NHS
Frimley Health
NHS Foundation Trust

Risk & Patient Safety

Level 2

Study Guide

Patient Safety (Level 2) – annual update for clinical staff

Introduction

This is a temporary training guide that replaces face-to-face patient safety training for new and existing staff. This guide has been created by the Frimley Health Patient Safety team with reference to the Draft National Patient Safety Syllabus (2020) and Trust's Policy for the Management of Incident Including the Management of Serious Incidents (2018).

Throughout the training guide there are optional questions in blue boxes to help learners reflect and relate the information to their work environment and clinical context. Although these are not compulsory to pass the assessment but they will add value to the learning experience and can be used as part of your professional revalidation process.

?	**What are you hoping to gain by completing this learning guide?**

Meet the team

There are two patient safety offices, one at Wexham near the crossroads café (ext 154312) and one at Frimley Park in C block, near the boardroom (ext 136160). The team consists of senior nurses, doctors and midwives, and non-clinical staff with experience in governance, litigation and complaints.

Outside of office hours patient safety concerns should be escalated to department leads and senior duty nurse or clinical site manager. For community services escalation should be to on-call Matron.

?	**Are you confident about who you would escalate patient safety concerns to within your work environment? If not, how will you clarify this process?**

What is Patient Safety?

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care and the interventions that are put in place following an adverse event. In order to reduce the impact to the affected patient and future patients. The local and national patient safety team support healthcare professionals to minimise patient safety incidents and drive improvements in safety and quality. Our aim is that all patients should be treated in a safe environment and protected from avoidable harm while learning from previous events to help make it easier to deliver safe effective care in the future.

Patient safety is also about learning when things go well and how we can make this happen more often.

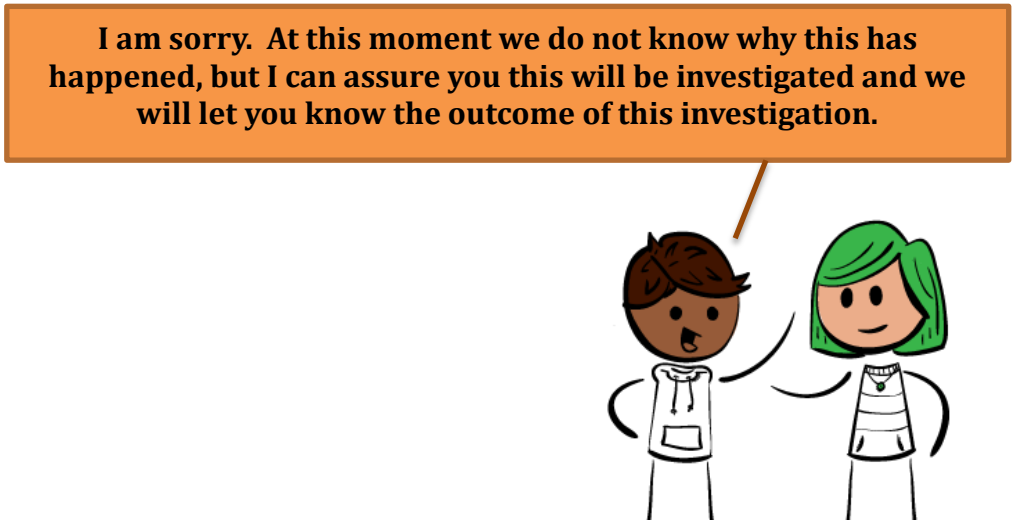
Common patient safety terminology:
Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

Proactive approaches to patient safety include risk assessments and interventions aimed to reduce the likelihood of a patient coming to harm.

?	**Make a list of all the proactive approaches you take for patients in your clinical environment. Is it always easy to put the required interventions in place?**

Reactive approaches to patient safety include interventions for specific patients who have come to harm due to a patient safety incident and reviews of care including audits.

Any patient involved in a patient safety incident should receive **open and honest** communication about the error or incident and what is being done to minimise the impact to them and how the department and Trust will learn from the incident.



Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified

?	What serious incidents have previously occurred in your work environment? What learning or changes in practice did this prompt?

Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

The **Duty of Candour** is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. As well as a documented conversation and apology from an appropriate healthcare professional, a formal letter with the outcome of the incident investigation must be provided to the patient or their family. To trigger duty of candour, as opposed a standard open and honest conversation, there must be both an act or omission of care and actual harm of moderate or above (or prolonged psychological harm). ***If you think an incident triggers formal duty of candour please discuss the case with the patient safety team***

Reporting & Investigating Incidents

Reporting

Incidents should be reported using the RL incident reporting system. This is available via the red "report an incident" button on the intranet front page (RL6 app is also available for mobiles). When completing an incident report remember to add patients, staff and visitor information in the 'people affected details' and include relevant information about the incident, including initial actions taken in the 'incident description'. Positive incidents or episodes can also be reported using the RL system by clicking on the PERForm star.

For more on how to use the RL incident reporting system check out the RL intranet page including:

- How to report an incident using RL
- Using RL as a manager
- RL6 mobile app

https://ourplace.xfph-tr.nhs.uk/staff-support/reporting-incidents//

If you have more questions or require further training please email fhft.rlsystem@nhs.net

Levels of harm

Staff often have difficulty determining the level of harm, and at the time of an incident, the full consequences may not be known. Below are a couple of examples of how to determine the level of actual harm caused to a patient following at patient safety incident.

Definition	Example - Fall	Example – Medication error
Near miss – no adverse outcome	Patient trips but is assisted to the floor	Wrong medication is prescribed but noticed before it is administered
No harm – no adverse outcome	Patient falls over but has no injury	Patient is given a double dose of laxative but has no adverse effect
Low harm/minimal – extra observation or minor treatment required	Patient falls over and has a cut requiring sutures	Patient given wrong dose of insulin requiring treatment with glucose which is effective
Short term harm/moderate – further treatment or procedure required	Patient falls over and breaks their hip requiring surgery	Patient given penicillin which they are known to be allergic to and have anaphylactic reaction requiring intensive care admission
Permanent harm/severe	Patient falls over and suffers a spinal injury causing paralysis	Patient prescribed warfarin (blood thinning medication) without monitoring clotting levels which lead to a brain haemorrhage and brain damage
Death caused by the patient safety incident	Patient falls over and suffers a head injury which leads to their death	Patient given 10 times the dose of morphine and dies because of the overdose

Investigation

All incidents that are reported are investigated. Most incidents are investigated by the department manager, or a nominated incident manager, with support and advice from the patient safety team if required. Serious incidents are overseen by a member of the patient safety team. Throughout an incident investigation it is important that the incident manager keeps patients and their families regularly updated to reduce unnecessary worry or stress. They also need to ensure that staff affected receive support in what can be a very difficult time.

As well as understanding why an incident has occurred it is vital that we consider how we can reduce the likelihood of a similar incident occurring again. This includes sharing patient stories, considering the way we work together and offering feedback to staff involved.

?	**Think about an incident that has happened in your area.** • **Could this have occurred on another day?** • **Could this have happened when different staff were on shift?** • **Could this have happened in a different ward?** • **Could this have happened in a different hospital?**

Learning not blaming

Watch this short video about Just culture https://youtu.be/zje765OEggs

Patient safety priorities

?	**How do you receive updates about Patient Safety initiatives and priorities for your department?**

Human Factors

There are decades of research about human and system factors from both healthcare and other industries such as aviation and energy. These all agree that people will make mistakes and our processes shouldn't depend on individuals being perfect or infallible.

In the patient safety team we have found Dupont's Dirty Dozen a useful tool when considering how we work as individuals and teams within our complex work environments often performing complicated tasks.

Supporting staff & civility

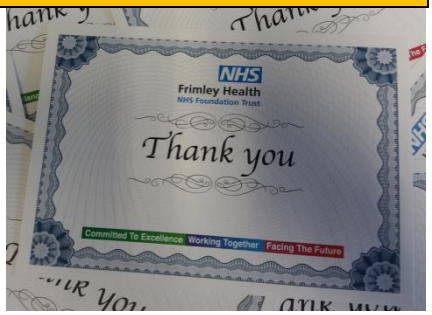
How we interact with each other has a massive impact on staff and patients. In a 2013 study it was found that witnessing incivility, such as sharp words, eye rolls, tutting or being purposefully ignored not only saw a reduction in performance of the person affected but also those who witnessed this episode.

Suzette Woodward makes 7 suggestions of how we can take care of each other on a daily basis:

- Be **respectful** of each other no matter what our background
- Be **kind** – it is an unbelievable strength
- Take **time** to get to know the people around you – you may have no idea what is going on in someone's life
- Be the leader people want to follow – **support** your team. Never be above making the tea, clearing up, being there to help
- **Listen** more than you tell
- Say **thank you**
- **Don't judge** – next time it could be you

?	**Which of these suggestions would you like to see your colleagues or team do more?** **Which of these could <u>you</u> do more of for your colleagues and team?**

A final reflection and thank you



We work in a complex adaptive system which is under greater pressure than ever. We know that staff come to work wanting to do their best but because of many reasons this doesn't always happen. We want all staff at Frimley Health to feel they can speak up when things go wrong and be interested and inquisitive about how we could work differently in the future for the benefit of our patients, their families and our staff.

Thank you from everyone in the patient safety team for the great work you do every day.

?	**What will you do with the information you have gained through this learning guide?**

References and further reading

A Just Culture https://improvement.nhs.uk/resources/just-culture-guide/

NHS Improvement Patient Safety Resources https://improvement.nhs.uk/improvement-hub/patient-safety/

NHS Patient Safety Strategy (2019) https://improvement.nhs.uk/resources/patient-safety-strategy/

Healthcare Safety Investigation Branch – National investigations
https://www.hsib.org.uk/investigations-cases/

Chameleogenics UK have lots of useful information on their website about human factors
https://www.chameleogenics.co.uk/HFA.html

Suzette Woodward writes a regular blog about patient safety including extracts from her books
https://suzettewoodward.org/