Barking, Havering and Redbridge University Hospitals NHS Trust

Patient Safety Memo

www.bhrhospitals.nhs.uk

DUTY OF CANDOUR

Duty of Candour is all about being open and honest with our patients and service users (and those acting on their behalf) about their care and treatment.

It is a statutory regulation within the Health and Social Care Act 2008 and sets out what processes we must follow when things go wrong with care and treatment, including letting people know about the incident, providing reasonable support and truthful information, and apologising.

If you have any queries about Duty of Candour within your role, please make sure you speak to your line manager.

AT OUR HOSPITALS, PATIENT SAFETY IS THE RESPONSIBILITY OF ALL OF US

During a visit to the NASA space center in 1962, President Kennedy noticed a janitor carrying a broom. He interrupted his tour, walked over to the man and said, "Hi, I'm Jack Kennedy. What are you doing?"

The janitor responded, "I'm helping put a man on the moon, Mr. President."

John F. Kennedy

"Duty of candour is basic human interaction"

DR ANDY HEEPS

CONSULTANT OBSTETRICIAN

My role includes a duty of candour when communicating with my patients. It is important for me to involve the patient in decisions that are made by providing them with the information they need to make those decisions. I do not see the doctor's role as that of a super hero and both I, and the patients I care for, accept that things can go wrong.

When wrong decisions are taken and there is a catastrophic outcome for the patient, it is my duty to launch an investigation into exactly what went wrong to find out where improvements can be made in order for it not to happen again.

This information is then communicated to the patient, their family as well as the staff members on the ward, both immediately and at a later date when there is an opportunity for a calm and clear conversation, when they no longer feel vulnerable.

Junior staff must not feel inhibited to communicate when mistakes are made and it is my job to create an environment where they feel supported to come forward openly and honestly.

"Saying sorry"

GRAINNE O'CONNOR

QUALITY AND SAFETY ADVISER–CHILD HEALTH

Involving children and their next of kin with truthful, prompt and accurate information with regard to any mistakes that have occurred while receiving care at BHRUT is now, according to new guidelines, enforceable by law.

This is in addition to the ethical requirement of 'Being Open' which promotes transparency and a culture of being honest. Identifying patient safety triggers within our Children's Services department allows the clinical team as a collective to quickly recognise what went wrong and notify the child's next of kin. This opportunity allows us to apologise to the patient and family for any possible harm caused.

If an investigation process is required we endeavour to involve patients and relatives in the process and discuss the findings in an open and transparent way. This process of investigation provides a platform for us as professionals to learn from our mistakes, rectify any areas of concern and put systems in place to prevent any further harm from occurring. As an organisation it is vitally important that we embrace candour and the improvements that could be made as a result.

TO ENSURE THAT EVERY PERSON IN OUR TRUST IS AWARE OF THEIR ROLE IN RELATION TO THIS WEEK'S PATIENT SAFETY ISSUE, WE WOULD APPRECIATE IF YOU COULD COMPLETE THE BRIEF SURVEY.

What impact does your role have on the duty of candour in the work environment?

Write response here

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- ☐ QUEEN'S HOSPITAL

I work in...

- ☐ ADMINISTRATIVE AND CLERICAL
- ☐ ALLIED HEALTH PROFESSIONALS
- ☐ HEALTHCARE SCIENCE SERVICES
- ☐ MEDICAL AND DENTAL
- ☐ NURSING AND MIDWIFERY
- ☐ PATIENT/ PUBLIC

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Good Governance Institute

TAKING PRIDE IN OUR CARE

Memo Number 2 - October 2015

Barking, Havering and Redbridge University Hospitals NHS Trust

Patient Safety Memo

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PATIENT FALLS

A fall isn't just a fall, particularly if the patient is frail. There could be serious consequences. So to make sure our patients are kept safe while they are in our care, it is vital we are all aware of the role we each play and know our specific duties to reduce the risk of falls.

To ensure that every person in our Trust is aware of their role to reduce falls, we would appreciate if you could complete the brief survey by following the URL provided.

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John F. Kennedy

LUMINITA GARBACIA

HEALTHCARE ASSISTANT
EMERGENCY DEPARTMENT, QUEEN'S HOSPITAL

I am responsible for helping to prevent falls here in the Emergency Department. A big issue we have here is spilling of liquids, especially cups of tea.

If there is a tea spill my first action is to warn people about the hazard with the yellow sign and make sure to tell people to be careful of falling because some tea had been spilt. I then mop up the tea spill with tissue paper immediately and call the cleaner to clean and dry the area. When the spill has been removed, I put the yellow sign away. If a patient is identified as someone who may spill their tea, we provide them with a special closed cup which they are able to sip from, and the nurses are informed. This further reduces the risk and keeps people safe from falling in the department.

JASON SEEZ

DIRECTOR OF PLANNING AND GOVERNANCE

At our Trust we work as a team to investigate all serious clinical incidents. Falls are one of the main themes of these. Compared to the national average we are better than many other hospitals in preventing falls, however, when they do occur, it is my job as the executive lead for quality and safety governance to ensure that lessons are learnt and that the actions to prevent patients from falling are implemented. We have established weekly patient safety summits every Tuesday at 1pm, where clinical leads discuss serious incidents openly and without blame in order to learn lessons and implement measures to keep our patients safe.

DR KAWA AMIN

CONSULTANT PHYSICIAN IN CARE OF THE ELDERLY
QUEEN'S HOSPITAL

I am involved in the development of our Trust Falls Prevention programme. We are in the process of bringing together an integrated service for our patients who experience, or are at risk of falls by proposing a four stage care pathway:

First, all adult patients who are admitted to hospital are assessed for their risk of falls. People aged 65 or over are automatically assumed to be at risk. The level of risk of individuals falling is assessed on the basis of their mobility, cognition and the medication they may be taking. At this stage the use of bed rails will be assessed and any walking aids required will be issued.

Second, anyone who is deemed to be at risk of falling will have a falls risk symbol added to their medical chart in order to warn clinical staff of the risk.

Third, we are in the process of reviewing and redesigning a leaflet that will make patients and their carers aware of the importance of falls and the potential serious consequences of a fall to the patient's overall health.

The fourth step is about rehabilitation and continuous practice management. I also work at the community falls clinic and we are in negotiations to refer more of our patients who fall to this clinic, once they have been discharged from BHRUT NHS Trust.

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What measures can we take to reduce the number of falls?

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TAKING PRIDE IN OUR CARE

Memo Number 3 - November 2015

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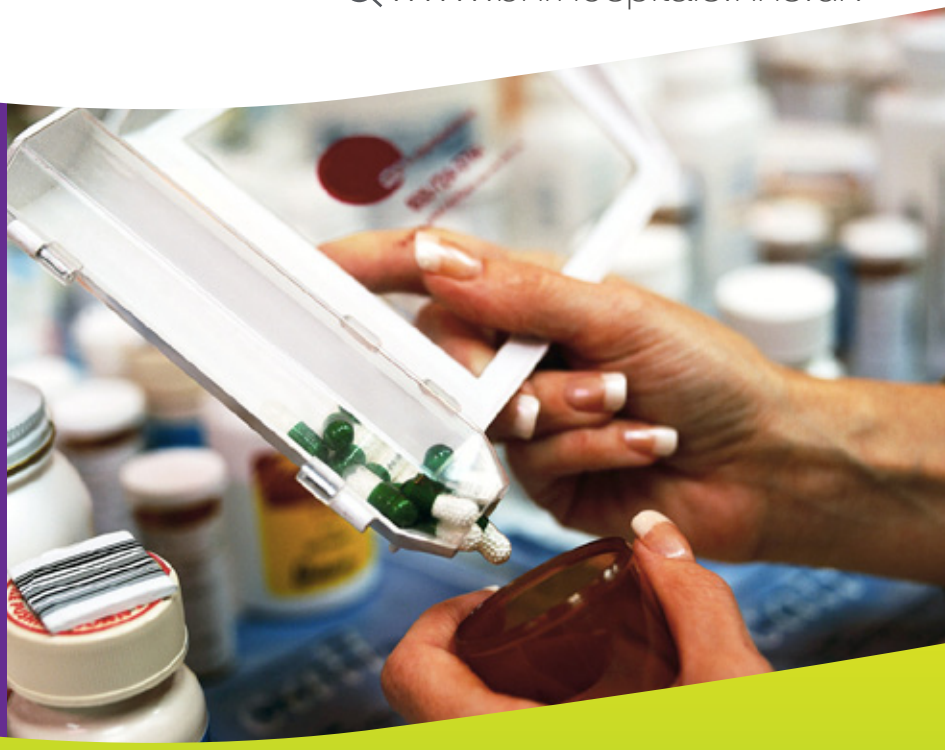
MEDICINES MANAGEMENT

Administering medicines is the most frequent intervention to patients in the NHS, and making sure we follow best practice in the way we manage medicines is vital to keep our patients safe. It is also important that we report any medication errors or near misses, as this helps us to learn lessons and reduce the frequency of these incidents.

Dr Nadeem Moghal, Medical Director



"PATIENT SAFETY IS EVERYONE'S RESPONSIBILITY"

We need to hear from you so we can improve the way we manage medicines to keep our patients safe. Please take two minutes to complete the quick survey at the end of this Patient Safety Memo, and tell us how you play your part.

Matthew Hopkins
Chief Executive

BALJIT SAHOTA

PRINCIPAL PHARMACIST, QUALITY AND SAFETY
KING GEORGE HOSPITAL

To ensure medicines are safe to be administered, they must be stored at the right temperature. If they are stored incorrectly they may not work in the way they were intended which could pose a potential risk to the health and wellbeing of our patients. Nursing staff and departmental leads should be monitoring the fridges daily to ensure that they are working properly, and I regularly audit the temperature logs in my clinical areas to check that medicines are being kept properly.

Controlled drugs are bound by legislation to make sure that they are securely stored, stock levels are correct, and each administration is accurately and clearly recorded. Pharmacists monitor controlled drugs every three months to check stock balances and check that all entries in the controlled drug record book are legally correct and legible.

All medicines on our wards and in our departments need to be stored safely and securely and we all have a role to play in that.

WAYNE HURST

MATRON, EMERGENCY DEPARTMENT
QUEEN'S HOSPITAL

Patient safety is at the core of everything I do. One of the ways I can achieve this is by ensuring doctors and nurses are undisturbed while preparing medicines behind a closed door, in the designated utility area. I have had extensive training in eliminating errors caused by the human factor.

The Emergency Department is a busy place; it is vital for us to learn how errors are made and to learn from those mistakes so we avoid them in the future. When errors do occur I promptly investigate, take on learning points and make urgent changes to protocol. It's about encouraging and adopting a learning culture.

ANGELA BELL

PRINCIPAL PHARMACIST, CLINICAL SERVICES
QUEEN'S HOSPITAL

When a patient is first admitted, I confirm which medicines they are taking by speaking with the patient, checking any medicines they have brought with them to the hospital, checking any previous discharge summaries and, where necessary, contacting their GP or accessing their Summary Care Record.

I also make sure that any medicines a patient has taken before they were admitted are reconciled against the medicines prescribed on their prescription chart and discuss any discrepancies with their doctor. When I am on the ward I make sure that any medication the patient needs is obtained from the pharmacy. When I am not on the ward I need the help of the doctors and nurses to let me know what changes have been made to a patient's prescription so that I can help to make sure the medicine is available.

If the pharmacy is closed, we have an extensively stocked emergency drug cupboard where medicines can be obtained and there is a pharmacy on-call service which can provide advice and information on medicines. Administering medication at the correct time is essential to keep patients safe from avoidable harm.

WE ARE ALL RESPONSIBLE FOR KEEPING OUR PATIENTS SAFE. PLEASE SHARE YOUR VIEWS ON HOW YOU MANAGE MEDICINES BY ANSWERING THE QUESTION BELOW.

How do you help to ensure safe medicine management for patients?

Write response here

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SPEAKING UP

A key part of keeping our patients safe is for staff to speak up when they are concerned about an issue, as well as to underline the organisation's commitment to quality care. We have a Guardian Service just as Sir Robert Francis recommended following his review into the failings at Mid-Staffordshire. Speaking up is everyone's job. When a colleague voices a concern we should listen and decide what action needs to be taken. In a busy hospital speaking up and reinforcing the safer care culture isn't always easy, and it's important we all feel able to raise concerns and worries and suggest ideas for improvement.

"PATIENT SAFETY IS EVERYONE'S RESPONSIBILITY"

We need to hear from you so we can improve the opportunities you have for your voice to be heard. Speaking up helps to keep our colleagues and patients safe. Please take two minutes to complete the quick survey at the end of this Patient Safety Memo, and tell us how you play your part.

Matthew Hopkins
Chief Executive

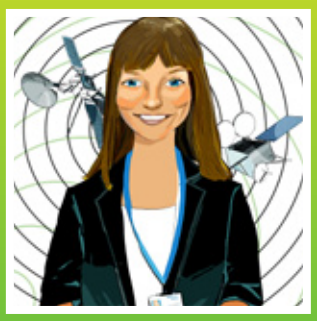
JENI MWEBAZE

GOVERNANCE MANAGER, SPECIALIST MEDICINE DIVISION

I am responsible for two staff, a Complaints Co-ordinator and a Quality and Safety Facilitator in our division. They know that they can come to me and raise concerns, or talk to my line manager or the divisional senior management team.

I encourage my staff to feel safe and to know that they are listened to when they speak up by being positive about any concerns raised, and to focus on solutions and learning rather than difficulties and problems.

Staff do not have to raise concerns to their line manager if they feel uncomfortable doing that. They can talk to their manager's manager or use the independent Guardian Service and their concerns will be dealt with appropriately and in confidence. The Guardian Service is available for all staff and details are on the intranet under HR.



RACHEL ROYALL

DIRECTOR OF COMMUNICATIONS AND MARKETING

Helping people to speak up is a core part of my job as Director of Communications and Marketing. I'm really passionate about people having honest conversations that help solve problems. Sometimes this means you need to be brave and take responsibility.

Speaking up, for me, means letting your manager know if there are things that you're unhappy or worried about. If you're still concerned then you need to raise it at the next level. To ignore things means that things won't get fixed and won't get better for colleagues or patients.

There are lots of forums to get your voice heard and to get involved, like coming along to a Meet the Chief session or if its more serious or confidential contacting our Guardian Service. We also have a responsibility to speak up about the good stuff too, work can be tough, so let's be proud of what we've achieved.

WE ARE ALL RESPONSIBLE FOR SPEAKING UP AND KEEPING OUR PATIENTS SAFE. PLEASE SHARE YOUR VIEWS BY ANSWERING THE QUESTION BELOW.

Give us the benefit of your experience. How can we improve patient safety in our hospitals?

Write response here

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TAKING PRIDE IN OUR CARE

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BETTER PATIENT RECORDS

We work hard to ensure the safety of our patients at all stages of their journey through our hospitals, and that includes making sure they have up to date, high quality patient records. As part of our continual improvement we need to keep asking ourselves if we are working in the best way that we can, because without excellent record keeping and a good flow of information, the quality of our patient care is affected. When we are all aware of each step in our patients' journeys, we can improve our communication with them and work better with each other across departments and across sites.

"PATIENT SAFETY IS EVERYONE'S RESPONSIBILITY"

High quality information helps to keep patients and each other safe. We want to hear from you so we can improve our systems and our patient records. Please take two minutes to complete the quick survey at the end of this Patient Safety Memo, and tell us how you play your part.

Matthew Hopkins
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RUSSELL EVANS

BUSINESS INFORMATION MANAGER, INFORMATION SERVICES
QUEEN'S HOSPITAL

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DR MAX CHAUHAN

ASSOCIATE MEDICAL DIRECTOR
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As a Consultant in Oral Surgery I need high quality information about each patient so that I can ensure that the best quality care, treatment and support is provided to them. Good quality, accurate records means that they include information for the clinical team about all test results, have a record of patient appointments, are clear, filed correctly and are available without delay.

Patient records are our most important source of clinical information. If the information or records are wrong, there can be very serious consequences. I know that for us as a healthcare team, as part of providing high quality care it is important to follow good practice guidelines to make sure that appointments are made within minimum time periods, and to keep notes secure, up to date and accurate. This will help us to ensure that we remove the potential for any avoidable harm to patients.

WE ARE ALL RESPONSIBLE FOR ENSURING THAT OUR PATIENT RECORDS ARE OF THE HIGHEST QUALITY AND KEPT SAFE. PLEASE SHARE YOUR VIEWS BY ANSWERING THE QUESTION BELOW.

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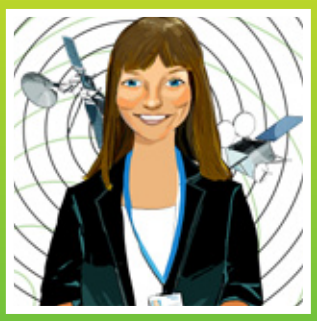

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