Independent Healthcare Providers Network

IHPN Share & Learn Community of Practice Quarterly Roundup

Issue: April 2023

Welcome!

As the second 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 March 2023.

Louise Pye - HSIB

The CoP were honoured to have Louise Pye from HSIB attend the last meeting to provide an overview on involving patients and family in incident management and investigation. Louise also shared some very interesting resources for providers to use.

Dates for your diary

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

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 get in touch with 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 second 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 March 2023, Louise Pye from HSIB attended to provide her thoughts on the involvement of the patient and their family when reviewing a particular incident brought to the table by a provider. This proved valuable and provided the group with some additional insight and approaches that can be adopted to ensure those involved in incidents feel inclusive.

Steve Reen from Smart Reset will be in attendance at the next Share & Learn meeting to provide a Human Factors perspective on the next incident to be discussed amongst the group members.

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

A patient was called for theatre and arrived in the anaesthetic room, unfortunately he was second on the list but had been called first. He was returned to his room and went down correctly sometime later. Following their procedure, the patient reported auditory awareness when they were in the anaesthetic room.

During the induction the anaesthetist noted the patients hand twitching:

- The patient was a difficult intubation but was monitored well throughout.
- Some challenges noted with achieving oxygen saturations.
- Some difficulties when trying to cannulate with one of the lines tissuing.

Action points

- When requesting a patient to be taken to theatre, do not use patient room numbers, room numbers can change often. Patients demographics should be used. This caused the patient an element of unnecessary anxiety pre op, plus the serious safety issue this poses.
- Ensure known issues are identified and fully documented at Pre-Operative Assessment. Could the challenges have been predicted earlier based on the pre-operative assessment outcomes?
- Consider how patients are coached and supported when receiving anaesthetic induction by anaesthetists and anaesthetic staff. For example, what explanation is given to patients about what to expect when going under anaesthetic and are patients asked to count down etc? Do we routinely inform of risks such as auditory awareness in high risk patients?
- Anaesthetist noticed hand was twitching during induction and took additional action including: increase monitoring of patient, observations and anaesthetic figures including the BIS reading and Et-Sevo concentration reading which gives a direct measure of the effects of anaesthesia on the brain identified IV cannula extravasation and mitigated it to prevent any adverse effects for the patient as patient had started to desaturate.
- A BRICE questionnaire was completed following the procedure when the patient indicated that he heard voices during the procedure. (BRICE questionnaire aims to identify the potential for suboptimal anaesthetic post-procedure). Please note not all patients are asked the BRICE questionnaire, this was done because the anaesthetist had concerns. He thought it was good practice to check if the patient had any pain during the procedure. It is suggested that the BRICE may be conducted at 0-24 hrs, 24-72 hrs and at 30 days following the procedure.
- Good practice – Anaesthetist comprehensively completed and submitted an incident report; the notes were very thorough and demonstrated a very good rapport with the patient.

Patient and family involvement

- When meeting with patients and family members following an incident aim, where possible, for a colleague - ideally a subject matter expert - to be present during the meeting to support with note taking and answering questions etc.
- Virtual technology is not reliable when meeting with patients and family to discuss an incident and where possible, meetings should be held in-person.
- If a virtual meeting is required to discuss an incident with a patient and family, testing of technology is crucial prior to the meeting.
- Meetings with patients on a Friday are not ideal as this may leave staff and patient over the weekend with additional thoughts or questions that need to wait until the Monday.
- Where possible aim to have a relative or friend to support the patient during and following incident meetings. Consider consent if speaking to family/friends.
- Virtual meetings with patients and family have the potential to cause a barrier to being wholly empathetic following an incident.
- A written follow up summary is key with clear outcomes to ensure the patient is clear of what is being investigated following an incident with clear expectations of timelines established and an expected end date.
- Appropriate signposting to be provided to patient and family following an incident investigation conclusion such as support groups/charities etc.
- During the incident investigation stage, be clear with the patient and family when there is a delay and expected revised timelines.
- Be clear, open and transparent with the patient and family when initiating Duty of Candour.

Louise Pye (HSIB) – Key Takeaways

- 'LearnTogether' toolkits available online that can be used by providers to localise.
- Organisational policies need to define exactly what family means to the patient as this means different things to different people.
- Consider what support is available on organisations websites for patient and family support.
- Ensure accessible information is available to support patients and families who may have dyslexia, language and communication barriers.
- Best practice is for patients and families to be asked to provide feedback on how well incidents were managed either via online/paper/telephone/face to face methods.
- A formal process should be in place to support staff dealing with difficult conversations with patients.
- Consider Trauma Risk Management training (TRiM) a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event. TRiM is based on 'watchful waiting'.
- The NHS Resolution Duty of Candour animation offers guidance on the importance of being open and honest. They have produced a short animation to help those working in health and social care to better understand the similarities and differences that exist between the professional and statutory duties of candour.