Patient Safety

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November 2022

Welcome to the Patient Safety Newsletter…

This month's shout out goes to Crowborough ICU who have been working had trialing the new enhanced care paperwork and reducing the use of falls alarms. The ward have now been a month without using falls alarms in the cohort bay 10 with only one falls alarm being used in the rest of the unit. The ward have increased comfort rounds for the patients and are working hard with the TAG team in the cohort bay. Crowborough ICU have also significantly reduced their falls from 4 in April 2022 to zero in August 2022 and 1 in September 2022.

What brilliant work, well done!

Best Wishes,

Debbie, Charlotte, Hannah and Mary Jo

The Importance of Wound Photography

A patient's pressure ulcer deteriorated following admission to an inpatient bed. A wound assessment chart (WAC) was completed, but there was no wound photography in the patient's notes to help confirm the category of the wound at this time. The patient was escalated to the acute trust, but later returned to the ICU. The WAC continued to be reviewed regularly but no wound photography was completed. The patient remained on the ward and sadly the wound deteriorated. This incident high-lighted the value of wound photography in ensuring that there is a clear and accurate record of pressure ulcers.

The "Pressure Ulcer Prevention & Treatment Policy and Procedure for Children, Young People and Adults" states "All pressure ulcer should be photographed at least monthly to provide information about the progression of healing. Where digital images are taken, this should only be undertaken in accordance with the Consent Policy and the photographing of wounds guidelines. Photographic images of wounds should only be taken using a Trust approved SMART phones or cameras. A photograph should also be uploaded onto Datix when reporting the pressure damage."

Patient Safety News Flash!

Last month saw the first cohort of the new Investigation Training take place! Well done an thank-you to all those who were involved, we hope you found it useful and you are now keen to have a go at an investigation! The next cohort will be running in February 2023 and is delivered in four sessions each lasting two hours. If you wish to take part in the training then please do email the Patient Safety Team on sc-tr.patientsafetyteam@nhs.net . Or contact us if you have any questions about the training!

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AO1 (assistance of 1) or SO1 (supervision of 1)?

When assisting a patient to move, transfer or mobilise, they are assessed by therapists as requiring different levels of assistance to complete that particular task. A recent investigation into a patient fall on one of the ICUs highlighted that this level of assistance is not always clearly understood, with different staff groups thinking they mean different things. It was really interesting to have these conversations between both therapy and nursing staff about establish their understanding of what the different terms meant, and identified that it was important to confirm and agree these definitions:

AO1/2/3 (assistance of 1, 2 or 3): This means the physical hands on assistance of 1, 2 or 3 members of staff to help a patient move.

SO1/2 (supervision of 1 or 2): This means that 1 or 2 members of staff are right next to the patient but are not providing any physical hands on assistance, but they are easily able to provide this assistance if needed.

Mascot of the month— Halo says sorry

I am Halo, and my wonderful human is one of the Patient Safety Leads. I would say that I am a pretty good dog (most of time), although I wonder whether my human would disagree (I have heard her use the word diva every now and then…..). Still I try to behave as best I can.

However I am aware there are times where I over step the mark, or do something that I possibly shouldn't. I remember the time I ended playing with toilet roll and I have to say it might have got a bit out of hand…. Seeing the look on my human's face confirmed this and I really tried my best to make it up to her and get across that was sorry. I really felt like I was in the dog house!

However it did make me realise that both humans and us dogs can make mistakes, and it is what we do afterwards that is so important for those affected.

I overheard my human talking about Duty of Candour, or what she referred to as saying sorry. It was clear that this means how important it is to apologise to a patient or their relative when something has gone wrong whilst the patient has been under our care. It really confirmed to me how important it is to speak to the person right away, and get this initial conservation correct, to ensure openness and honestly and make sure those affected feel supported!

It makes sense as I know that when I got a little carried away with the toilet roll, I wanted to make sure my human new I was truly sorry and restore the trust between us!

For further information on all things Patient Safety please visit our team page on The Pulse, or follow us on twitter at @scft_quality. You can also the contact the team on: sc-tr.patientsafetyteam@nhs.net