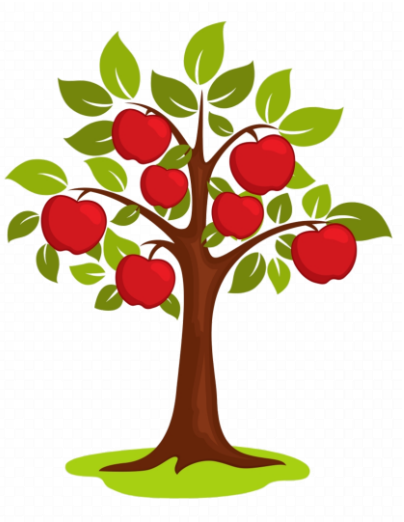
Learning Lessons

Sandwell and West Birmingham Hospitals NHS
NHS Trust

A Quality and Safety Update

Key themes and messages from the governance directorate

January 2022



Welcome to your new lessons learned from the governance directorate, this will be a monthly newsletter to share the highlights and lessons learned from incidents, complaints, audits, mortality reviews and any positive nominations put forward.

Hope you enjoy, any suggestions please email:

swb-tr.RiskManagement@nhs.net

<u>Learning from a recent SI:</u> Patient presented to Sandwell ED on the 7/5/20 with a 2 week history of leg pain and a fractured right NOF (confirmed on x-ray). Patient admitted to L3 and had Right cemented hemiarthroplasty. Patient had a Chest X ray during that admission done for ?HAP which was reported as - 21mm area of right peri hilar shadowing could be prominent vessels. No focal collapse, no large pleural effusion. Findings indeterminate, could represent infection also. Follow up imaging in 8 weeks to ensure resolution advised. No follow up chest x-ray done was done, the patient was discharged 17 May 2020 and follow up X-Ray was not requested. He returned to hospital on 16 May 2021 (a year later) with SOB and haemoptysis. Patient subsequently diagnosed with lung cancer with lymphatic spread and under the care of the Oncology team.

<u>Recommendations:</u>

- **When multiple clinical teams are involved in a patient's care, a lead consultant must be identified and agreed by the team.**
- **Review UNITY system for the possibility of having the current documentation on the daily ward round proforma rather than all the previous information**
- **Locum doctors working within the hospital need to be allocated/set up within the specialty team they are working rather than the ED pool**
- **Orthopaedic team to share the incident as a case study for learning**
- **•Theme/trend of incidents where investigations requested that are not acted upon correctly will be pulled into a thematic review which will then be shared with junior doctors and others in an open learning session that will be organised**

Learning from a recent SI: **Learning from a recent incident:**

There have been previously Serious Incident investigations into Never Events regarding the administration of medical air instead of 02. The lessons learned/recommendations from the previous investigation were:

Recommendations:

- **All staff using medical air to be adequately trained (mandatory medical gas training).**
- **All medical air flowmeters to be audited and maintained so that they are fitted with a working movable flap (AirGuard).**
- **Review all clinical areas and designate those that require air for patient treatment as "Air Permissible Areas" (APA)**
- **In areas that are not APAs**

a. Medical air terminal outlets are to be covered with designated caps.

b. All medical air flowmeters to be returned to EBME

In areas that are APAs

a. Medical air terminal outlets are to be covered with designated caps

b. Medical air flowmeters are to be removed from terminal units and stored in a locked cupboard when not in active use

c. When medical air flowmeters are required for patient treatment:

- **They are to be removed from the locked cupboard and signed for by two trained members of staff recording the patients name and bed space, date and time of removal.**
- **As soon as the individual treatment has been completed the air flowmeter must be returned to the locked cupboard and signed for, recording the time it was returned. (Air flowmeters must not be left in the terminal outlet at a patient's bedside in anticipation of the "next dose")**
- **To set up a task and finish group to implement the actions required by the safety alert.**

To eliminate the risk of further incidents:

- **Remove air flowmeters from all clinical areas and consider an organisational change to using nebuliser boxes or ultrasonic nebulisers.**

Introducing the Patient Safety Team

We would like to introduce you all to the new Patient Safety Team who are based In Trinity House, Governance Department at Sandwell Hospital

James Bielby	**Head of Patient Safety & Risk** Direct Dial - 0121 507 4974 Mobile: 07929 653159 robert.bielby@nhs.net
Alex Thomson	**Patient Safety Manager for Medicine, Imaging, Pathology and Pharmacy** Direct Dial - 0121 507 4850 Mobile: 07929 653028 alex.thomson6@nhs.net
Julie Goodwin	**Patient Safety Manager for Surgery, PCCT & Women Child Health** Direct Dial – 0121 507 4885 Mobile: 07814 228478 Julie.goodwin16@nhs.net
Claire Richards	**Patient Safety Facilitator** Direct Dial - 0121 507 2346 claire.richards14@nhs.net

Email address of the team is swb-tr.RiskManagement@nhs.net