# Learning from Mistakes

Spring Educators Conference

May 2016

Fiona Crosfill

Lancashire Teaching Hospitals NHS

NHS Foundation Trust

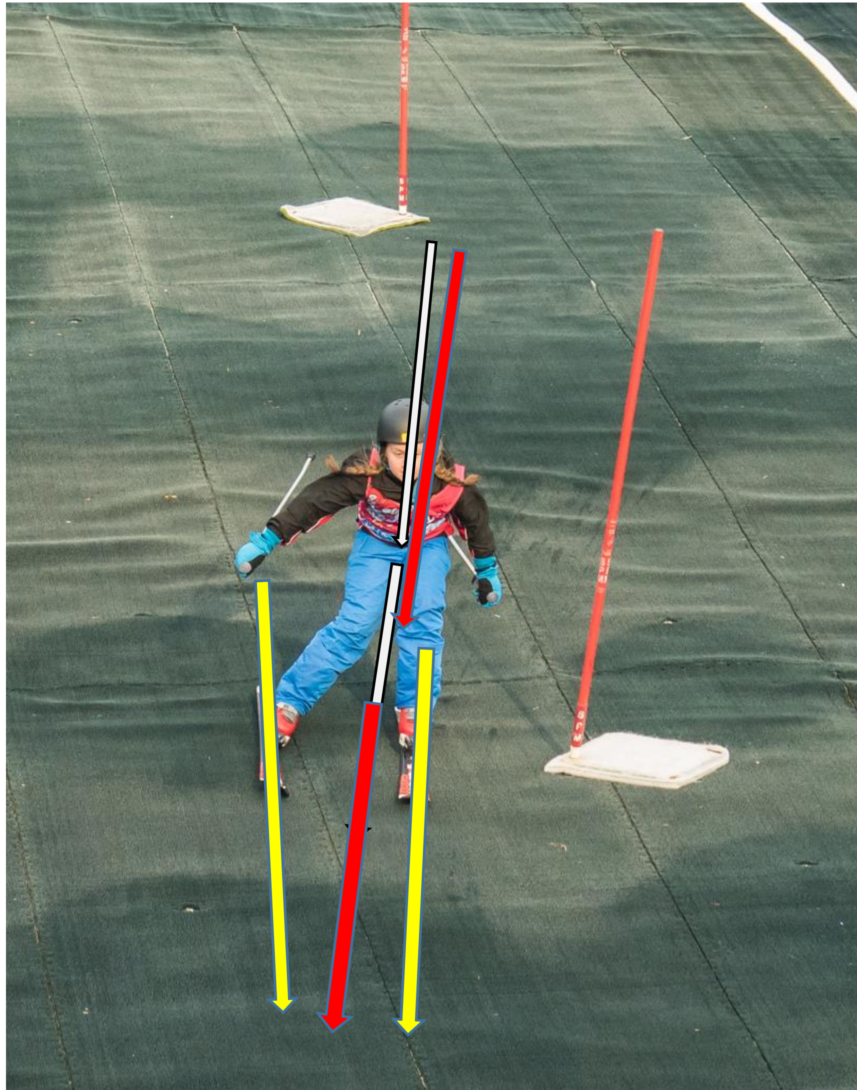
We’ve all been there…………..

# The more I practice, the luckier I get

- https://www.youtube.com/watch?v=t0GESlaVNdE 26
- https://www.youtube.com/watch?v=RGHoQfSjsXY 21

Practice Makes Perfect?

# Recognising Mistakes



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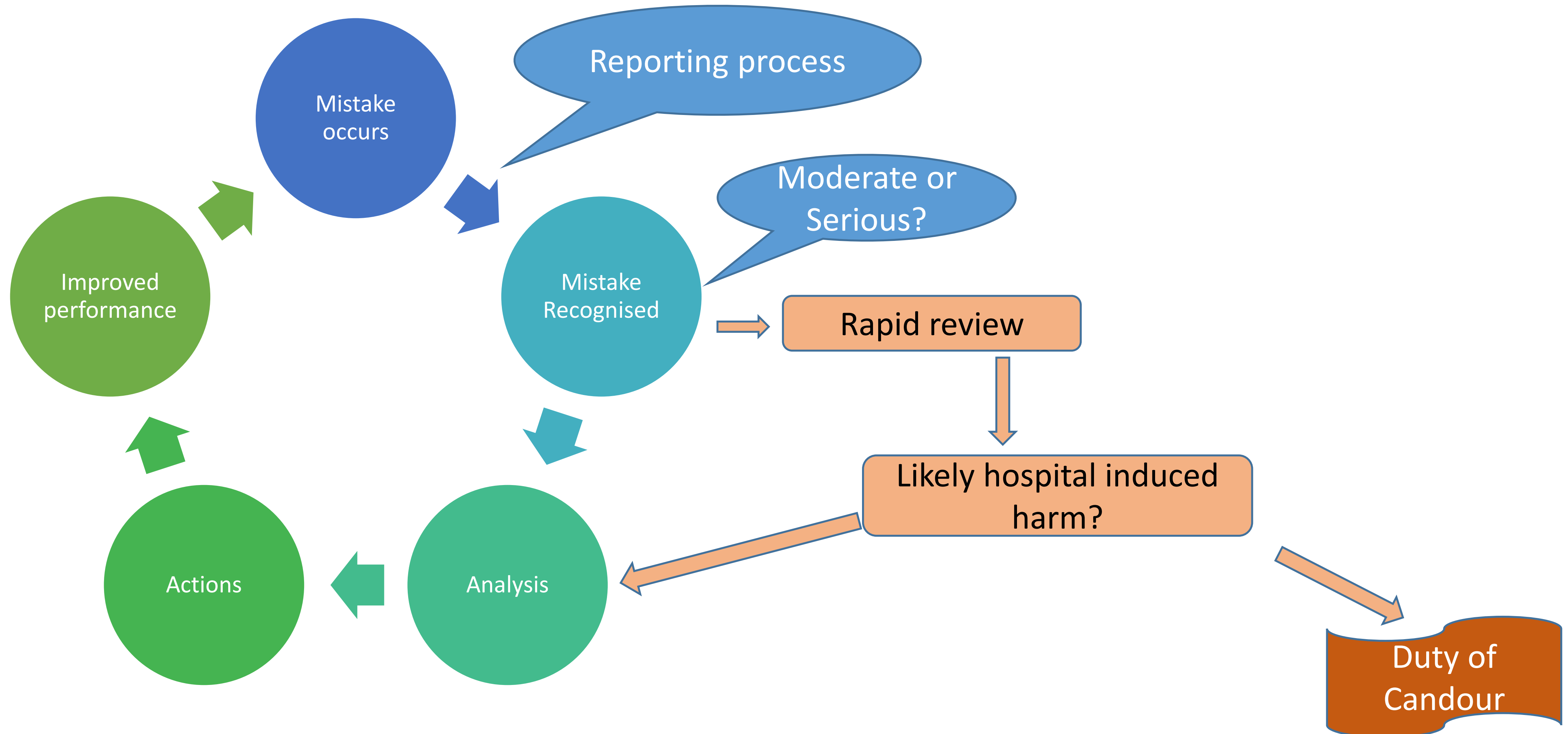
# Improving/Coaching



# Reporting Incidents

Please choose one of the following options

# Analysing

| Low Harm | Moderate Harm | Severe Harm |
|---|---|---|
| **Potential harm incident, inconvenience to patient** | **Unexpected additional treatment or longer hospital stay** | **Sig[illegible]ificant event requiring invest[illegible]ation in all cases** |
| Blood sam[illegible]e mislabelled | Extended hospital stay due to operative complications | Unexpecte[illegible]ath |
| Cance[illegible]peration | Hospital acquired infection | Unexpect[illegible]al care |
| [illegible]on error | Hospital acquired pressure sores | Never events |

Usually closed by area manager following brief investigation

Rapid Review

# Rapid Review form

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**CONFIDENTIAL**

**RAPID INCIDENT REVIEW REPORT – PART 1**

| **REVIEW PANEL** | |
|---|---|
| **Division:** | **Specialty:** |
| **Date of review:** | |
| **Review team (name/designation):** | |
| *1 Senior Consultant* | |
| *2 Senior Nurse/allied health professional* | |
| *3 Clinical Governance team member* | |
| *4 Other (if required)* | |

| **PATIENT INFORMATION** | |
|---|---|
| Patient's last name:<br>First name/s:<br>NHS No: | DoB: Age:<br>Gender: |
| Date of admission:<br>Reason for admission: | Consultant:<br>Past medical history: |

| **INCIDENT INFORMATION** | |
|---|---|
| **DATIX WEB NUMBER:** | Date reported: |
| **Incident date:** | **Time of incident:** |
| **Exact location** | |
| Details of the incident: | |
| **Provide detail of the consequence and outcome for the patient:** | |

English (United States)

| | | |
|---|---|---|
| 6 Was there evidence of a lack of regular review by nursing staff? | ☐ Yes | ☐ No |
| ***If yes**- what were the circumstances and what was the impact on the patient's outcome?* | | |
| 7 Was there evidence that key policies/procedures/ or treatment protocols were not followed? | ☐ Yes | ☐ No |
| ***If yes**- please give details and what was the impact on the patient's outcome?* | | |
| 8 Is there evidence of harm caused by hospital acquired infection? | ☐ Yes | ☐ No |
| 9 Is there evidence of harm caused by hospital acquired pressure ulcer? | ☐ Yes | ☐ No |
| 10 Is there evidence of harm caused by procedural error? | ☐ Yes | ☐ No |
| 11 Is there evidence of harm caused by medication error? | ☐ Yes | ☐ No |
| 12 Is there evidence of harm caused by inpatient fall? | ☐ Yes | ☐ No |

| **PREVENTABILITY OF INCIDENT** (CHECK APPROPRIATE BOX) | |
|---|---|
| 1 Definitely not preventable | ☐ |
| 2 Possibly preventable (but unlikely) | ☐ |
| 3 Probably preventable | ☐ |
| 4 Definitely preventable | ☐ |

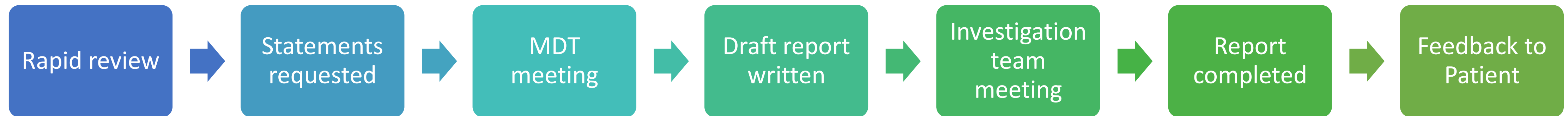
| **PATIENT OUTCOME & SUMMARY** | |
|---|---|
| **Please evaluate the care provided and whether the patient's outcome been affected by the incident?** *(ie. additional treatment, return to theatre, long term disability, prolonged length of stay).* | |
| 1 No substandard care, no effect on outcome | ☐ |
| 2 Substandard care, but would not have affected outcome | ☐ |
| 3 Substandard care, might have affected outcome | ☐* |
| 4 Substandard care, would reasonably be expected to have affected outcome:<br>***If the responses above are 3 or 4 and there is evidence that an error has or may have occurred by an act or omission CONSIDER THE APPLICATION OF THE DUTY OF CANDOUR.*** | ☐* |



English (United States)

# Serious incident investigation

Small MDT group to decide actions and recommendations, responsible parties and timelines




Estimates likely hospital induced harm – level 1, 2, 3 or 4

All involved parties and investigation team, agree chronology, reconcile statements

Levels of hospital caused harm
1: No substandard care
2: There are deficiencies in care unlikely to have affected the outcome
3: Deficiencies in care which may have affected the outcome
4: Deficiencies in care which are more likely than not to have affected outcome

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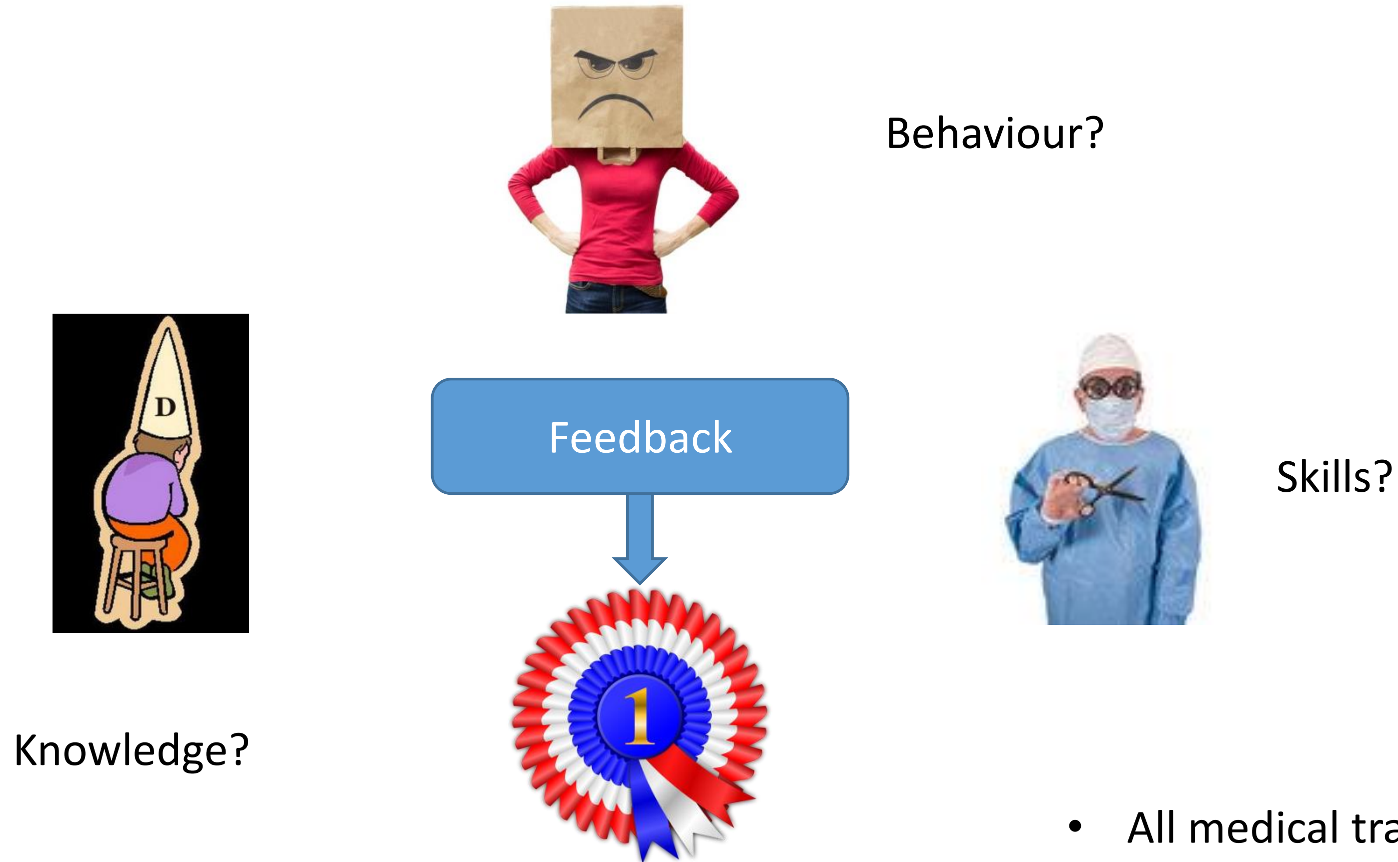
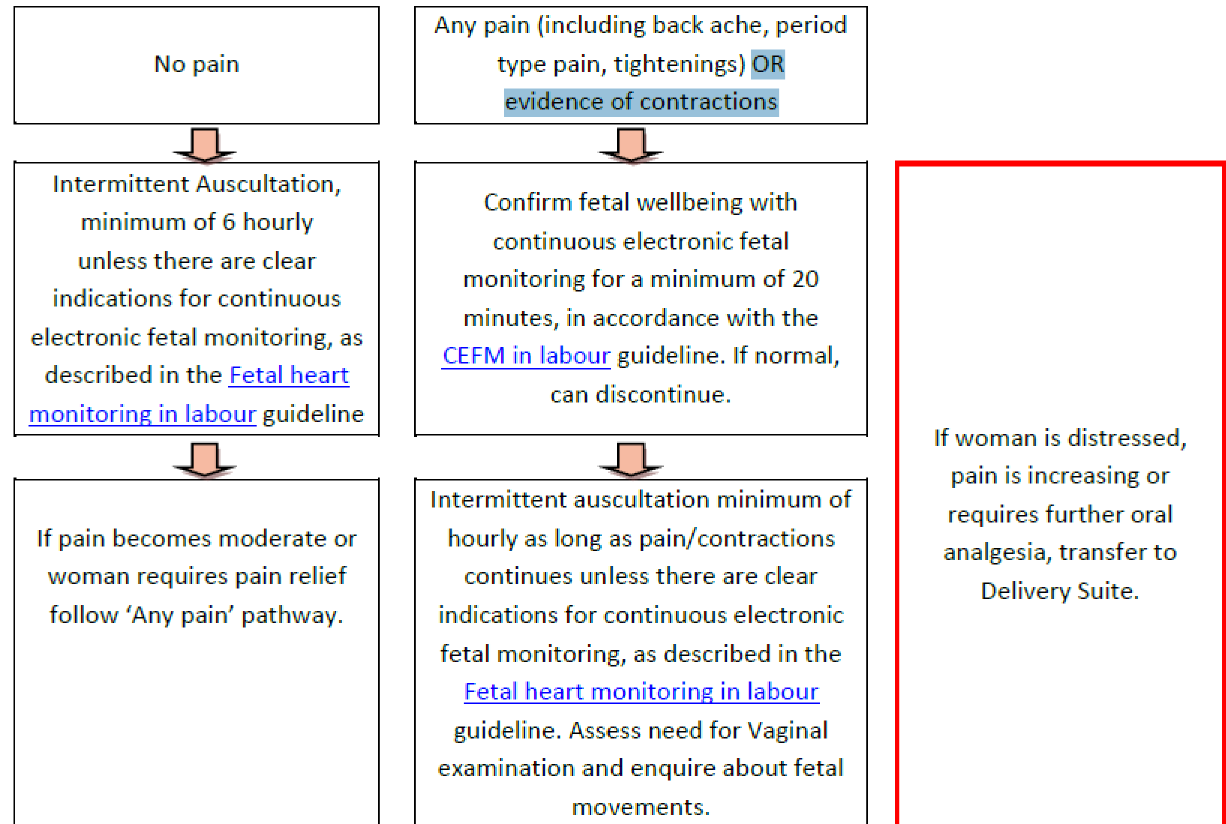
# Learning Lessons – Individuals




- All medical trainees involved in serious incidents should be recording this for revalidation
- Supervisors should escalate concerns not easily resolved locally

# Learning Lessons - General Guideline Changes


**Fetal observations that should be carried out during induction prior to the establishment of labour**

Observations should be documented in the maternal records

- Prior to Prostaglandin administration - Continuous electronic fetal heart monitoring should be performed no more than two hours prior to Prostaglandin administration, to confirm a normal fetal heart pattern.
- Following Prostaglandin administration - Continuous electronic fetal monitoring should be performed for a minimum of 20 minutes as soon as possible after administration
- Review minimum of six-hourly
- Following amniotomy - auscultate fetal heart; if normal, Intermittent auscultation minimum of hourly until regular contractions occur. If not normal, Continuous electronic fetal heart monitoring is indicated
- After commencement of Oxytocin - Continuous electronic fetal monitoring is indicated



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# Mandatory Training – skills drills

| Time | Programme<br>Venue: Seminar 7 Ed centre 1 | Format | Trainer/s |
|---|---|---|---|
| 08.30 | **Coffee and registration** | | |
| 08.45 | Perinatal Mental Health update | Lecture | Sue Rowlands |
| 09.45 | CTG update | Lecture | Angela McKee |
| 10.15 | Shoulder Dystocia | | Dr Grossmith |
| 10.45 | **Coffee** | | |
| 11.00 | Neonatal Resuscitation Update | Lecture and Drill | Lynne Walker |
| 11.30 | Vaginal Breech Birth | Lecture | Emma Ashton |
| 12.00 | Normal Birth update | Lecture | Emma Ashton |
| 12.30 | **Lunch** | | |
| 13.15 | Eclampsia | Lecture | Dr Shuheibar |
| 13.45 | The Management of Neonatal IV antibiotics on the postnatal ward | Lecture | Sharon Roden |
| | **Transfer to Delivery Suite** | | |
| | Each Team moves around each of the workshops as per times on the programme. | | |

| | Team 1 | Team 2 | Team 3 | Team 4 |
|---|---|---|---|---|
| 14.30-14.50 | Shoulder Dystocia-<br>Dr Grossmith | Vaginal Breech<br>Emma Ashton | Massive Obstetric Haemorrhage-<br>Dr Shuheibar | Neonatal Resuscitation-<br>Lynne Walker |
| 14.50- | Vaginal Breech | Shoulder Dystocia- | Neonatal | Massive Obstetric |

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# Learning Lessons: Noticeboard

SAFETY & QUALITY GROUP (Maternity)
Womens' Health • Lancashire Teaching Hospitals NHS Foundation Trust

Safe & effective care
Infection control update
New guidelines publish
Maternity safety therm

Patient experience
Friends and Families:
Friends + family
AN = 12% response rate
EQIP results:
78% positive
15% negative
Negative = waiting times

Performance measurement
Audits completed this month:
NOV 2015
Care in labo
IOL
Postnatal
Shoulder d
Term admiss
Audit results:
see below
Action plans:
Obstetrics & Gynaecology
2016

Lessons Learned
Incident reports:
Newsletter:

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Learning lessons:
Lesson of the week
for handovers

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# ‘Our lessons of the week’

for week commencing 25 April 2016

- **Fetal monitoring** - please ensure you obtain a quality trace that can be interpreted.  In a recent HLI, the quality of the monitoring was poor and appropriate actions were not taken following an abnormal trace. If you have concerns about the fetal heart and are not able to monitor adequately, this should be escalated to a coordinator or medical staff without delay”

- When a woman is admitted, her **hospital records must** be obtained and reviewed and any relevant documentation completed.

- It is a requirement that a **shoulder dystocia checklist** is completed for  babies being disch home following shoulder dystocia.

# Learning Lessons: Quarterly Newsletter

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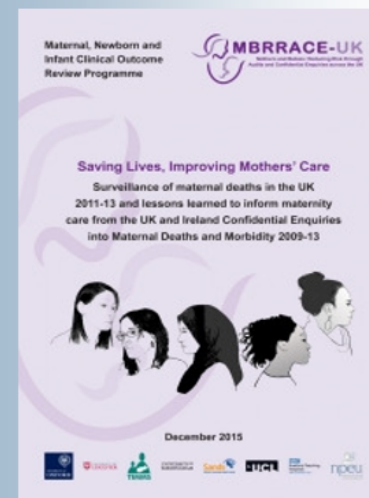
## OUR PRACTICE

Maternity Service Governance Magazine April 2016




The most recent MBRRACE-UK confidential enquiry report into maternal deaths was launched on the 8th December 2015. The report presents the findings of maternal mortality surveillance 2011 to 2013 in the UK and the lessons learned from the confidential enquiries into maternal deaths of women with mental health-related problems, substance misuse, cancer and blood clots and women who died by homicide.

Overall the maternal mortality rate in the UK continues to fall largely as a result of a reduction in deaths from 'direct' pregnancy causes. However, the rate of deaths from 'indirect' causes has not reduced significantly; these are deaths from conditions not directly due to pregnancy but existing conditions which are exacerbated by pregnancy, for example, women with heart problems. More of these deaths will need to be prevented in the future to reach the UK Government aspiration of a 50% reduction in maternal deaths by 2030.

The care of more than 100 women who died by suicide during pregnancy or in the year after giving birth between 2009 and 2013 was reviewed in detail. One in eleven of the women who died during or up to six weeks after pregnancy died from mental health-related causes. However, almost a quarter of all maternal deaths between six weeks and a year after birth are related to mental health problems, and one in seven of the women who died in this period died by suicide. Although severe maternal mental illness is uncommon, it can develop very quickly in women after birth and the woman, her family and mainstream mental health services may not recognise this or move fast enough to take action.

The care for women with substance misuse problems and those living socially complex lives was also reviewed with messages for future care echoing those for women with mental health problems and the need for joined up multi-agency care to ensure that these women do not fall through the cracks between services. The report also contains messages for the future care of women with cancer and those at risk of blood clots, which is the primary cause of 'direct' maternal deaths.

Clear pointers for improving services and care by individual practitioners were identified and these are dis-

# Teaching events

Postnatal debrief
October 2014

Fiona Crosfill
Neesha Ridley

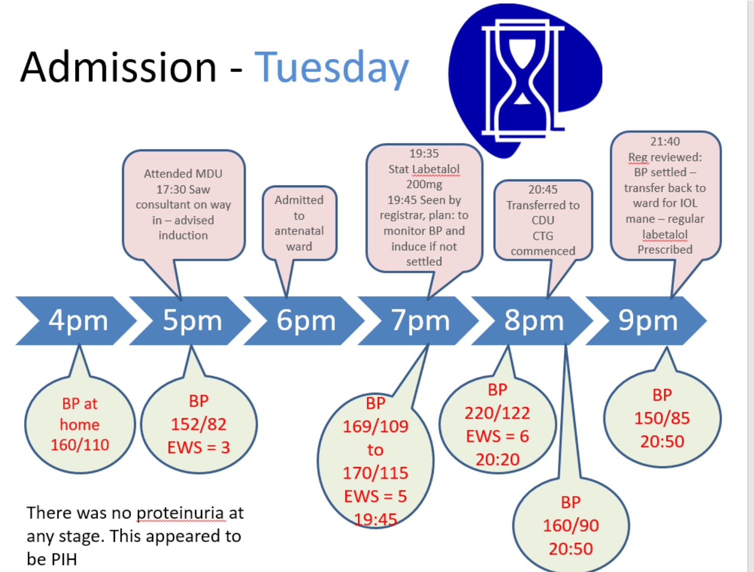
Following long complaint about post-natal care and audit of debrief process

Following admission of patient with ketoacidosis in labour

Shape Effects
Apply a visual effect to the selected shape, such as shadow, glow, reflection, or 3-D rotation.

Why Does Diabetes Make Pregnancy Difficult?

Study day March 4th 2013




Case review, workshop on hand-over and induction process

# Patient Experience Videos

- https://www.youtube.com/watch?v=sCDR3LZbbyw

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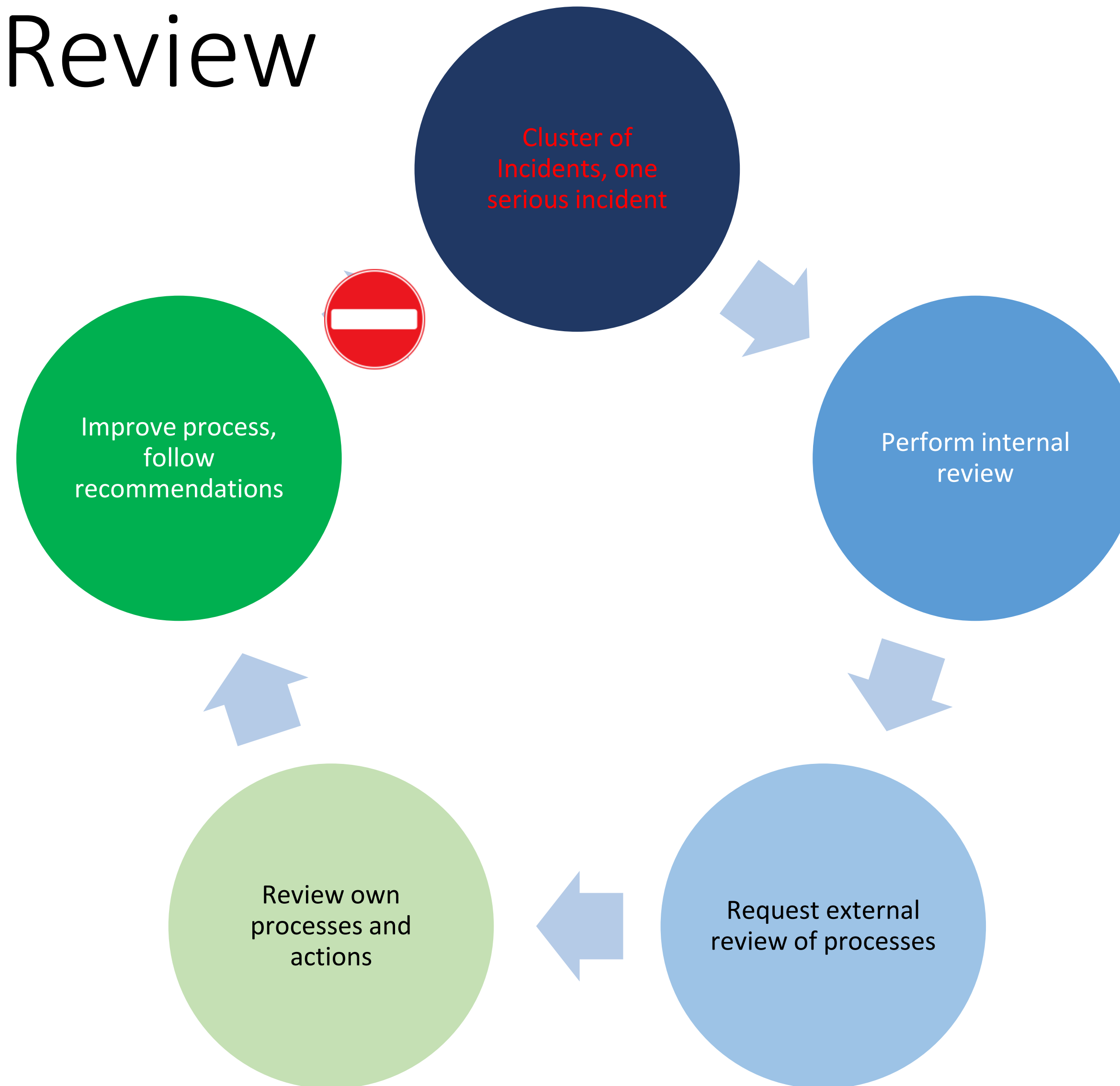
# External Review



# Don’t Forget:

- Review action plans at each CG meeting
- Close actions when complete – may need to feed this back to patient
- Feedback to Trust Clinical Governance Group

*Thank you*