CARDIFF AND VALE UHB

Patient Safety & Quality NEWSLETTER

8th Edition
Easter/Spring 2021

@CV_UHBSafety

Between November 2020 and February 2021.....

TOTAL NUMBER OF PATIENT SAFETY INCIDENTS REPORTED **6113**

22 **NATIONAL CLINICAL AUDITS PUBLISHED**

NUMBER OF SERIOUS INCIDENTS REPORTED TO WG - 39

NUMBER OF NEVER EVENTS REPORTED TO WG - 2

SIs CLOSED WITH WG **57**

WELSH GOVERNMENT PATIENT SAFETY NOTICES ISSUED

PSN055 Safe Storage of Medicines

PSN056 Foreign Body Aspiration during Ventilation

NICE National Institute for Health and Care Excellence

30 PIECES OF NEW AND UPDATED NICE GUIDANCE REVIEWED AND CONSIDERED

INTERNAL PATIENT SAFETY NOTICES ISSUED

ISN 2020/Nov/010 Wrong Route Administration of Controlled Drug
ISN 2020/Dec/012 SST Gold Top Tubes
ISN 2021/Jan/001 COPAN Swab Batch Recall
ISN 2021/Feb/002 PPE Changes
ISN 2021/Feb/004 Community Blood Sampling
ISN 2021/Feb/006 NG Tubes

87 staff attended Datix training

STAFF NEWS

Hello...

We are delighted to welcome **Tara Cardew** to the team as our Interim Head of Patient Safety and Quality .

Tara was previously Lead Nurse in Specialised Medicine and has considerable experience in patient safety, having worked in roles in emergency nursing and as a resuscitation practitioner.

Tara spent 2 years in the Patient Safety Team as a Patient Safety Facilitator giving her a strong foundation to take on a Senior Nurse role in Specialised Medicine in 2014, and soon progressing to the Lead Nurse role in 2015.

A very warm welcome back Tara, we are very much looking forward to working with you and benefitting from your leadership role within the team!

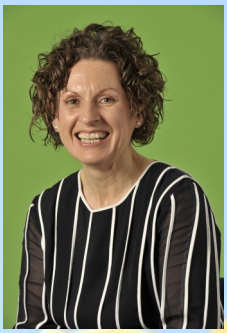
At the beginning of the year we welcomed **Annie Burrin** to the QI arm of the team as Patient Safety and Organisational Learning Manager.

A registered midwife with a strong governance background, Annie was previously a Governance Matron for Maternity and Neonatal Services in England. We are excited to work with Annie who brings a wealth of experience in the management of QI projects and organisational learning. Annie's portfolio within the team includes Falls, Patient Safety Solutions and NatSSIPS. Contact Annie.Burrin@wales.nhs.uk

We are incredibly fortunate to welcome **Carla English** (previously a senior nurse in the Patient Access team) and **Maureen Edgar** (previously Research and Development Manager) to the team. Carla and Maureen are playing a vital role in the investigation of deaths as a result of nosocomial Covid-19 infection. We already have early learning from this work which we have shared further on in the newsletter.

We welcomed two new patient safety facilitators to the team in February. **Tracy Johnson** is seconded 3 days a week from her role as practice development nurse within Trauma and Orthopaedics. Tracy is supporting patient safety within Specialist and Medicine Clinical boards. **Debbie Jones** has joined us for 2 days a week from her role as a midwife sonographer and she is supporting Surgery Clinical Board. We are delighted that Tracy and Debbie have become part of our team– we are certain that they will bring a different perspective to the roles.

...and Goodbye!



We said a fond goodbye (temporarily) to **Maria Roberts**- Head of Patient Safety and Quality in February of this year. Maria has secured a pivotal secondment opportunity within Welsh Government leading on the implementation of the Duty of Quality. Maria has played a huge part in leading the Patient Safety agenda in Cardiff and Vale over several years. She is a very credible and respected individual; patient centred, but supportive to clinicians and kind and respectful to everyone she works with. She is well known for her incredible memory and attention to detail!

She has been involved in numerous important patient safety projects and in recent years has contributed to an international research project, which included fieldwork at Stavanger University Hospital in Norway. She was also instrumental in securing Health Foundation Funding for the recent very successful Advancing Analytics Award.

We will miss Maria very much, however we know she will be an asset within Welsh Government and we wish her well. We look forward to keeping our connections going and ensuring that we are compliant with the new Duty which comes into force in April 2021. Thanks for everything Maria!

We bid a fond farewell to **Julia Barrell** our Mental Capacity Act Manager who retires at the end of the month. Julia has been an incredible source of expertise and experience for several years in her role and we will miss her wise counsel. Congratulations and thanks Julia—its time to take a well earned rest. Now go and do all that you love.

Two longstanding members of our Clinical Audit team are also taking well deserved retirement at the end of March this year.

Alena Ball -a senior clinical audit co-ordinator has dedicated 38 years of her working life to the clinical audit team and was one of the original members of the team. We all wish her much happiness and peace in her retirement. All the best for this new chapter in your life Alena and thank you for your commitment and hard work over the years.

Mick Mcgeogh -a clinical audit coordinator for many years is also finally hanging up his audit boots. After retiring and returning a few years ago, Mick has decided to take full retirement. We know Mick won't be hanging up his running shoes though! No doubt, Mick's retirement will give him more time to follow his passion for running. Good luck Mick and thanks for your contribution to the team.

PATIENT SAFETY

Quality, Safety and Experience (QSE) Framework Update

In our winter newsletter we told you about the virtual Quality, Safety and Experience (QSE) workshop that was held to engage with senior clinicians and managers across the organization. The purpose of the workshop was to start the discussion to identify our QSE priorities for the next 5 years. A total of 66 people attended the workshop for part or all of the day.

Prior to the workshop, a short safety culture survey was sent out to all delegates. They were also provided with some pre-reading material – The Patient Safe Future –a Blueprint for action and Safety Culture Discussion Cards. Themes from the survey and the pre-reading material were identified and facilitated virtual groups which were set up to discuss each theme and feedback to the main virtual room. The key themes identified were:

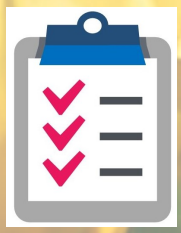
- Organisational Safety Culture
- Leadership and the prioritisation of quality, safety and experience
- Patient experience and involvement in quality, safety and experience
- Patient safety learning and communication
- Staff engagement and involvement in safety, quality and experience
- Patient safety,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

What are the next steps?

Using the 7 themes identified a number of virtual workshops are being planned with the wider UHB audience of clinical and non-clinical staff. A review is being carried out of the current organisation committee and group structures to support QSE, and a first draft of the Quality, Safety and Experience Framework for 2021-2024 will be presented to the April 2021 QSE Committee. You can find the minutes of all QSE committee meetings on the Cardiff and Vale UHB internet pages. All meetings are open to the public, which are currently taking place via Microsoft teams.

Safety Culture Survey

Professor Paul Bowie led a virtual session at a Quality and Safety Framework development day during which culture surveys were debated. Following his advice we have adapted what he felt was the best available. The survey is available in Welsh and English and accessed via Survey Monkey.



The questionnaire is about your experience and views of patient safety. Your views are important and will help us identify patient safety priorities for improvement. The questionnaire should take around 10 minutes to complete. Please click here to access the survey.

Changes to reporting requirements to Welsh Government

Revised arrangements have been put in place for Serious Incident (SI) and No Surprise (NS) reporting channels.

The reporting of SI's at a national level transferred to the NHS Wales Delivery Unit (DU) from 1 October 2020 in line with the Putting Things Right (PTR) guidance. NS notifications will continue to be reported to Welsh Government.

PATIENT SAFETY

Mental Capacity Act/Consent

Older people and those with dementia have been among the early groups to be offered **a coronavirus** vaccine. Deciding whether to have the vaccine or not is a choice for those who are offered it, although some people with dementia will not be able to decide for themselves.
The following case highlights concerns administering the COVID –19 vaccination where the patient lacks the mental capacity to consent to or to refuse the vaccination; there is disagreement about whether the patient should be given the vaccination; and how the patient's best interests were determined.
https://www.bailii.org/ew/cases/EWCOP/2021/7.html

Advice for clinicians when producing Mental Capacity Assessment for Court as well as generally.

Another interesting Court case can be found by following the link below;

https://www.bailii.org/ew/cases/EWCOP/2020/58.html

Paragraph 28 sets out helpful advice when producing mental capacity assessment for Court. This information is also relevant for clinicians when assessing mental capacity generally – i.e. not just for Court.

Please do get in touch with Julia.Barrell@wales.nhs.uk if you have any queries about these.

Once For Wales Concern Management

The new RL Datix Incident Module is planned to go live on 1st July 2021! The C&V Implementation Board has been meeting regularly, with Clinical Board representatives invited.

In preparation for the new system, it **is critical that managers update and close incidents in a timely manner on the current Datix system**. Key Performance Indicators are now being used to monitor the progress being made with incident closures.

Training on the current system will cease after May 2021 to enable us to focus on the preparation of training materials for training sessions for the new RL Datix later in June 2021.

From 1st April onwards we will start going live with other modules that support the corporate teams in their management of complaints, claims, redress cases and inquests. You can keep up to date with the project by visiting the Once for Wales Concerns Management System website.

System Rheoli Pryderon Unwaith dros Gymru
Once for Wales Concerns Management System

RLDatix™

Covid-19 related incidents

The UHB has been working with Cardiff University to undertake a thematic review of Covid –19 related incidents. The results were presented to the Medical Leadership Group last year and have been used to identify learning opportunities.

The work will continue with prospective analysis of all reported incidents during the 3 next months by an Academic GP trainee who will be working with the Patient Safety Team to ensure rapid learning.

All Covid-19 related patient safety incidents are also reported as part of the regular Integrated Quality, Safety and Experience (QSE) report to Board.

Emerging themes from the reviews will be discussed by the UHB Infection, Prevention and Control (IP&C) Cell and in the weekly SI/Concerns meeting

QUALITY ASSURANCE

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report released– TIME MATTERS

'Time Matters'- a review of the care provided to people in hospital following an out-of-hospital cardiac arrest (OHCA) has been released by NCEPOD. The UHB participate in all NCEPOD studies, and although its not possible to drill down to hospital level data, the UHB will benchmark against the recommendations to drive improvement where appropriate.

Key messages of the report

1. **Bystander Cardiopulmonary Resuscitation (CPR)**

Ongoing strategies are needed at a population level to ensure that people who sustain an OHCA are treated rapidly with high quality resuscitation, including defibrillation, through a co-ordinated network of accessible and identifiable public access devices.

2**. Advance treatment plans**

When advance treatment plans are in place, they should be documented using a standard process (such as the ReSPECT form) to ensure that people receive treatments based on what matters to them and what is realistic. Effective communication between all parts of the healthcare system, including, primary care, community services, ambulance services and acute hospitals is then needed to ensure that appropriate decisions are made, irrespective of time or location.

3. Prediction of survival

No single factor is accurate enough for clinical decision-making at the time of admission to hospital following an OHCA. Time is needed to ensure an accurate assessment of prognosis can be made. Neurological prognosis is particularly difficult to assess, and this should be delayed for at least 72 hours after return of spontaneous circulation.

4. Targeted temperature management

Elevated temperature is common following an OHCA and is associated with a worse prognosis, but this can be improved by accurate, active temperature control. The current approach in clinical practice appears to be inconsistent and a more active approach is needed.

5. Rehabilitation

Physical, neurological, cardiac and emotional impairment following an OHCA can all affect quality of survival, and patients benefit from targeted rehabilitation and support. In some areas of the UK there is no provision of these services. These gaps should be closed by local clinical teams and commissioners working together.

If you wish to read the full report you can find it here

Clinical Effectiveness Committee

The inaugural Clinical Effectiveness Committee met in February of this year chaired by the Assistant Medical Director Dr Raj Krishnan. The committee has several functions in monitoring the implementation of national and local evidence, guidelines and standards and in providing strategic direction for the UHB's national and local clinical audit programme. It will be pivotal in providing assurance to, as well as escalating issues to the Quality Safety Experience (QSE) committee on the afore mentioned.

The committee will also contribute to the production of the Annual Quality Statement to be presented to the Board of Directors. We will update you of the progress of the Committee in future newsletter editions.

QUALITY ASSURANCE

Healthcare Inspectorate Wales Update

HIW continue to use a three tiered model of assurance and inspection during the pandemic that reduces the reliance on onsite inspection activity as the primary method of gaining assurance. This includes **Tier 1** activity which will be conducted entirely offsite; **Tier 2** activity a combination of offsite and limited onsite activity and **Tier 3** a more traditional onsite inspection. In December last year HIW undertook a Tier1 check of the **Medical Emergency Assessment Unit (MEAU**) at the University Hospital Llandough.

Environment-HIW reported that the information provided by the MEAU demonstrated that the MEAU was confident in applying a range of environment measures to reduce the risk of COVID-19. The report reflected positively that visitors were permitted in exceptional circumstances such as end of life care or specific needs such as learning disabilities and end of life care, and that arrangements were in place to ensure regular communication with patients' relatives, which included designating one family member to be called by staff. Staff also provided patients with tablets and cordless telephones to contact relatives.

Improvements were identified with compliance with falls and pressure area audits which were 75% compliant, there were suggestions that this was due to documentation issues and learning would be shared with staff in staff briefings, HIW advised that a process should be developed that would evidence sharing of any learning with staff to ensure future learning on required standards particularly around documentation. HIW were also keen that learning from HIW inspections would be shared across the Health board. The MEAU were unable to provide evidence of a full up to date environmental risk assessment and HIW requested that this be undertaken as soon as possible.

Infection control- Overall this aspect of the report was very positive, patients that were nursed on ambulatory chairs, trolleys or beds were all screened off with curtains and provided with call bells. All patients were risk assessed on admission which was audited monthly. Patient's nutrition and hydration needs were met by a dedicated catering throughout the day.

It was demonstrated that appropriate triage of patients for any infectious symptoms was undertaken and the unit was compliant with hand hygiene and the correct use of PPE with compliance being monitored by monthly audits.

The Health Board system of sharing updates for COVID-19 was also featured as a positive aspect in the report, including the daily CEO updates, a dedicated COVID 19 page on the intranet and links to access the National Infection Prevention Manual, the Public Health Wales and NICE websites which allows staff to access the most up to date guidance.

There were some areas identified for improvement. When HIW accessed the health board intranet pages they selected two IP&C guidance to view, one of which appeared out of date since 2019. An explanation was provided regarding the process of reviewing guidelines and that guidance was still valid, it had already been formally reviewed at the point of inspection and would be on the intranet imminently.

Governance-This aspect of the inspection was very positive and there were no recommendations for improvement.

Patient flow-This aspect of the report was overall very positive. There was one action identified for improvement. Whilst it was recognised that patients would not normally stay on the unit for more than 48 hours, this did occur on occasions and it was identified that there was no process in place to monitor how often this happened or how long patients would wait to be seen by a health professional. This was viewed as a missed opportunity to identify themes and trends. HIW recommended that the health board should consider introducing targets to monitor patient waiting times and how long patients spent on the unit.

The full report and improvement plan can be found here . **Please ensure you are assessing your own clinical area to ensure you are compliant with the recommendations within the report.**

You can read about the positive themes, good practice and emerging risks of Covid-19 identified by HIW in their publication Quality Insight bulletin .

Update on thematic reviews- HIW have announced their intention to carry out a National Review Of Mental Health Crisis Prevention in the Community. It is anticipated that the review will be completed and published by Autumn 2021. The Terms of Reference can be found here

QUALITY IMPROVEMENT/LESSONS LEARNED

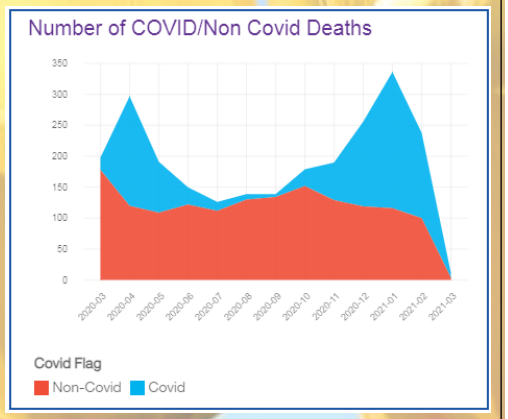
Mortality Review Group

Following an opinion of the Medical Director in the paper to committee in April 2020 a Mortality Review Group was established in the UHB. The first meeting was held in July 2020 with the ultimate purpose of learning from deaths. All clinical boards and relevant corporate teams are represented and there is regular attendance from the Lead Medical Examiner for Wales. The group meets bi-monthly. The purpose of the group is to:

1. 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. Strengthen the processes for recording, measuring and reporting mortality rates and closely monitor these.
3. Generate and support an ongoing system of learning and improvement as a result of the mortality reviews and from other sources such as national clinical audit reports.

Deaths due to Covid-19

WG issued guidance on the 6th of November stating that all patients who meet the criteria for the 'Probable' and 'Definite' category are deemed to be a nosocomial infection which require a review into their care.



The graph opposite shows the number of COVID and Non-COVID deaths. 89% (n=83) of hospital acquired COVID-19 deaths were linked to outbreaks with 14 patients dying on one ward. 44% of inpatient COVID-19 deaths were hospital acquired (n=93). Colleagues in the Patient Safety team together with the Claims department have developed the Rapid Assessment Toolkit for patients who developed Covid-19 eight days and onwards in to their hospital stay. The toolkit has been piloted across the UHB and was presented to the All Wales National Investigation Task and Finish Group. It has been modified to be adopted across Wales to form part of a national standardised approach to investigating the acquisition of Covid-19 within the healthcare setting. The toolkit along with the other investigation documentation is in the final stages of being approved by the network and will be issued for use in the near future. Please feel free to contact the Covid–19 Investigation Team based within the PST for more information.

Themes from Covid-19 Death Reviews

- Transfers from other health boards didn't have an admission swab or appropriate testing in the other health board was not undertaken
- Patients discharged home from outbreak areas being readmitted within 10 days and testing positive
- Patients moved into suspected or closed areas (mainly out of hours)
- Patients having multiple moves and then testing positive
- Missed opportunities to test symptomatic patients
- Misuse of PPE
- Issues with documentation
- Results from swabs not being checked or not being written in patient notes.

Learning from Suicide

Prevention of suicide and self harm remains a major public health and community challenge. The Mental Health Clinical Board has invested in an upcoming roll out of a Suicide Awareness and Mitigation Training Programme, with one module suitable for all health board staff, one for staff with a triage role, and one for those who undertake care planning with suicidal people.

This is as a result of learning from suicides, which is the key patient safety risk in Mental Health Services. Being able to help individuals cope with emotional pain has never been more important than the times we now find ourselves in. Once the training priorities have been agreed by the Mental Health Clinical Board, further information will be shared widely. For more information contact Jayne Bell, Consultant Nurse, Complex Risk, Jayne.Bell@wales.nhs.uk

QUALITY IMPROVEMENT/LESSONS LEARNED

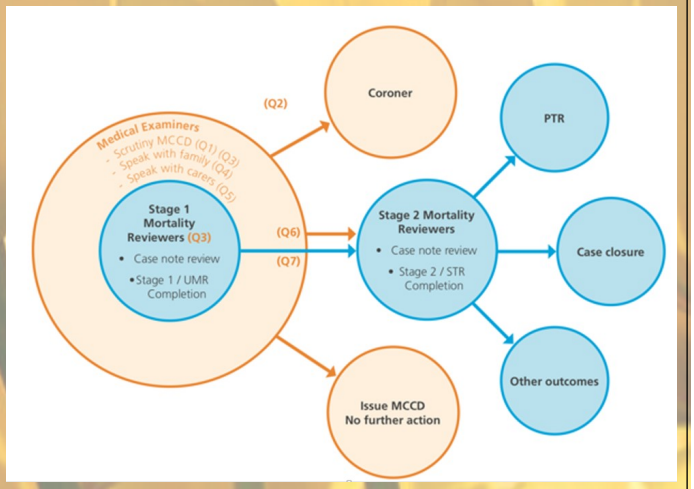
Update on the Medical Examiner

Progress is being made with the introduction of the Medical Examiner Service across Wales. Eventually all deaths not referred to HM Coroner will be subject to independent scrutiny by a ME and supported by Medical Examiner Officers (MEO).

All four Medical Examiner hub sites across Wales are now active and running at 40% staff capacity and focusing on inpatient deaths. Supportive legislation is delayed but plans will continue to develop the service. Cardiff and Vale University Health Board (UHB) is part of the South East Wales hub. A pilot commenced on 18th January 2021 in University Hospital Llandough to establish systems and processes and ensure consistency of outcomes by the MEs. Medical records has a critical role following a standard operating procedure to scan case notes to the ME office. The ME implementation plan is to be functioning on all sites in June 2021 with a subsequent roll out to deaths in primary care. A summary of the discussion with the bereaved is added to the narrative. The final conclusions and directions from the ME draw attention to the issues which the UHB might wish to address. This is a more comprehensive, objective and precise replacement for stage 1 reviews. Cultural burials will be prioritized to minimize the risk delays.

The ME service is not responsible for investigating or instructing others. They may only advise that an in-patient stage 2 review should be considered.

The UHB still lacks robust governance around stage 2 mortality reviews. This will be resolved by an electronic reporting system. 'Once for Wales' procured a Datix mortality module. However, the shift in requirements because of the introduction of Medical Examiners has led to the decision that the Module is not fit for purpose anymore and so it is being further developed. In the interim the ME referral process has enabled us to develop a more robust assessment and monitoring system that is currently being tested.



Any concerns about the quality of care identified will be recorded on Datix and proceed through the Putting Things Right process.

Early learning reporting and learning system -CoRSEL

An early learning reporting system has been established by the Delivery Unit and the UHB is required to share any early learning opportunities from incidents, events, outbreaks, near misses and/or good practice from in -hospital staff or patient transmission of Covid-19. Feedback reports issued to the UHB by the Delivery Unit are shared with Clinical Boards.

Whilst there are many local and national systems for sharing learning from investigations and reviews, sometimes it can take weeks or months for investigations to be completed. However, some of the most important learning can occur within hours or days of an incident or event. It's therefore important that NHS organisations can quickly and easily share that learning with each other, so other organisations can take steps to make local improvements where necessary.

Not all learning is related to incidents, outbreaks or events – learning can come from near misses, and of course from good ideas or practices that staff want to share. CoRSEL was established in response to NHS staff reporting that while early learning was being shared through personal and professional networks, sometimes the messages took too long to get to the right part of the organisation to make effective and systemic changes.

Currently the scope of CoRSEL is limited to in-hospital transmission while the system becomes established, but may be expanded in the future if organisations find it a useful mechanism for sharing learning. Please contact Ann.Jones11@wales.nhs.uk if you wish to share any early learning or improvement with CoRSEL.

QUALITY IMPROVEMENT/LESSONS LEARNED

FOCUS ON FALLS

Falls Prevention and Management

Patient falls are the most common incident reported via Datix. The data reported will be published quarterly in this part of the Patient Safety & Quality Team newsletter so that awareness can be raised about this issue and learning from investigations can be shared across the whole Health Board.

During Quarter 4 of 2020 (1st October 2020 to 31st December 2020) there were a total of 868 falls reported, displayed by Actual Harm as in Fig 1. The injurious falls (moderate, major or catastrophic) harm are thankfully relatively rare but can have a devastating impact on the individual. During Quarter 4, there were a total of 48 injurious falls, which represents about 5.5% of all falls. Fig 2. shows that these types of falls are increasing.

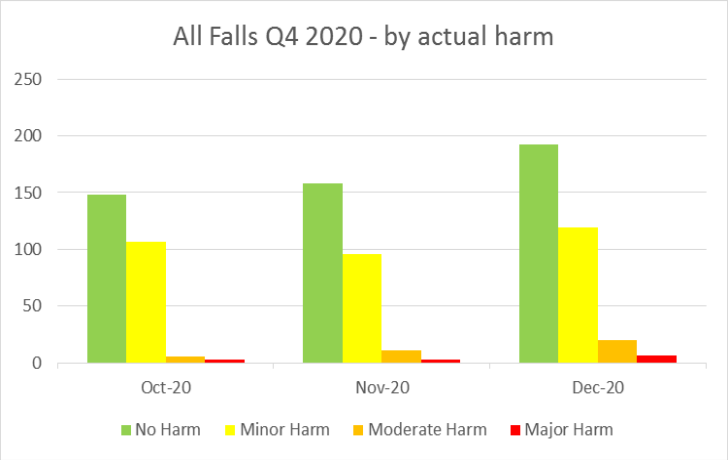


Fig 1. Falls by actual harm

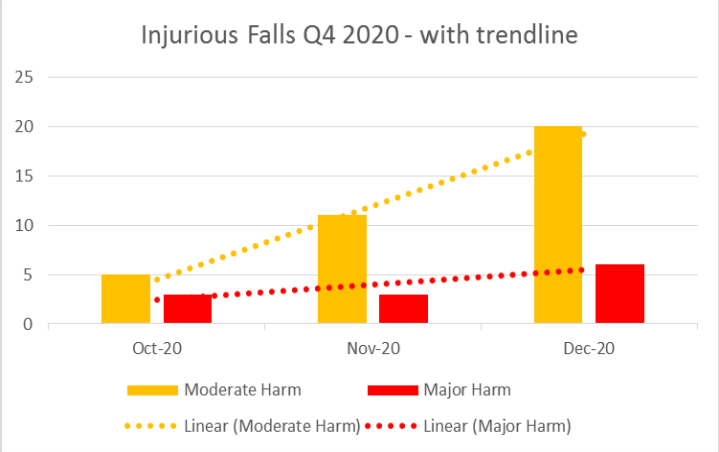


Fig 2. Injurious falls

The Falls Prevention and Management Policy

This is currently being updated but can be found on the Internet here, or the Intranet here. This Policy clearly sets out actions staff should taking when caring for adult inpatients. The Multifactorial Risk Assessment (MFA) part of the Generic Assessment Booklet needs to be completed for all adult inpatients and appropriate Multifactorial Interventions (MFI) be provided for patients with specific risks. In the absence of specific risk, patients should receive Standard Guidance.

Mandatory actions: Standard Guidance:
Must take into account the patient's ability to understand and retain information

Standard Guidance:
- Call bell working and in reach (where applicable)
- Advise on safe transfer/mobility and promote consistent messages
- Advise on safe footwear
- Give the 'reducing harm from falls' information leaflet
- Note warfarin/anticoagulants and identify at safety briefing/handover

Environment and/or Equipment:
- Orientate patient to ward
- Advise on risks from drips/tubing/aids
- Mitigate any slip or trip hazards

Post anaesthetic/procedure
- Advise about transfer/mobilising following anaesthetic/procedure

Use of Trolley/Bedrails Record and Decision Aid tool must be used for ALL patients.

Falls Review Panel

The first Falls Review Panel convened recently and provides the Clinical Boards with a forum to share learning about falls; promote good practice and review where appropriate what could have been done better in terms of falls prevention.

The group is multidisciplinary and chaired by the Assistant Director of Patient Safety and Quality. It is intended to run monthly and we aim to share relevant learning and spread best practice through our newsletter.

QUALITY IMPROVEMENT/LESSONS LEARNED

FOCUS ON FALLS

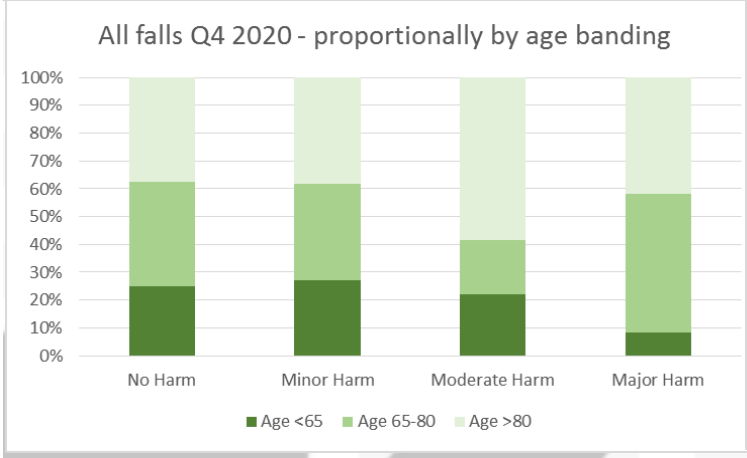


Fig 4 age banding– all falls

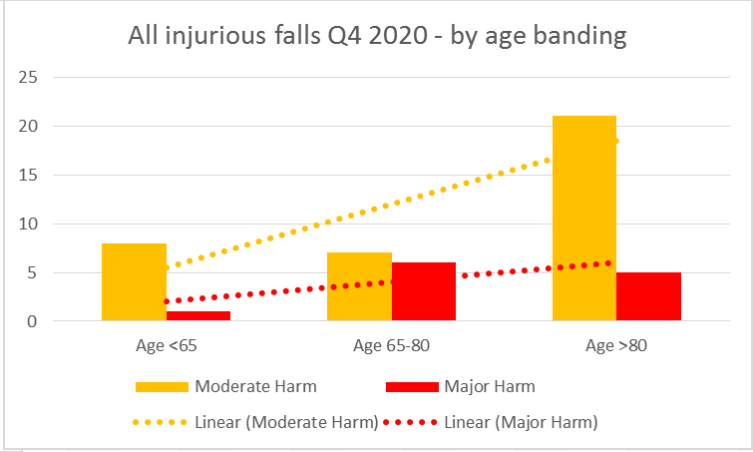


Fig 5– Injurious falls age banding– all falls

Adult inpatients over the age of 65 are at an increased risk of falls, and this risk increases with age (Fig 4). Falls are more common therefore in areas where there are a higher proportion of older patients (Fig 5)

Cardiff & Vale UHB participate in several National Audits relating to falls, including the National Hip Fracture Database and the National Audit of Inpatient Falls. The latest reports are available by clicking on the images:

These national audit reports allow us to analyse our own data and compare to other Health Boards and Trusts.

During quarter 4 of 2020, Cardiff & Vale UHB reported 10 falls incidents to the Welsh Government, although currently reporting requirements have been relaxed due to the operational pressures caused by the pandemic. All of these cases are investigated and an analysis of the themes and trends from these 11 cases follows:

- Multifactorial Risk Assessment and Interventions and bed rails assessments not completed in line with guidance, i.e. within 6 hours of admission to inpatient area, upon change of clinical condition, after a fall, every 7 days
- Enhanced supervision documentation not completed in line with guidance
- Hoverjack not used when injurious fall suspected.
- Neurological observations not completed in line with guidance
- Lack of training for completion of MFA / MFI
- Delayed intentional rounding due to high acuity
- Staffing shortages and reliance on temporary staffing

IN OTHER NEWS!

Patient Safety and Quality team welcome nursing students

We are excited this year to have welcomed a number of nursing students to the team to spend their "spoke" placement week with us. Its been great to meet our nurses of the future and to help shape their knowledge of patient safety, ensuring they leave us with a lasting memory of their experience to take back to clinical practice.

We are committed to providing a stimulating and appropriate learning experience for students and in the spirit of learning and improving we welcome feedback from students on their placement. In response to early feedback we have created a specific student objectives booklet which is crammed full of information and resources to help students achieve their goals during their stay with us.

"I would like to thank the whole team for my spoke week placement, I learned so much! And am ready to apply and keep with me and develop for the rest of my nursing career. Hopefully will return soon! "

"Investigations were extremely fun, having a set of notes and reading through them makes you realise the importance of clear documentation . I enjoyed this learning experience and have realised that patient safety is different but similar to clinical patient care as at the end of the day we all want the best for our patients"

Random Acts of Patient Safety competition– nominations please!

Do you know an exceptional individual or team who has gone that extra mile to improve patient safety during the last year? If the answer is yes, then get nominating! We are not looking for large scale projects. This is about simple interventions or changes that have helped to keep patients safe. To nominate an individual or team tell us in no more than 500 words what was the intervention or change and why you think this individual or team should be recognised for this work. Don't forget to tell us the name and place of work of the individual or team. Send your nominations by **June 1st** to ;

Ann.Jones11@wales.nhs.uk

We will announce the winner in our Summer newsletter when the prize will also be revealed. Good luck!

The Patient Safety Clinic

We are continuing to provide our Patient Safety Clinics (formerly known as Quality Clinics) via Microsoft Teams.

Please do look out for the upcoming dates on the Staff Connect app or on our intranet page. Dates of the clinics will be aligned with the already established UHB Quality and Safety Meeting Days.

We have changed the format of the clinic. For the first part of the meeting we will be providing a variety of updates on the different aspects of our work including;

- Datix Once For Wales Progress
- Covid-19 hospital acquired investigations
- National audit findings
- QSE framework updates
- Patient safety hot topics
- Medical Examiner

and lots more!

The second part of the meeting is dedicated to supporting staff with any issues, queries or questions. We would really love to meet you– the clinic is open to ***all*** staff. If you have any queries or are unsure how to participate contact Ann.Jones11@wales.nhs.uk