Learning to Improve

The learning lessons journey

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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 s… 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 n… 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 … stead of sodium chloride - a potentially fatal error if injected into a patien… ride was kept in an identical beige box in a glass vial, the only distinguish… band around the neck of the vial.
I have never forgotten that morning - the consequences would have been… 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:

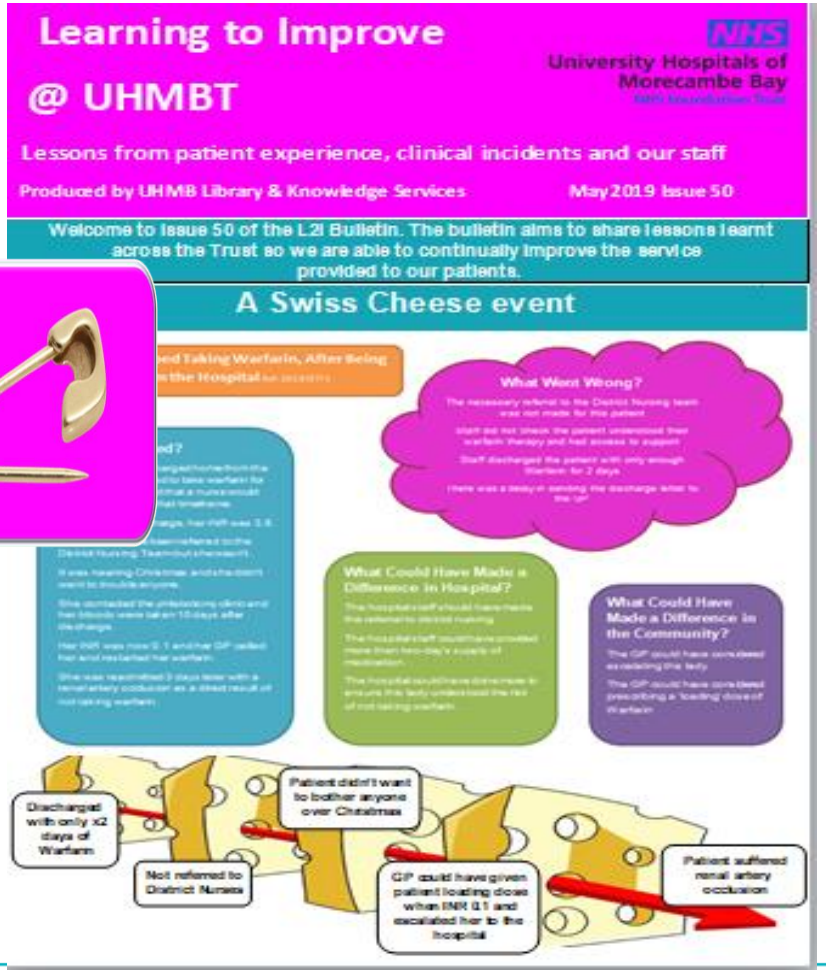
- Always check the name and expiry date of the drug I intend to give.
- Read out the details of the drug to a colleague.
- Make sure that I am giving the right drug to the right patient at the right time.
- Team working is essential – we must work together in an environment where we can challenge each 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



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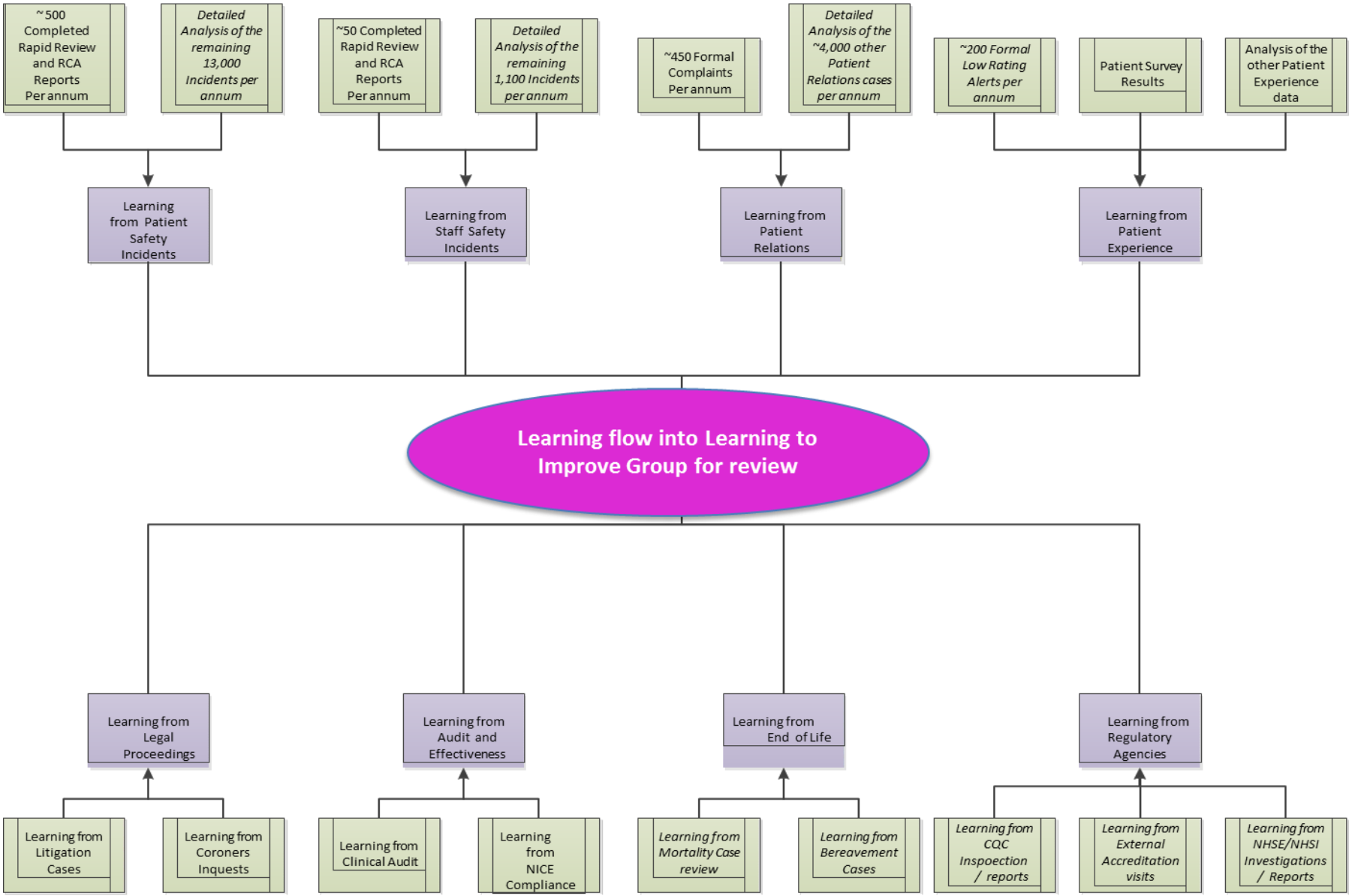
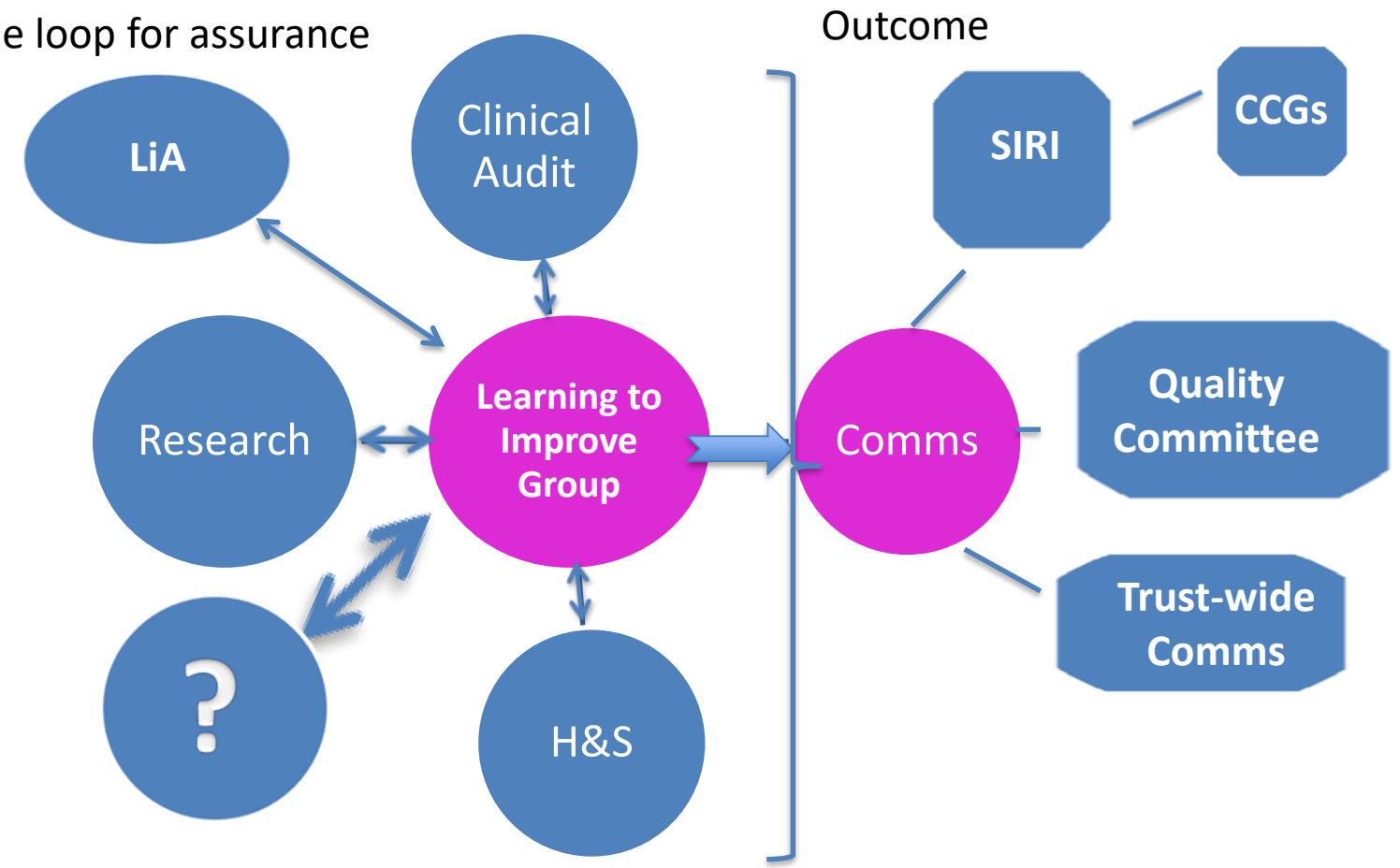
Evaluation?
What happened?
How have we shared it?
Proving our Learning Journey
What did we learn?
Where's the evidence?
What did we improve?

Information Flow into L2I Group



Learning Flow out of L2I Group

Closing the loop for assurance



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