



CARDIFF AND VALE UHB
**Patient Safety
& Quality**

Newsletter

Summer 2021
10th Edition



Total Number of Patient
Safety Incidents Reported

5063

17

National
Clinical Audits
Published



Number Of Serious
Incidents Reported To DU

11

Number Of Never
Events Reported To WG

0

Welsh government patient
safety notices issued

[PSN057](#)
[PSA012](#)

Internal patient
safety notices
issued

22

Staff attended
Datix training



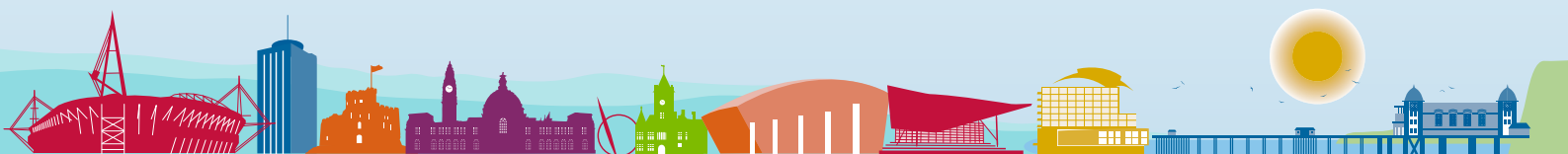
Sl's closed
with WG/DU

53

[ISN 2021 May 011](#)
[ISN 2021/May/007](#)
[ISN 2021/May/010](#)
[ISN 2021/Apr/009](#)
[ISN 2021/Mar/003](#)
[ISN 2021/Apr/005](#)

NICE National Institute for
Health and Care Excellence

42 Pieces of new and updated nice
guidance reviewed and considered



Staff News

In May we wished a warm welcome to our first hub placement student Siobhan Bird. Siobhan is a first year nursing student who began her university education last Autumn. Siobhan spent 5 weeks with the team gaining a rounded experience of patient safety and quality. We hope that by hosting students at an early stage in their career they will go back into clinical practice with a greater understanding of patient safety and how it underpins and shapes patient/citizen care. It was an absolute pleasure to have Siobhan in the team and we wish her much success in her future studies.



There have been lots of exciting staff changes in the Clinical Audit team. Congratulations to Carlos Loureiro who has been promoted to the role of Clinical Audit Facilitator. Carlos originally joined the clinical audit team as an administrative assistant working his way up to a Trauma Audit and Research Network (TARN) co-ordinator. Carlos has now joined the core clinical audit team and will be focussing on the National MINAP and Heart Failure audits.

We also welcome two new members to the Clinical Audit Team as Clinical Audit Facilitators. Cara Vernon is moving from her current role in the Internal Audit team and Helen Griffiths we welcome from outside the UHB. We wish them all well in their new roles.

We are delighted to share that Rochelle Clutterham and Daniele Richards have both secured successful promotions within the Clinical Audit Team. Rochelle is taking up the role of TARN co-ordinator, whilst Dani has been promoted to a Senior Clinical Audit Co-ordinator. Well done to you both !

In other news!

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 and links on the Staff Connect app or on our intranet page. We have changed the format of the clinic. The first part of the meeting is dedicated to information exchange 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. Our next Patient Safety Clinic will be held on WORLD PATIENT SAFETY DAY on September 17th. Everyone is welcome.

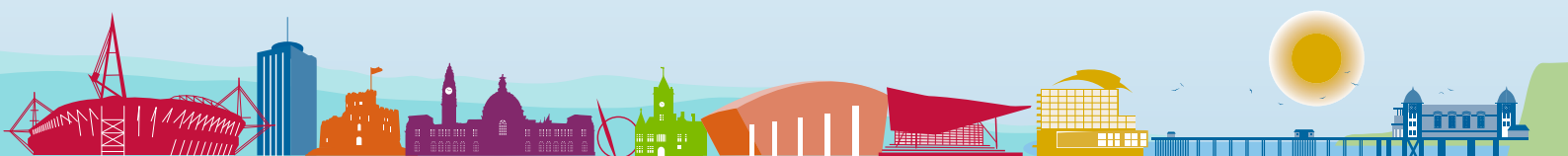
NEW DOCUMENT - Coroner's Inquests - a guide for NHS staff

The Patient Safety Team has developed a helpful guide to coroner's inquests that covers topics such as writing statements, attending court and giving evidence. The guide contains lots of practical advice and information for staff on the inquest support available within the Health Board. You can find the document on our [intranet](#) page.



Coroner's Inquests

A guide for NHS staff



Patient Safety

Pressure damage collaborative

The established Health Board Pressure Damage group was re-launched as a collaborative in April 2021 and will refresh and advance the work that has been delayed over the last year of the Covid-19 pandemic. Members of the Patient Safety, Improvement and Organisational Learning Team are supporting the collaborative to ensure learning is captured and requisite quality improvement taken forward. The group overall is being led by the Director of Nursing for Surgery.

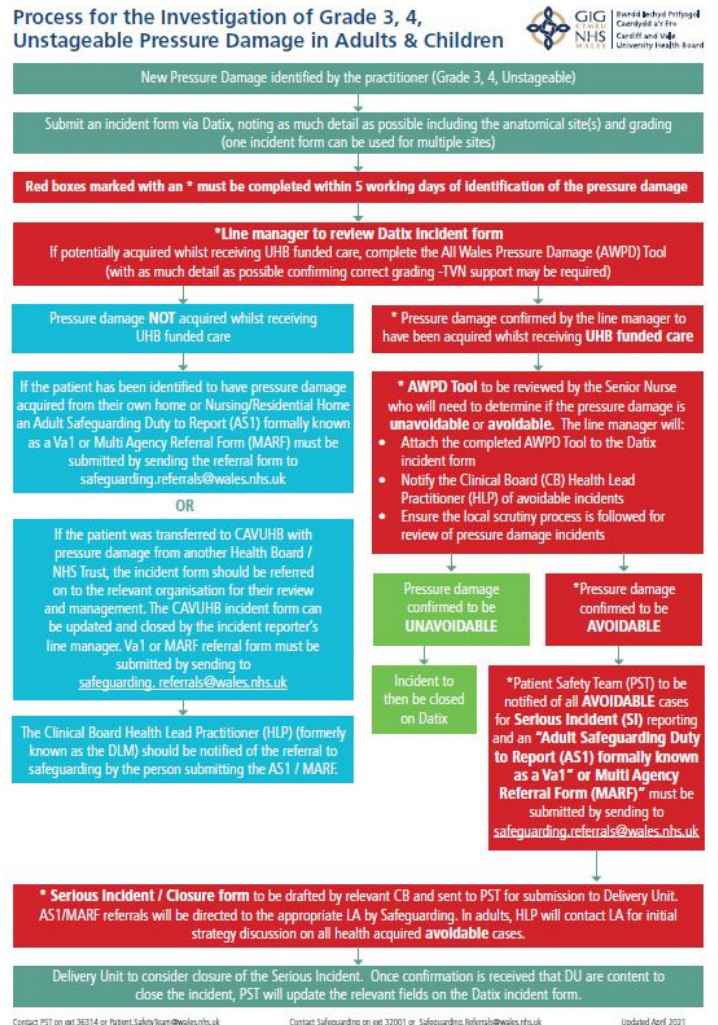
Despite the pressures during the pandemic, many achievements have been made; eg, training has continued through virtual platforms, e-learning developed for Purpose T, and a pressure ulcer workbook rolled out across some areas. In podiatry the use of e-advice and comms, and a software system to triage referrals and provide comprehensive advice for the management of heel pressure damage, has enabled prompt response to nursing staff.

'Attend Anyway' Video consultations have worked well in podiatry to provide essential management and advice on pressure damage to other health care professionals, patients and their relatives and carers in nursing and residential homes. It has enabled rapid access to podiatric advice and treatment to those with the greatest need.

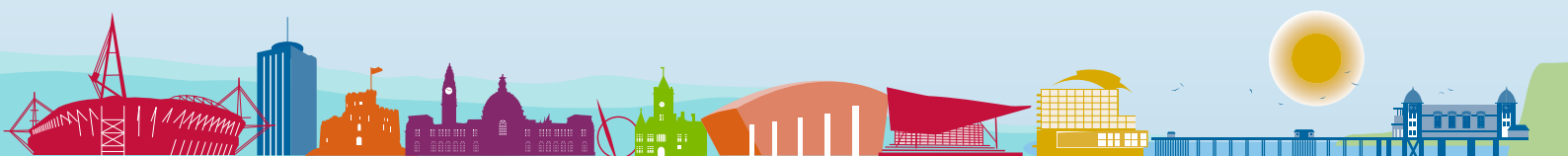
More recently, media resources have purchased a photography app for use in the Emergency Unit to photograph wounds/pressure ulcers out of hours which will be directly uploaded to 'Fotoweb'. This will be invaluable across the UHB and useful in pressure ulcer investigations to reduce variation and improve accurate categorisation of pressure damage, ensuring the most appropriate pressure relieving equipment is utilised.

The objective of the collaborative is to strengthen processes for prevention, correct identification and management of pressure ulcers and ultimately reduce the incidence of hospital acquired pressure damage. We will report back on the progress of the collaborative in our Autumn newsletter.

Process for the investigation of grade 3, 4 unstageable pressure damage



The Patient Safety and Safeguarding Teams have been working together for the last 12 months to align pressure damage reporting and investigation processes. A flow chart has been developed to assist staff in the management and investigation of grade 3, 4 and unstageable pressure damage. An electronic copy of the flow chart and hard copies have been shared with the clinical boards for distribution to all clinical areas and community settings. It's important to note that the processes have not changed, rather they have been aligned to provide clearer guidance for staff.



Patient Safety

Quality, Safety, Experience Framework Update

On World Patient Safety Day 2020 (17th September), a virtual Quality, Safety and Experience (QSE) Workshop was held to engage with senior clinicians and managers across the organisation in order 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.

The backdrop to the day was the new Health and Social Care (Quality and Engagement) (Wales) Act which will be implemented in 2021. This will place quality considerations and a duty of candour at the heart of all that NHS bodies in Wales. It will also strengthen the voice of citizens and the governance arrangements.

Prior to the workshop, a short safety culture survey was sent out to all delegates. They were also provided with

some pre-reading material. Themes from the survey and the pre-reading material were identified and facilitated virtual groups were set up to discuss each theme and feedback to the main virtual room.

Since the workshop, the Patient, Safety and Quality Teams and Patient Experience Team have continued to engage with hundreds of staff and with external stakeholders to continue the discussion on priorities for the next five years. An organisation wide Safety Culture Survey and a Patient Experience survey have been distributed and the feedback and results will be used to identify important areas for focus in the new 5 year Framework. Since the workshop we have identified an 8th work stream and currently we are proposing that our 5 Year QSE Framework is based on the following 8 key enablers:

Safety Culture

Leadership and prioritisation

Patient experience and involvement

Patient safety learning and communication

Staff engagement and involvement

Data and insight

Professionalism

Quality governance

QSE framework update sessions.

Please join us at one of our virtual QSE framework sessions to discuss our priorities for the next 5 years.

Friday 13th August 2021 at 09.30am - 10.30am

Monday 16th August 2021 at 3.00pm - 4.00pm

Tuesday 17th August 2021 at 1.00pm - 2.00pm

To book a place please contact Jules on 02921836324 or at Juliet.Evans2@wales.nhs.uk

We are very happy to come and present at any groups or meetings or out of hours so please do contact us if these dates are not suitable for your needs.

We are also interested in your views on what we should call our QSE Framework for the next 5 years and will be running a short poll in the coming weeks to explore this more.



Important Changes to the National Patient Safety Incident Procedure

From 14 June 2021 the way Health Boards report incidents to NHS Wales Delivery Unit (Welsh Government) changed. **The term SI (Serious Incident) has been replaced with Nationally Reportable Incident (NRI).**

The National Patient Safety Incident reporting policy supersedes the Serious Incident section (Section 9) of Putting Things Right guidance. Never Events, In-patient suicides, maternal deaths, avoidable healthcare acquired pressure damage and incidents affecting a significant number of patients will continue to be reported to the Delivery Unit (DU) immediately. In addition, the following changes will take place:

Phase 1 (immediate effect) requires incidents potentially causing major or catastrophic harm to be reviewed internally by Clinical Boards with onward reporting to the DU if any causative or contributory factors are established.

Phase 2 (implementation date to be confirmed) involves the thematic reporting of healthcare incidents based on common factors regardless of the harm outcome

In order to determine the facts surrounding the incident to decide on need for external reporting, the clinical areas will need to complete a **Patient Safety Fact Finding tool** and return to the Patient Safety Team within **5 working days** (for those incidents graded major or catastrophic harm).

The Patient Safety Team will submit an NRI form to the Delivery Unit within the next 2 working days if it is assessed or suspected an action or inaction is likely to have caused or contributed to the unexpected or

avoidable death, or caused or contributed to severe harm.

Clinical Boards, in conjunction with the Patient Safety Team, will now determine the level of investigation required and the timeframe for completion (30, 60, 90 or 120 working days) dependant on the complexity of the incident. The timeframe and type of investigation required will be agreed at the **Fact Finding (previously known as SI) meeting**. Previously the timeframe for investigation was set by the Delivery Unit. Clinical Boards will undertake a proportionate investigation to establish whether any action or inaction, unintended or otherwise, caused or contributed to the reportable incident. On completion of the investigation, rather than submit one closure form for all incidents, the Clinical Boards will complete one of three forms; a Learning from Event form (where causative factors have been determined), Outcome report (where there were no causative factors) or downgrade request form (where further investigation finds that the incident did not meet the criteria for national reporting) dependant on the findings of the investigation report.

Clinical Boards and Directorates are asked to record in their Q&S meetings that this notice has been received and distributed with a record of any actions taken. Please now use the provided Fact Finding tool to help determine the need for external reporting and return within 5 days of the incident/knowledge of the incident to the generic Patient Safety email address: Patient.SafetyTeam@wales.nhs.uk. For any further questions on the changes, please do not hesitate to contact the Patient Safety Team, either directly to your designated Patient Safety Facilitator or via the generic email address above.

Resources for staff well-being and support

Being involved in a difficult incident, complaint or inquest can be upsetting and stressful for staff. In addition to accessing support through your Clinical Board, there are a range of helpful external resources available.

[Health for Health Professionals Wales \(HHP Wales\)](#) offers a free, confidential service that provides NHS staff, students and volunteers in Wales with access to various levels of mental health support

[HealthCare Safety Investigation Branch-National Learning Report](#) Support for staff following patient safety incidents

[National Learning Report](#)

[NHS Resolution](#)

[The Joyful Doctor](#)



Quality Assurance

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) New studies commencing 2021



Improving the quality of healthcare

National Confidential Enquiry into Patient Outcome and Death

Epilepsy

NCEPOD commenced this study in February 2021 to investigate variation and remediable factors in the processes of care of patients presenting to hospital following an epileptic seizure. The objectives of the study are:

- To identify patients seen in hospital with suspected seizure and to investigate their care, from presentation to resolution.
- To evaluate the quality of assessment, of physical, psychological and social contributors to their illness.
- To assess the availability of care and identify avoidable delay, obstacles to care, and harmful intervention.
- To assess organisational aspects of care including education, local and national guidelines, and delivery of care.
- To produce recommendations for improvement.

You can find out more [here](#) about this study

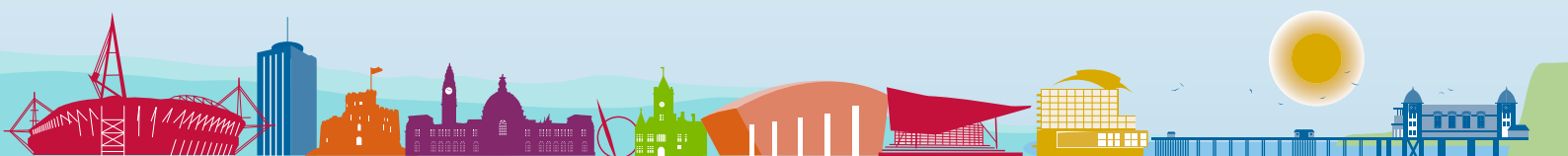
Transition

NCEPOD have been commissioned to undertake a study to explore the process of transition from child to adult health services. The study will include young people between the ages of 13 years and their 25th birthday with one or more of eleven conditions below:

- Epilepsy
- Sickle cell
- Juvenile idiopathic arthritis
- Cerebral palsy
- Spina bifida
- Muscular dystrophy
- Post-transplant patients (heart, liver or kidney)
- Autism (including Retts)
- Brain Tumour (Medulloblastoma)
- Type 2 diabetes in obese young people
- End stage renal disease (young people on dialysis)

Data collection will commence during the summer and the study protocol made available on the website shortly.

All NCEPOD studies are co-ordinated through the Patient Safety and Quality Assurance Team



Healthcare Inspectorate Wales Activity Update



Teenage Cancer Trust Unit.

On the 31st of March 2021 a quality check was undertaken on the Teenage Cancer Trust Unit. The findings of the report were very positive and no areas for improvement were identified. The team are commended for such a positive report.

Social aspects of life are particularly important to this young group of people. HIW was provided with evidence that adaptations had been made to the environment to ensure that socialisation continued safely.

During the quality check, HIW evaluated how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe and were provided with satisfactory assurance.

Evidence was provided of sufficient numbers of appropriately trained staff on the unit to provide safe and effective care. Although the unit had endured some challenges during the pandemic, with the reallocation of staff, short term sickness and with staff isolating, the unit was able to maintain adequate staffing in line with the Nurse Staffing Levels Wales Act. Measures are in place to provide additional support to staff, including referral to occupational health and sign posting to resources available within the health board to support staff wellbeing.

You can view the full published report [here](#)

Hazel Ward – Hafan y Coed.

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Hazel Ward, Hafan Y Coed on the 18th of March 2021. Positive findings by HIW included evidence that the ward conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. A review of the staff vacancies and absence data did not indicate any staffing issues. HIW were also satisfied that incidents are reported appropriately.

Compliance data for staff mandatory training was provided. Whilst there were a number of areas showing a high rate of compliance, this was not reflected in all training topics. During the review of the training statistics there were issues identified which need to be reviewed. A number of improvements were identified for the following areas:

- A ligature risk assessment to be undertaken and any remedial work by estates to be completed- (This has since been undertaken)
- The UHB must provide an up to date cleaning audit – (This has now been provided to HIW)
- The UHB must review training data and ensure staff are up to date with skills and knowledge to provide safe and effective care –(All staff allocated a study day to ensure they have access to a PC to complete online mandatory training. Staff are booked on face to face training as the training is reinstated)

The improvement plan was accepted by HIW. You can view the full published report [here](#)

Update on thematic reviews: WAST

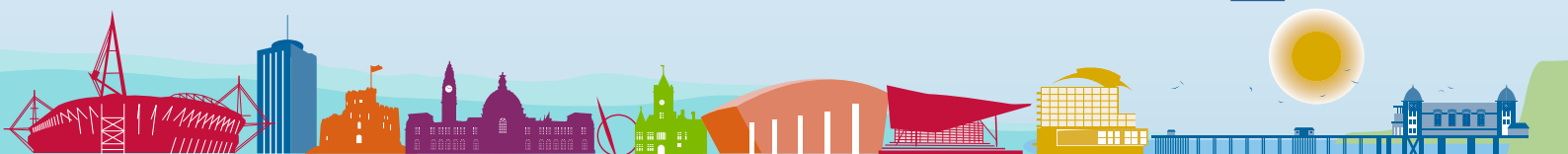
As part of Healthcare Inspectorate Wales' (HIW) annual reviews programme for 2020-21, a local review of the Welsh Ambulance Service Trust (WAST) is being undertaken. The focus of the review is to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and their overall experience. A copy of the Terms of Reference will be available on the HIW website on the link below.

<https://hiw.org.uk/local-review-welsh-ambulance-service-trust-delayed-handover>

The UHB is working with HIW to encourage relevant staff to participate in a survey in relation to ambulance handovers. This has been promoted through all available UHB communication channels.

Mental Health Crisis Prevention in the Community

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 Assurance

Health and Care Standards Update



The Health and Care Standards set out the Welsh Government's framework of standards to support NHS organisations in providing effective, timely and quality services across all healthcare settings. The standards provide a consistent framework that enable health organisations to look across the range of their services in an integrated way, to ensure that the care that they provide is of the highest standard and they are doing the right things, in the right way, in the right place, at the right time with the right staff and to allow service users to understand what they can expect.

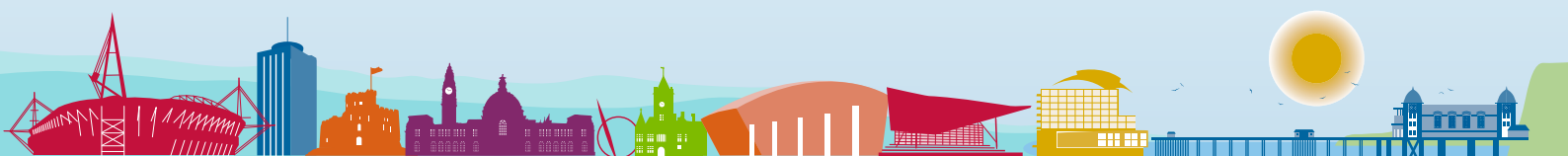
In December 2017 the QSE Committee agreed an ongoing approach to align the 16 Health and Care Standards to existing groups or committees within the UHB. The aim was to support a system that promotes continuous monitoring and development of the services underpinning each of the Health and Care Standards and to reduce variation across the UHB. Those 16 Standards are subject to ongoing scrutiny throughout the year. Performance against the individual standard has been monitored and where necessary the requisite improvements have been implemented and reviewed. An annual assessment of performance and identification of the 2021/22 actions is undertaken by the Corporate leads in conjunction with each of the groups and committees that are subject to Executive review and sign off by the relevant Independent Member.

Each self-assessment is multi-factorial and considers a number of components relating to the individual standard. To reduce variation between Clinical Boards a scoring matrix is used to standardize definitions aligned to four scores:

- Getting Started
- Getting There
- Meeting the Standard
- Leading the Way

A review of the current self assessments and scoring has been compared to the previous self-assessment in 2018/19 and shows the following:

- Standard 2.2 – Safeguarding and 6.1 - Planning Care to Promote Independence have both maintained their scoring of 'Leading the Way'.
- The vast majority (10 standards self assessments) have maintained their previous scoring, seven of which are scored as 'Getting There' and three 'Meeting the Standard'.
- Two self assessment standards showed a lower scoring, 2.3 Falls prevention, although the scoring is lower than for 2018/19, a dedicated Health Board Falls Lead was appointed in January 2021 and significant progress has been made to date, several key deliverables have been identified within the self assessment SBAR for the coming year.
- Standard 7.1 – Workforce was previously self-assessed in 2018/19 and scored as 'Leading the Way', although this years self assessment was scored as 'Meeting the Standard', many of the elements met the 'Leading the Way' criteria. However, through evaluation of relevant strategies e.g. Workforce chapter of the UHB IMTP (Integrated Medium Term Plan), WOD Delivery Plan, UHB Employment Policies, and learning from the first wave of Covid-19 and the NHS Wales Staff Survey results, areas for further improvements were identified and therefore self-assessed as 'Meeting the Standard', several key deliverables are identified for 2021/22.



Safety Culture Survey

Firstly – a huge thank you to the 988 people who started the Safety Culture Questionnaire. We chose the questionnaire on the recommendation of Professor Paul Bowie and adapted it so that it could be used in additional areas to hospitals.

What is a Safety Culture?

Safety culture refers to the way patient safety is thought about and implemented within an organisation and the structures and processes in place to support this.

There is a strong link between culture and patient outcomes. When we developed our values and behaviours we worked with a company called April Strategy. They suggested that there is a clear relationship between the wellbeing of staff and patients' wellbeing.

A 5% increase in staff working in real teams is associated with 3.3% drop in mortality rates. There are better outcomes and fewer mistakes. In the most successful teams people get 5 times more appreciative comments about their work than critical comments. Whereas rudeness between staff reduces cognitive function and increases the likelihood of safety incidents.

So this is not fluffy stuff. This affects patient experience and outcomes and can make the difference to our staff's ability to cope with day to day pressures.

The questionnaire covered 12 sections-

- Manager/supervisor expectations and actions when promoting safety
- Organisational learning and continuous improvement
- Teamwork within a team/department
- Communication openness

Figure 2: Reciprocal relationship between culture and outcomes

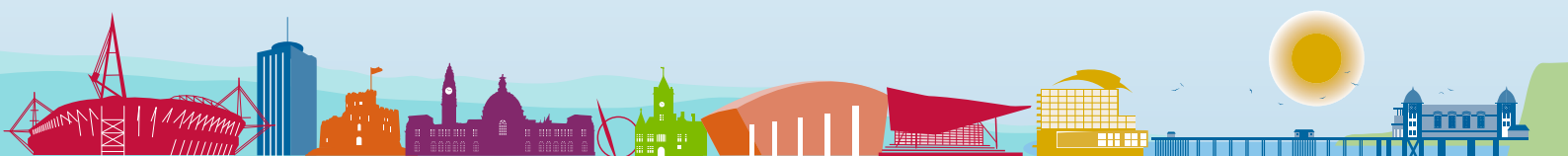


THE HEALTH FOUNDATION

Research scan: Does improving safety culture affect patient o

- Feedback and communication about error
- Non-punitive response to error
- Staffing
- Management support for patient safety
- Teamwork between teams/departments
- Handoffs and transitions

The distribution of answers was virtually identical regardless of whether people worked in UHW, UHL or Primary Care or length of service in the UHB. We didn't split the results into professional groups because the number in most groups was fairly small. You can access the full report [here](#).



Safety Culture Survey

Positive highlights from the report include:

- 48.5% responders said they agree or strongly agree with the statement 'My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures' and 22% disagreed or strongly disagreed.
- 71% agreed or strongly agreed the 'People support one another in this team/department'.
- 67.5% agreed or strongly agreed that 'Staff will freely speak up if they see something that may negatively affect patient care'.
- 76% agreed or strongly agreed that 'When a lot needs to be done quickly, we work together as a team to get the work done'.
- 65.5% said 'We are actively doing things to improve patient safety' and 12% disagreed or strongly disagreed.
- 51.5% said they agree or strongly agree with the statement 'We are informed about errors that happen in this team/department.'
- 57.5% agreed or strongly agreed with the statement 'In this team/department, we discuss ways to prevent errors from happening again'.
- 65% disagreed or strongly disagreed with the statement 'My supervisor/manager overlooks patients' safety problems that happen over and over. 16% agreed or strongly agreed.

There is still a perception of punitive responses to error. 36% agree or strongly agree that they feel like mistakes are held against them. 44.5% feel like the person is being reported, not the problem. And 46.5% agreed or strongly agreed to the statement 'Staff worry that mistakes they make are kept in their person file'.

Where do we need to focus improvements?

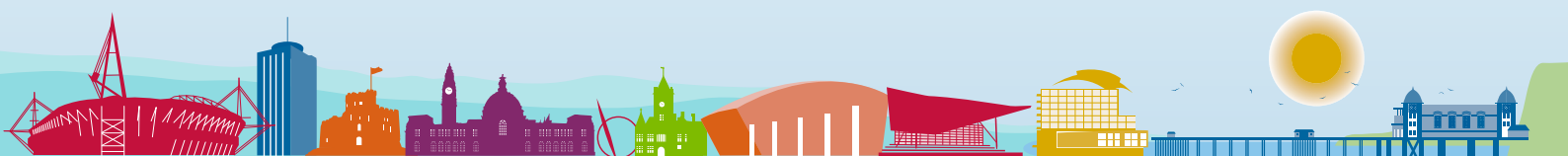
- 30% respondents agreed or strongly agreed with the statement 'Important patient care information is often lost during shift changes'.
- 48% agreed or strongly agreed with 'Problems often occur in the exchange of information across teams/departments'.
- 45% respondents agreed or strongly agreed that things fall between the cracks when transferring patients from one team/department to another.

The overall perception of safety is mixed. 40% respondents agreed or strongly agreed with the statement the 'Patient Safety is never sacrificed to get more work done'. Whereas 15% disagreed or strongly disagreed. 24% agreed or strongly agreed that 'We have patient safety problems on this unit'. 46% agreed or strongly agreed that 'Our procedures and systems are good at preventing errors from happening' and 15% disagreed or strongly disagreed.

The frequency of incident reporting is generally low when there is a 'near miss' or no harm to the patient. This deprives us of important sources of information that we learn from and prevent the 'accident waiting to happen'.

Our next steps are to share the full results widely and agree actions to include in the Framework.

Thank you again to those who completed the survey.



Quality Improvement/Lessons Learned

Focus on Falls

May 2021 Falls Review Panel – Learning and Feedback

Standing / Lying BP should be part of the Multi Factorial Risk Assessment for Falls for all inpatients who can stand. Use the QR codes to refresh your knowledge.



Falls Policy



How to measure BP

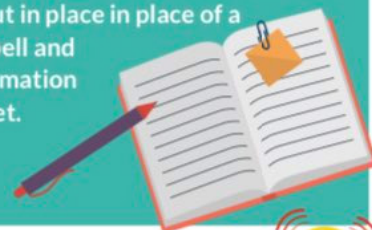


Procedure reference cards

Importance of MDT medication review for all patients as part of multifactorial risk assessment to consider whether all medication necessary.



If patients are felt not to be able to retain information then it is important to consider what else can be put in place in place of a call bell and information leaflet.



The importance of considering whether glasses or hearing aids are still optimal. e.g.

When was last sight test?
Has a formal bedside vision assessment taken place?



Ensure appropriate use of sensor equipment

The biggest learning point from this month is the use of Kirton Chairs. The use of Kirton Chairs must be demonstrated to have a benefit.



A thorough individualised risk assessment must be undertaken to ensure there is no inappropriate use - this could represent restraint and careful consideration is needed for their use.



CARDIFF AND VALE UHB
Patient Safety & Quality

@CV_UHBSafety

Please contact Annie Burrin for more information - Annie.Burrin@wales.nhs.uk

Steady on... Stay SAFE



In 2021 Public Health Wales expect...



132,000 older people will fall more than once in their home



7,750 older people will be hospitalised



2,800 older people will have a hip fracture



1,400 older people will lose their independence



700 older people will die following a fall

But falls are NOT an inevitable part of growing old. How we helped older people most recently



Care & Repair helped 36,607 people adapt their home to help prevent trips, slips and falls



Age connects' toenail clipping service helped 13,309 older people stay steady and safe on their feet



Age Cymru helped 1,622 older people to stay active through taking part in tai chi, Nordic walking and LIFT classes. With 9,728 views of our online classes



Sadiwch i... Gadw'n SAFF



Yn 2021 mae Iechyd Cyhoeddus yn disgwyl y bydd



132,000 o bobl hŷn yn cael mwy na un godwm yn eu cartref



7,750 o bobl hŷn yn mynd i ysbyty



2,800 o bobl hŷn yn torri clun



1,400 o bobl hŷn yn colli eu hannibyniaeth



700 o bobl hŷn yn marw yn dilyn codwm

Ond NID yw codymau yn rhan anochel o heneiddio. Sut wnaethon ni helpu pobl hŷn yn fwyaf diweddar



Helpodd Gofal a Thrawsio 36,607 o bobl i addasu eu cartref i helpu atal pobl rhag baglu, lithro a syrthio



Gwnaeth gwasanaeth torri ewinedd traed Age Connects 33,309 o bobl hŷn i sadio a chadw'n saf ar eu traed



Helpodd Age Cymru 1622 o bobl hŷn i aros yn egniol trwy gymryd rhan mewn dosbarthiadau tai chi, cerdded Nordig a LIFT. Gyda 9,728 o olygfeydd o'n dosbarthiadau ar-lein.



In other News!

Retirement of our Assistant Director of Patient Safety and Quality



As some of you may know our Assistant Director of Patient Safety and Quality Carol Evans is retiring in September 2021. We would like to take this opportunity to wish her a long, healthy and happy retirement. Carol is a registered nurse who specialised in respiratory nursing before entering the world of patient safety. Carol came

to Cardiff from Hywel Dda UHB where she was a clinical risk manager and has spent the last 7 years leading the Patient Safety and Quality Team here in Cardiff and Vale. Through her great leadership she has strengthened and developed the team and the patient safety, assurance and quality improvement agendas.

Carol will be leaving the UHB on Friday 17th September which is World Patient Safety Day. A great note to depart on. A farewell do will be held in Aroma, Woodland House on that day from 16.00hrs.

Thank you Carol for being a great leader and manager. We will miss your sense of humour, your professionalism and kindness. We know you will enjoy the next phase of your life spending more time with your grandchildren and purchasing new art pieces!!



Follow us on Twitter
[@CV_UHBSafety](https://twitter.com/CV_UHBSafety)

Diary marker! World Patient Safety Day 2021



World Patient Safety Day was established in 2019 by the Seventy-second World Health Assembly through the adoption of resolution [WHA72.6 – “Global action on patient safety”](#). The Day is firmly grounded in the fundamental principle of medicine – first do no harm. World Patient Safety Day builds on a series of successful annual global ministerial summits on patient safety which began in London and Bonn in 2016 and 2017, respectively. The overall objectives of the Day are to enhance global understanding of patient safety, increase public engagement in health care safety, and promote global action to prevent and reduce avoidable harm in health care. Each year a theme is selected to shed light on a priority area critical to patient safety and ultimately the achievement of universal health coverage.

The theme selected for World Patient Safety Day 2021 is “**Safe maternal and newborn care**”, due to the significant burden of risks and harm women and newborns are exposed to when receiving unsafe care during childbirth.

The Patient Safety and Quality Team will be marking the day with a number of activities. We do hope you can join us.

