# Lessons Learned

## October 2011

**Volume 6, Issue 3**

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Our website: [www.cmft.nhs.uk](http://www.cmft.nhs.uk)
Trust Wide Activities

A ‘Patient Safety Week’ pack was provided to all Departments. A Trust wide ‘Patient Safety Questionnaire’ was run via ‘Staffnet’: we asked whether Patient Safety was a high priority in their area of work. 1156 members of staff voted: 76% of staff said ‘yes’, 18% said ‘no’ and 6% of staff felt they did not know.

We also carried out a more detailed patient survey asking staff what their biggest risk to patient safety was. The themes that came out of this are as follows:

<table>
<thead>
<tr>
<th>Theme</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication / Documentation</td>
<td>37</td>
</tr>
<tr>
<td>Procedures not followed</td>
<td>20</td>
</tr>
<tr>
<td>Tests including Sampling, Delivery and Results</td>
<td>18</td>
</tr>
<tr>
<td>Environment</td>
<td>12</td>
</tr>
<tr>
<td>Medications</td>
<td>11</td>
</tr>
<tr>
<td>Accidents / falls</td>
<td>9</td>
</tr>
<tr>
<td>Staffing</td>
<td>7</td>
</tr>
<tr>
<td>Administration</td>
<td>7</td>
</tr>
<tr>
<td>Knowledge / Training</td>
<td>6</td>
</tr>
<tr>
<td>Human Factors</td>
<td>5</td>
</tr>
</tbody>
</table>

When asked what would most improve patient safety, staff indicated the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Staff</td>
<td>23</td>
</tr>
<tr>
<td>Information Technology / automation</td>
<td>17</td>
</tr>
<tr>
<td>Improved Communication</td>
<td>16</td>
</tr>
<tr>
<td>Training / Education / mentorship</td>
<td>12</td>
</tr>
<tr>
<td>Adherence to procedures</td>
<td>10</td>
</tr>
<tr>
<td>Improved Documentation / Record Keeping</td>
<td>8</td>
</tr>
<tr>
<td>Improved Team Working</td>
<td>5</td>
</tr>
</tbody>
</table>

On Friday, 16th September a Patient Safety event was held. Ann Parker-Clements, Head of Patient Safety and Risk Management, provided feedback about the patient safety questionnaires and gave an update about incident reporting and improvements made in reducing harm to patients.

In 2009/10 there were 50 incidents with actual harm at level 4/5, however in 2010/11 this was reduced to 28.

The graph on the right shows total numbers of incidents reported and high level harm incidents since April 2009.
Patient Safety Week Report

Division of Research and Innovation

This theme has provided the opportunity to promote good practice in clinical and research activities that involve record keeping and documentation. The R&I division undertook several activities during the week.

Patient Safety packs were available for staff to review or access in a variety of areas.

The Divisional Quality Lead, George Georgiou, presented two teaching sessions on Good Record Keeping. These sessions were aimed at clinicians, study coordinators and clinical research nurses. George also presented at the one day event, three sessions focusing on Good Clinical Practice in Research and Documentation.

An audit was undertaken of the medical research notes in five research settings across the Trust; Renal Medicine, Lipids, Diabetes, IVF and Gynaecology. This was led by Judith Rucklidge, Quality Lead, Welcome Trust Clinical Research Facility and Janette Dunkerley, Clinical Research Nurse Manager. The results of which are awaited from clinical audit.

Finally, the Lead Nurse for R&I, Gail Holmes, and Acting Divisional Director for R&I, Kathy Evans, undertook a Patient Safety walk around to a variety of clinical areas. This offered staff the opportunity to discuss key issues relating to patient safety and clinical research. Many patient safety issues in relation to studies are covered in ethics applications so staff didn’t feel there were many problem areas. It was pleasing that staff were aware Trust incident reporting processes and many had reported incidents, albeit more in relation to clinical issues.

CSS Division

Poster Campaign

The Directorate of Laboratory Medicine (DLM) ran a highly visible campaign to highlight the importance of correct labelling of blood samples at the patient bedside, entitled “Don’t gamble with patient safety, Play your cards Write”. The consequences of ‘wrong blood in tube’ for all lab tests carries potentially serious risk of harm to patients; incorrect pathology results may lead to inappropriate treatment being given or more seriously, an ABO mismatched blood transfusion.

Analysis of incident reports has revealed a worrying trend across the Trust. There have been 10 incidents with varying level of severity, 5 of which are level 4. ‘Play Your Cards Write’ is an important patient safety message that advocates that all staff taking blood samples follow 5 simple steps to minimise errors, namely:

- Avoid distractions
- Positively identify patients at the bedside
- Label all samples at the bedside
- Send samples to the labs immediately
- Undertake annual blood sampling/Aseptic Non Touch Technique assessments.
Divisional Walk Around
The division conducted several unannounced patient safety walk around.
Areas visited included:
• High Dependency Unit (HDU)
• Intensive Care Unit (ICU)
• Adult Radiology
• Paediatric Radiology
• Medical Engineering and Maintenance
• Directorate of Laboratory Medicine
During these walk arounds the Clinical Director, Clinical Governance Manager, Departmental Risk Leads and Directorate Managers spoke to a range of staff groups using a simple questionnaire on 6 aspects of patient safety / risk management. In total 29 staff were ‘interviewed’ revealing some useful insights into our governance processes.
• 100% stated they are familiar with the incident reporting process and knew how to access the online system.
• 69% stated that they did receive feedback on incidents;
• 83% had reported an incident in the last 12 months.

When asked if there were any barriers to reporting incidents the following comments were made;
• Lack of time and easy access to PC.
• The junior medical staff interviewed reported they had not received any ‘official’ training on incident reporting and that this would be helpful. There is an on-line incident reporting training package available via the Trust’s e-learning platform which is accessible to all staff.
• Hierarchy within clinical teams may discourage junior staff to report incidents involving more senior staff.
• Choosing the correct Severity levels can be difficult.
• Where incidents involve medical devices, clinical areas do not enter full details on service reports for devices involved in incidents and often omit the Division’s name.
The Division will use this information to develop local action plans as part of its effort to support and encourage all grades of staff to report incidents in a timely manner.

Record keeping audit
During the course of the week Critical Care undertook a snap shot record keeping audit of 20 patient care records looking at 7 key standards. All entries into the patient record in the preceding 24 hours were reviewed. This was a total of 631 entries; medical staff 64 (10%), Nursing 535 (85%) AHP staffs 32 (5%). The standards assessed were;
• Entry is dated & timed
• Entry is legible
• Healthcare professional’s name is printed
• Entry is signed
• Designation is stated
• GMC No is stated (medical staff only)
The overall compliance of each staff group is shown below in Table 1.

Key concerns this audit has highlighted are;
• Use of GMC numbers - 48% of all records assessed complied with this standard. Slight variation was noted between HDU (57%) & ICU (41%)
• Designation stated – All staff groups have poor compliance with this standard, of note is nursing, achieving only 1%
The division has shared the results with the directorates concerned who will develop local action plans to target the areas of poor compliance.
Patient Safety Week Report

Manchester Royal Eye Hospital
The Trust’s theme for Patient Safety Week 2011 was embraced with enthusiasm by all members of staff within the Eye Hospital.

Furthermore, a ‘Zero Tolerance’ week was held, whereby staff strived to ensure that case notes did not leave their area unless they were in the correct order. The positive feedback was that the majority of notes were found to be in good order.

A snapshot audit of Clinical Record Keeping was undertaken. 12 sets of case notes were reviewed with the following outcomes:

<table>
<thead>
<tr>
<th>Standard Audited</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of record</td>
<td>91%</td>
</tr>
<tr>
<td>Time of record entered into notes</td>
<td>83%</td>
</tr>
<tr>
<td>Legibility of the record</td>
<td>100%</td>
</tr>
<tr>
<td>Name of the person completing the record</td>
<td>100%</td>
</tr>
<tr>
<td>Their Signature</td>
<td>100%</td>
</tr>
<tr>
<td>Designation</td>
<td>83%</td>
</tr>
<tr>
<td>GMC/ Professional Registration Number</td>
<td>77 %</td>
</tr>
</tbody>
</table>

The results will be discussed at the Division’s next Clinical Effectiveness meeting.

Each Department used the Patient Safety Board to highlight the Patient Safety issues for their area. Examples of issues raised were:

- Responsibility for patient identification, medication checking and filing.
- Legibility of clinical records
- Use of clinical stamp
- Use of plain English
- Importance of giving a copy of the consent form to patients
- Ensuring patients receive the correct treatment information leaflets
- Use of patient passports

Henshaw’s, Manchester’s local charity for the Blind, have a patient contact office in the Hospital Atrium and they manned a Patient Safety stall on Wednesday 14th; demonstrating patient safety aids for the visually impaired.
Dental Hospital

All of the Dental Hospital staff and clinicians ensured that all case notes only left their area once correctly filed and in good order; this continues as the new student term commences.

One of the topics presented at Student tutorials is ‘Standards of record keeping’ - a group of Dental students will undertake a re-audit of standards of record keeping as part of their final year, which will be shared with the whole Hospital.

Each Department displayed their Patient Safety Board in patient areas, highlighting the patient safety issues they are currently concentrating on. Examples of issues raised were:

- Importance of notes being completed fully
- Use of the clinical stamp
- Correct labelling of blood samples chairside
- Update of the medical history at each visit
- Adherence to medical record keeping policy
- Correct site surgery policy being adhered to
- Making new patient leaflets available

A general display was also held through the main patient corridor, along with audit posters.

A snapshot audit of Clinical Record Keeping was undertaken. 12 sets of case notes were reviewed with the following outcomes:

Feedback was given to the individuals on the day, again with good results. The audit findings were then reviewed and actioned by the Division’s Clinical Effectiveness meeting held on 5th October 2011.

<table>
<thead>
<tr>
<th>Standard Audited</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of record</td>
<td>100%</td>
</tr>
<tr>
<td>Time of record entered into notes</td>
<td>50%</td>
</tr>
<tr>
<td>Legibility of the record</td>
<td>100%</td>
</tr>
<tr>
<td>Name of the person completing the record</td>
<td>100%</td>
</tr>
<tr>
<td>Their Signature</td>
<td>100%</td>
</tr>
<tr>
<td>Designation</td>
<td>90%</td>
</tr>
<tr>
<td>GMC/GDC Number</td>
<td>100%</td>
</tr>
</tbody>
</table>

Children’s Division:

The Division arranged a series of patient safety walk arounds involving senior members from the medical and nursing teams. Two or three staff visited a ward /department outside their own area of work to talk to staff.

Aims of this were:

- to raise awareness of Patient Safety Week and Patient Safety in general
- to raise awareness of the implications of mis-labelled samples (each ward / department received two posters in their pack)
- the staff survey questions:
  - Do you know how to report an incident?
  - Have you reported an incident in the last 3 months?
  - What do you think are the barriers to reporting incidents?
Do you get feedback on themes of incidents or individual incidents reported in your area and actions taken as a result?

Who do you think is responsible for escalating the care of patient’s triggering amber or red on the Early Warning Score?

What do you see as the main patient safety risk in your area?

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To highlight the Trust wide educational session on Friday 16th September 2011

To audit 2 sets of case notes, with the aim of highlighting the importance of good record keeping. The Divisional Clinical Effectiveness team developed a documentation audit tool, focusing on documentation by medical and nursing staff (auditing current practice against the Trust documentation policy standards). Two sets of case notes were randomly selected in each area.

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2. Results

2.1 Patient Safety Walkabout Results

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know how to report an incident?</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Have you reported an incident in the last 3 months?</td>
<td>92%</td>
<td>8%</td>
</tr>
<tr>
<td>What do you think are the barriers to reporting incidents?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you get feedback on themes of incidents or individual incidents reported in your area and actions taken as a result.</td>
<td>78%</td>
<td>22%</td>
</tr>
<tr>
<td>Everybody</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Named Nurse</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Most Senior Nurse</td>
<td>19%</td>
<td></td>
</tr>
</tbody>
</table>

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Themes: Perceived barriers to reporting incidents

Methods cited

Word Managers 40%
Meetings 20%
1:1 18%
Manuscript form 18%
Q6 What do you see as the main patient safety risks in your area?

2.2 Patient Safety Week Documentation Audit - Summary of results

The audit tool used measured current medical and nursing documentation practice against the standards set out in the Trust Record Keeping policy. Two sets of case notes for each area were audited (total = 32)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Yes % (n)</th>
<th>No % (n)</th>
<th>Compliance Aug 2011 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard 10:</strong> The following must be recorded at the top of every MEDICAL continuation sheet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>97 (31)</td>
<td>3 (1)</td>
<td>↔ 97</td>
</tr>
<tr>
<td>DOB</td>
<td>47 (15)</td>
<td>53 (17)</td>
<td>↑ 18</td>
</tr>
<tr>
<td>Hospital number</td>
<td>78 (25)</td>
<td>22 (7)</td>
<td>↑ 76</td>
</tr>
<tr>
<td>Location in Hospital</td>
<td>69 (22)</td>
<td>31 (10)</td>
<td>↑ 37</td>
</tr>
<tr>
<td>Lead Clinician</td>
<td>62 (20)</td>
<td>38 (12)</td>
<td>↑ 54</td>
</tr>
<tr>
<td><strong>Standard 11:</strong> All MEDICAL entries must be</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronological</td>
<td>91 (29)</td>
<td>9 (3)</td>
<td>↓ 97</td>
</tr>
<tr>
<td>Black Ink</td>
<td>97 (31)</td>
<td>3 (1)</td>
<td>↔ 97</td>
</tr>
<tr>
<td>legible</td>
<td>91 (29)</td>
<td>9 (3)</td>
<td>↓ 92</td>
</tr>
<tr>
<td>dated</td>
<td>94 (30)</td>
<td>6 (2)</td>
<td>↔ 94</td>
</tr>
<tr>
<td>Timed (24hours)</td>
<td>72 (23)</td>
<td>28 (9)</td>
<td>↑ 52</td>
</tr>
<tr>
<td><strong>Standard 12:</strong> When a MEDICAL practitioner has written in the Health Record, entries must contain the following</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>78 (25)</td>
<td>22 (7)</td>
<td>↑ 55</td>
</tr>
<tr>
<td>Signature</td>
<td>91 (29)</td>
<td>9 (3)</td>
<td>↓ 92</td>
</tr>
<tr>
<td>designation</td>
<td>45 (15)</td>
<td>55 (18)</td>
<td>↑ 37</td>
</tr>
<tr>
<td>GMC number</td>
<td>38 (12)</td>
<td>62 (20)</td>
<td>↑ 11</td>
</tr>
<tr>
<td><strong>Standard 13:</strong> The following must be recorded at the top of every NURSING continuation sheet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients name</td>
<td>97 (31)</td>
<td>3 (1)</td>
<td>↑ 95</td>
</tr>
<tr>
<td>DOB</td>
<td>70 (21)</td>
<td>30 (9)</td>
<td>↑ 50</td>
</tr>
<tr>
<td>Hospital number</td>
<td>70 (21)</td>
<td>30 (9)</td>
<td>↓ 80</td>
</tr>
<tr>
<td><strong>Standard 14:</strong> All NURSING entries must be</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronological</td>
<td>100 (29)</td>
<td>0</td>
<td>↑ 99</td>
</tr>
<tr>
<td>Black Ink</td>
<td>100 (29)</td>
<td>0</td>
<td>↑ 99</td>
</tr>
<tr>
<td>Legible</td>
<td>100 (29)</td>
<td>0</td>
<td>↔ 100</td>
</tr>
<tr>
<td>Dated</td>
<td>93 (27)</td>
<td>7 (2)</td>
<td>↓ 100</td>
</tr>
<tr>
<td>Timed (24hours)</td>
<td>93 (27)</td>
<td>7 (2)</td>
<td>↓ 95</td>
</tr>
<tr>
<td><strong>Standard 15:</strong> When a NURSING practitioner has written in the Health Record, entries must contain the following</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>69 (20)</td>
<td>31 (9)</td>
<td>↑ 54</td>
</tr>
<tr>
<td>Signature</td>
<td>93 (27)</td>
<td>7 (2)</td>
<td>↑ 91</td>
</tr>
<tr>
<td>Designation</td>
<td>59 (17)</td>
<td>41 (12)</td>
<td>↑ 41</td>
</tr>
</tbody>
</table>
Manchester Heart Centre

It was reported that the biggest risk areas were falls, interruptions to medication rounds and poor communication from the medical staff who are caring for the patients on the wards.

Feedback from incidents does happen, although this tended to be only for the higher level incidents. Ward 6 were particularly looking forward to their new ward environment as staff felt that lighter and bigger surroundings would have a real impact on providing a safe environment for our patients.

In terms of suggestions for improvements, it was felt that better engagement with the senior medical teams would be very beneficial for improving the standard of ANTT care they provide for their patients. Additionally, more detailed feedback on all incidents would help staff to learn valuable lessons and a reduction in the amount of paperwork would allow more face-to-face ‘real’ time with patients.

Renal Medicine

It was reported that issues with patient transport had a significant impact on patient safety, resulting in stressful conditions for both patients and staff, and also leading to delays in the patient’s treatment regime. Additionally, falls and the amount of medical cover provided on the wards were felt to be contributory factors to the incidents on the wards.

Ward 37 felt that the trial of the Patient Focus scheme on their ward was making a significant reduction in the number of falls occurring on their ward.

With regards to improving, it was felt that communication could be better between all teams, and that the standard of documentation could also be enhanced, in terms of condensing paperwork and perhaps having some aspects to be completed online.

Specialist Medicine

The biggest issues within this Directorate were falls, absconding patients and the acquisition of hospital acquired infections. These incidents are all due to the type of patients that are cared for on the Specialist Medicine wards.

AM4 felt that they received excellent feedback from incidents, and that the Ward Manager had ensured that feedback was provided to all staff by email.

AM3 were particularly impressed with the focus provided by the Brilliant Basics campaign.

In terms of enhancing the standard of patient safety, staff felt that improved ward environments would help and that a continuing commitment to the measures already in place would be beneficial.
Patient Safety week Report

Audit Results

The audit of patient healthcare records revealed several areas of improvement in the standard of documentation. We audited against the standards used in the recent Trust Record Keeping Audit.

The results of the Trust audit have already been discussed at the Division’s Clinical Effectiveness Board and our Divisional Audit will also be discussed at a forthcoming meeting to ensure that we are doing all that we can to effectively address this issue.

Feedback Cards

These were distributed to all wards and departments within the Division for completion by staff, patients and visitors. The completion rate for these was good and clearly helped to raise the profile of the National Patient Safety Week campaign. The results of this particular survey will also be discussed at a forthcoming Divisional Clinical Effectiveness Board, where plans for action will be developed.

Division of Medicine and Community Services

Numerous activities took place across the Division of Medicine and Community Services during Patient Safety First Week.

All departments displayed suggestion boxes asking staff for their opinion about what the Division could do to improve patient safety in their areas. The results were interesting and very much themed according to different areas.

For example, communication at discharge between the hospital and intermediate care was one of the main causes of concern in Kirkley and Gorton Park. Falls were also raised as an area of concern by a number of the departments however it was encouraging to note that most areas felt that everything possible was being done to minimise falls. The Divisional team now aims to develop working parties around some of the areas of feedback in order to streamline processes and help improve patient safety.

Patient Safety Walk Arounads also took place where staff were asked about incident reporting processes. The feedback was again encouraging as staff reported feeling confident that incidents they reported were acted upon and they were familiar with incident reporting processes.

The Division also undertook an audit of the revised Medical Clerking Document. The audit is still ongoing and the results will be used to assess whether or not the document needs further revision.
Summary of walk rounds / Departmental actions

- A number of ward rounds were attended by the Clinical Effectiveness Manager during which conversations yielded a high level of knowledge of the Health Records Policy standards and the Trust / divisional audit results for all levels.
- All documentation undertaken during these observations was within the Trust Policy.
- The Health Records were generally in a fair state, though not all to the agreed Trust standards, and loose filing was noted on a number of occasions.
- Communication between the patients / medical and nursing staff was excellent.
- It was highlighted that the Acute Abdomen Pathway was not very visible to the staff and immediate actions were undertaken to ensure that they are now very visible.
- Patient ‘handover’ lists were felt to be invaluable in ensuring information was up to date.
- No staff at any of the events were noted to have blue pens and all staff spoken to recognised that this was Trust Policy.
- Most departments had a ‘case note amnesty’ where all filing was undertaken, however it was noted that due to staffing constraints this is not always undertaken.
- The Clinical Effectiveness Manager attended all wards and departments during the week to raise the profile of Patient Safety Week and the Trust focus on documentation was discussed / debated with all staff.
- A presentation was undertaken for Divisional staff, although a small number of staff attended this was insightful in terms of the current issues staff face and reflected the same issues as at Trust level.

Division of Surgery

A range of activities were undertaken across all the specialities within the Division, including nursing, medical, administration and laboratory teams. These included:

- Multidisciplinary Ward / theatre documentation audits
- Observation and inclusion in medical staff ward rounds by the Clinical Effectiveness Manager
- Range of walk rounds including pharmacy staff / senior nursing staff
- Divisional presentations at ‘Open Sessions’ and Team meetings
- Distribution of Trust Health Records Policy and associated audit and NMC Record Keeping Standards

Summary of results from the Divisional audits

The overall results demonstrated similar findings to the Trust recent audit, in terms of entries not dated and or signed, and on occasions difficult to decipher handwriting.
The majority of staff at the presentation and spoken with during the week felt that staffing in terms of numbers was a key issue. Following on from this a number of conversations took place with senior nursing teams in relation to the competencies and allocation of staff within ward and departmental areas, and how the assessment of and introduction of more efficient ways of working may impact positively on patient and staff safety.

- Communication was a key issue in terms of how issues can impact upon staff in different areas for example delays in patient’s arrival at theatre and how this is communicated to staff from differing areas.

- Some discussions highlighted clerical staffing issues which impacted upon Out Patient Clinics. Following discussions an immediate action plan was put into place. These actions included raising the issue at Directorate Manager Level, reviewing staffing levels and service provision and ensuring that a robust plan is in place in terms of adequate staffing levels, positively reinforcing the need to report any incidents and raising this as a risk on the divisional risk register. All of these actions demonstrated to staff that results can be obtained from reporting and escalating issues in a supportive way, which has had a positive impact upon working as a team.

- All staff are aware of how to report incidents and felt that patient safety was a high priority of all the Divisional teams.

**Divisional Actions**

- Re-launch of stamps for the use of medical and nursing staff
- Review and amendment of the nursing documentation is being undertaken by the Matrons and staff education sessions will follow on from this
- Designated Patient Safety Board
- Nursing and Medical Professional Standards of documentation disseminated
- Working with Falls Nurse to ensure accuracy of reporting severity of falls in Out Patients
- Clinical Effectiveness Manager to assess availability of training in case note filing
- Divisional Ward Clerks meetings to be re-established

**Summary**

In summary the events undertaken allowed for open discussions with staff, explanation of the necessity to report incidents, the role of the Clinical Effectiveness Manager and provided a safe opportunity for staff to discuss patient safety issues.

Case notes remain an ongoing issue primarily due to staffing issues and not as was expected due to lack of knowledge of the Trust Health Records Policy.
Patient Safety week Report  
Division of Saint Mary’s  

There was a Trust wide presentation day on 16th September which comprised of presentations from all Divisions recognising problems with documentation.

For SMH, Shirley Rowbotham presented a High Level Investigation completed in Gynaecology which recognised the need to improve documentation of the Surgical Safety Checklist as one of the immediate actions. Considerable progress has been undertaken within Gynaecology, led by Dr Fiona Reid and Louise Samworth. Please see details about this theme further on in this edition.

There were a number of activities across the Division to raise awareness and make some headway into raising our standards:

There was a Divisional focus for the 3 weeks running up to 12th September:
- w/c 22nd August – Medical Documentation
- w/c 29th August – Quality of Nursing documentation and filing
- w/c 5th September – Condition of records, filing and organisation

Patient Safety first packs for all areas distributed comprising of Division and local Incident information.

Finding information in patient records: workshops for staff to find the information they need in the medical records to respond to a complaint, comparing a good set of notes to a poor one were held.

Collective record of GMC numbers were laminated and available for reference in Gynaecology ward and outpatient areas, for medical staff to refer to when completing medical entries in notes.

An audit of tracking system in Genetics was held, to see if records had their location tracked and if where they were tracked to (ie filing, awaiting clinic appointment, clinics, individual members of Medical, Counselling and Clerical staff).

Patient Safety Walk round: These were undertaken by the Senior Management team and Governance Leads and asked general questions about patient safety. Out of 35 members of staff approached, 92% knew how to report an incident and 60% had reported an incident in the last 6 months.

Spot check audit of current inpatient episodes: Obstetrics, Gynaecology and Neonatal Intensive Care Unit (NICU). Results were fed back to the teams on the day for action.

NICU had drop in sessions whereby various standards relating to documentation were displayed. There were some interactive sessions whereby people could look at good and poor standards of documentation.

NICU- There was a staff suggestion / mood board whereby staff could express their thoughts feelings in regards to things we did well and things which we didn’t. There were also some one to one sessions regarding general aspects of patient safety.

Obstetrics: Focus on legibility, mode of corrections, correct ‘headers’ on continuation sheets, completion of both pages on transfer sheets, what should be contained in CTG envelopes.
There is a wealth of information and guidance available on Health Record keeping from many organisations, professional bodies and the Department of Health.

Accurate and comprehensive information is essential for high quality patient care.

The Trust has a Clinical Record Keeping Policy which brings the key recommendations together as good practice standards to be implemented across the Trust in order to:

- Maximise patient safety and quality of care
- Support professional practice

An audit of compliance with the Policy is undertaken across the Trust on a regular basis and this was last undertaken in August 2011.

The results outlined below show a selection of standards relating to entries made by staff. Details of the whole audit can be obtained from your line manager.

**Results for Medical Staff Audit**

Medical staff have improved in a number of areas but deteriorated with regards to printing their name below notes entries.

Please remember it is the individual responsibility of every member of staff who makes an entry in the Patient Record to comply with the simple standards outlined below.

**Would your entries pass the ‘good practice’ test?**
Results for Nursing Staff Audit

Nursing staff have improved in a number of areas, however, some areas were not audited in 2009 and there is therefore no base for comparison and there are a number of areas for improvement such as timing of entries, printing of names and designation.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Compliance (%) 2011</th>
<th>Compliance (%) 2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (printed)</td>
<td>33% (82/248)</td>
<td>36% (278/766)</td>
<td>↓</td>
</tr>
<tr>
<td>Signature</td>
<td>86% (213/248)</td>
<td>72% (554/766)</td>
<td>↑</td>
</tr>
<tr>
<td>Designation</td>
<td>24% (59/248)</td>
<td>15% (118/766)</td>
<td>↑</td>
</tr>
<tr>
<td>GMC Number (Medical staff only)</td>
<td>8% (19/248)</td>
<td>9% (69/766)</td>
<td>↓</td>
</tr>
</tbody>
</table>

13. The following must be recorded at the top of every NURSING continuation sheet: (5.2)6

<table>
<thead>
<tr>
<th>Standard</th>
<th>Compliance (%) 2011</th>
<th>Compliance (%) 2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Name</td>
<td>86% (203/236)</td>
<td>81% (568/701)</td>
<td>↑</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>58% (137/236)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hospital Number</td>
<td>74% (175/236)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Location in the hospital</td>
<td>32% (75/236)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lead Clinician</td>
<td>27% (63/236)</td>
<td>17% (122/701)</td>
<td>↑</td>
</tr>
</tbody>
</table>

14. All NURSING entries must be6:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Compliance (%) 2011</th>
<th>Compliance (%) 2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronological (5.4)</td>
<td>98% (231/236)</td>
<td>89% (679/766)</td>
<td>↑</td>
</tr>
<tr>
<td>In black ink – pharmacy entries may be in green (5.5)</td>
<td>98% (232/236)</td>
<td>76% (584/766)</td>
<td>↑</td>
</tr>
<tr>
<td>Legible (5.5)</td>
<td>93% (220/236)</td>
<td>83% (482/766)</td>
<td>↑</td>
</tr>
<tr>
<td>Dated (5.5)</td>
<td>92% (217/236)</td>
<td>88% (673/766)</td>
<td>↑</td>
</tr>
<tr>
<td>Timed (24 hours) (5.5)</td>
<td>74% (175/236)</td>
<td>22% (167/766)</td>
<td>↑</td>
</tr>
</tbody>
</table>

15. When a NURSING practitioner has written in the Health Record, entries must contain the following: (5.5)6

<table>
<thead>
<tr>
<th>Standard</th>
<th>Compliance (%) 2011</th>
<th>Compliance (%) 2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (printed)</td>
<td>32% (76/236)</td>
<td>36% (278/766)</td>
<td>↓</td>
</tr>
<tr>
<td>Signature</td>
<td>93% (220/236)</td>
<td>72% (554/766)</td>
<td>↑</td>
</tr>
<tr>
<td>Designation</td>
<td>22% (52/236)</td>
<td>15% (118/766)</td>
<td>↑</td>
</tr>
</tbody>
</table>
Results for Allied Health Professionals (AHP’s) Staff Audit

Whilst generally documentation by AHP’s is good, some areas covered in this audit were not measured in 2009 and there is therefore no base for comparison and there has been some deterioration in compliance regarding deletions and corrections.

As indicated by the areas highlighted in red, there are a number of areas for improvement.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Compliance (%) 2021</th>
<th>Compliance (%) 2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. All AHP entries must be 2:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronological (5.4)</td>
<td>100% (139/139)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>In black ink – pharmacy entries may be in green (5.5)</td>
<td>100% (139/139)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legible (5.5)</td>
<td>96% (133/139)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dated (5.5)</td>
<td>99% (138/139)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timed (24 hours) (5.5)</td>
<td>42% (58/139)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard</th>
<th>Compliance (%) 2021</th>
<th>Compliance (%) 2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. When a AHP has written in the Health Record, entries must contain the following: (5.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name (printed)</td>
<td>51% (71/139)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>91% (127/139)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designation</td>
<td>51% (71/139)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard</th>
<th>Compliance (%) 2021</th>
<th>Compliance (%) 2009</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Deletions or corrections must be: (5.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruled through</td>
<td>63% (36/57)</td>
<td>79% (33/42)</td>
<td>↓</td>
</tr>
<tr>
<td>Signed by the person making the alteration</td>
<td>12% (7/57)</td>
<td>12% (5/42)</td>
<td>↔</td>
</tr>
<tr>
<td>Dated</td>
<td>4% (2/57)</td>
<td>12% (5/42)</td>
<td>↓</td>
</tr>
<tr>
<td>Timed (24 hours)</td>
<td>4% (2/57)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Health Foundation: Safer Systems Project

We are delighted to announce that the Trust was successful in its bid to become part of the Health Foundation’s Safer Systems Project (Phase II).

Dr Bronwyn Kerr and Dr Ian Doughty will be working with a multi-disciplinary team in the Royal Manchester Children’s Hospital over the next two years. The project will focus on developing safe and effective care pathways, with a focus on handover, for the sick complex child.

We congratulate the team on this achievement and look forward to seeing the outcome of the work.
Lessons learned – Newborn Screening

The UK National Screening Committee (UKNSC), guidance recommends that all babies in the UK are offered screening for:

**Phenylketonuria (PKU):** a rare genetic condition that is present from birth. Left untreated, PKU can disrupt the normal development of a child’s brain and can cause severe learning difficulties.

**Congenital hypothyroidism (CH):** a condition of thyroid hormone deficiency present at birth. If untreated for several months after birth, this can lead to growth failure and permanent mental retardation.

**Cystic fibrosis:** a genetic disease which affects the entire body, causing progressive disability and often early death. Difficulty breathing is the most serious symptom and results from frequent lung infections.

**Sickle Cell Disease:** a genetic blood disorder, characterized by red blood cells that assume an abnormal, rigid, sickle shape. Sickling decreases the cells' flexibility and results in a risk of various complications. Life expectancy is shortened, with studies reporting an average life expectancy of 42 in males and 48 in females.

**Medium-chain acyl-coenzyme A dehydrogenase deficiency (MCADD):** is a disorder where fats are not dealt with by the body correctly. It is recognized as one of the more rare causes of sudden infant death syndrome, although it may be better described as a mimic, rather than a cause, of SIDS.

The main objective of the screening programme is to ensure the early detection and referral of those babies found to be high risk of the above conditions.

5-8 days of age is the recommended sampling period for Newborn Blood Spot Screening but it can be carried out up to one year of age for PKU, CHT, SCD and MCADD, the screening for CF is not valid for babies tested after 8 weeks of age.

Between November 2010 and May 2011 there were 5 internal incident reports, where babies were not offered Newborn Screening between 5-8 days of age as per National Guidelines.

**Problems identified:**

- Nursing and medical staff at the Children’s Hospital look after a small number of neonatal babies and therefore are unfamiliar with the timescale requirements of screening and expected milestones in the first few days of life.
- No clear process in place to ensure hospitalised children are screened within optimum timescales.

**Actions planned to improve compliance:**

- The Paediatric Transfer of Care Form, shortly to be introduced, is to include a question on whether newborn screening has been completed, or date required.
- The Nursing Admission Pack, shortly to be updated, will include a newborn screening section which will be completed for babies under 28 days old.
- A flow chart and resource pack has been developed to guide health care professionals. In collaboration with St Mary’s NICU.
- Training on newborn screening will be provided in clinical areas where there is potential for neonates to be admitted.
Reducing Pressure Ulcers and the Way Forward

Pressure ulcers are painful, can be life threatening for patients and are expensive in terms of increased length of stay and additional treatment requirements. The estimated cost of treating pressure ulcers in the Trust in 2010/11 was £3.5 million. The risk of pressure ulcers affects all age groups, any patient of any age can develop a pressure ulcer whilst in hospital and it is estimated that up to 95% of pressure ulcers are avoidable.

Through a series of improvement strategies the Tissue Viability Team have led a number of initiatives to support nursing and midwifery staff in delivering high standards of care in terms of assessing patients at risk for pressure ulcer development and then providing care that reduces this risk for the patient. This work has resulted in a number of key achievements:

Achievements

- Figures for 2011 compared to the same time last year show a reduction in grade 3 and 4 pressure ulcers of 65%.
- Preventing pressure ulcers was the theme of Brilliant Basics in August. Various events took place during the month which resulted in over 250 staff and members of the public receiving information and advice on pressure ulcer prevention.
- Over 150 health care professionals have attended the Reducing Pressure Ulcer study days.
- ‘Preventing Pressure Ulcers in Children’ information leaflet was launched in August, aimed at parents and carers.

Work to improve and enhance the care we give to patients in order to prevent the development of hospital acquired pressure ulcers continues and the Tissue Viability Team are currently working on the following developments:

- As a result of the findings from Key Performance Indicators, the pressure ulcer root cause analysis and your feedback, we are in the process of making changes to the Adult Pressure Ulcer Prevention Integrated Care Plan (PUPICP) and introducing a Paediatric ICP.
- Changes have also been made to the manner in which the Waterlow scores are recorded to reduce incorrect scoring and so that significant changes in the patient’s risk factors can be easily identified.
- A pressure ulcer risk assessment tool has also been developed by maternity.
- These documents will all be launched in the New Year with education and support from the Tissue Viability Team.
- The Trust has teamed up with the national campaign, “Your Turn” which focuses on preventing pressure ulcers and educating members of the public and carers. This, with the joining of the community Tissue Viability nurse from the Primary Care Trust means as an organisation we can also focus on reducing community acquired pressure ulcers which may reduce hospital admissions and unnecessary distress to the patient.

The achievements the Trust has made in reducing hospital acquired pressure ulcers could not have been accomplished without the support of all members of the Trust and the hard work and enthusiasm of all health care professionals. Each and every member of staff has a role in play.
Pressure Ulcers Continued.............

in supporting this work and keeping our patients safe whilst they are within our care.

It is crucial that the work in reducing pressure ulcers and thus preventing harm is ongoing and remains a high priority within the Trust.

Remember, preventing pressure ulcers is everybody’s responsibility!

The Safer Surgery Checklist
Lessons Learned in the Division of Saint Mary’s

Key Facts:
A patient had been consented for a hysterectomy (removal of the womb). It was agreed that the woman’s ovaries should be left in place, however, during the operation it was realised that the right ovary had been removed in error.

This incident falls under the category of a ‘Never Event’ which is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.

The patient was informed of the event on the first post-operative day and an apology was given. The patient was reassured that she would not suffer any adverse effects as her left ovary had been left in place.

Key Contributory Factors:
• The surgeon undertaking a very familiar procedure in a very familiar environment had entered into ‘automatic practice mode’.
• Team members in theatre are often focussed specifically upon the task that they have responsibility for and don’t consider ‘the overall picture’.
• Knowledge and experience of teams is not always such that they could recognise wrong site surgery is occurring.

There are differences in practice with regards to allocation of checklist co-ordinators at ‘time out’ and ‘sign out’ stages.

• Members of the multi-disciplinary theatre team can alter through the course of a surgical procedure.
• The 2011 audit in the Saint Mary’s Division demonstrated poor compliance with the Safe Site Surgery Checklist (SSCL) process.
• The Safe Site Surgery Checklist is not included in the gynaecology integrated care pathway documents, which has resulted in staff losing sight of the SSCL and failing to remember or noticing that such documentation requires completion.
Lessons Learned

- Particularly in a situation like the one described above, there is much more onus on the lead surgeon to conduct the ‘time out’ stage of the SSCL process.
- All members of the theatre team must be fully attentive and involved in the SSCL process.
- Greater emphasis is required to ensure teaching during surgical procedures. This may reduce the risk of lead surgeons entering into automatic practice mode.
- Awareness of this incident will be raised across the theatre team, reiterating the importance of completion of the SSCL.
- Spot checks of SSCL processes and documentation will be initiated.
- Local ongoing SSCL documentation monitoring to be set up with mechanisms for feedback.
- The possibility of re-attaching an ovary removed in error will be investigated with the transplant team.
- The pre-operative checklist will be reviewed to enable the step of reconfirming consent with the patient to be documented more clearly.
- The integrated care pathway documentation will be updated to ensure the SSCL is included in the relevant booklets.
- The ‘Never Events’ listing by the National Patient Safety Agency will be widely circulated across the Division of Saint Mary’s.
- Feedback monthly results widely, identifying any recurrent noncompliance.
- Making of local video for training purposes- ‘How to complete the checklist’.
- Named leads within theatre to support and drive continuous improvements in line with TPOT programme.
- Utilisation of quarterly theatre education board.
- Continue local auditing to monitor further improvements and target further actions when needed.

Introduction

To detect the deteriorating patient, clinical acumen and the assessment skills of the clinicians are vital. To support this recognition the Early Warning Scoring System (EWS) was developed by Morgan et al in 1997 with the aim of providing a simple scoring system which could be readily applied by nurses and doctors to help identify patients developing critical illness. The use of such early warning tools has been recommended in the National Institute in Clinical Excellence (NICE) Clinical guidance “Acutely ill hospital patient”, suggesting these tools enhance, equity in care by ensuring timely recognition of all patients with potential or established critical illness. This will:

- Minimise risk;
- Ensure appropriate personnel respond dependant on the patients level of risk of deterioration ;
- Ensure complete and accurate communication and documentation of changes in
clinical parameters and interventions on the ward, department or unit;

**What have we done to improve recognition and response?**

Within Central Manchester University NHS Foundation Trust (CMFT) the EWS has been introduced in acute areas since 2000 and used with varying levels of effectiveness since its inception. With the progression in technology it has been recognised there are even safer and more effective ways to apply the results of observations, reduce inaccurate assessment of EWS and more efficiently summon the appropriate level of assistance. As a Trust we have increased compliance with EWS policy through:

- Implementation of a bedside observation recognition alerting system (BORAS). This system allows observations to be inputted electronically and accurately works out the EWS; the wireless system automatically bleeps the correct nursing or medical personnel and will continue to do so escalating until the response has been undertaken. This means that in clinical areas where the system has been implemented, accuracy of calculation is 100% and that the level of response is more closely mirroring the EWS policy.
- Clinical mandatory training of EWS for all clinical staff run on a weekly basis
- Added the EWS policy to all acute care courses
- Updated the Acute Care website with learning resources
- Added EWS to the monthly Quality Care Round
- Increased the acute illness management courses for junior doctors and all registered nurses
- Acute Care Study Day for all Senior nurses
- Created MACC (Manchester Acute Care Course) for surgical and gynaecological trainees
- IMPACT for all medical doctors
- Acute care training in the wards
- Simulation
- Communication of good and improving practice
- Dissemination of shortfalls through the Governance structure

**EWS Policy Standards – What have we achieved?**

The EWS policy is audited utilising a number of methods. Data is collected using the Patientrack (BORAS) system which provides reports on a monthly basis to divisions and an annual more in depth report has just been performed. For each standard the combined results are as follows:

**A. Adult inpatients will have an accurate EWS calculated.**

**Chart 1. Accuracy of EWS calculation**
B. The response to an EWS 3 shall be as set out in the EWS policy
Table 1 Appropriate response

C. Documentation of nursing and medical response is as set out in the EWS policy
Table 2 Documentation

Where do we need to improve?
D. The frequency of observations shall be as set out in the EWS policy
Chart 2- patienttrack data on observation timeliness

To assist in the early recognition of deteriorating patients, an arterial blood gas is required within the medium and high risk groups of patients.

Table 3 Arterial blood gas taken as per policy
Compliance with requirement for arterial blood gases (ABG) was better in ED than trust wide. In response to this poor compliance there has been a review of the EWS policy examining the appropriateness of ABGs in certain patient groups, such as haematology patients and amendments have been made to the policy to reflect this.

Conclusions
The recent EWS audit has demonstrated some clear improvements in the accurate monitoring, recognition and response to acute illness utilising the EWS. A marked improvement of documentation has also been seen. The acute care training that has been implemented in conjunction to the roll out of the BORAS system appears to improve adherence to the policy. The adherence to the policy is key but we also need to ensure that the responder has the correct competencies and training to ensure that the patient does get the right treatment, at the right time, by the right individual, to improve the patient outcome.

Patient Confidentiality
Following an incident whereby an unencrypted memory stick was lost and a recent concern raised by a member of the public, may we take this opportunity to remind all colleagues about the importance of patient confidentiality.

- Please do not discuss patient related information in public areas such as the Trust cafes and dining areas.
- Please do not take patient information out of the clinical area unless appropriate (such as on community visits). If information is transported it should be stored securely and not left in cars or reviewed on public transport or in public areas such as cafes.
- Please take care when discussing patients in ward or other clinical areas where other patients or the public may overhear.
Clinical Audit and Risk Management Fair

This year was the 8th Clinical Audit and Risk Management Fair [CARM] took place on the 11th & 12th April 2011. This was a great success with over 450 staff attending from all Divisions across the Trust.

The first day of the Fair gave a chance for all staff to drop in and view posters and displays. The 110 Posters submitted by all groups of staff highlighted the wide range of patient safety and clinical effectiveness initiatives being undertaken across the Trust and were entered into the prestigious CARM Fair poster competition to be judged on clarity, visual communication of topic, creativity and also whether the project generated a significant improvement in patient care and safety.

Winning posters:

1st Prize: (Nursing): ‘Reducing pressure ulcers one year on’
(Please see article about progress made in this area in this edition)

2nd Prize: (Dental Division): ‘A first class service’

3rd Prize: (CSS Division): ‘Working together to reduce cardiac and respiratory arrests in CMFT one year on’

Most Popular Poster: (Children’s Division): ‘Listening to children and young people with juvenile idiopathic arthritis and their families’

Copies of all posters and the presentations from the second day can be seen on the Clinical Audit Website via Staff net.

Interested in submitting a poster for the 2012 CARM Fair to be held on Monday 16th & Tuesday 17th April 2012?
Contact: Clinical Audit Department - 276 4172 or Risk Management Department - 276 5144

Learning Lessons from High Level Investigations

Learning from incidents continues to go from strength to strength in the Trust and we thank all colleagues for their participation, whether it is reporting incidents or helping with some of the detailed and complex investigations undertaken.

Earlier in the year some concerns had been raised with regard to the role of the Chair of a Root Cause Analysis (RCA) and the requirement to present these reports at Inquest hearings. In July the Clinical Effectiveness Team and the Medical Director met with Mr Meadows, HM Coroner, to discuss the process and how these reports are presented in his Court. He was extremely complimentary about both the process of investigation and the open and transparent way we communicate with families when things have gone wrong. He was also very clear that the role of the Clinician presenting the report was one of a Trust representative and not ‘expert witness’.

The Clinical Effectiveness team will be producing some guidance information for senior staff who may need to present these reports in the future.
Incident Reporting Training in the Community

As part of the Government’s Transforming Community Services (TCS) programme, on 1st April 2011 around 1,400 members of staff and their services transferred to CMFT. The aim of the TCS programme is to provide greater effectiveness and efficiencies in the community so that they can continue to provide a modern personalised and responsive care of a consistently high standard. It also provides a unique opportunity for increasing joint working between the hospital and the community setting.

Our community services include Adult Services (eg District Nursing and Intermediate Care) for the central Manchester area, Specialist Services including Contraception and Sexual Health, Community Dentistry, Learning Disabilities and Children’s Services for the whole of Manchester.

The community services work within a different complex and diverse environment with many distinctive challenges. During the transfer process the community services harmonised with the CMFT incident reporting system. Using the incident reporting system we can analyse the issues raised within these services. Since the transfer over 300 incidents have been reported from community. Table 1 demonstrates the top 5 causes of incidents, and compares them to the top 5 incidents causes reported in CMFT hospital setting.

Table 1 shows that in both settings medication errors are the highest reported incidents this demonstrates a good patient safety and reporting culture for these errors. There are various work streams on going in both areas as well as across the Division and Trust to decrease the occurrences.

Table 1 also demonstrates the other challenges the community face with physical abuse and risks associated with treating people in their own homes. To lessen the extent of these there have been various initiatives highlighted such as Safeguarding training (including the Mental Health Act and Deprivation of Liberty) and Conflict Resolution Training. Also discharge is a high reported issue, with a large number of these incidents originating from the hospital setting, further process mapping in to the issue is required. There is an opportunity, now that ‘Community’ has joined us, to develop a more seamless transfer of care between the ‘Acute’ and ‘Community’ service.

In Graph 1 below, we can also look at the severity levels which the community incidents have been validated. Over 64% of the incidents reported have been of level 1. low severity score and there has been one severity 4. major near miss incident reported, which was regarding a discharge from hospital to the community setting involving communication issues. This incident has had a high level investigation completed and an action plan is currently being implemented including developing an electronic single consolidated district nurse referral form from the discharge summary. Following implementation of the action plan, the likelihood of the incident occurring again will be greatly reduced.