CARDIFF AND VALE UHB

Patient Safety & Quality

7th Edition
Autumn2020

NEWSLETTER

@CV_UHBSafety

Between August and October 2020...

66 people attended our virtual Quality, Safety and Experience workshop held in September !

TOTAL NUMBER OF PATIENT SAFETY INCIDENTS REPORTED: **4754**

SIs CLOSED WITH WG

34

NATIONAL CLINICAL AUDITS PUBLISHED

NUMBER OF SERIOUS INCIDENTS REPORTED TO WG - 53

NUMBER OF NEVER EVENTS REPORTED TO WG - 1

3 WELSH GOVERNMENT PATIENT SAFETY NOTICES ISSUED

PSN054 Risk of death from unintended administration of sodium nitrite

PSN055 Safe storage of medicines: cupboards

PSN056 Foreign body aspiration during intubation

NICE National Institute for Health and Care Excellence

35 PIECES OF NEW AND UPDATED NICE GUIDANCE

6 INTERNAL PATIENT SAFETY NOTICES ISSUED

ISN2020006 Paediatric tracheostomy ties

ISN2020007 T34 Syringe driver

ISN2020008 Tissue damage from plaster cast saws

ISN2020009 Expired blood-tubes

ISN2020010 Wrong route admin of Controlled Drug

34 staff members attended Datix training

World Patient Safety Day 2020

The 17th September 2020 was the second World Patient Safety Day and 194 World Health Organisation members were invited to participate.

The COVID-19 pandemic has unveiled the huge challenges and risks that health workers are facing globally including health care associated infections, violence, stigma, psychological and emotional disturbances, illness and even death. Furthermore, working in stressful environments makes health workers more prone to errors which can lead to patient harm.

In light of this, the World Patient Safety Day 2020 theme was 'Health Worker Safety: A Priority for Patient Safety.'

To mark the day in Cardiff and Vale UHB we held an executive -led virtual workshop to start developing the next 5 year framework for patient safety and quality improvement.

Seven virtual groups each discussed one of the seven proposed pillars of the new framework that make up **The patient-safe future: a blueprint for action**. These are:

- Organisational Safety Culture
- Leadership and the prioritisation of quality, safety and experience
- Patient experience and involvement in quality, safety and experience
- Patient safety learning and communication
- Staff engagement and involvement in safety, quality and experience
- Patient safety, quality and experience data and insight
- Professionalism of patient safety, quality and experience

We were delighted to be joined by Professor Paul Bowie (Programme Director, Safety & Improvement) from NHS Education for Scotland, who taught us more about the attributes of a safe organisation. He reminded us that in the complexities of healthcare we can't achieve zero harm. In order to do this we must report more of our incidents, near misses and concerns yet it is estimated that only about 10% are formally reported. We must develop a positive culture where we are open and honest to enable learning from failure.

Our own Professor Jonathon Gray, Director of Transformation, presented a session on Obstacles and solutions to realising our full QSEI potential. He said we must see things through patients' perspectives, have strong leadership, bold ambition and optimism. We must measure and learn in a vibrant sharing network.

Throughout the day the Patient Safety Team facilitated a schedule of short presentations keeping to the theme of health worker safety followed by Q&A on Microsoft Teams. The wide variety of topics presented can be found **here**.

Thanks to Radio Glamorgan and Rookwood Sound who interviewed Head of Patient Safety Maria Roberts, we were able to spread the word across the radio waves about the meaning of World Patient Safety Day for both patients and staff.

A World Patient Safety Day intranet page was developed which has some useful resources related to patient safety and staff wellbeing which can be found through the link below.

Cardiff and Vale of Glamorgan Councils celebrated with us by lighting up some buildings, including the City Hall in Cardiff, in orange which is the WHO campaign colour.

Finally, we held a competition inviting staff to tell us how they have enhanced the safety of patients and health workers during the Covid-19 pandemic. The quality of the entries was strong and described some superb work. The winning entry was from the **Immunology and Allergy Team** submitted by **Emily Carne, Lead Nurse,** and the multidisciplinary team will receive a prize of £75. The team transformed both the treatment and service delivery for patients receiving immunoglobulin therapy.

We will be holding a quarterly competition which will be announced very soon. Make sure you follow us on our Twitter feed to find out more– **@CV_UHBSafety**

See our Intranet page for our full

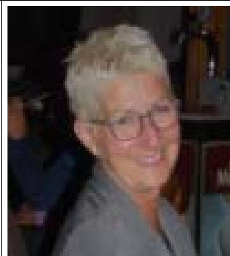
STAFF NEWS

Hello...

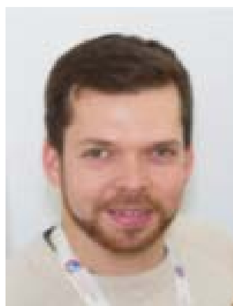
We would like to introduce you to the UHB's new Assistant Medical Director for Patient Safety and Clinical Governance, Dr Raj Krishnan. Raj was appointed to his new role earlier this year following the retirement of Dr Tony Turley.

Dr Krishnan is a Consultant Paediatric Nephrologist. He was the Deputy Clinical Director for Acute Child Health and had a key role in improving patient safety and quality in the Children and Women's Clinical Board before taking up the AMD post.

Welcome Raj! We are looking forward to working with you.



Congratulations to Ann Jones and Matthew McCarthy who will job share the new role of Patient Safety (Learning and Improvement) Manager. They will work flexibly with a wide range of stakeholders to support individuals and teams across the breadth and depth of the Health Board to design and deliver effective solutions for other quality and safety priorities, providing training and development to others where necessary.



We are delighted to welcome Angharad Oyler to the team as our new Head of Patient Safety and Quality Assurance.

Angharad is both a registered midwife and nurse who will bring a considerable wealth of experience to this key role.

Mr James Ansell from the Surgical Services Clinical Board has been appointed as the new chair of the NatSSIPs group.

The UHB launched the Major Trauma Centre (MTC) in September. Two key roles were created to help provide data input to the Trauma Audit Research Network (TARN). Carlos Loureiro and Vaughan Owens, were successfully appointed into these roles. The post requires energetic and motivated individuals with an eye for detail, medical terminology and excellent analytical skills as they are expected to extract clinical data from patient notes and other hospital databases, to enable them to complete data submissions to the TARN body. This data will then be analysed and benchmarked for the sole purpose of improving the care of severely injured patients. The Clinical Audit department warmly welcomes the two new recruits! It is a great opportunity for Carlos, Vaughan and the Major Trauma service to take forwards this important work.

...and Goodbye!

Alex Scott, Head of Patient Safety and Quality Assurance secured the post of Assistant Director of Patient Quality and Safety in Aneurin Bevan Health Board and started her new post in May 2020.

Alex was a huge asset to our team, and was responsible for taking forward many great pieces of work during her time with us including production of the Annual Quality Statement, improved systems and processes for local and National Audit, NCEPOD and NICE as well as the development of a QSE (Quality, Safety & Experience) dashboard – to name just a few. She was part of the UHB team that secured Health Foundation Funding for an Advancing Applied Analytics project - harnessing data analytics to maximise NHS learning from patient safety incident reports. She also worked with the Blood Transfusion Team on a project to reduce the risk of 'Wrong Blood in Tube' incidents which is likely to lead to patient safety improvement across Wales.

Although we were very sorry to see her go, we are delighted for her in her success and wish her the very best of luck in her new role. Thanks for everything Alex!

Annual Quality Statement

The UHB Annual Quality Statement (AQS) was published in September. It describes the successes and challenges that we have experienced in 2019 / 2020. The AQS is an opportunity for the Health Board to demonstrate in an open and honest way how it is performing and the progress that is being made to ensure that all of the services that we provide meet the high standards required. The AQS has been set out under each of the health and care standards, each one underpinning the quality and safety of the care that we deliver. The overarching theme this year is community mental health and we would like to thank all our staff and service users for their contribution to the document.

Medical Examiner Role

There are expected to be many benefits to the introduction of Medical Examiners. All deaths will be independently assessed to generate learning and bereaved families will have the opportunity to discuss their experiences of the care and treatment provided. Custom and practice around death certification will be standardised and there should be a reduction of queries to the Coroner's office regarding death certification.

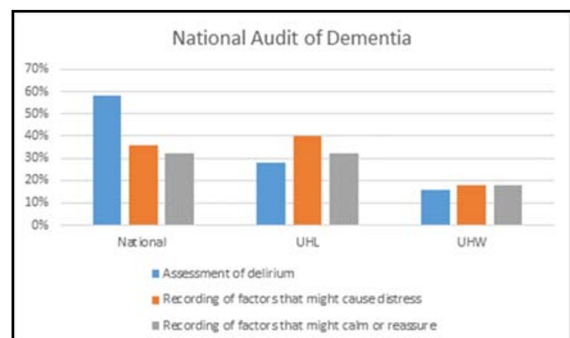
4 hub sites have already been established across Wales. 28 Medical Examiners have been appointed (4 WTE) along with 16 Medical Examiner Officers to develop processes and share learning. More will be recruited in January with the aim of being fully operational by April 2021. You can access the website of the Medical Examiner Office here.

National Audit of Care at the End of Life (NACEL)

Care at the end of life affects everyone. The NACEL audit was established to review the quality and outcomes of care experienced by patients reaching the end of life and those important to them. The audit measures a number of factors including how we involve the patient and their families in decision making . The Health Board participated in the 2019/20 audit and these performance scores below demonstrate that the care provided was in line with or exceeded national benchmarks.

The National Audit of Dementia

The national audit of dementia care in general hospitals examines aspects of care received by patients with dementia when cared for as inpatients in general hospitals in England and Wales. Recent studies demonstrate that up to 42% of people over 70 who have an unplanned hospital admission have dementia. Previous rounds of the audit have demonstrated the need for improvements in a number of areas including in relation to assessing and recording of delirium and collection of personal information about the persons with dementia's care need. The audit demonstrated that within the UHB there was variation in compliance with both of these components of care between UHL and UHW. This fits with the results of local audits that demonstrated that only half of patients with either dementia or cognitive decline have the "Read about Me" proforma completed. There will be changes in the way that the audit is run in 2020 /21 with case notes being audited prospectively throughout the year which will support ongoing quality improvement around care delivery.



Mortality Review Group

A Mortality Review Group has been established for several reasons:

1. To facilitate the introduction of the Medical Examiner, Medical Examiner Officer and associated roles to enable all patients who die in hospital to have an accurate cause of death recorded on the certificate and an independent review of treatment and care leading up to the death. This will be expanded to primary care deaths as the Medical Examiner role expands.
2. To strengthen the processes for recording, measuring and reporting mortality rates and closely monitor these.
3. To establish robust processes that support clinical teams to do level two reviews on patients referred to them via the pathologist or Medical Examiner in the long term.
4. To generate and support an ongoing system of learning and improvement as a result of the mortality reviews.
5. To become the forum for holding clinical boards to account for sharing learning from level 2 reviews.
6. To provide membership to the All-Wales steering group.

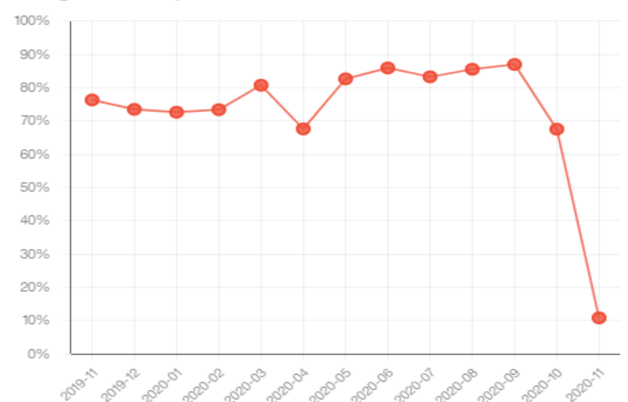
A new dashboard has been developed to provide data for the steering group and further support learning from deaths. All clinical boards and directorates should have access to the dashboard which can drill down to individual patients.

An example from the dashboard below shows the

% stage 1 mortality reviews completed. **Note:** the data is incomplete for November 2020.

For more information contact Joy.Whitlock@wales.nhs.uk

A Learning from Deaths policy and procedure will be published on the intranet for consultation in the near future.



Advancing Applied Analytics

A successful application to The Health Foundation

We wanted to learn from errors and adverse events in healthcare through patient safety incident reporting but a major criticism is that the NHS collects too much data and does too little with it.

To address this, an application to the Health Foundation was made to deliver a research project entitled 'Harnessing Data Analytics to Maximise NHS Learning from Patient Safety Incident Reports'.

The pilot site is the Acute Child Health Directorate. Key achievements of this project include the development of a patient safety dashboard in the Business Intelligence System (BIS) that will enable staff to access high level data from multiple sources to inform Quality Improvement (QI) projects. E-learning modules have been developed to support staff in QI using the BIS dashboard, and several standard operating procedures.

Two groups of junior doctors supported the development of the project and resources. As a result, they worked on two data-driven QI projects – medication errors and communication at handovers. A second workshop for the Acute Child Health Directorate was held recently to update them on progress.

The project, in conjunction with Dr Andrew Carson-Stevens from Cardiff University and Professor Sir Liam Donaldson from the London School of Hygiene and Tropical Medicine is led within the UHB by Matt McCarthy. Matt will be starting the roll out of the project as part of his new role in the Patient Safety Team. You can find out more at the Clinical Senate meeting on 11th December 2020 when Matt will be presenting the project or you can contact Matt for more information by email- Matthew.Mccarthy@wales.nhs.uk

Investigating COVID-19 Deaths

Coronavirus is a topic on everyone's lips at the moment. Safety and Quality has never been more important. Here in the Patient Safety team we are engaging in an all Wales approach to investigate the transmission of the virus within the healthcare setting. This includes being involved in the development of a Staff and a Patient Investigation Toolkit. The all Wales approach has been designed to provide a unified investigation into the current pandemic, with a goal of sharing learning and developing strategic improvement plans. Currently we are working to undertake a systematic review of our cases and developing an investigation plan with a timeframe.

Thank you to Karen Lewis, Claims Manager and the Health and Safety Department for their valuable support in this piece of work.

If you would like more information or to discuss this process please don't hesitate to get in contact via the generic Patient Safety Team email address or by contacting Carla.English@wales.nhs.uk

Healthcare Inspectorate Wales (HIW) Update

HIW stepped down their usual inspection programme at the start of the outbreak of Covid-19 maintaining a scaled down service of assurance and inspection. They are piloting a different approach to their work which will allow them to deploy their workforce in a more agile way. A key feature of the new approach will be the use of a three tiered model of assurance and inspection that reduces the reliance on onsite inspection activity as the primary method of gaining assurance. This will include;

Tier 1 activity which will be conducted entirely offsite and focus upon Covid-19 arrangements, Environment, I, P&C and Governance

Tier 2 will introduce a combination of offsite and limited onsite activity,

Tier 3 will represent a more traditional onsite inspection.

HIW have carried out 3 Tier 1 reviews since September 2020;

East 3 and 4 ,UHL and Morgannwg ward ,Barry hospital

Tier 1 reviews were carried out on 7/10/20 and 22/09/20 respectively on these wards. The reviews were extremely positive and no areas for improvement were identified.

T4 Neurosurgical HDU

A Tier 1 review was carried on 30/09/20 which overall was very positive. Two areas for improvement were identified by HIW however. The first was relating to a longstanding water leakage on the ward resulting in bed capacity being reduced. HIW also identified that the ward had not had an IP&C audit carried out since September 2019. The clinical board have developed a robust improvement plan which HIW have accepted.

Prior to the Covid-19 pandemic HIW carried out a number of on- site inspections including the following;

National Maternity Review

HIW published an all Wales report on phase 1 of the review on 19th November 2020 which you can read here.

As a part of phase 2 of the review the UHB has undertaken a self- assessment of maternity services and a number of interviews were conducted with key Executive and senior staff to look at how organizational governance arrangements promote safe and effective care.

Unannounced inspections-Between January and March 2020 three unannounced inspections took place:

Sam Davies Ward, Barry Hospital- HIW found overall that the ward provided a very good environment to support the care and treatment of the patients. You can read the published report here

Hafan Y Coed- Elm and Maple wards- Overall, HIW found a dedicated staff team that were committed to providing a high standard of care to patients. However, an immediate assurance was issued relating to the sleeping out policy and mandatory training compliance. You can read the published report here

Emergency Unit/Assessment Unit follow up inspection

A follow up inspection took place of the Emergency and Assessment units at UHW in March 2020. HIW reported positively on the Medicine Clinical Board (MCB) efforts in successfully addressing a number of the actions in the improvement plan. However, HIW did issue an immediate assurance at the re-inspection due to finding 6 patients not wearing patient identification bands. You can read the published report here

Please take the time to read individual HIW reports and check whether you are meeting the required standards in your own clinical area.

Pressure Damage Reporting

#StopThe Pressure

It is now possible on Datix to differentiate between pressure damage incidents and moisture lesions.

1.3 Please Help Us By CATEGORISING The Incident

Examples of categories for the most commonly reported incidents can be found by **Clicking Here**

* Who was Primarily Affected?	Patient Incidents: PI
* Incident Type Tier 1	Pressure Ulcers/Moisture Lesions: PR0000
* Incident Type Tier 2	
* Incident Type Tier 3	
* Does this Incident need to be Reported to: • **WG as a Serious Incident or Never Event** • **HSE as a RIDDOR** • **or an IR(ME)R?** Please refer to ? for more detailed information	

1.3a Pressure Damage/Moisture Lesion(s)

* Pressure Damage/Moisture Lesion(s) Classification Please ensure that these accurately reflect the 'All Wales Pressure Ulcer guidance' Please refer to Help for more detailed information. or view the:- 'All Wales Pressure Ulcer Reporting and Investigation' guidance 'UHB Pressure Ulcer Risk Assessment' procedure	Moisture Lesion(s): PUMOIS Grade 1: Non-Blanchable redness of intact skin: PUGRD1 Grade 2: Partial thickness skin loss or blister: PUGRD2 Grade 3: Full thickness skin loss (fat visible): PUGRD3 Grade 4: Full thickness skin loss (muscle/bone visible): PUGRD4 Suspected Deep Tissue Injury (SDTI)-depth unknown: PUSDTI Unstageable/Unclassified: PUUNST
* Did the Pressure Damage/Moisture Lesion(s) develop/deteriorate in C&V funded care?	Moisture Lesion(s): PUMOIS

Attachment details

* Link as	
* Description	Action/Improvement Plan: ACTION Alert/Notice: ALERT
* Attach this file	All Wales Review Tool for Pressure Damage Investigation: ALLPU E_Mail: EMAIL

Line managers can also now specify when they are uploading the All Wales Pressure Damage Investigation Tool to Datix. It helps us to search for these documents to ensure they are being completed.

Electronic Testing

The UHB is implementing the Welsh Clinical Portal (WCP) which will supersede the Cardiff Clinical Portal. The WCP has an electronic test requesting module (eTR). There are very significant advantages to using eTR but handwritten test requests continue to be sent to Laboratory Medicine. If you would like to discuss this project further, please contact **Wcp.ProjectCAV@Wales.nhs.uk**

Clinical Risk Management

Electronic requesting (e-TR) is the safest method of requesting Pathology tests on your patient. ***Get it 'RIGHT FIRST TIME'.***

Problems with paper Pathology requests

Unknown / illegible requestor
Who is responsible for following up the patients test results?
Results / notifications may never go back to the correct clinician.

Missing or illegible clinical details

Missing or illegible contact details
Unable to communicate urgent results or discuss investigations with the right person.

NHS No:
Unit No:
Name:
Address:
D.O.B: Sex: M / F
Location:
Consultant: (Surname + Initials)
Clinical Details
Requester's Details
Name:
Contact Details Pager / Tel No:

Lab Use Only
Specimen Type (e.g. Blood/Urine/Faeces
Emergency (call to Biochemistry lab required)
Test Requests (Only one test group per box)
1. 6.
2. 7.
3. 8.
4. 9.
5. 10.
Collection Information
I confirm that I have positively identified this patient by checking that all relevant details match before taking the sample.
Date: Time:
Print Name:

Datix Incidents
Patient not identified properly.
Specimen / request form patient mis-match.

Wrong or insufficient number of samples taken

Surplus Samples taken

Illegible Test Requests
- Important tests missed
- Wrong tests requested
- Poorly legible forms slow the process

Complies with Right First Time Policy

- ✓ Decreases DATIX incidents
- ✓ 100% identification of the patient
- ✓ 100% identification of requestor
- ✓ 100% Clinical details required
- ✓ Lab has requestor details to communicate urgent results and discuss investigations

Quality use of pathology

- ✓ Legible requests
- ✓ No laboratory transcription errors resulting in missing or wrong tests
- ✓ Improved turn around time
- ✓ Specimen types/number of specimens are specified
- ✓ Eliminates the risk of surplus or wrong specimens
- ✓ In progress message
- ✓ View previous result before you order the next test
- ✓ Reduces duplicate / unnecessary testing
- ✓ Demand management (test rejection due to repeat period) in hands of requestor
- ✓ Bespoke test profiles available
- ✓ Bulk Requesting available

Mental Capacity

An interesting and sad case about the great importance of making timely decisions under Mental Capacity Act 2005 - **Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospital NHS Trust and H.**

In this case, the patient had a growth on her face. She had been assessed to lack mental capacity to make decisions about treatment for the growth in May 2019, but it was not until 20th December 2019 that an application was made to Court about her treatment. Whilst she appeared to be compliant, in fact she did not turn up for appointments made to carry out the surgery.

The Judge, Mr Justice Hayden, had this to say –

I have now, in a number of judgments, emphasised that whilst avoidance of delay is not incorporated into the framework of the Mental Capacity Act in specific terms, it is to be read into that Act as a facet of Article 6 and Article 8. It is self-evident and, indeed, striking, that time here was of the essence and delay was likely to be inimical to Mrs H's welfare. Not only inimical but as it has transpired, potentially fatal.

There is also some **Practice Guidance**, about when decisions re. medical treatment should be referred to Court. Please note particularly –

… an application to court may also be required where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and the restraint may go beyond the parameters set out in sections 5 and 6 Mental Capacity Act 2005. In such a case, the restraint will amount to a deprivation of the person's liberty and thus constitute a deprivation of liberty.[6] The authority of the court will be required to make this deprivation of liberty lawful.

A key learning point to remember is that if patients who lack the mental capacity to consent to/refuse treatment are likely to need significant restraint (including anaesthesia) for the treatment to be carried out, it is most important that legal advice is sought.

Consent

The revised **All-Wales Consent to Treatment or Examination Policy** has been published and disseminated widely. Consent training is available for anyone who feels they need a refresher – particularly re. Montgomery and Mental Capacity Act issues. Please see the **LED Training Prospectus**, page 63. We actively encourage staff to ensure they've had a recent update on consent.

The GMC has released updated consent guidance, which comes into force on 9th November 2020. The guidance can be found here .

The GMC says – "Our guidance will support doctors to practise shared decision making and help their patients to make healthcare decisions that are right for them."

Please do take the time to read and follow this guidance, as the GMC states that "***Serious or persistent failure to follow this guidance will put your registration at risk. You must, therefore, be prepared to explain and justify your actions."***

On 6/11/20 NWSSP Legal and Risk Services hosted a consent webinar with a barrister from 2 Temple Gardens. The recorded session will be uploaded to YouTube in due course. It's well worth an hour of your time!

If you have any queries about this guidance, or consent in general, please do not hesitate the contact the UHB's Consent Lead – Julia Barrell, MCA Manager, by email to Julia.Barrell@wales.nhs.uk

Coroner's Regulation 28 Prevention of Future Deaths Reports

In February 2020 the Coroner wrote to the UHB following the tragic death of an infant from meningococcal disease. The Coroner raised concern that there were multiple missed opportunities in the treatment of the infant. He highlighted a failure to treat the infant with antibiotics at an early stage which significantly contributed to his death.

The Coroner made a number of recommendations and the Health Board has put in place a number of improvements to address the learning from this very sad case.

In the Autumn of 2019, the UHB responded to the Coroner following an earlier Regulation 28 report. The inquest involved the death of a patient under the care of Mental Health services. The patient was receiving Clozapine treatment when he suffered an atypical early onset of coronary artery atherosclerosis while taking a large number of prescribed complex medications. The Coroner highlighted use of the Yellow Card Scheme to report side effects to medicines; the need for appropriate review by suitably qualified persons when patients are on multiple medications; the importance of de-prescribing where appropriate and ensuring communication and drug monitoring procedures between primary and secondary care.

In response to the Coroner, the UHB made reference to resources on the All Wales Medicines Strategy Group website. It contains very useful information and can be accessed here: **www.awmsg.org**. You can also learn about the Yellow Card Scheme by visiting **www.yellowcard.mhra.gov.uk**

TALK: A Clinical Debriefing Tool

www.talkdebrief.org @TALKdebriefing

WHAT IS TALK?

- The World Health Organisation (2009) promoted clinical debriefing to aid team communication and reflection.
- Debriefing is the process of formally reflecting on performance after a particular task, shift or critical event.
- Following a thorough literature search, a team of doctors led by Dr Cristina Diaz-Navarro, Consultant Anaesthetist, developed the TALK framework in 2014 as they found no widely applicable tool to guide structured team self-debriefing.

TALK values

TALK is underpinned by several core values.

- **Positivity:**
- Identify positive strategies and behaviours. Avoid negative comments; choose neutral expressions.
- **Focus on finding solutions**, rather than pointing out blame.
- **Professional communication**, valuing everybody's input.
- **Step by step**: identify small objectives and follow up outcomes.

TALK research

- TALK is financially supported by:
- European Commission Horizon 2020 funding programme
- Marie Skłodowska-Curie Actions
- Research and Innovation Staff Exchange (RISE) grant.

◊ TALK is a 3 year research programme that commenced in 2017.
◊ The research is assessing the international impact of TALK.
◊ The funding programme promotes international collaboration to turn creative ideas into innovative processes.

TALK international community

- Horizon 2020 encourages international collaboration and cultural exchange.
- Cardiff, Barcelona and Stavanger, Norway have collaborated in the research and participated in exchange programmes for staff.
- There have been opportunities for the authors to experience working in the healthcare systems of the collaborating countries.
- Other countries are also showing an interest in TALK including Australia, Denmark, Morocco, Portugal, Sweden and USA.
- The authors have contributed to developing TALK training materials for international presentations and for the TALK website.

T	**Tell: Share your perspective on a clinical situation.** **Target: Agree on what is important to discuss.** • How do you see the situation? • What shall we discuss to improve patient care?
A	**Analysis: Let's focus on specific points.** Explore as appropriate 1. What helped or hindered: • Communication? • Decision-making? • Situational awareness? • Efficiency? 2. The way forward: • How can we repeat successful performance? • How can we improve?
L	**Learning points.** • What can the team learn from the experience?
K	**Key actions.** • Let's find solutions and agree on responsibilities. • What can we do to improve and maintain patient safety?

Andrea Davies-Tuthill, (Perioperative) and Debbie Hendrickson, (Resuscitation) were filmed for an educational video when they visited Barcelona as part of the research project.

Arsenia Davies (Perioperative) spent time observing simulation education in Barcelona.

Dr Tom Cromarty, Paediatric trainee, was scheduled to present a poster about TALK at the prestigious IHI/BMJ International Forum on Quality and Safety in Copenhagen in May 2020 which was unfortunately cancelled due to Coronavirus.

Maria Roberts, Head of Patient Safety, spent time in Stavanger University Hospital in Norway in 2019 and prior to lockdown, midwife Chelsea Thomas Hamblin returned from the first of her planned visits to Stavanger! They have been able to observe the approach to implementing the TALK debriefing tool in Stavanger University Hospital. Chelsea wrote a blog when she was there which you can read at www.offexploring.com/chelseamth

Next steps for TALK in Cardiff and Vale UHB

The intention is to establish a TALK network across the UHB, ensuring use of the tool beyond the clinical areas participating in the initial research.

Once For Wales Concern Management

We told you in the previous edition of our newsletter about the project underway in NHS Wales to implement new RL Datix software to manage concerns. This includes complaints, incident reporting, and claims amongst other areas.

We have formed our own project board to manage this process and more communication will follow soon.

In preparation for the new system, it is critical that managers update and close incidents in a timely manner on the current Datix system.

Access and training queries for our current system need to be discussed with the Patient Safety Team.

You can keep up to date with the project by visiting the **Once for Wales Concerns Management System website**.

Action Plans On Datix

Audits have continued to identify that there is room for improvement with use of the investigation fields and uploading of action plans to the RL Datix system.

It is fundamental as part of our safety, quality and governance that we have rigorous processes in place to investigate when adverse events have occurred and to ensure we implement the learning as a result.

We also need to be able to demonstrate that we have established procedures to monitor that we are making the changes we committed to do.

The Datix system can help with this! Please speak to the Patient Safety Team if you would like more information on how you can use the system to help you.

Quality Clinic

The department will be re-launching Quality Clinics virtually in the near future.

My concern was taken seriously and it was reassuring to be able to talk about what we can do about it.

The aim of the Quality Clinic is that staff who require information, guidance or signposting around quality and safety issues are able to access the full range of knowledge and skills within the patient safety, clinical audit, and quality improvement teams .

No issue is considered too small!

Dates for forthcoming virtual clinics will be advertised in December. In the mean time, if you want any help or advice please do contact the Patient Safety Team.

I feel encouraged that there are things we can do to address a problem I raised.

Suggested Reading

Suzette Woodward is an internationally respected patient safety expert with a clinical background in paediatric intensive care nursing. She has written two books on patient safety. She is active on Twitter and regularly blogs. She recently wrote a blog about safety myths. **You can read it here.**

Earlier this year we were able to listen to James Coulston, a Vascular Surgeon in NHS England deliver a presentation on Human Factors at the Medical Director's conference. Human Factors is a subject of great interest to the Patient Safety and Quality Department. Indeed, many clinical staff tell us of their interest in it too. You can learn more about Human Factors in the surgical setting in **this open access article**.

Measuring safety and quality of care is regularly debated. **This free to access article** from BMJ Quality & Safety is an interesting read.

Civility Saves Lives includes a humorous but poignant TED talk about the impact of even mild rudeness and its detrimental affect on quality and safety, leading to patient harm and even death.