Patient Safety Matters

PROMOTING A CULTURE OF SAFETY AND QUALITY AMONGST JUNIOR DOCTORS ISSUE 8 - October 2016

THE INCIDENT TRIANGLE

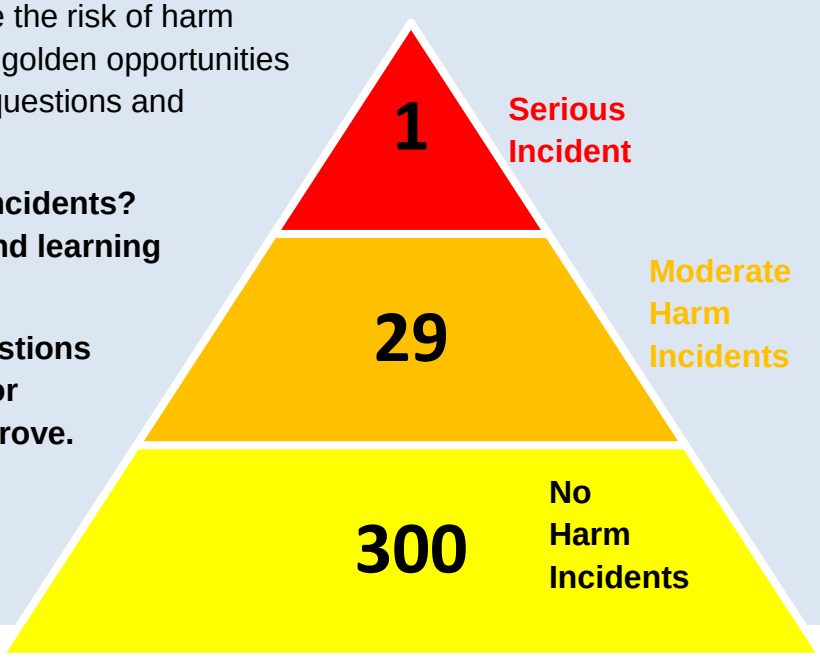
In 1931 William Heinrich, working in industrial accident prevention, introduced the **accident triangle**. The accident triangle proposes that for every **300 unsafe acts** there are **29 minor injuries** and **one major injury**. Although healthcare has distinguishing characteristics from other sectors, analysts point to similarities and suggest opportunities to learn from other industries. Human factors science would be one such example which has come from the airline industry. Root cause analysis, a widely used tool in healthcare is another example with its origins in engineering. The principle of the accident triangle has been transferred to healthcare to suggest a ration between the number of incidents with different degrees of harm. The healthcare incident triangle suggests that:

For every 1 serious incident there will be 29 incidents resulting in moderate harm and 300 no harm incidents.

It is important to realise that this model does not suggest that the causal factors for different harm incidents are the same. What some say this model does suggest is that if we investigate and learn from the 300 no harm events we may be able to make changes and improvements that reduce the risk of harm incidents. These no harm incidents are golden opportunities to learn and improve. This lead to two questions and challenges:

1. Are we **reporting these no harm incidents?**
2. Are we **effectively investigating and learning** from these no harm incidents?

Until we can say yes to these two questions we are ignoring these warning signs or golden opportunities to learn and improve.



Heinrich, 1931. Bird 1969.

William Lea
Clinical Leadership Fellow, william.lea@york.nhs.uk

PHARMACY

Helen Holdsworth (Deputy Chief Pharmacist)

Monitoring platelets in patients on Low Molecular Weight Heparin (LMWH)

There were several incidents earlier this year where patients where started on LMWH when their platelets were low, or where LMWH was continued inappropriately when the platelet count fell.

We asked the haematologists for some guidance:

- FBC should be checked before starting a patient on LMWH
- If platelets are less than 75 discuss risk/benefits with your consultant
- If platelets are less than 50 discuss risk/benefit with haematology
- Recheck FBC after 3-5 days then every 5-7 days.

See Heparin Induced thrombocytopenia guidance on staff room for more information

Blast from the past – Do not prescribe methotrexate routinely for inpatients

Just a reminder that the Trust's policy is that Methotrexate should **NOT** usually be prescribed on admission to hospital. This is because there is the risk or inadvertently prescribing this on a daily, rather than a weekly basis, and also that it may be inappropriate for the methotrexate to be continued.

Methotrexate should be documented on the drug chart but the administration section scored out.

Controlled Drug Prescribing

When prescribing, reviewing or changing **controlled drug prescriptions**, follow Trust guidelines and take into account the following:

- Appropriate route, formulation and the dose (including when dose conversions or dose equivalence is needed).
- Ensure the dose and frequency is correct and clear on the prescription chart.
- Reduce the potential for confusion by avoiding decimal points whenever possible (use 2mg to 5mg rather than 2.5mg to 5mg).
- Write the dose clearly and confirm the dose in words. This is particularly important for confirmation of high doses e.g. more than 10mg morphine and other high strength opioids.


NICE Guidance 46

Safe use and management of controlled drugs

The National Institute for Health and Clinical Excellence (NICE) published a guideline on the safe use and management of controlled drugs (CDs) in April this year. The recommendations seek to reduce the safety risk associated with CDs.

Safe prescribing

When prescribing, reviewing or changing CD prescriptions, follow Trust guidelines and take into account the following:

- Appropriate route, formulation and the dose (including when dose conversions or dose equivalence is needed).
- Ensure the dose and frequency is correct and clear on the prescription chart.
- Reduce the potential for confusion by avoiding decimal points whenever possible (use 2mg to 5mg rather than 2.5mg to 5mg).
- Write the dose clearly and confirm the dose in words. This is particularly important for confirmation of high doses e.g. more than 10mg morphine and other high strength opioids.

How can the risks be reduced?

When making decisions about prescribing CDs, take into account:

- The benefits of the CD treatment and the risks of dependency, overdose and diversion.
- The documentation of indication, regimen and arrangements for review.
- The use of evidence-based sources, such as BNF, palliative care and anticipatory medicines guidelines etc. available on staff room.
- Prescribing different routes separately.
- Providing advice to patients and documenting what has been done.

For more information check out the NICE Guidance and Medicine Matters 69.

Safety Huddles

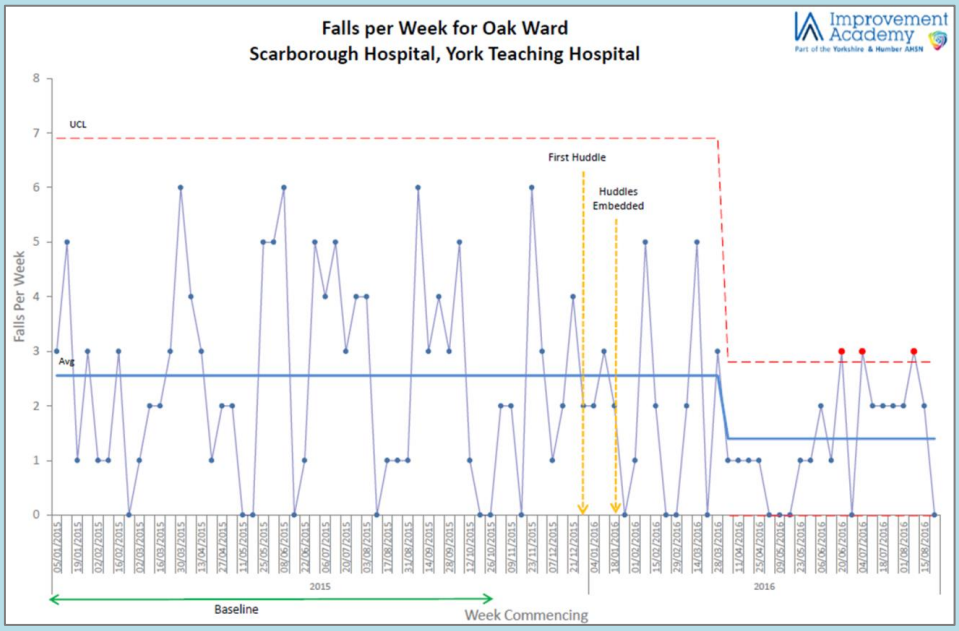
What is a safety huddle?

Safety huddles (or safety briefs) are short meetings (typically held on a once daily basis) used for sharing information about potential or existing safety problems. They increase safety awareness among front-line staff, allow for teams to address identified safety issues, and foster a culture of safety. Safety huddles should be designed so anyone in a leadership position can call for and facilitate them.

Our Trust has been supported by a Health Foundation grant, through the Yorkshire and Humber Improvement Academy, with *Huddling up for Safer Healthcare* (HUSH). Implementation has focussed on the Scarborough site, with good evidence of benefit.

Is there an evidence base?

Safety huddles within the Trust have been shown to lead to improvements in safety areas such as the number of cardiac arrests, falls and observation compliance. Staff report a more cohesive culture and increased awareness of safety issues following implementation of safety huddles.



The graph above illustrates the number of falls per week on Oak Ward at Scarborough, and the introduction of safety huddles marked with yellow arrows. The photographs show **safety huddles** on Oak and Anne Wright wards in Scarborough Hospital.

A Trust wide group is being developed to support implementation of safety huddles on both the Scarborough and York sites.

For further information about safety huddles in the York NHS Trust contact the patient safety team or Lisa Pinkney on 7712860, lisa.pinkney@york.nhs.uk

Lisa Pinkney, *Patient Safety Manager*

NEW GUARDIAN APPOINTED – Lisa Smith

Safer Working and Freedom to Speak Up.

Lisa joined the Trust at the beginning of September after it was agreed that there should be an **independent** person responsible for championing safe working hours for junior doctors who can provide assurance that doctors are both rostered safely and actually working safely and where problems have not been resolved doctors can escalate their concerns to the guardian who will be empowered to require departments to take necessary action.

Lisa will convene a junior doctors' forum on a regular basis to advise on safe working hours, and says, "these *forums are a potentially beneficial opportunity for junior doctors to come together locally and work together to ensure their colleagues' views and concerns are represented to management, and to share knowledge and ideas about how to improve their working lives and I am keen to hear from any junior doctor wishing to become involved. I also have the role of 'Freedom to Speak Up Guardian' in the Trust and this is about developing a supportive culture for any staff who wish to raise safety concerns confidentially"*

Lisa Smith, *Freedom to Speak UP/Safer Working Guardian*
You can contact Lisa by email (lisa.smith@york.nhs.uk), **Call or Text Mobile 07818 427420**

SEPSIS KILLS
RECOGNISE · RESUSCITATE · REFER

Trust Sepsis Study Day

Celia Ingham Clark MBE
Medical Director for Clinical Effectiveness, NHS England

Friday 11th November 08:45 – 12:30

Contact Liz Jackson (liz.jackson@york.nhs.uk) to register.

GROUP REPRESENTATION

We are working to **empower** and **support** junior doctors to attend and **contribute** to Trust level meetings. Junior doctors and groups will benefit! The following groups are looking for junior representation:

- **DNACPR**
- **EPMA (Electronic Prescribing)**
- **HIPCG (Infection Prevention)**
- **Point of Care Testing Committee**
- **Patient Experience Steering Group**
- **Admission Proforma Group**
- **Deteriorating Patient Group**
- **Serious Incident Group**
- **Mortality Steering Group**

Contact PatientSafetyMatters@york.nhs.uk for more information or if you want to get involved.

EDITORIAL TEAM

William Lea (Improvement Fellow), Diane Palmer (Patient Safety), Helen Holdsworth (Pharmacy), Donald Richardson (Quality Improvement), Liz Jackson (Patient Safety), Elaine Vinter (Media & Communications)
Follow us on Twitter @PtSafetyMatters
Email PatientSafetyMatters@york.nhs.uk if you have any comments or would like to contribute.
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