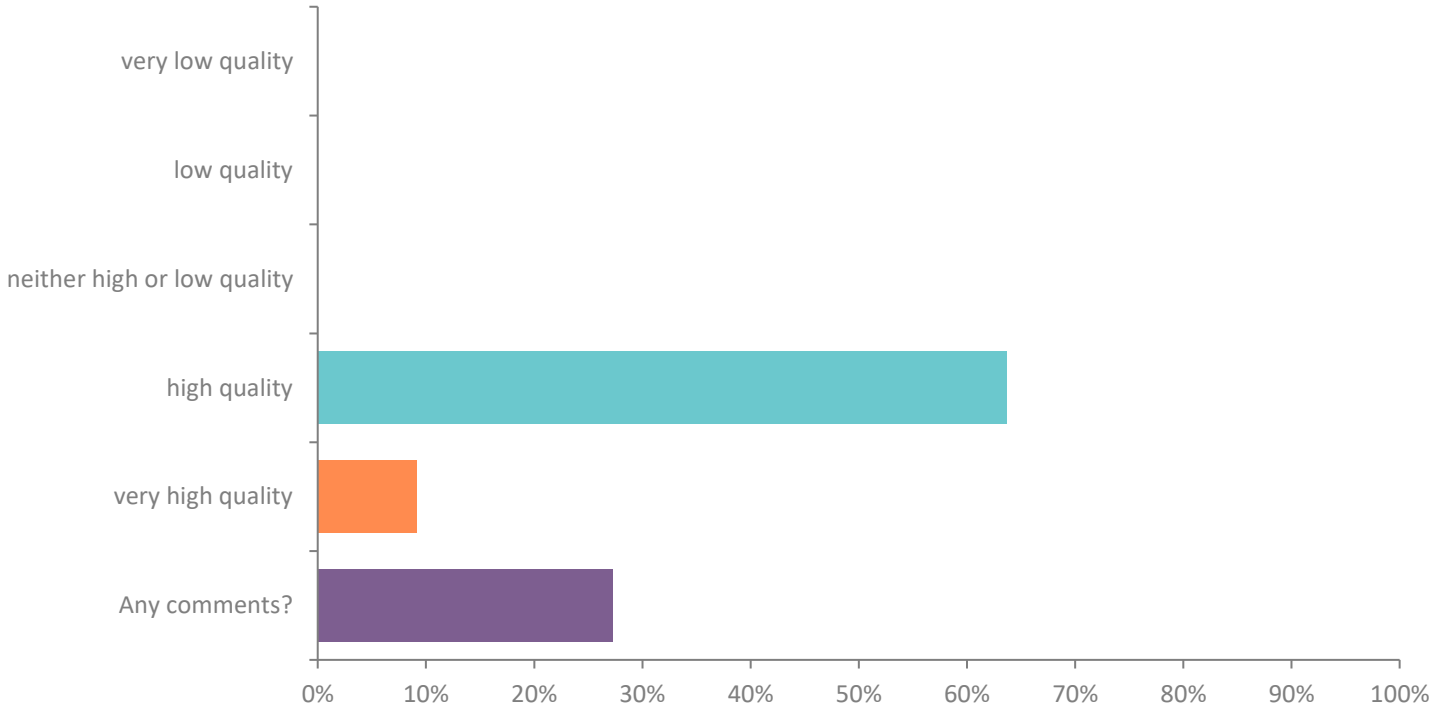
Q4: Do receive the patient safety bulletin?

- **Answered: 15 Skipped: 0**



Q5: How would you rate the quality of the bulletins you have received and read?

- **Answered: 11 Skipped: 4**



CURRICULUM SETTING

Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly

Etienne and Beverly Wenger-Trayner 2015

Q1 Please let us know your job title.

Q2 What are your expected learning outcomes?

Q3 Below is a list of topics identified as priorities by colleagues in the survey monkey.

Please write in the chat any others. Speakers?

PSIRF
Sustainability and Patient Safety
MDT approaches to patient safety
Grading of incidents
Wounds and safeguarding referrals
Tissue viability, categorisation of PUs
LFPSE
Deterioration tools in palliative care
How to write a policy

Sharing incidents / conundrums

EDI and Patient Safety
Human Factors
Outcome measures
Medicines Safety (CDs)
QI methodology
Using the data in a meaningful way

Case Studies
Positive risk taking & engaging patients

Q4 Participants are encouraged to share challenges and learning from experts and peers. Please let us know if there is a particular topic on which you would like to present.

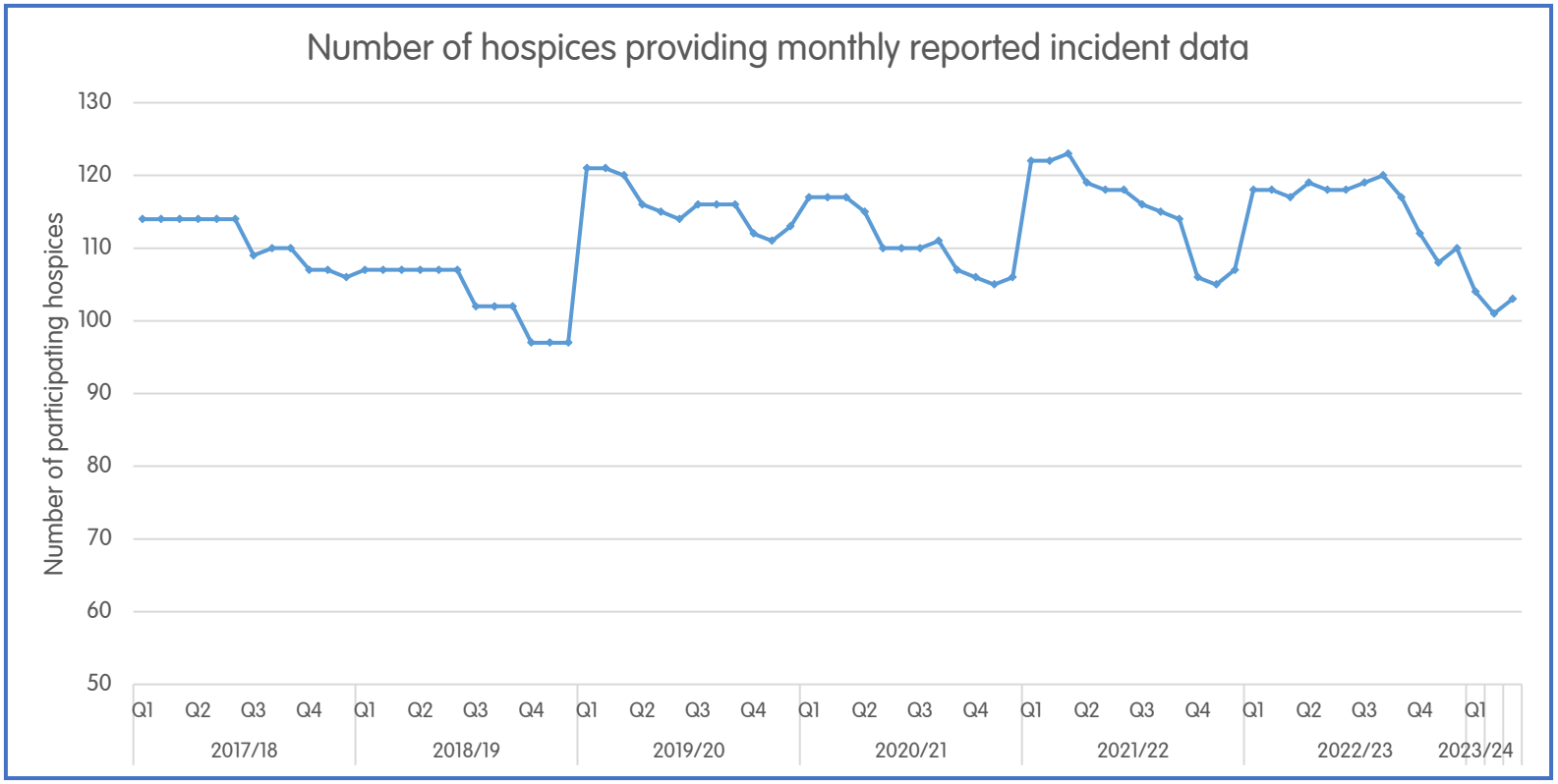
Q5 Do you have any other thoughts for the curriculum of the Patient Safety Network?

Would you like a HUK Share & Learn Community of practice?

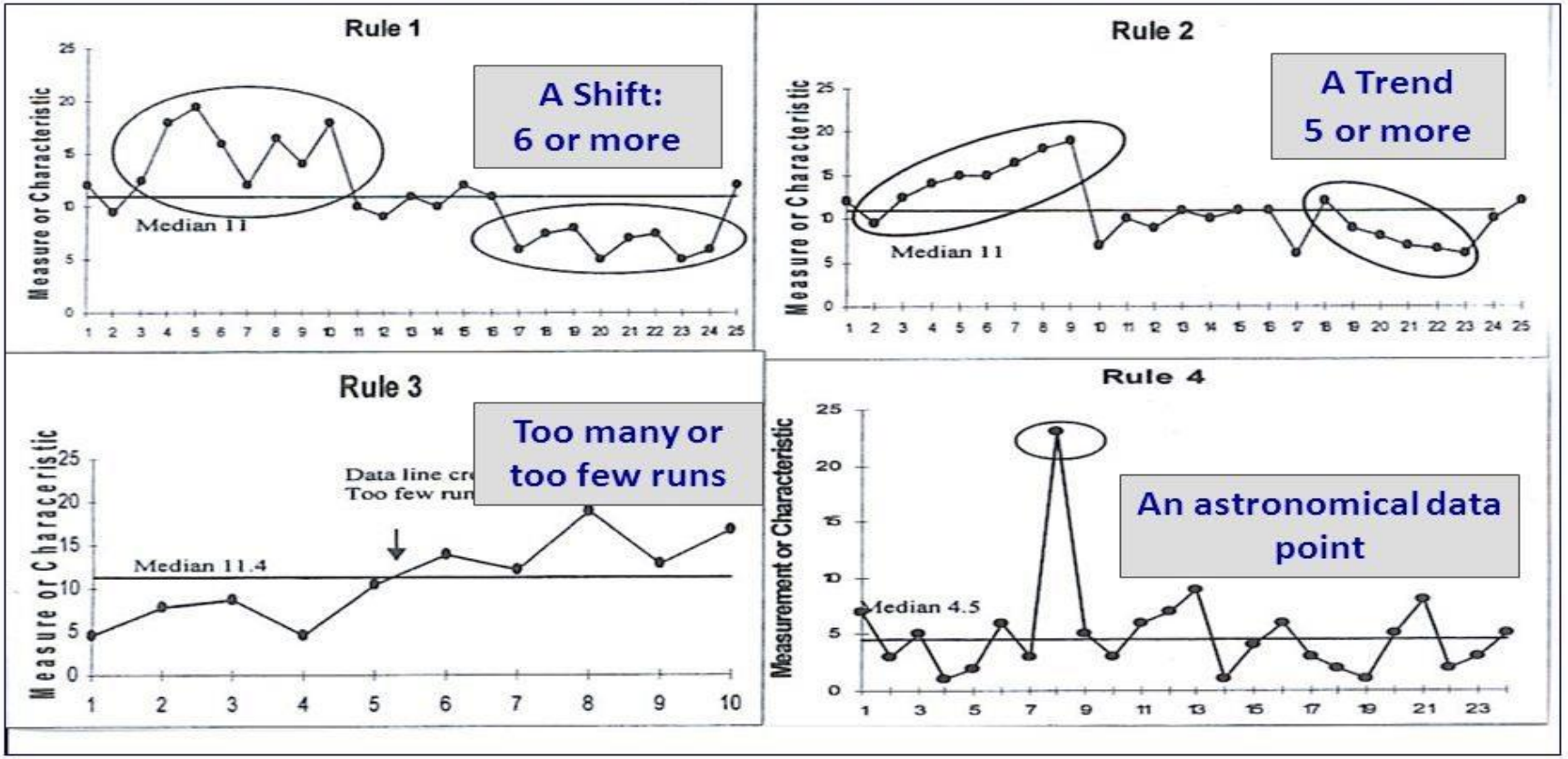
- small number of representatives from hospices
- come together to discuss an incident in a safe space
- share ideas, best practice and learnings
- quarterly meetings
- aims to improve patient safety by sharing learnings widely.

Patient Safety Incident Data self-reported by (Adult) Hospices

Data Submissions: Years and Quarters



Non-Random Signals on Run Charts

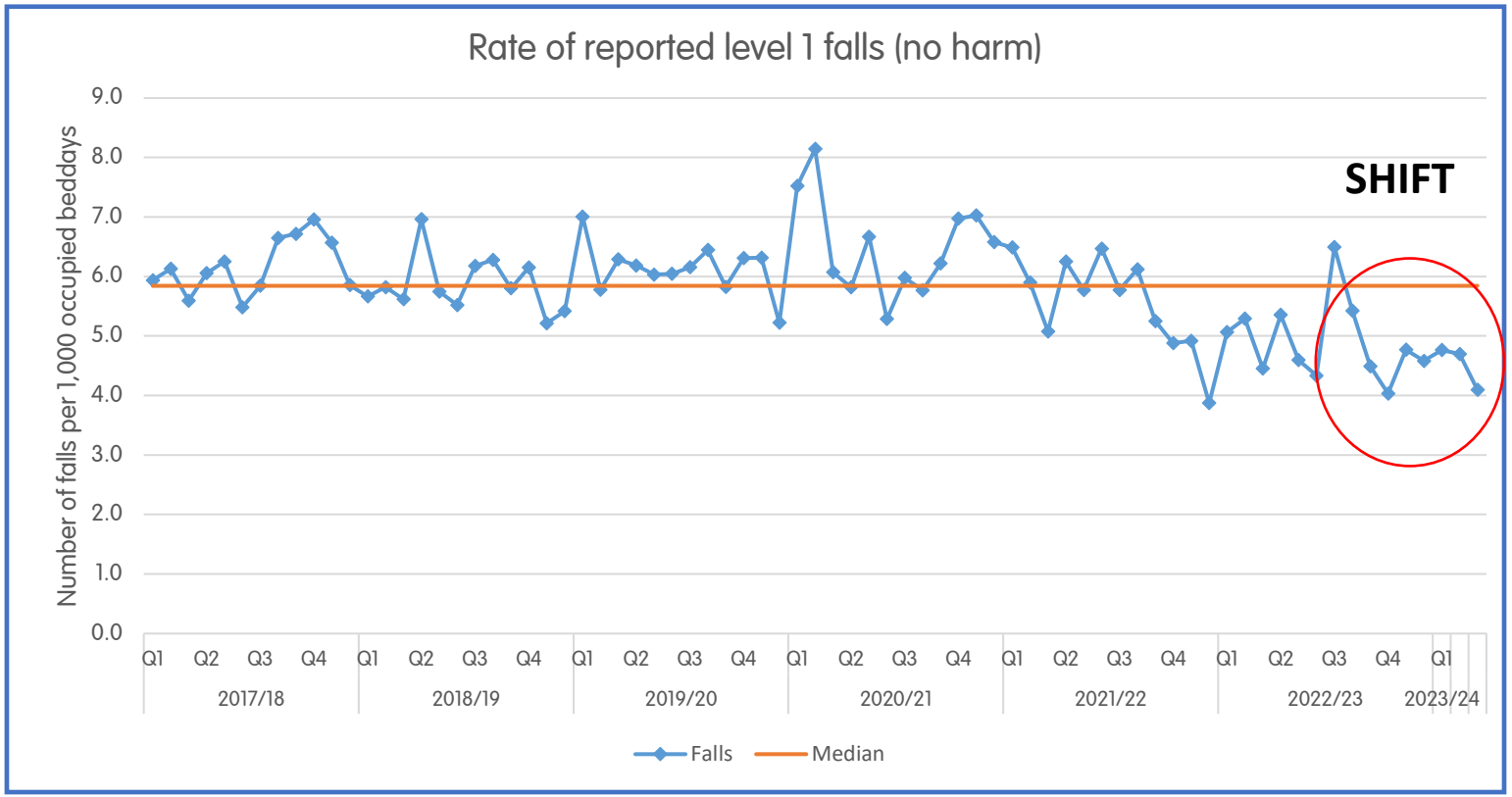


Evidence of a non-random signal if one or more of the circumstances depicted by these four rules are on the run chart. The first three rules are violations of random patterns and are based on a probability of less than 5% chance of occurring just by chance with no change.

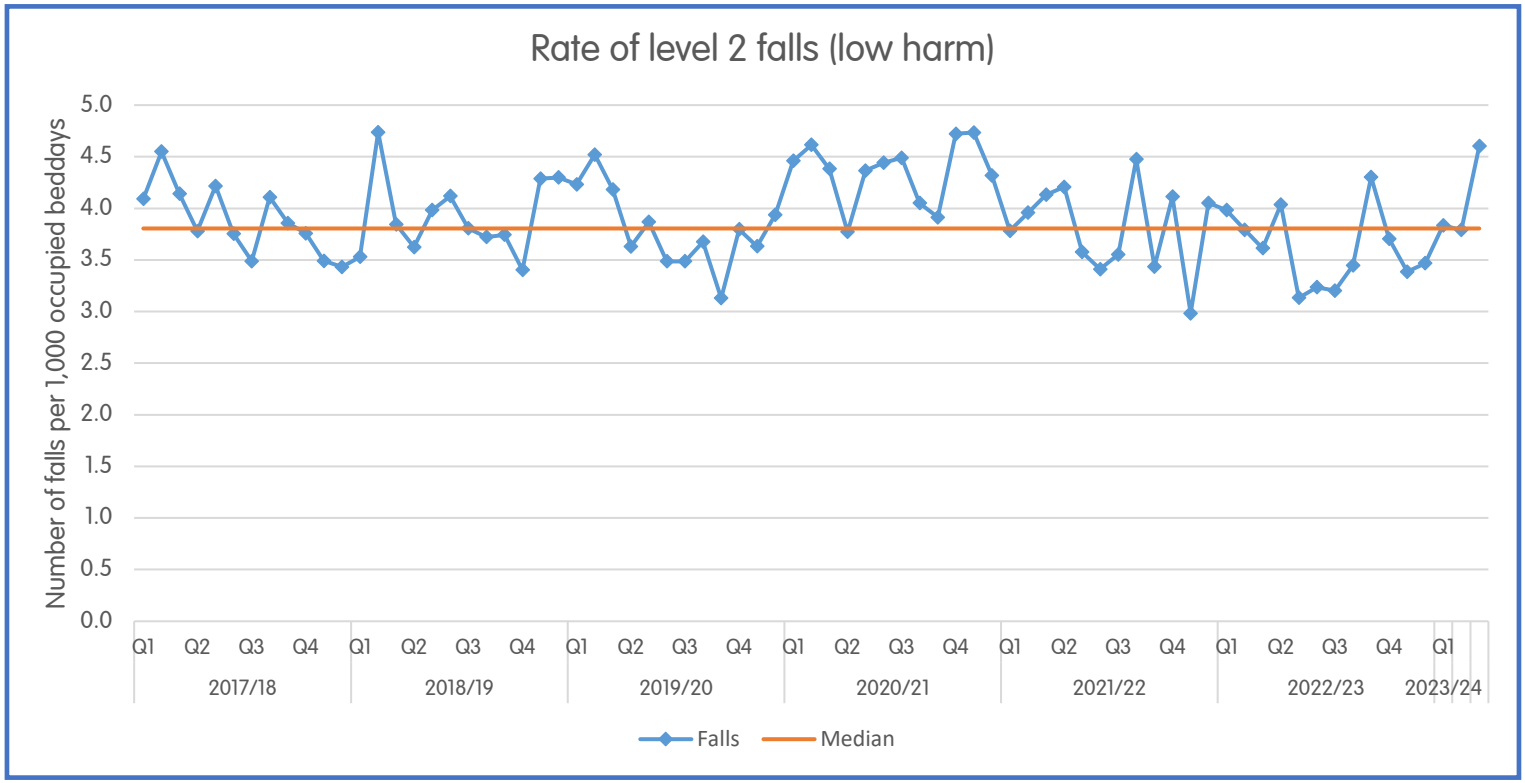
The Data Guide, p 3-11

FALLS

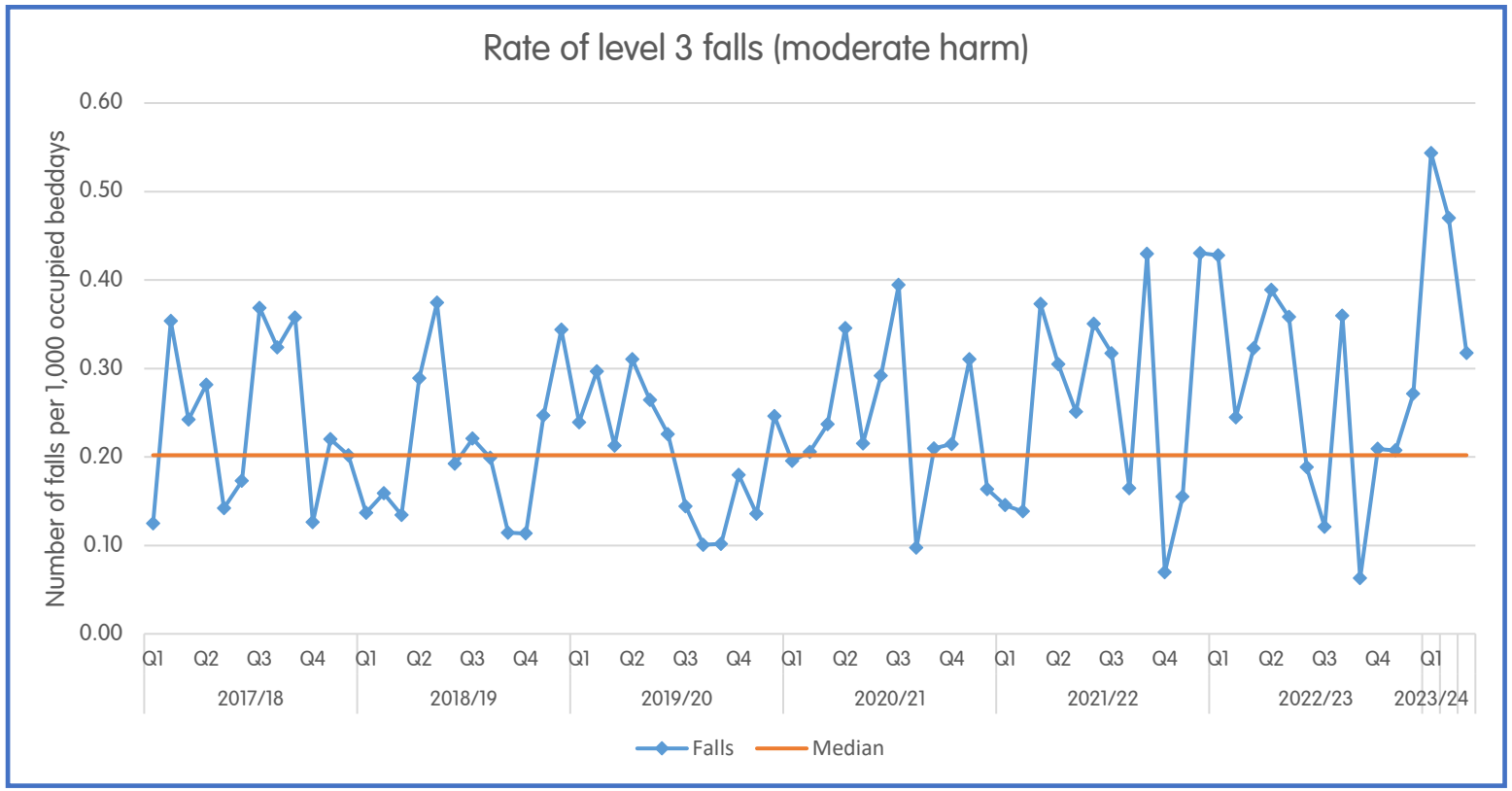
Level 1 falls over time



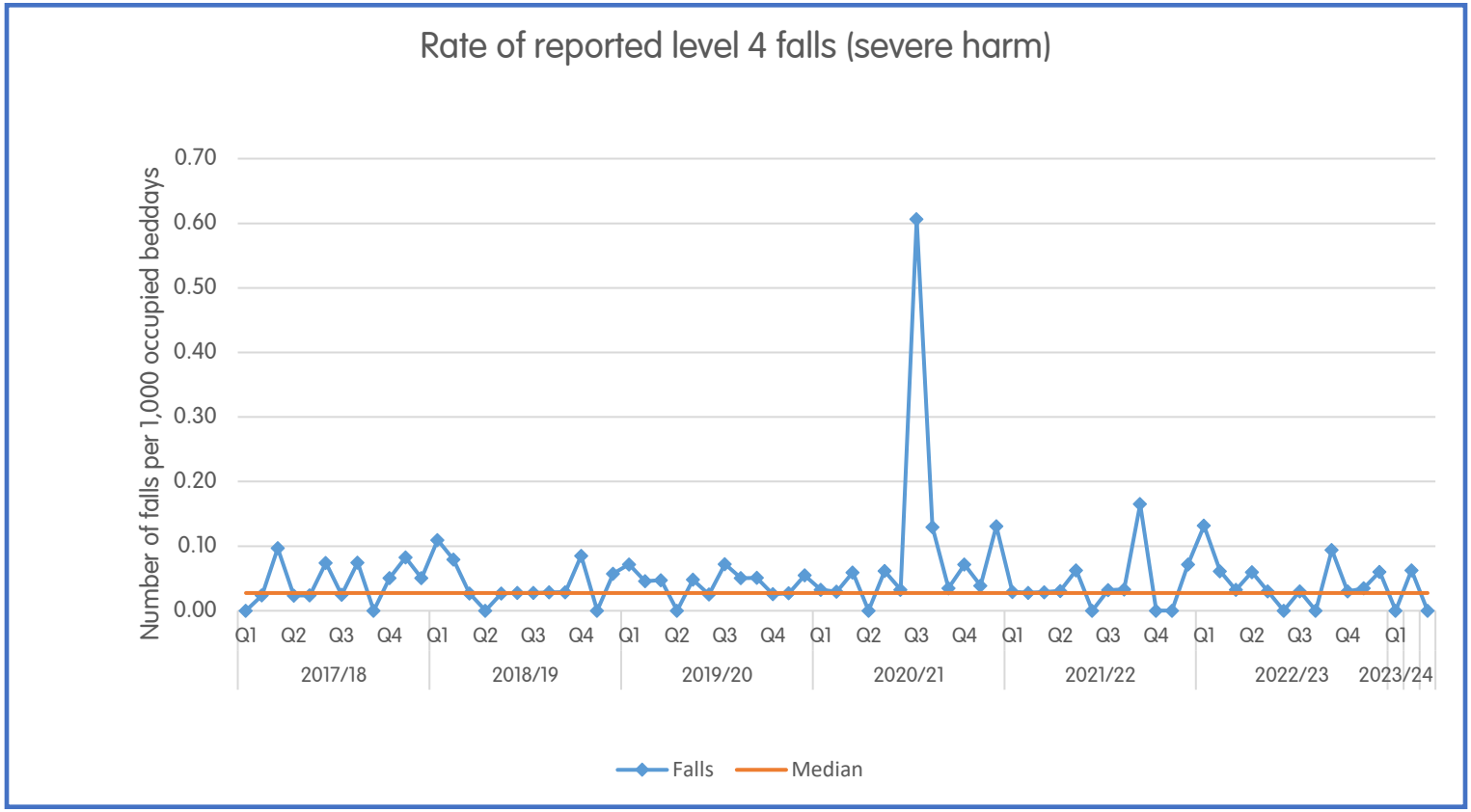
Level 2 falls (low harm) over time



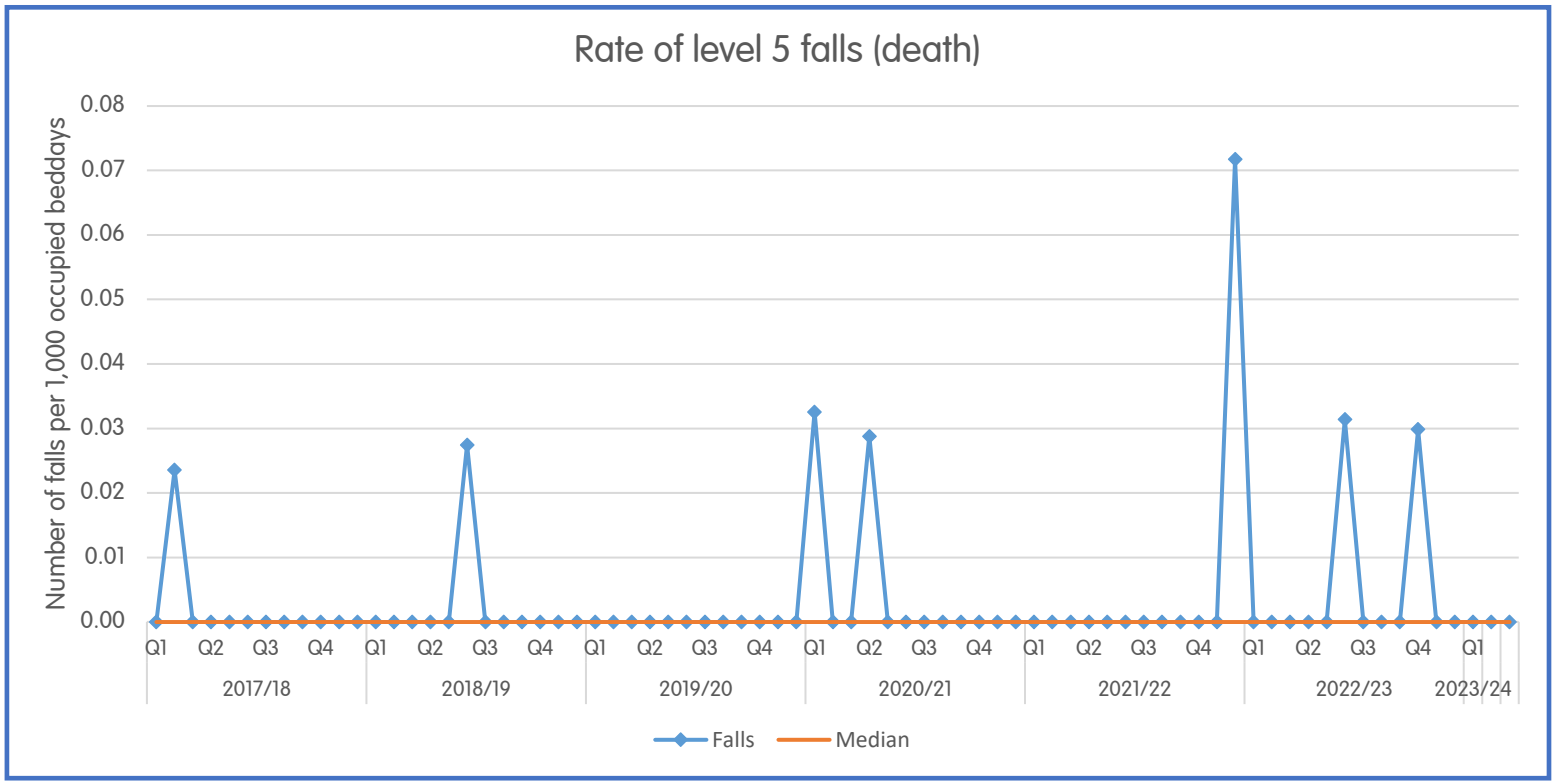
Level 3 falls (moderate harm)over time



Level 4 (severe harm) falls over time

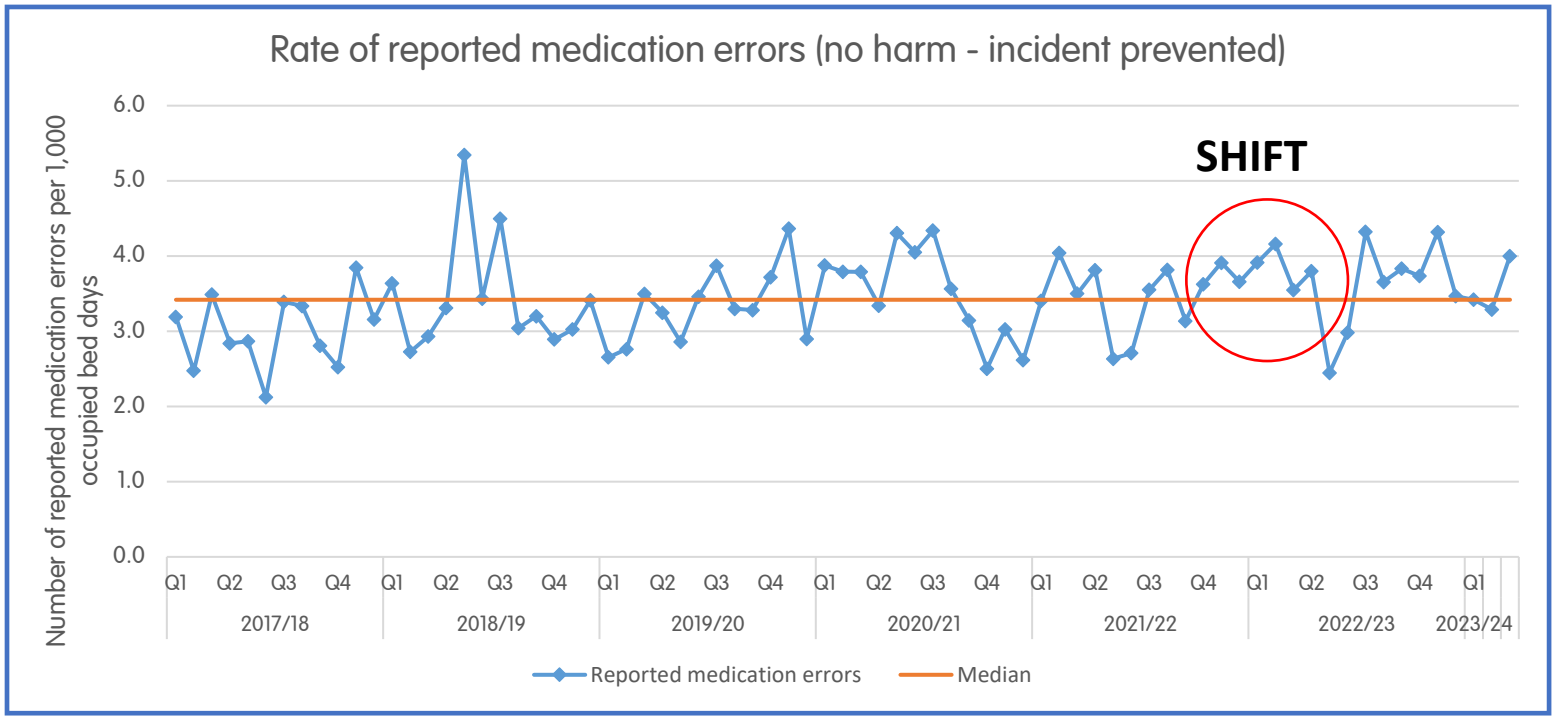


Level 5 (death) falls over falls over time

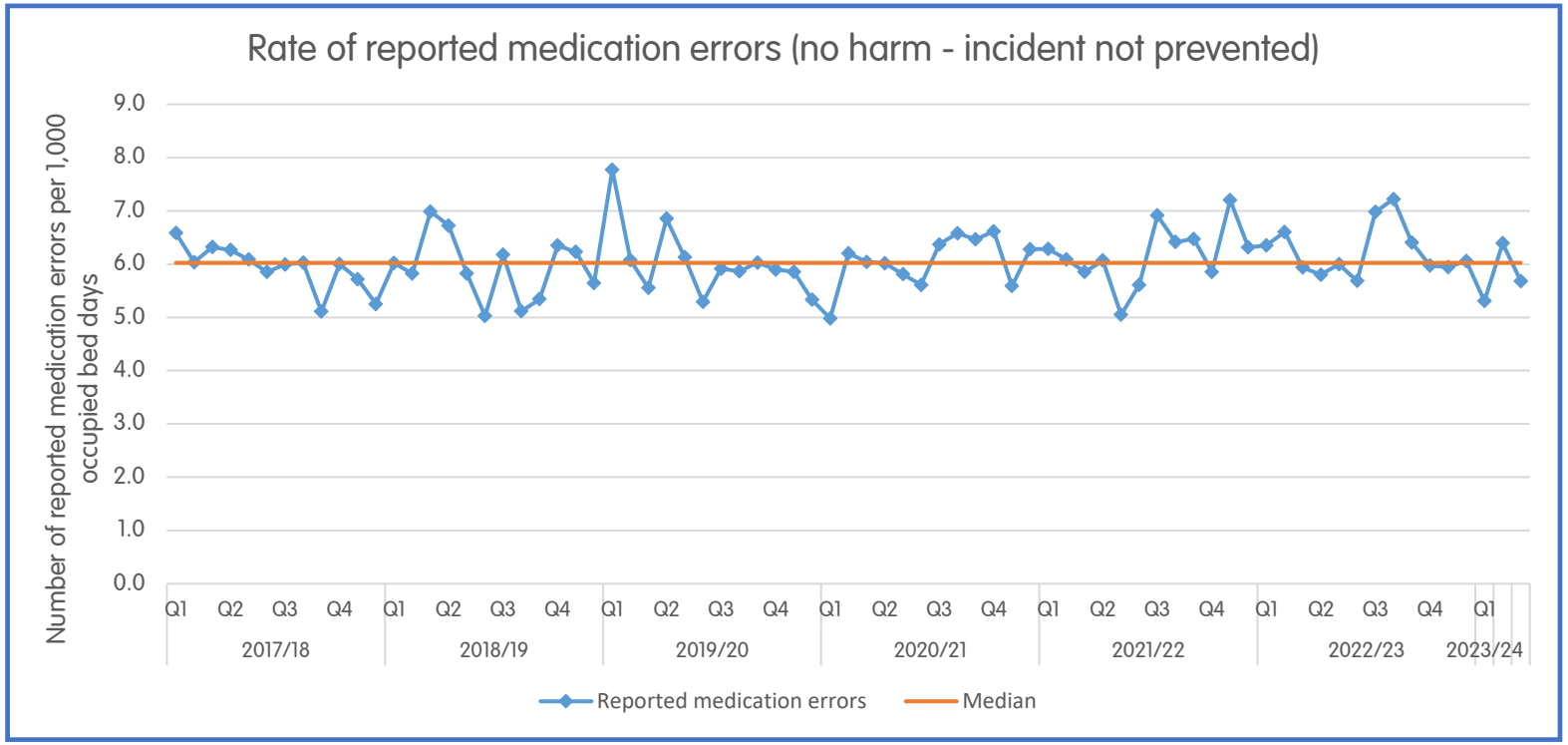


MEDICATION

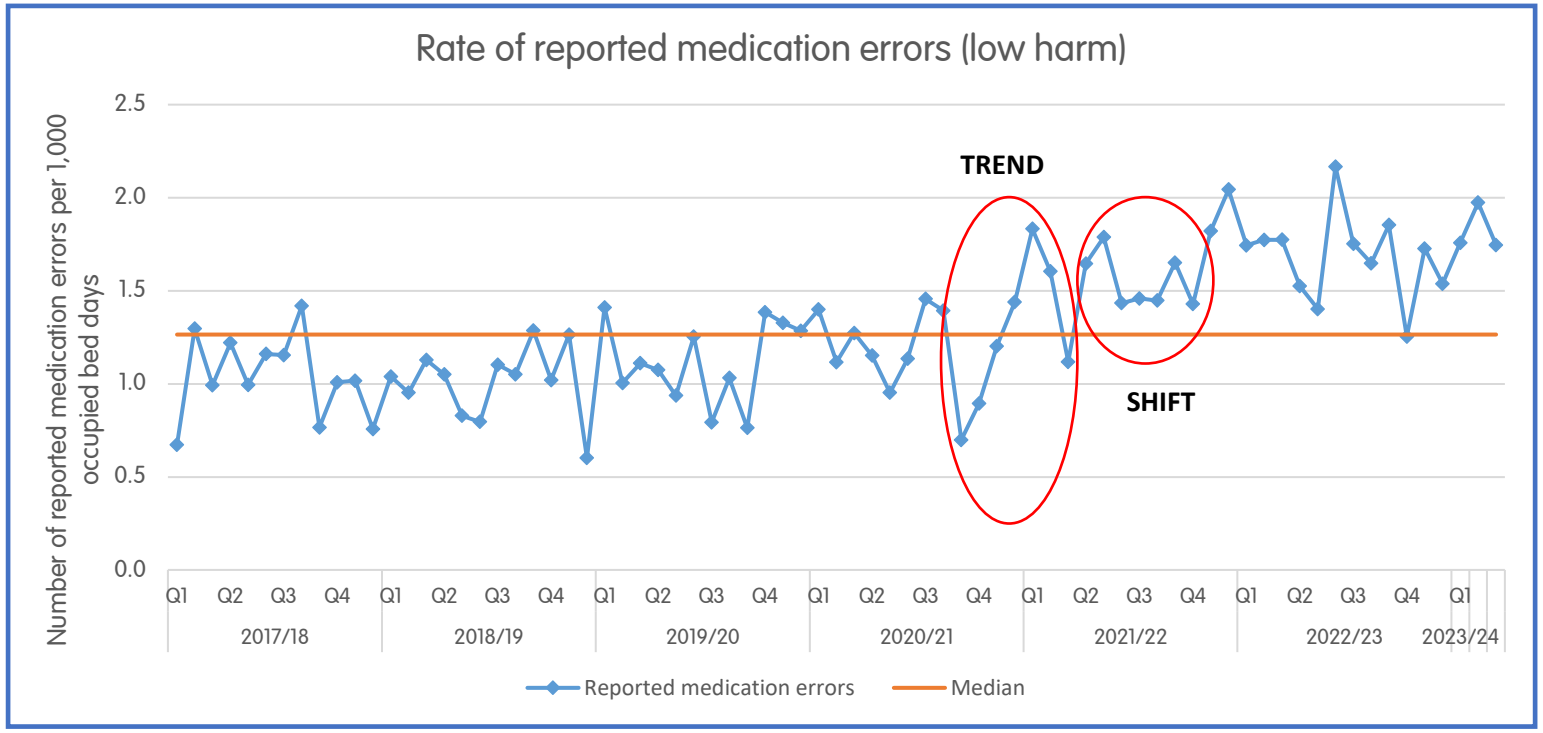
Rate of medication incidents; no harm – incident prevented (adults)



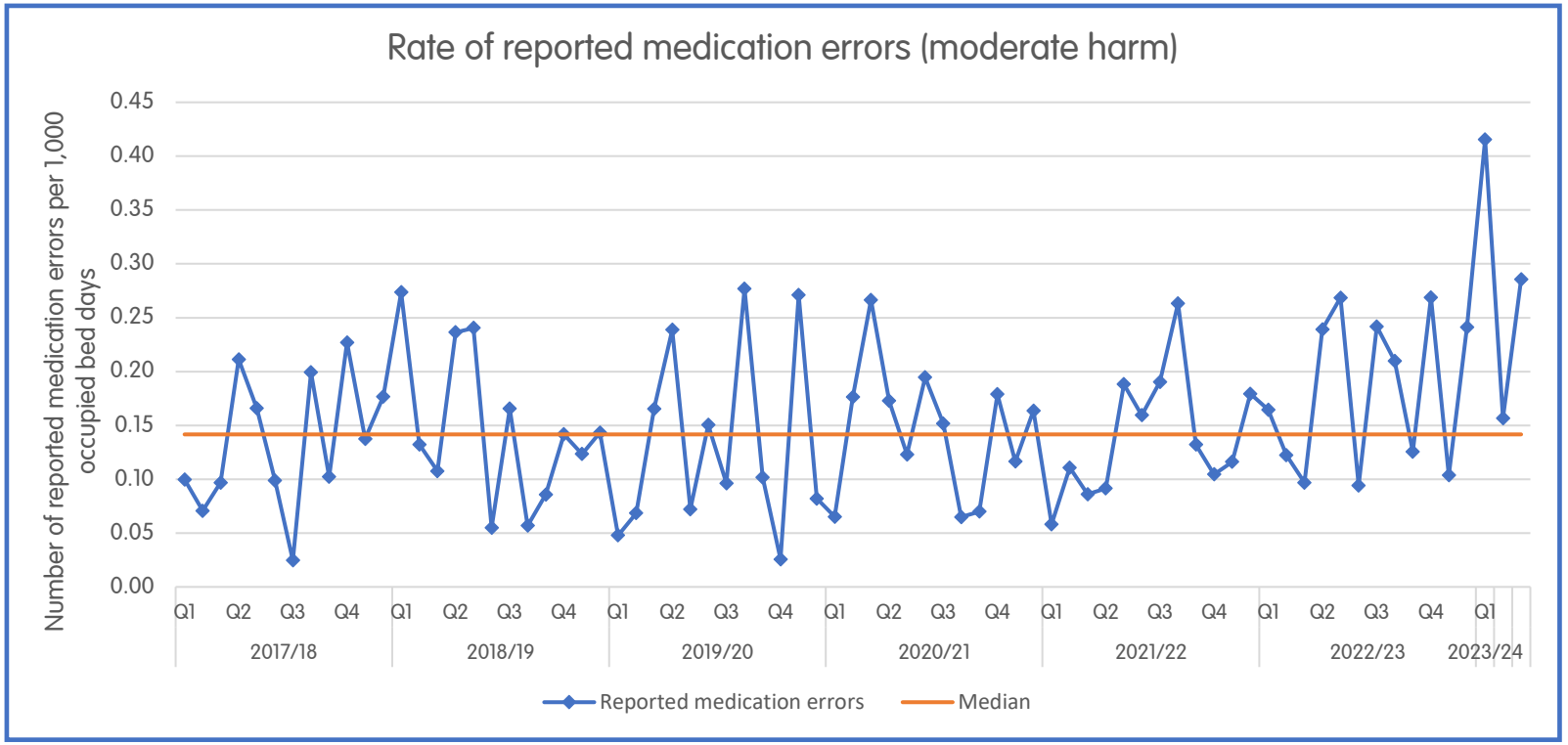
Rate of medication incidents; no harm (incident not prevented)



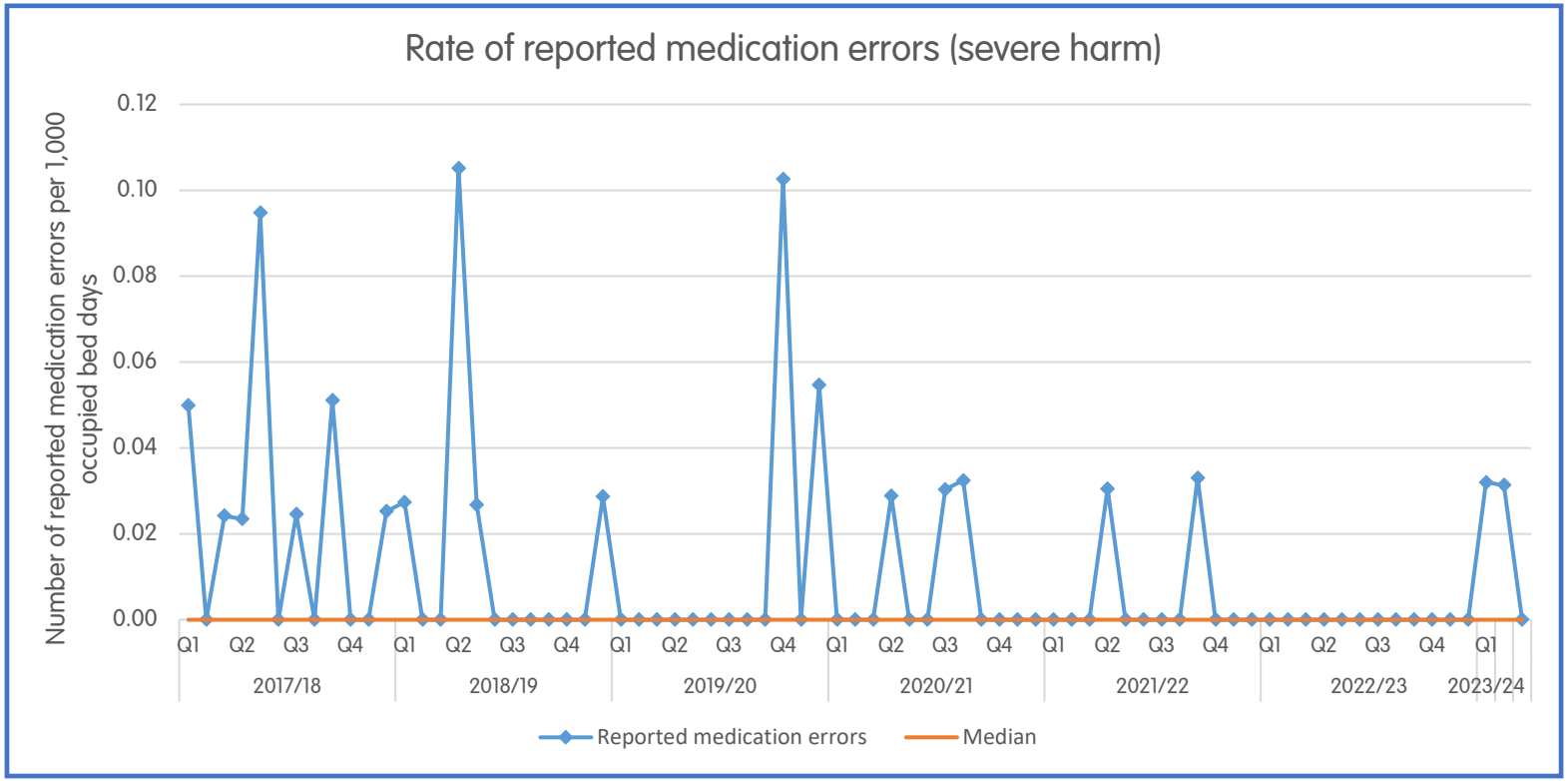
Rate of medication incidents; low harm



Rate of medication incidents; moderate harm



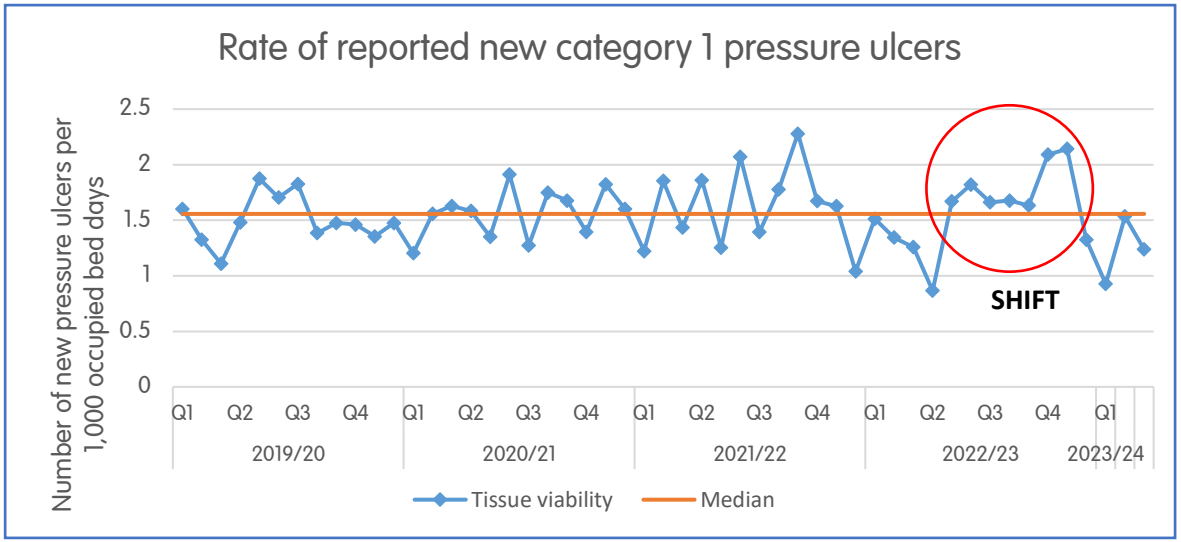
Rate of medication incidents; severe harm

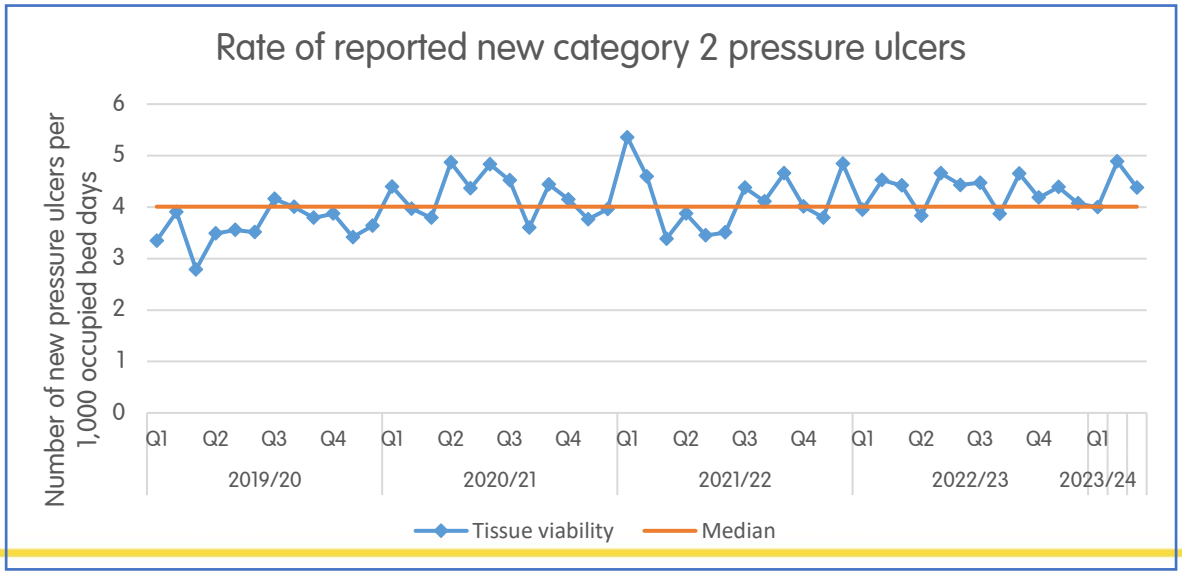


TISSUE VIABILITY

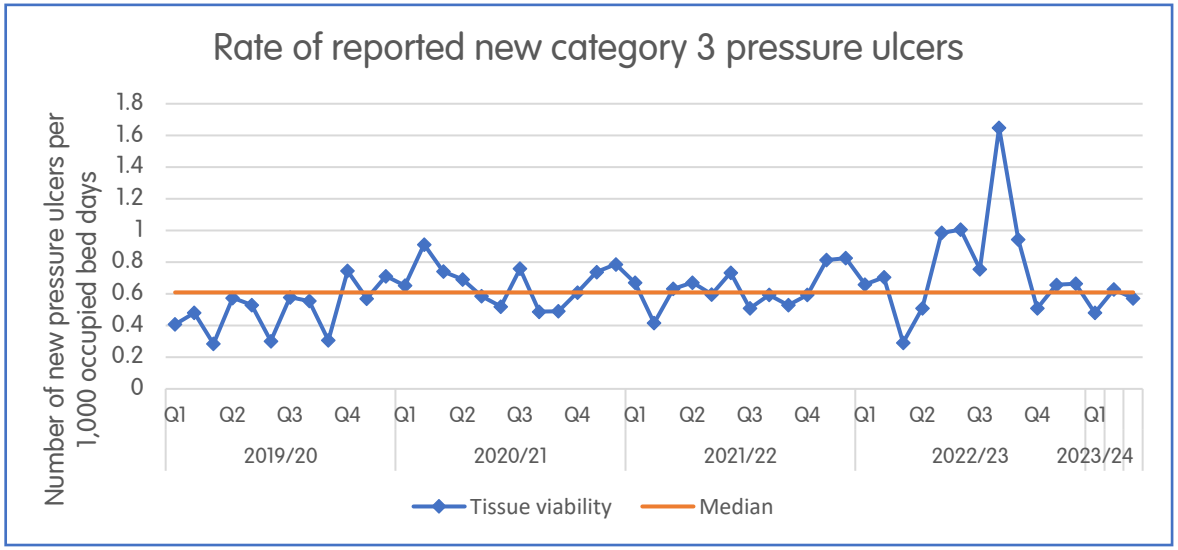
New Pressure Ulcers

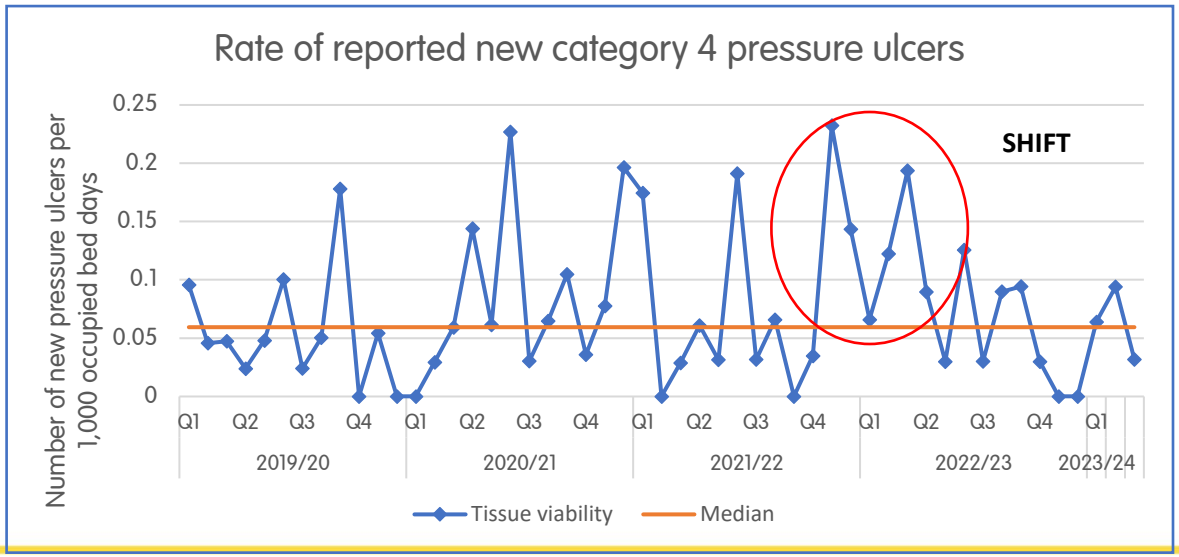
Rate of new Cat 1 & Cat 2 Pressure ulcers



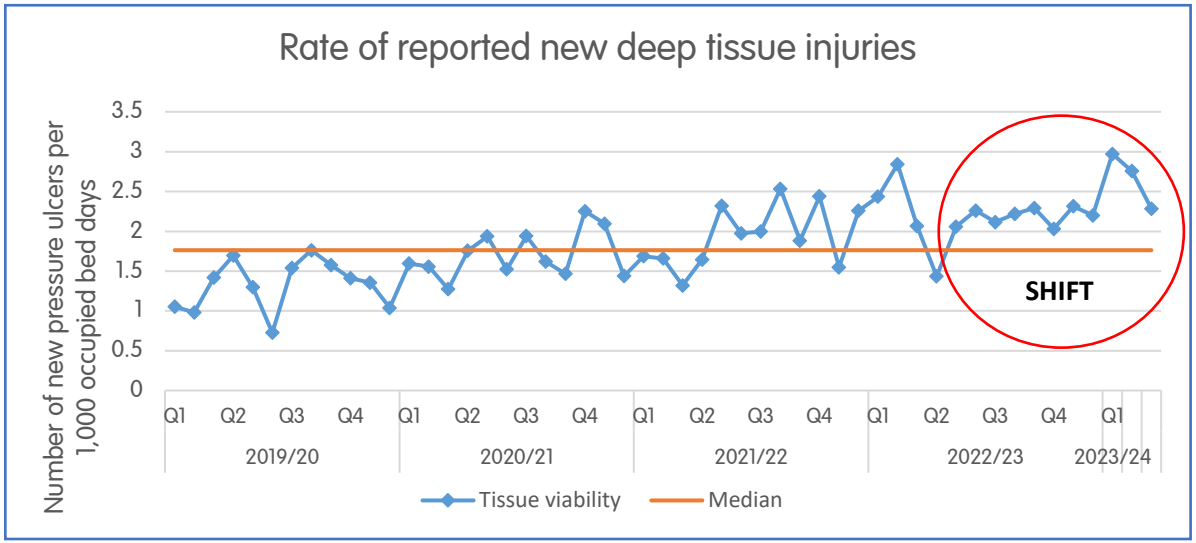


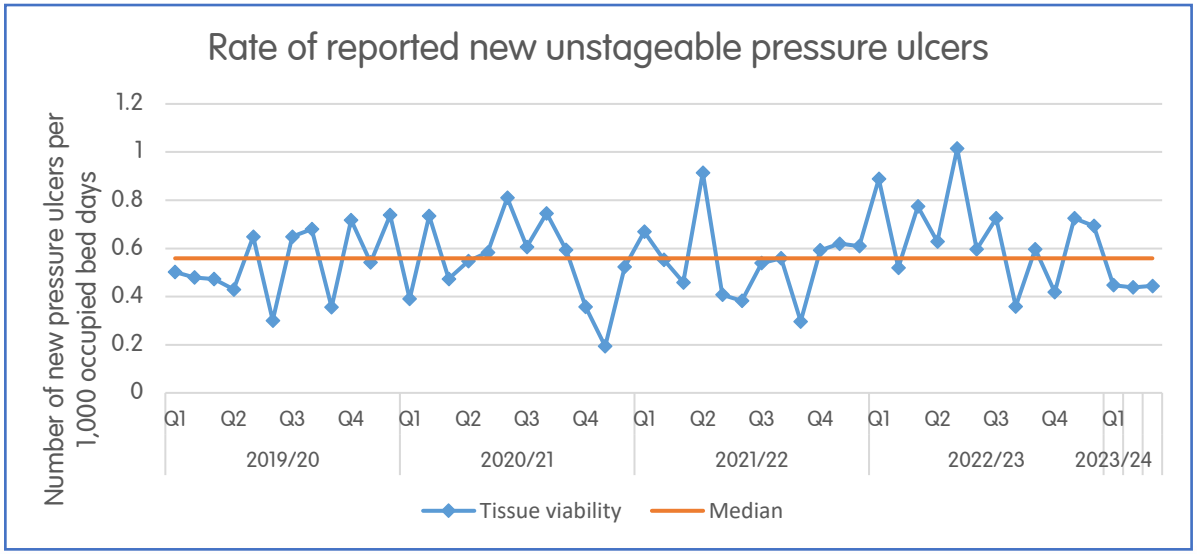
Rate of new Cat 3 & Cat 4 Pressure ulcers



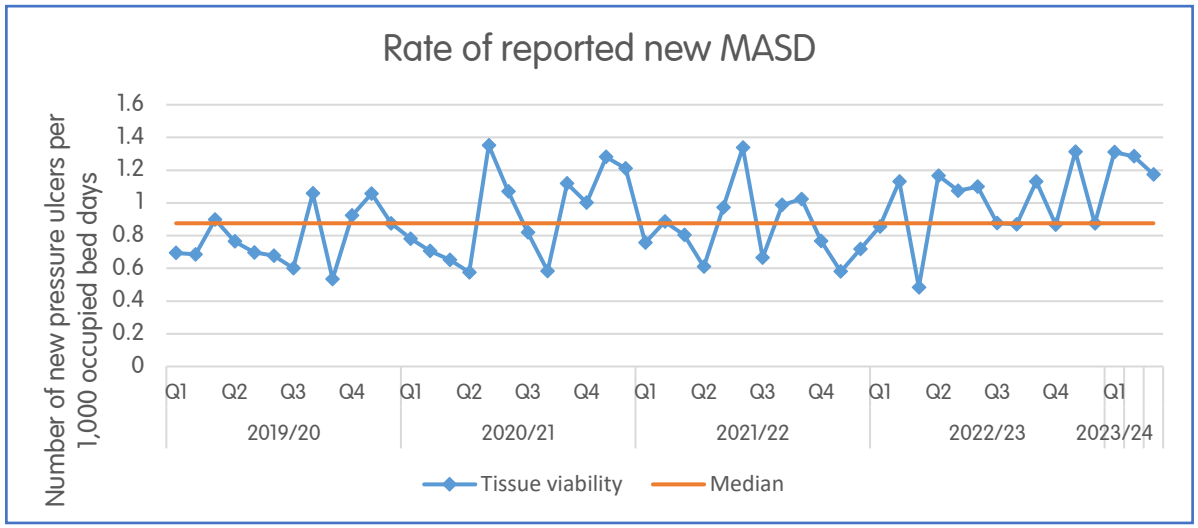


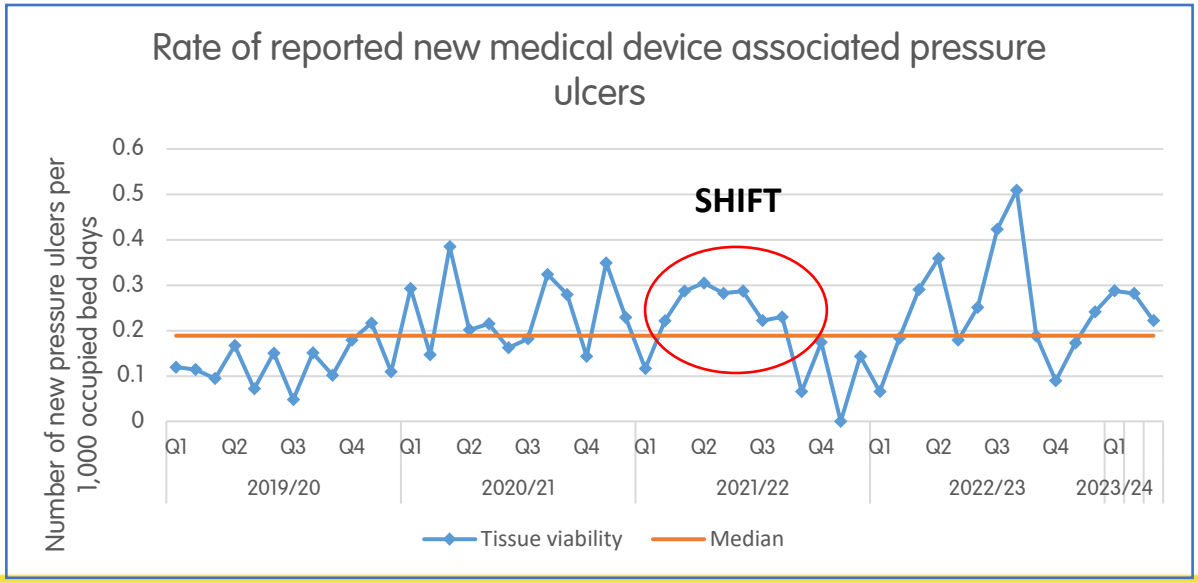
Rate of new DTI's & US Pressure ulcers





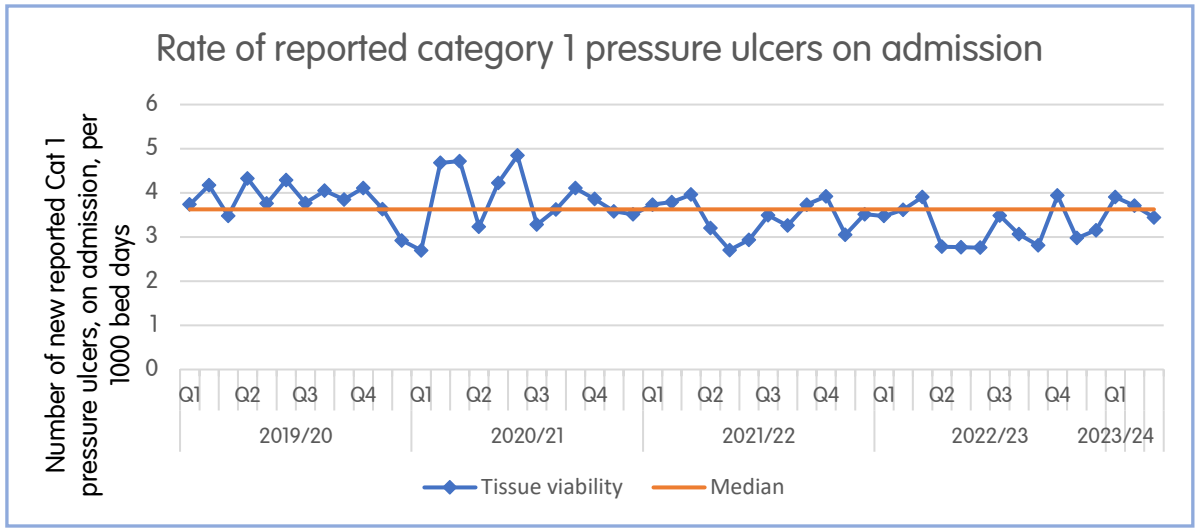
Rate of new MASD & MDA Pressure ulcers

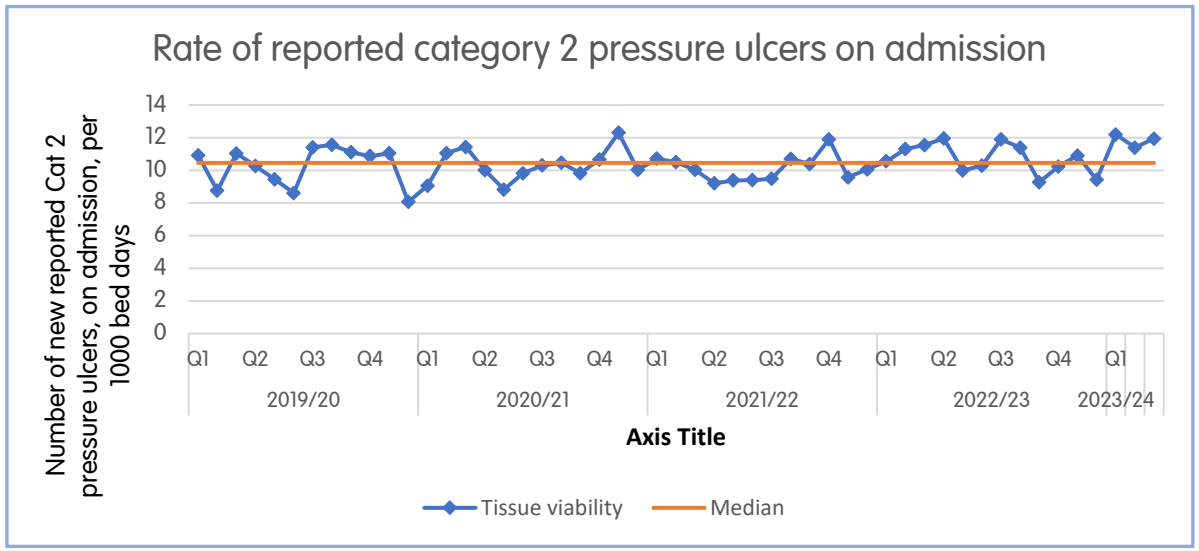




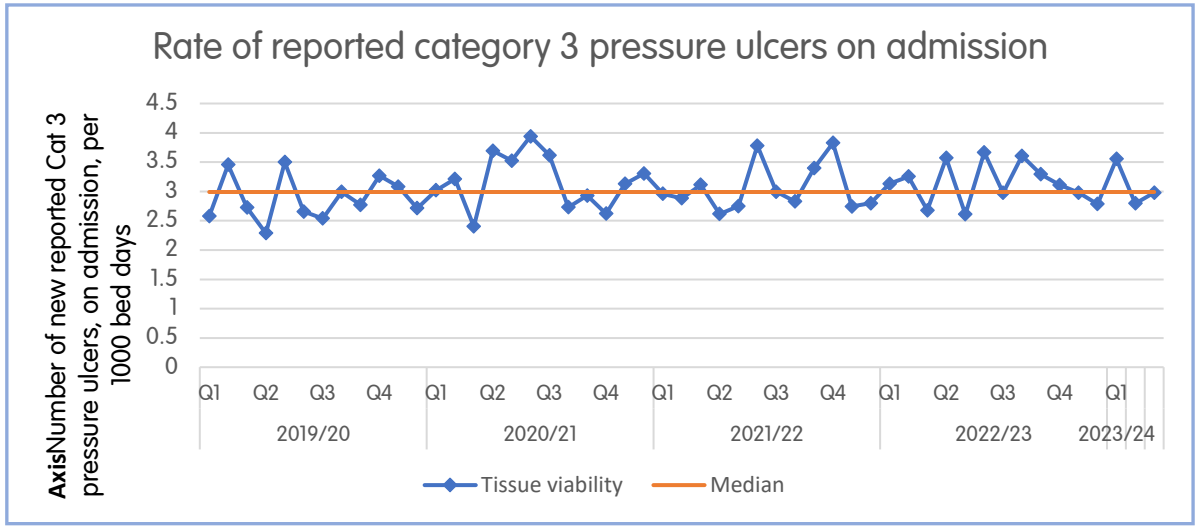
Pressure Ulcers on Admission

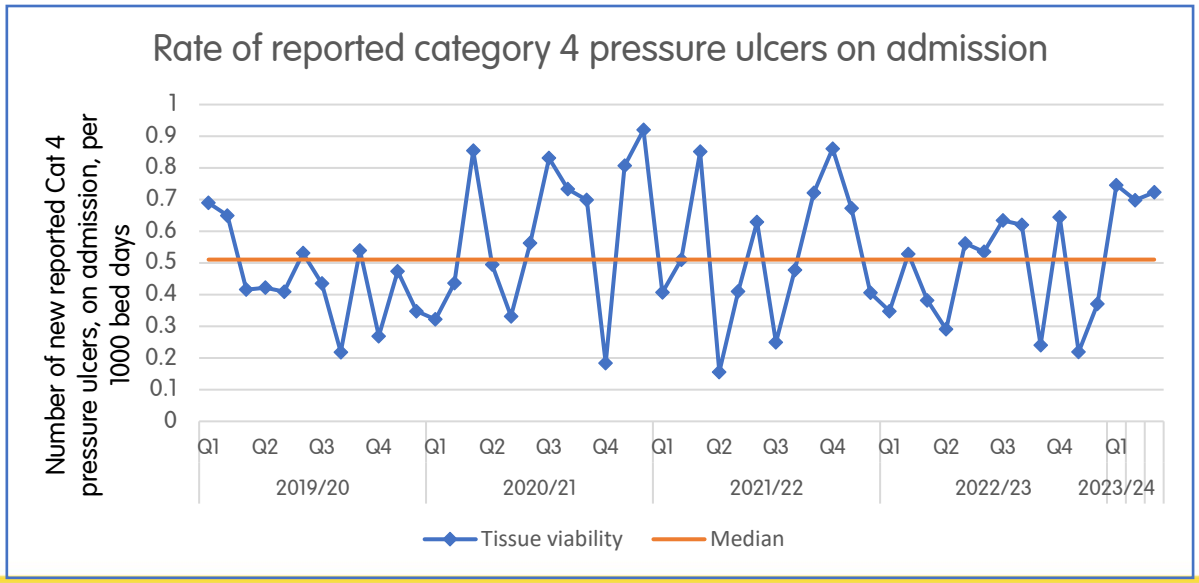
Rate of Cat 1 & Cat 2 Pressure ulcers



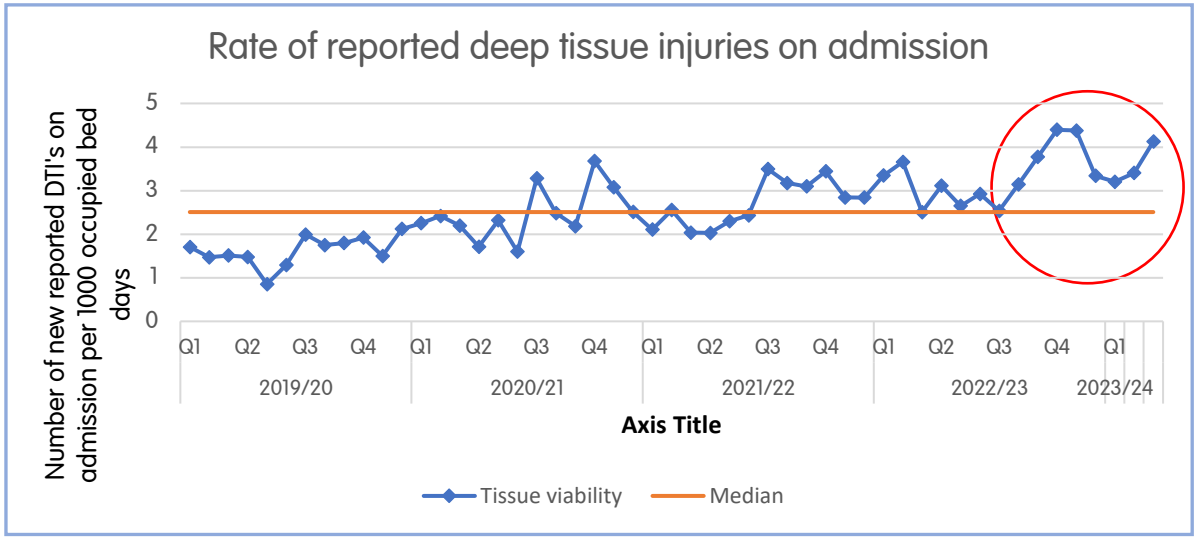


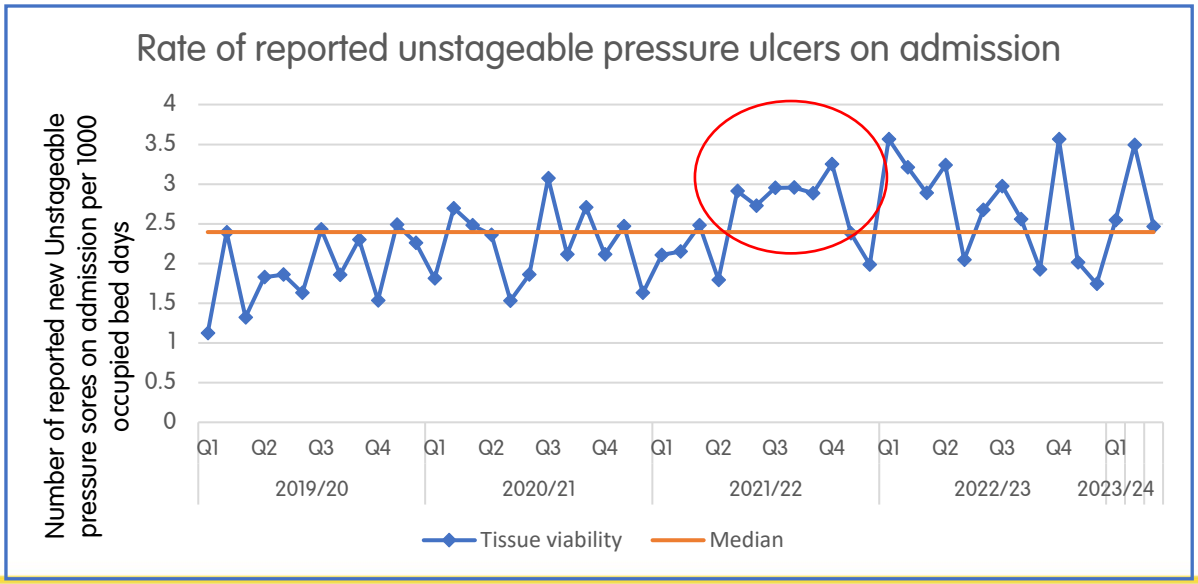
Rate of Cat 3 & Cat 3 Pressure ulcers



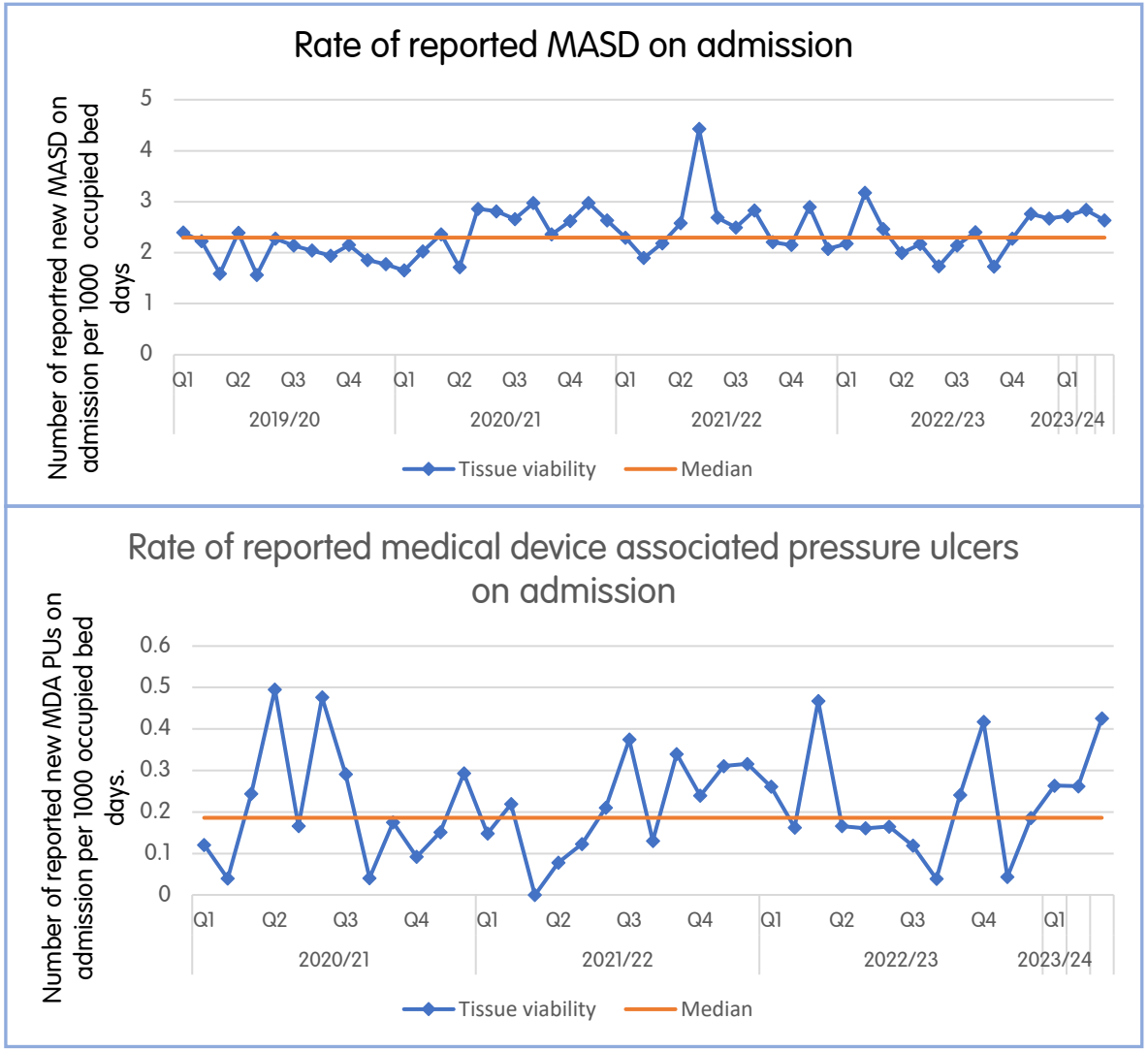


Rate of DTI & US Pressure ulcers





Rate of MASD & MDA Pressure ulcers



PSIRF TEAMS CHANNEL

Please contact Julia if you'd like to join.

[Broken trust: making patient safety more than just a promise | Parliamentary and Health Service Ombudsman (PHSO)]

Broken trust: making patient safety more than just a promise

26 June 2023

There have been significant developments in patient safety over the last decade. But there is a concerning disconnect between increasing activity and progress made to embed a just and learning culture across the NHS.

Recognising the challenging operational context for the NHS, this report draws on findings from our investigations.

It asks what more must be done to close the gap between ambitious patient safety objectives and the reality of frontline practice.

Read the report.

Related files

Download a pdf of Broken trust: making patient safety more than a promise [.pdf, 866 KB]

NHS England » Improving patient safety culture – a practical guide.

RCN Wales Roundtable: Growing Collaborative Nursing Networks in the Independent Sector, 8 August

RCN Wales will be holding an in-person roundtable discussion around 'How can we Facilitate Greater Collaboration amongst nurses working across the Independent Sector in Wales?' on 8 August from 1:30pm - 4pm at Ty Cwm Gwendraeth, Upper Tumble, Llanelli, Carmarthenshire, SA14 6BU.

This event is open to both members and non-members who work in Wales in the Independent Health and Social Care sector. The event will provide an opportunity to network with other colleagues based within the Independent Sector to share stories and your unique experiences of working in Wales. We hope this event will develop relationships across the sector which will build confidence and amplify the voice of nurses. To register your interest to attend and for further information about the roundtable events, please email sian.wilson@rcn.org.uk.

Recommendations - Care Quality Commission (cqc.org.uk)

The Safer Management of Controlled Drugs Annual update, published July 13 2023.

Hospice UK National Conference | Hospice UK

Hospice UK Awards | Hospice UK

The deadline for entries is Friday 8th September.

Next Meeting: 16 November 2023, 2pm

TOPICS? SPEAKERS?

Submit

https://www.hospiceuk.org/innovation-hub/clinical-care-support/quality-improvement/patient-safety

Quarter	Months	Submission deadline	Final reports circulated
Q1	Apr, May, Jun	14 July 2023	28 July 2023
Q2	Jul, Aug, Sep	13 Oct 2023	27 Oct 2023
Q3	Oct, Nov, Dec	12 Jan 2024	26 Jan 2024
Q4	Jan, Feb, Mar	12 Apr 2024	26 April 2024

request a copy of the submission links:

https://www.hospiceuk.org/professionals/clinical-and-care-support/quality-improvement/patient-safety-project/request-submission-links

Thank you