Independent Healthcare Providers Network

IHPN Share & Learn Community of Practice Quarterly Roundup

Issue: January 2023

Welcome!

As the first quarterly Round Up for IHPN Share and Learn we would like to extend a warm welcome to everyone and hope you find this useful.

New Share & Learn updates this quarter

Find enclosed recent learnings identified following previous Share & Learn meetings.

Human Factors - Safety Management Implementation Manual

You will find an interesting resource shared by Steve Reen at Smart Reset – Human Factors trainer who attended the Share & Learn meeting in December 2022

Dates for your diary

Dates of the Share & Learn CoP for 2023 have been shared with CoP members.

To learn more about the Share & Learn CoP please email info@ihpn.org.uk.

Welcome

Welcome to the first quarterly IHPN Share & Learn Community of Practice Round Up which intends to keep you up to date with learning outcomes following the IHPN Share & Learn meetings.

IHPN Share & Learn CoP

The IHPN Share & Learn Community of practice consists of a small number of representatives from the Independent Sector who come together to discuss an incident in a safe environment, sharing ideas, best practice and learnings right across the sector. The meetings are scheduled to take place every quarter and aims to improve patient safety by sharing learnings widely.

Share & Learn Update

IHPN Share & Learn met in September and December in 2022. In December, Steve Reen from Smart Reset, a Human Factors trainer, attended to provide an overview of systems thinking when reviewing a particular incident brought to the table by a provider. This proved valuable and Steve will be invited to some future meetings to provide insight from a Human Factors point of view.

At the next meeting in Q1 2023, Louise Pye from HSIB will be invited to meet the members of the group and will share her perspective on managing incidents and difficult conversations with family and patients primarily. Additional guest speakers will be invited to attend as the Community of Practice evolves.

Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.

Etienne and Beverly Wenger-Trayner 2015

Medications Error

When checking the CD cupboard after the list it was noted that there was an additional vial of alfentanil in the cupboard which suggests that one of the patients was administered the emergency drug that was left on the side instead of alfentanil. The list took place in the endoscopy suite on a Friday evening.

- Emergency drugs when required in endoscopy suite were stored in main theatres on a different floor – consider storing emergency drugs in endoscopy suite.
- Staff are shared between theatre and endoscopy suite - review quality of staff handovers when staff are changing shift or covering for breaks to include medication administered.
- Medication arrived from theatre department and placed on the side in endoscopy suite anaesthetic room with a syringe and label for use as required by anaesthetist - consider changing the colour of the drug trays to identify emergency drugs.
- Two of the four patients on the list were removal of gastric bands and one patient required some additional airway support after the procedure which could have distracted the teams before moving onto next patient - consider acuity of procedures undertaken in endoscopy suite and if appropriate for the environment at certain times.
- Four patients on the list had four different Consultants - empower teams to initiate a pause at any point to regroup, review to ensure briefings are completed for each individual patient, identify who is in charge of the theatre (senior nurse/ODP), briefing to only start once everyone has arrived in theatre.
- The CD book had been signed suggesting the practitioner had witnessed the drug administered but this cannot be verified due to a change of staff during procedure - CDOA audits may support identification of cultural and practice failings.
- Consider the person in charge of the theatre being supernumerary to facilitate efficient running of lists.

Significant Wound Infection

A patient developed a significant wound infection post-operatively. The patient had been dressing their wound at home and had received some hydrotherapy treatment as part of the recovery process. The patient had also been admitted in to the NHS of which the hospital were unaware of.

- Review detail of hardcopy/electronic copies of wound care information provided to patients on discharge to ensure current and relevant.
- Consider if patients are told what not to do as well as what to do in relation to wound care on discharge.
- Review areas where wound care treatment/advice is documented to ensure hospital staff always have access to latest documented wound care intervention.
- Remaining up to date with latest IPC guidance for key members were identified as a challenge due to IPC specialists having additional roles.
- Admitting Consultant had not informed hospital the patient had received care within the NHS post discharge. IHPN noted the updated Medical Practitioner Assurance Framework publication and the Consultants obligation to inform hospitals if a patient is admitted/treated in NHS.
- Some members have specialist IPC staff to call on when issues with wound care arise potentially enhancing management of wound care issues.
- The use of hydrotherapy pool as part of patient rehabilitation was discussed. Water safety guidelines were last updated in 2021. Review to ensure the most recent water safety guidelines are in place.
- Aim where possible to standardise consultant instructions and preferences where possible to establish consistency.
- One member shared how they are expanding their patient involvement by inviting patient focus group member/s onto their Clinical Safety Committee.
- The list was running late on a Friday evening – consider having discussions with staff about late/delayed finishes and are they safe to continue and ensure they are getting protected breaks.

The next IHPN Share & Learn Community of Practice meeting will be scheduled in Q1 2023 so be sure to look out for the next IHPN Share & Learn Round Up for more updates and useful resources to help keep turning up the dial on patient safety in the Independent Sector.

Useful Resources

Safety Management Implementation Manual - shared by Steve Reen Smart Reset

Non-technical competencies and associated Behavioural Markers - shared by Steve Reen Smart Reset

NHSE Safety culture: learning from best practice report (published Nov 2022)
This report shares insights from their work with NHS organisations that are CQC rated outstanding/good for safety, to understand how they are supporting safety culture improvement. It includes a number of case studies and is a useful resource in supporting providers to improve safety culture in their own organisation.


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Safety culture: learning from best practice
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