Independent Healthcare Providers Network

IHPN Share & Learn Community of Practice Quarterly Roundup

Issue: June 2023

Welcome!

As the third quarterly Round Up for IHPN Share and Learn we hope you find this update useful, please feel free to share with your colleagues!

New Share & Learn updates this quarter

Find enclosed recent learnings identified at the meeting held in June 2023.

Dates for your diary

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

Extending the invite across all sectors

If you would like to be invited to the CoP please contact Linda.Jones@ihpn.org.uk.

Medical Colleagues

The CoP would welcome to hear from any medical colleagues that would be interested in joining or presenting a case study during the meetings. Please contact Linda.Jones@ihpn.org.uk.

Feedback to IHPN

IHPN would be very keen to hear about any changes you have made to practice since receiving these share and learn updates. We would be delighted to be able to demonstrate that the group is contributing to turning the dial on patient safety. Please contact Linda.Jones@ihpn.org.uk if you would like to share any changes you have made following to outcomes of the Share & Learn Community of Practice.

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

Welcome

Welcome to the third 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 June 2023, Steve Reen from Smart Reset attended the Share & Learn meeting to provide a Human Factors perspective on the patient safety incident that was discussed amongst group members. Steve shares valuable insight into patient safety incidents from a human factors angle. Steve shared with us a decision-making tool that is commonly used in the aviation industry and supports people to make quick decisions during a critical incident. Read more below.

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

Shared Learning from incidents

The case study related to a patient who had a Primary Hip Replacement and experienced a rare complication. Read research article here.

- Uncemented with ceramic head.
- Post-operative x-ray late afternoon suggested hip dislocation.
- Plan to return to theatre the following day for closed reduction.

Following day, patient consented for closed reduction.

Closed reduction not attempted as when on table x-ray showed femoral head disengaged.

Open retrieval attempted, assisted by surgical colleagues, unable to retrieve.

Procedure abandoned after full discussion with MD and SLT.

Replaced femoral head construct, hip stable.

Action points

Patient had x-ray in theatre once anaesthetised, patient deemed as requiring open reduction.

- Consider if an x-ray should be completed prior to the patient being anaesthetised?

Patient had consented for closed reduction prior to going to back to theatre the following day for reduction surgery. Question raised in theatre regarding proceeding to open reduction as patient had not signed consent form for open reduction.

- Ensure controls are in place around **consent** when the consent form does not cover all aspects of surgery proposed.
- **Best interest decisions** to form part of consent policy to ensure we do what is right for the patient. Ensure it is clear who runs the decision-making process and who needs to be involved.
- Consider providing case studies during consent training for staff so they can work through best interest decision making processes.
- Could all procedures of this nature be consented for closed/open reduction rather than just closed reduction?
- If best interests' decision is made, document fully the decision-making process and who was involved.

Create a **'just culture'** where teams feel empowered to make a decision based on the best interests of the patient.

General Discussion Points

How organisations share learnings from the Share & Learn CoP

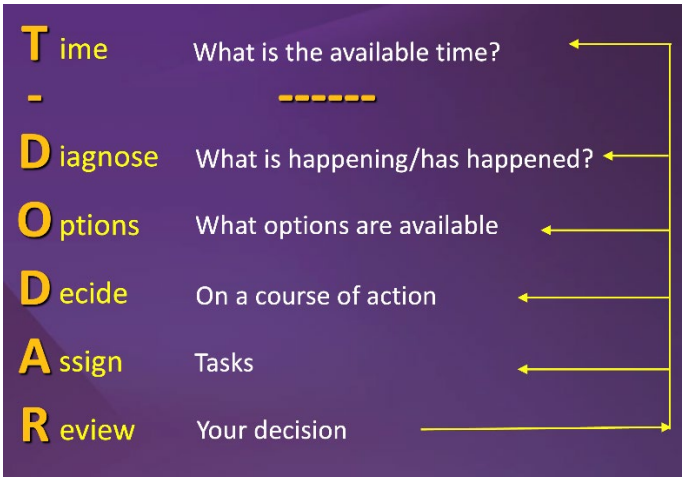
- Learnings form part of the Clinical Governance agenda and are discussed in the weekly 'share in the learnings' meetings held on site. No set agenda, all staff are invited to attend.
- Learnings are shared via various patient safety forums.
- Discussed with staff during site visits to capture learnings.
- Poster competitions and prizes associated to learnings to encourage sharing of information.
- Included in organisations clinical bulletins and QR codes added to provide a prize to staff.

Other possible ways to share learnings include:

- Use case studies to present to staff.
- Keep written information brief and to the point and verbal information no longer than 5-10 minutes.
- Praise and encourage good behaviours.

Decision Making

Steve Reen https://smartreset.co.uk/ walked through a Decision-Making Tool (T-DODAR). Read more here. Steve is also happy to be contacted should anyone wish to learn more about training options available.



Medical Professionals involvement

- Consider increasing the opportunities within the sector for involving medical professionals in shared learning.
- Share & Learn CoP asked to consider inviting medical colleagues along to the CoP to co-present a case study.
- One organisation holds Divisional Directors Meetings where they undertake speciality reviews. Held remotely and discuss case studies, never events, serious incidents. Key is improving the attendance and a full discussion takes place at PP reviews. Agenda to be shared with CoP members.

Surgical Safety Checklist completion/compliance

- IHPN to explore the availability of an auditory prompt and its use in completion of a surgical safety checklist.