Independent Healthcare Providers Network

IHPN Share & Learn Community of Practice Quarterly Roundup

Issue: March 2024

Welcome!

As the sixth Round Up for IHPN Share & Learn we hope you find this update useful, please feel free to share with your Patient Safety, Clinical Governance and Heads of Department colleagues !

New Share & Learn updates this quarter

Find enclosed recent learnings identified at the meeting held in March 2024.

Dates for your diary

2024 dates for the Share & Learn CoP 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 hearing from any medical colleagues that would be interested in joining or presenting a case study during the meetings. Please get in touch with 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 get in touch with linda.jones@ihpn.org.uk if you would like to share any changes you have made following any 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 sixth 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.

IHPN Share & Learn Webpage

IHPN have developed a webpage for the S&L CoP. Here you will find copies of this Round Up and other valuable resources that are shared within the meetings. Please use this link to access the webpage.

Share & Learn Report

To read the '12 months on' report please click here.

Future Meetings

IHPN are looking for providers who have services in central London to host future meetings for approximately 15 CoP members. Please get in touch if you can support.

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 incident

Case study background

The case study related to a 48-year-old male:

- Admitted for laparoscopic sleeve gastrectomy.
- A planned admission to Critical Care for post-operative surgery requirements (level 1 care).
- BMI: 47 (Weight: 146kg & Height: 175cm).

PMH / PSH:

- SOBOE; investigated without any underlying causes identified.
- Hypertension.
- Obstructive sleep apnoea - CPAP 14 years.
- Hypercholesterolemia 2011.
- Type 2 diabetic 1996.
- Previous DKA admissions 2015 and reviewed by an Endocrinologist every 6 months.
- Chronic back pain.

Initially listed in the NHS. Suffered multiple postponements due to diabetic control and the pandemic.

Elected for private health care and suffered further postponed dates due to raised HbA1C.

Eventually TCI confirmed once patient lost 11 kilograms in weight and HbA1C results were acceptable.

48 hours post surgery

- Patient developed post operative complications of abdominal pain and received on site CT scan.
- Leading to a further unplanned re-admission into critical care (level 2 care).
- CT reviewed by two Consultant Bariatric Surgeons who agreed patient did not require surgical intervention.

96 hours post surgery

- Two days later, following a further deterioration, the patient went into cardiac arrest and had an unsuccessful resuscitation attempt.
- Impression for deterioration was due to acute renal failure (e-GFR 23).

Assessments – initial themes identified were:

- Due to a complex resuscitation, there were three independent reviews undertaken by Consultant Bariatric Surgeon; Consultant Anaesthetist and a Consultant Intensivist.
- Reviews considered patient suitability for admission to an independent healthcare setting.
- There were learnings identified in the management of initial acute kidney injury and respiratory failure.
- Considerations around need for earlier transfer to NHS.
- Difficulties outlined in the management of delirium and new confusion. Staffing mix, skill, competence and training.
- Significant difficulties in securing an airway. "Cannot intubate cannot ventilate" (CICV)

Post incident reflections:

- A key factor resulting in the tragic outcome for this gentleman was an inability for the team to secure an airway during an unplanned rapid sequence induction (RSI).
- These challenges led to a complex, protracted unplanned event, which later deteriorated into an emergency resuscitation due to hypoxaemia.
- There were enough colleagues present at the commencement of intubation. There were enough people with experience and seniority. These clinicians were not a "junior" team.
- The team had attended many unplanned emergency events over their careers previously.

So, why could staff not secure an airway in a patient previously assessed to have grade 1 airway?

- Planned and unplanned airway management are not the same.
- Difficult airway standard guidelines may only work, should all stages of these guidelines be progressed through.
- All colleagues need to have an understanding for DAS to be aware when guidance is not adhered to.
- Distraction regarding EtC02 measurement or lack of.
- Situational awareness and clinical human factors were key.
- Elaine and Martin Bromiley (2005) have had a lasting impact, though one must not assume "work as done" matches "work as perceived".

Learning outcomes:

- Planned care can immediately alter to emergency care without time to pause.
- Colleagues who are less exposed to emergencies may require more drills or emergency scenario sessions to aid preparedness.
- How confident are experienced, senior colleagues to insist on a pause and "time out" moment.
- Enable an open culture to allow colleagues to debrief safely. This is imperative to ascertain true route causes.
- The importance of sharing best practice and where practice is more challenging.
- Provide extensive scenario training sessions, so colleagues understand the value and limitations of national clinical guidelines.
- Awareness of impact on family and loved ones.

For Information:

- Just a routine operation https://www.youtube.com/watch?v=JzlvgtPlof4.