



Learning to Improve

The learning lessons journey

Tracey Roberts Cuffin
Learning Lessons Lead
Head of Library & Knowledge Services
@L2IUHMB



University Hospitals **NHS**
of Morecambe Bay
NHS Foundation Trust



Learning does not take place in isolation, it needs to be shared and this is the core process. The Learning to Improve group identifies lessons and disseminates them using newsletters, focused bulletins, ward meetings and handovers. This ensures that lessons are shared from the board to the ward

Capture

Learning is captured from every area, including incidents, research, audit and patient relations within both corporate and divisional areas

SHARE

Reflect

Everything needs to be continually evaluated. Monitoring the impact and reviewing the implementation of lessons is essential through audit, assurance frameworks and patient experience

Evaluate

It is important to review and reflect on these lessons. Identify what they are telling us, what needs to be changed and what needs to be reinforced. This is done through RCAs, SIRIs, team meetings and formal committees

Improve

Whatever the lesson, it will have an impact. This is about making sure things improve by using personal reflection, changing policies/procedures or practice, it may also be referring matters to professional bodies or external regulators



The First & the Last

A Lesson Learned ...

“O! this learning what a thing it is”
(Taming of the Shrew Act I, Scene II Shakespeare)

Senior colleagues will remember a time before European Working Time Directive when, during our training, we were expected to work for extended periods of time, often covering for absent colleagues – essentially living on the job.

I was midway through my medical house job at a hospital in the West Midlands during one such period and as a colleague was on annual leave I had to do his on-call as well as my own. It was 9am on a Sunday and I was starting my fourth day of continuous work, having grabbed a few hours sleep. Sister had called me to the haematology ward to flush a blocked cannula with saline (salt water or sodium chloride). This was a routine procedure, which I had done a few moments and one that I had done dozens of times before.

Sister and I were chatting in the prep room and I pulled together all the necessary equipment - syringe, needle, gloves and saline. The saline was kept in a box which I opened, broke the vial and started to draw up the saline.

“You’re not going to give that are you?” asked Sister.

“Yes”, I replied (thinking, ‘that’s what you’ve asked me to do’).

“You’re not going to give that, are you?” she asked again.

“Yes, that’s to flush the cannula,” I again replied.

At which point, Sister took the syringe and vial from me. I had drawn up potassium chloride instead of sodium chloride - a potentially fatal error if injected into a patient. The vial was kept in an identical beige box in a glass vial, the only distinguishing feature being a black band around the neck of the vial.

I have never forgotten that morning - the consequences would have been dire. After a strong cup of coffee, I went back and gave the correct flush.

So, the lessons I learned that day and which have stayed with me are:

- Always check the name and expiry date of the drug I intend to give.
- Read out the details of the drug to a colleague.
- Make sure that I am giving the right drug to the right patient at the right time.
- Team working is essential – we must work together in an environment where we can challenge each other if necessary.
- We need to create an environment where patient safety incidents are reported in a no blame culture and where genuine learning can take place.

The boxes have been changed – having a dangerous drug in the same coloured and shaped box as another drug was not sensible. Potassium chloride is now not left out on a side shelf now.

Today this would be reported as a ‘near miss’ or as the National Patient Safety Agency (NPSA) would prefer ‘a patient safety incident (prevented)’. It certainly wasn’t reported in 1989!

Peter Dyer, Medical Director

If there’s anything you would like to share in the next issue,
Contact Tracey Roberts Cuffin at the Library on ext 46176
or email tracey.roberts-cuffin@mbht.nhs.uk

Learning to Improve @ UHMBT

NHS
University Hospitals of
Morecambe Bay
NHS Foundation Trust

Lessons from patient experience, clinical incidents and our staff

Produced by UHMB Library & Knowledge Services

May 2019 Issue 50

Welcome to issue 50 of the L2I Bulletin. The bulletin aims to share lessons learnt across the Trust so we are able to continually improve the services provided to our patients.

A Swiss Cheese event

Safety Pin

@UHMBT



Good Taking Warfarin, After Being Discharged from the Hospital on 10/12/18.

What?

The patient was discharged from the hospital on 10/12/18 for a stroke.

The patient was discharged on 10/12/18.

The patient was discharged on 10/12/18.

The patient was discharged on 10/12/18.

The patient was discharged on 10/12/18.

The patient was discharged on 10/12/18.

The patient was discharged on 10/12/18.

The patient was discharged on 10/12/18.

The patient was discharged on 10/12/18.

What Went Wrong?

The necessary referral to the District Nursing team was not made for this patient.

Staff did not check the patient understood their warfarin therapy and had access to support.

Staff discharged the patient with only enough warfarin for 2 days.

There was a delay in sending the discharge what to the GP.

What Could Have Made a Difference in Hospital?

The hospital staff should have made the patient to attend nursing.

The hospital staff should have checked more than two days' supply of medication.

The hospital staff should have done more to ensure the fully understood the risk of not taking warfarin.

What Could Have Made a Difference in the Community?

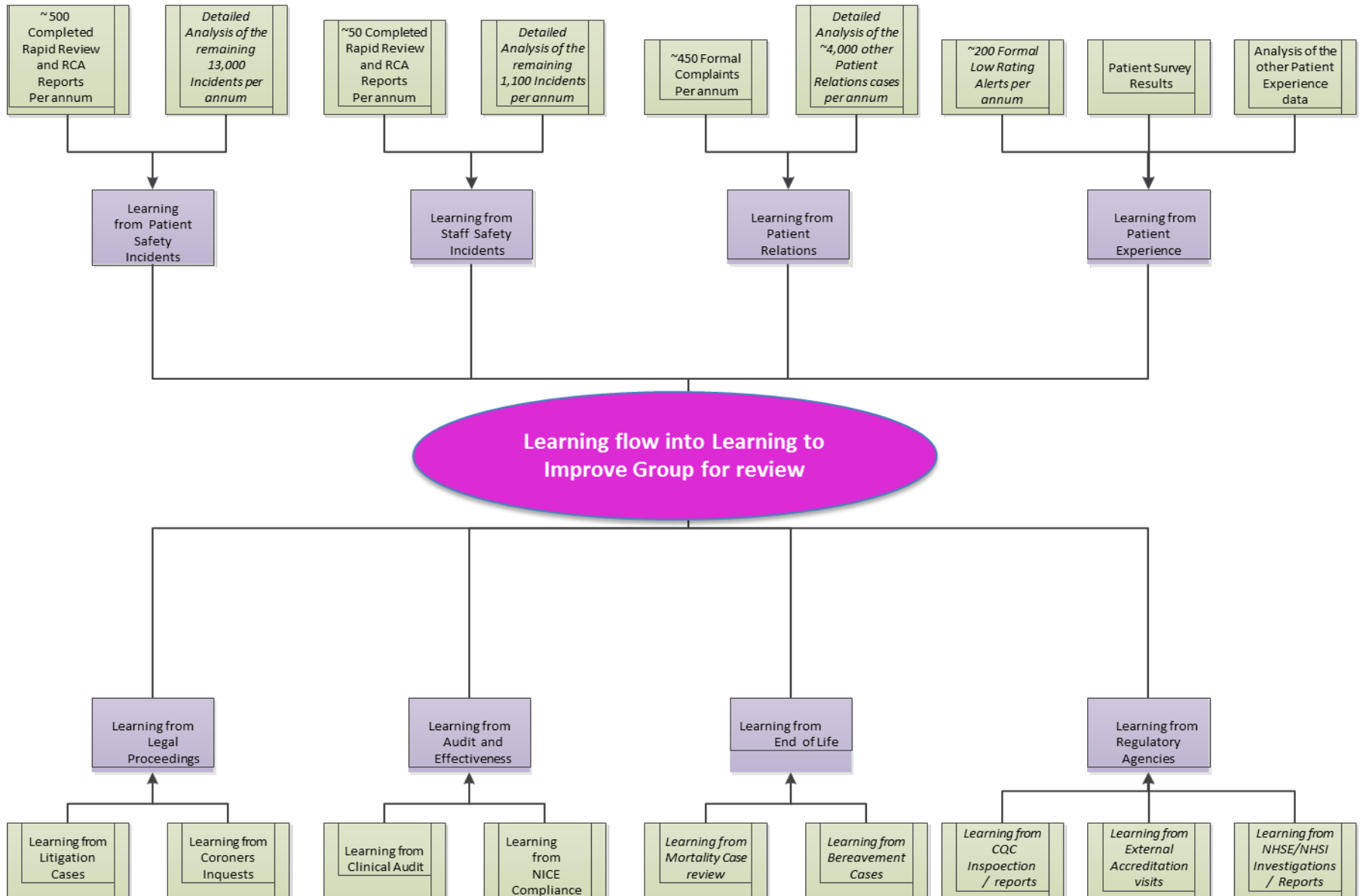
The GP should have considered escalating the body.

The GP should have considered prescribing a loading dose of warfarin.





Information Flow into L2I Group

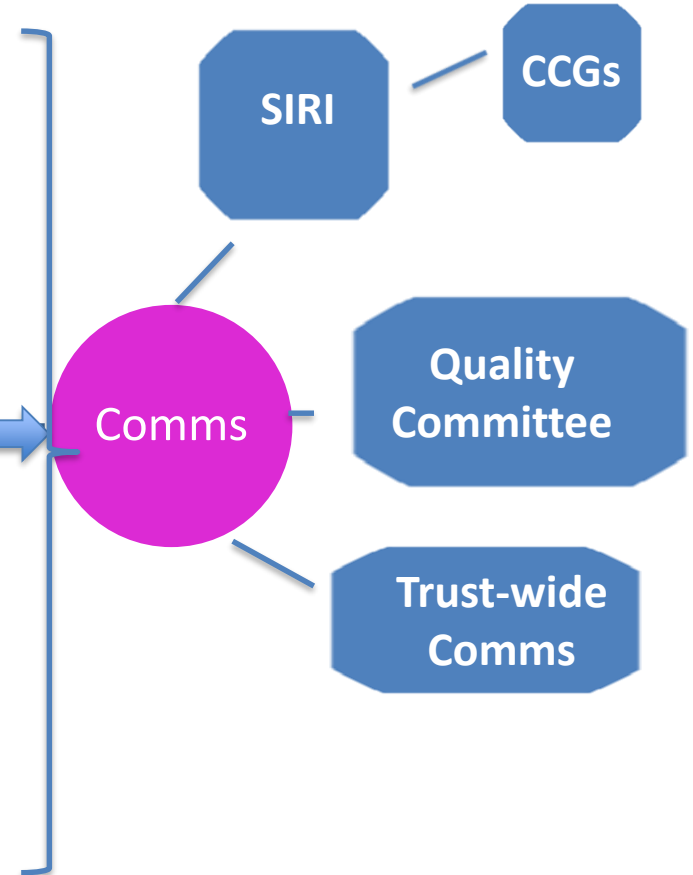


Learning Flow out of L2I Group

Closing the loop for assurance



Outcome



Improvement of L2I Group

- Improve the identification of Learning opportunities
- Standardised triage assessment process to identify real
- Agreeing measures for improvement
- Focussed on staff education/ training and system/process changes
- Include Patient voice/ story
- Post Implementation review and report

Identify and fully embed Learning

Learning to Improve – Assessment Checklist			
Assessment Details			
Assessment No:	[Each Assessment should have a unique reference number]		
Date of Learning to Improve Meeting:	DD/MM/YYYY		
Originating Care Group/Division:	[Name]		
Originating Committee/Group:	[Name]		
Source of the Learning:	Patient Safety Incident	Staff Safety Incident	
	Patient Relations	Patient Experience	
	Inquest	Litigation	
	Mortality Review	Bereavement Case	
	Clinical Audit	Assurance Processes/Checks	
	Other (please specify):		
	Summary of the events that caused the learning:		
Summary of the learning to implemented:			
Summary of the improvement measures to be used:			
Assessment Triage Process			
Assessment Criteria	Assessment Rating		
Is the Learning applicable to the clinical or operational services currently undertaken by the Trust?	Fully	Partially	Not at All
Is the Learning something that is 'Need to Know' or 'Need to Do', or is it just 'of Interest'?	Need to Know/Do		Of Interest



Any Questions



University Hospitals 
of Morecambe Bay
NHS Foundation Trust

