welearn

NHS
Sandwell and West Birmingham
NHS Trust

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Organisation Wide Learning

SPECIAL EDITION
end of year learning

December 2022 | Issue 5

#welearnWednesday

This Month we are reflecting on Safety Headlines with a

Roundup of Incidents, Never Events and consequential learning in 2022

Each Month since June we have **presented a key learning theme** from local serious incidents, investigations, complaints, litigation, or coroner cases.

The learning may not have had a direct link to your area of work.

However, the l**earning provides an opportunity to reflect** on some of the wider issues to consider.

LEARNING AND IMPROVEMENTS FOLLOWING NEVER EVENTS (2022)

Never Events are adverse incidents that are considered wholly preventable because national safety recommendations that provide strong systemic protective barriers are defined as Serious Incidents (SIs). Not all Never Events necessarily result in harm to the patient.

1. Wrong Site Surgery Excision of the wrong ankle. The unusual positioning of the patient on the Theatre Table contributed to this. There was also Human Factors Learning of 'Automation' of a highly functioning team. Learning was the need for a Local Standards for Invasive Procedures (LocSSIP) **Sharp Stop – pause point prior to surgical incision**

Actions to avoid recurrence
Introduction of a LocSSIP: Sharp Stop

2. Wrong route medication 3 INCIDENTS: Oral Morphine solution given IV, Nebulised Adrenalin given IV, Crushed Medication given via PICC line

Actions to avoid recurrence
Quality Improvement Project identifying Human Factors – Psychological Safety to offer Professional challenge
System Factors – Unity workarounds – lack of evaluation post go live
Dashboards created of Medication Incident reporting at local level for oversight and ownership.

3. Wrong use of Air Flow meters Oxygen wrongly administered Check Before You Connect

Actions to avoid recurrence
All Clinical areas supplied with a Nebuliser Box

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COMPLIANCE WITH VTE ASSESSMENTS

Incident – prophylactic enoxaparin not prescribed as per assessment e.g. Mr X admitted with complex history: background of advanced neuroendocrine tumour and recurrent C difficile infection. VTE assessment completed on admission stated he was high risk and for enoxaparin: however, was not prescribed prophylactic enoxaparin: **confirmed a large PE.**

Learning
Inconsistencies in compliance, data deep-dive identified areas of required performance improvement
Learning shared

Improvement
Improving compliance in elective care

KNOW YOUR NUMBERS: PERFORMANCE AND INSIGHT IMPROVING REPORTING

Learning
Lack of single oversight of rolling data making it challenging to see patterns, themes and episodes of incidents

Improvement
Improved Near Miss Reporting

SOUND BITES

Failure to Communicate the right information, in the right mode, to the right person and timely – **SBAR**

Poor Infection Prevention Compliance – including **Remove Your Gloves**

Am I OK? – recognise your limitation it's really important to check in with yourself and check if you are ok. Consider talking to your line manager or someone you trust about the impact of your work. You may want a referral to our employee wellbeing service. **#Stress #Fatigue #Human Factors**

Know your CIWA... Clinical Institute Withdrawal Assessment for Alcohol

Play your part as a Learning Organisation – Learn and Share findings from Incidents, Complaints, Near Misses and when things have gone well

#welearn: Contact us

Please contact the we learn team for more information

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