Aneurin Bevan University Health Board

PUTTING THINGS RIGHT
ANNUAL REPORT 2017/2018

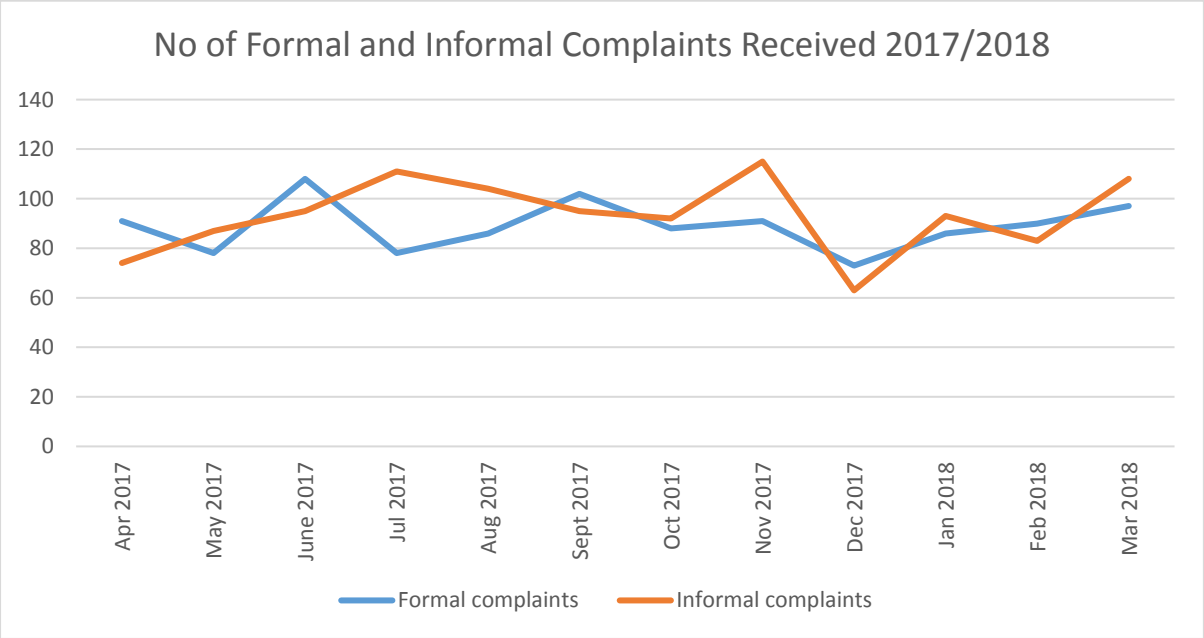
Complaints

Complaints Received

In 2017/2018 the Health Board received 1068 formal complaints and 1120 informal complaints. Last year's figures were 992 and 920 respectively. The increase in formal complaints is modest at 7.6% whilst the number of informal complaints has risen by 21%. This has been driven by a move to resolve complaints at a local level to ensure concerns are addressed in a timely manner. There has also been an improvement in the data capture systems.

Work is underway at a national level to provide consistency in data collection and, as part of this, a standard definition and guidelines will be in place shortly for when a complaint is deemed to be informal and formal. This will affect the numbers reported for the coming year.

Chart 1: No of Formal and Informal Complaints Received by Month



Below is a chart showing the top 10 specialties (primary) for formal complaints received during the year as recorded on DATIX.

Table 1: Top 10 Specialties Where Complaints Received

	2017/2018	2016/2017
Trauma and Orthopaedics	160	110
General surgery	102	80
Accident and Emergency	93	81
Primary Care	60	43
Adult Mental Health	60	65
Care Of The Elderly	53	59
Gynaecology	41	35
Midwifery	36	38
Ophthalmology	32	31
GP Out of Hours Service	24	22

Of note are the significant increases in the number of complaints received for Trauma and Orthopaedics 52% (50) increase (mainly due to complaints associated with delays and cancellations (17) and clinical care (12), Primary Care 39% (17) increase, General Surgery (including Vascular Surgery, Breast and Colorectal Surgery) 27% (22) increase, Accident & Emergency 15.6% (12) increase. These figures are highlighted on a monthly basis through the Executive report.

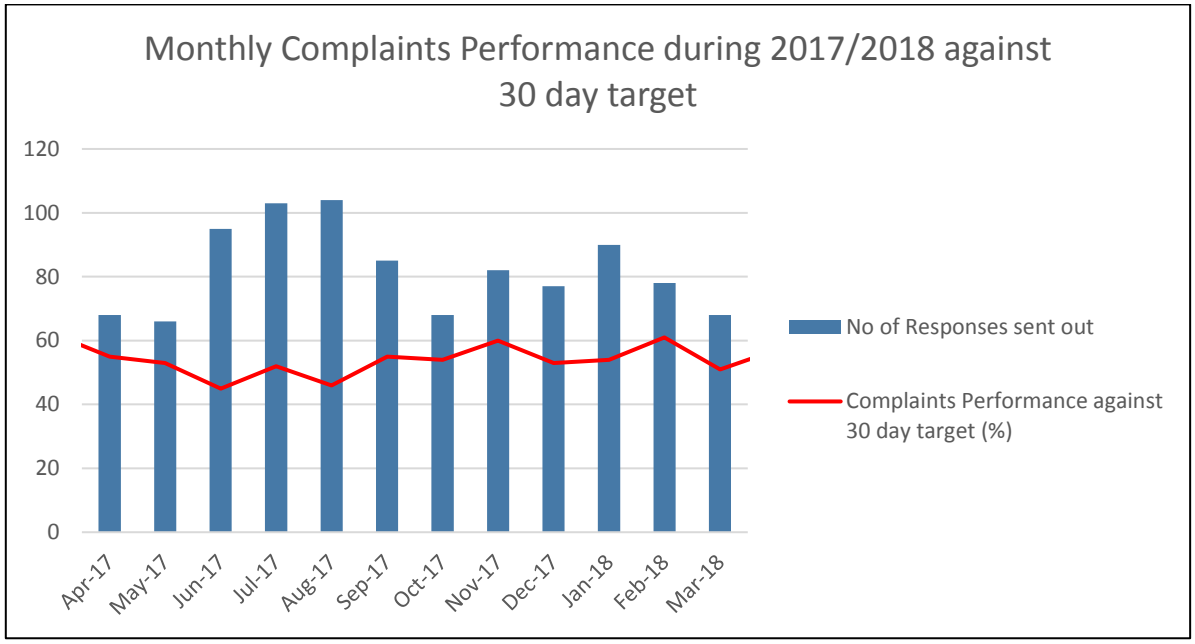
Complaint Performance

For formal complaints, the complaints performance for 2017/2018 against the 30 day target was 53% compared to 54% in 2016/2017 (see chart 2). This does not take account of the 'informal' concerns, issues and complaints that are resolved well within the 30 day timescale. Complaints performance figures are monitored by the Executive team on a monthly basis.

Complaints performance continues to be a priority for improvement for 2018/19 with complaint performance being aligned to Divisional performance reviews and assurance review meetings led by the Chief Operating Officer and the Executive Team. Closer work has commenced with the Health Board's Divisional senior management teams to identify a consistent approach to both resolving and monitoring complaint responses to ensure that they are returned in a timely manner. Specific attention is being paid to the management of complex complaints which span a number of services and Divisions. A Service Improvement Plan has been developed to improve compliance against the 75% target.

The Service Improvement Plan includes Divisional trajectories for improvement which are being monitored by the PTR team. In addition the plan will focus on the quality of responses provided.

Chart 2: Complaint Performances by Month



Subject of Complaints

Clinical care is the most reported complaint subject for 2017/2018, as it was in 2016/2017. A total of 613 complaints were received where the primary subject for the complaint was recorded as clinical care. Most complaints in this category were received in September 2017. Additional causes for complaints include waiting times (154) and staff attitude (127).

The trend in the subjects of complaints received during the year is shown below.

Chart 3: Primary Subject of Complaints Received by Month

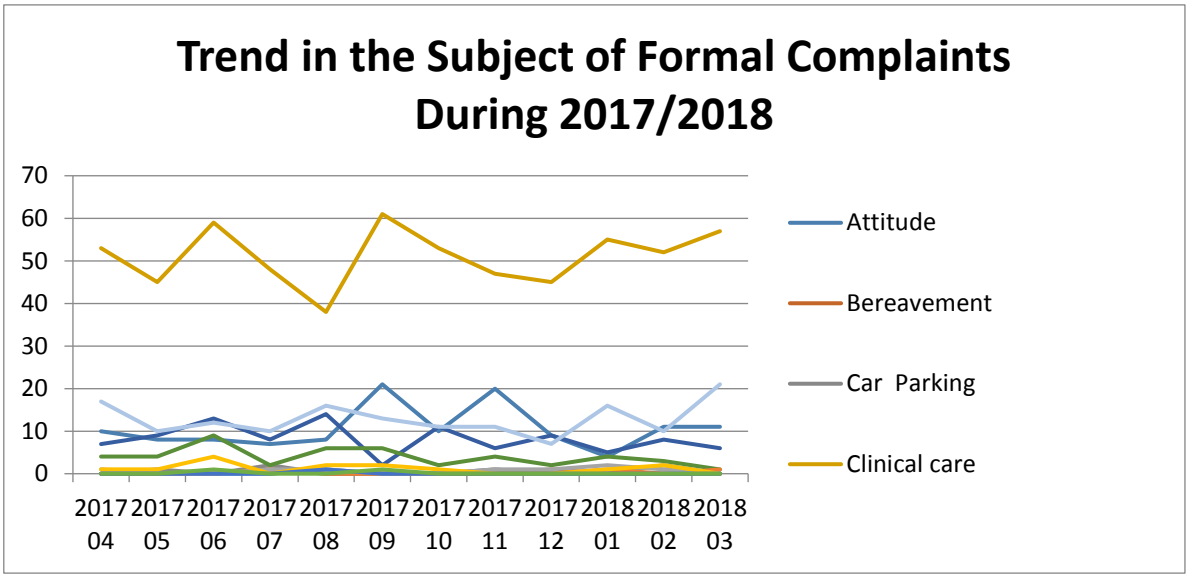
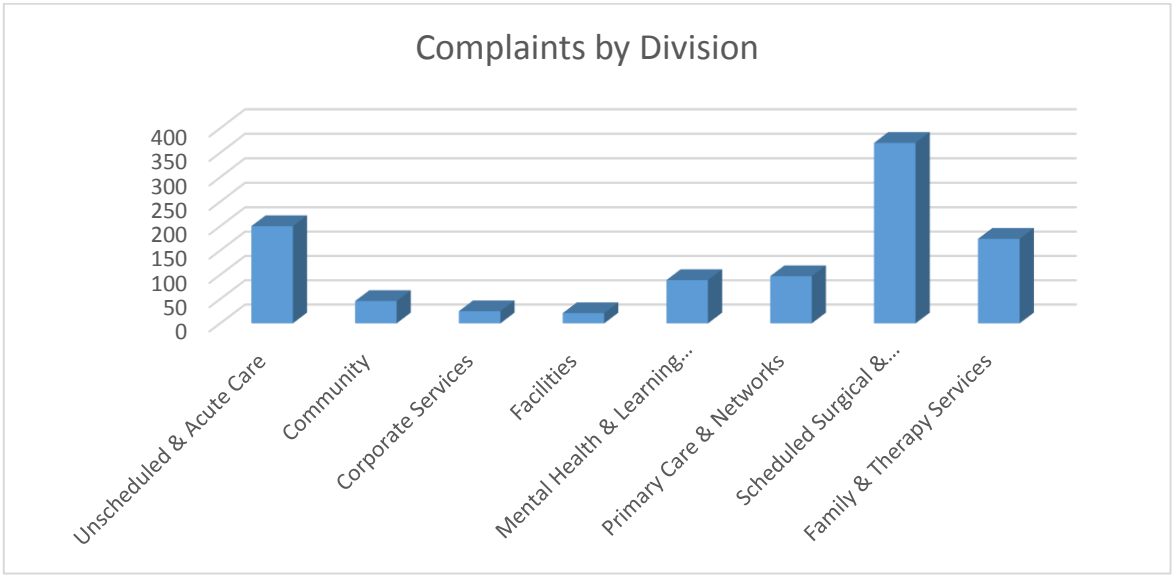


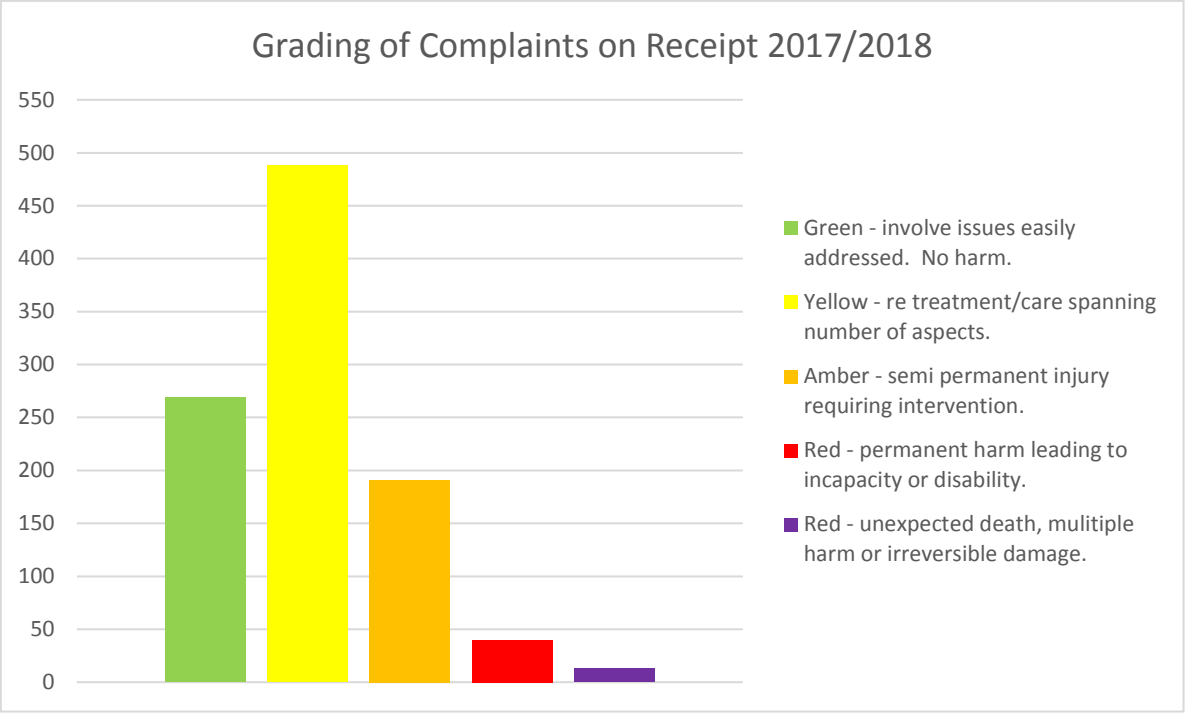
Chart 4: Complaints Received By Division



Grading of Concerns

Complaints are graded on receipt, and those received in 2017/2018 were graded as shown below.

Chart 5: Grade of Complaint on Receipt



Key Principles Incorporated in Complaints Management

- The importance of early contact with a complainant by telephone on receipt of a concern to clarify whether this can be resolved informally or formally.

- Keeping the complainant updated with how their concern is proceeding by regular communication either by telephone or a letter to ensure the complainant is aware that we are still looking into their concerns and advising where necessary what is causing the delay.

- Offering of a meeting to discuss their concern is good practice if the complainant is dissatisfied with the complaint response in order to seek resolution.

Key Learning from Complaints

- During this period there were a total of 2188 informal and formal complaints received. As identified previously these covered a number of themes. Below is a snapshot of the learning that has been taken forward as a result.

- Although not formally recorded in many cases as a primary subject of a complaint, the issue of communication is a key element in most

cases. Where identified, staff have been reminded of the importance of keeping patients and their families up to date with information and the need to demonstrate more sensitivity in times of bereavement and stress. Such reminders have included the reinforcement of the Health Board's Values and Behaviours Framework.

- The medical secretarial teams have been reminded of the importance of making sure that patients are kept regularly updated by ensuring that consultants are aware of results becoming available so that any treatment plans can be progressed quickly and without delay.

- Formal reporting of lumbar spine X rays by radiologists to be considered when patients are seen by orthopaedic surgeons in fracture clinics.

- Introduction of improved signage to raise awareness for patients/families on how to raise a concern.

- Training has been provided throughout the Health Board on the new Multifactorial Falls Risk Assessment and the accompanying care plans to ensure that they are specific and individualised for the patient.

- In Mental Health opportunities are given when assessments have been undertaken by the community liaison team to discuss them in a multi-disciplinary forum.

- Directorates are aware of the delays for patients waiting for certain procedures and are actively working with the Consultants to agree additional surgical sessions. Where capacity and resource allows, patients are being offered appointments at other sites within the Health Board to reduce the demand on the Royal Gwent site.

- The District Nursing Teams telephone GP surgeries each day to confirm whether there have been any further referrals.

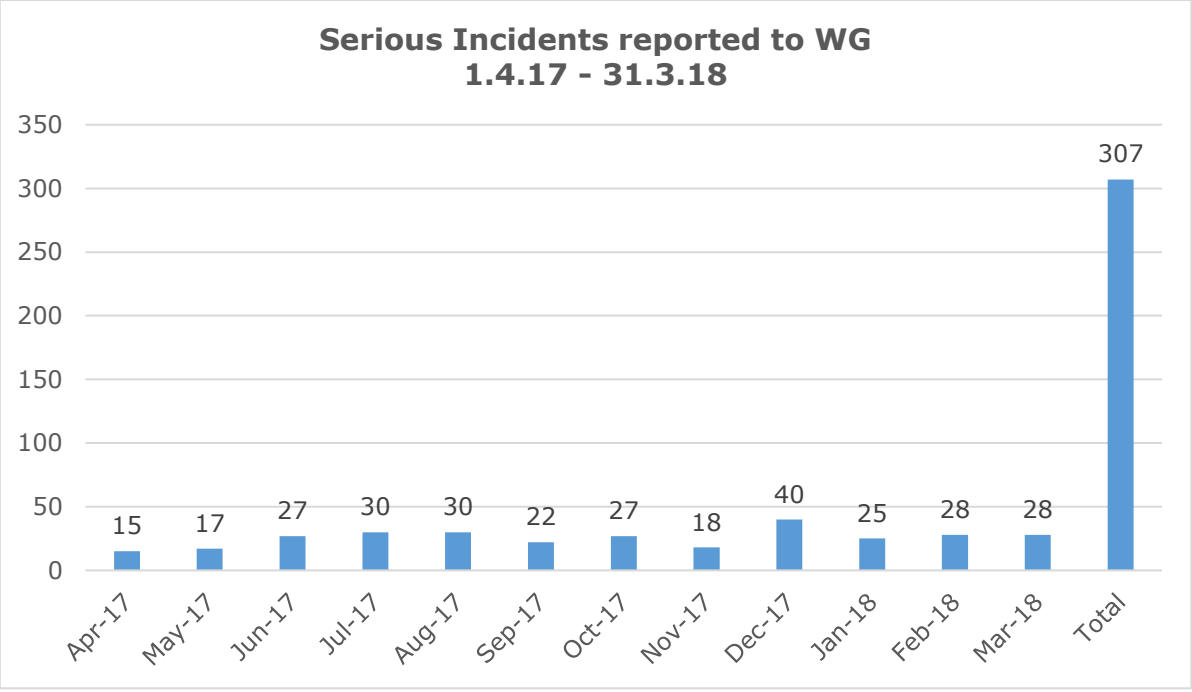
Patient Safety Incidents

Patient Safety Incidents (PSIs) are reported through an electronic database (Datix) and any member of staff has the ability to report or raise an incident electronically. Any incident which has caused serious or catastrophic harm to a patient is reported to Welsh Government (WG) and managed through the Serious Incident process. Additionally incidents involving the development of a Grade 3/4 hospital acquired pressure ulcer (HAPU), an inpatient fall where a long bone fracture is sustained, Clostridium difficile contributing to death, are also reported and investigated through the WG Serious Incident Investigation process.

Where incidents are reported to WG, a 60 working day timescale for completion of the investigation is given. WG expects a closure assurance form to be provided by the deadline outlining findings, learning and actions taken. WG measure the Health Board's compliance with this reporting and assurance process.

Serious Incidents reported to WG 1.4.17 – 31.3.18

Chart 6: Serious incidents report to WG by month



Description of serious incidents reported to WG 1.4.17 – 31.3.18

Table 2: No of incidents reported by description

Description	Number
In-patient falls - fractures	64
Absconsion whilst detained	6
Infection control	39
Adolescent admitted to adult MH ward	5
Delay in treatment	6
In-patient fall - head Injury	3
Information Governance	2
Pressure ulcers	89
PRUDiC	12
Never Events	1
Mental Health unexpected deaths	52
Suicide - in-patient	1
Unexpected outcome	6
Unexpected death	5
Absconsion	1
Alleged sexual assault	2
Attempted murder	1
Patient accident	1
Deliberate Self Harm	2
Fracture - neonate	1
Intrauterine Death	1
Maternal death	1
Pathology error	1
Patient on staff assault	1
Patient on patient assault	1
Sexual assault of staff member	1
Wrong medical gas	1
Surgical procedure ophthalmology	1
TOTAL	**307**
No Surprises	**31**

The number of incidents reported to WG during the year increased from 211 in 2016/2017 to 307 in 2017/2018, a rise of 45%. This is in part due to the processes of scrutiny and reporting of pressure ulcers (where reportable incidents increased from 46 in 2016/17 to 89 in 2017/18).

There has also been an increase in unexpected deaths within the Mental Health and Learning Disability Division which rose from 43 in 2016/2017 to 52 2017/2018. On further analysis of the 52 in 2017/2018 - 17 were GSSMS (Gwent Specialist Substance Misuse Service) related deaths

compared to 6 in 2016/17. These figures include suspected suicides and further analysis is carried out by the Mental Health and LD Division. All unexpected deaths are reported to WG and are subject to investigation.

The other incident types where significant increases were reported related to infection control incidents (17 in 2016/17 to 39 in 2017/18). This is because of an increase in cases of C.difficle over the summer months resulting in some ward outbreaks. The Executive Team were kept continually informed of the increase. Following review the learning identified related to the reduced number of deep cleans implemented the previous year. In light of this a robust programme was re-established with good results.

The slight rise in the identification of inpatient falls resulting in a fracture can be attributed to the monthly review of the hip fracture database which is carried out by the Quality and Patient Safety team.

Overview of all patient related incidents reported 2017-2018

Total number of patient related incidents on Datix	**19389**
Category for highest reported incidents is Falls	**4289**

The number of patient related incidents reported increased by 8.2% or 1,605 in number from previous year.

As can be seen from the table above the category for highest reported incidents as in previous years remain falls (4289). The reporting of patient slips, trips and falls as for all incidents is actively encouraged. It was noted that there was a decrease of 286 recorded from the previous year. There is a considerable amount of work being undertaken within the Health Board in respect of falls e.g. the roll out of the new Multi Factorial Risk Assessment which is then incorporated into the individual care plan.

Never Events

Never events are a subset of serious incidents and are defined as serious preventable patient safety incidents that should not occur if the available preventative measures had been implemented. The list provided by the Department of Health describes 14 such events. If a Never Event occurs the Health Board must notify Welsh Government. The Delivery Unit oversees the investigation process of all Never Events to ensure that all root causes are identified, lessons are learned and remedial actions are taken.

On completion of the serious incident investigation process the Delivery Unit provide assurance to Welsh Government that the investigation and learning generated are robust and complete.

Overview of Never Event

Only one such event occurred and was reported during 2017-2018.

Mismatched hip replacement prosthesis
A patient underwent Total Right Hip Replacement and was discharged home following an uneventful recovery.

A Surgical Care Practitioner was inputting information onto the National Joint Register and identified that during the procedure mismatched components were used. The patient was readmitted and underwent revision surgery, was discharged home and made a good recovery.

The root cause identified in this case was the correct checking procedure was not undertaken.

The patient was informed of the incident at the time and the matter taken to the Health Board's Redress Panel for consideration as to whether there was a qualifying liability. This was confirmed and an offer of financial Redress made to the patient for the harm caused.

Key learning from Serious Incidents

As stated above 307 incidents were reported to WG, in addition to this WG were also alerted to 31 'No Surprises'.

Pressures over winter months (November 2017 – March 2018)

A number (26) of incidents were specifically identified as being related to pressure over the winter. A review of the 26 incidents was undertaken and the findings and learning in relation was presented to the Executive Team. The incidents were reviewed to understand how the pressures had the potential to affect clinical care and whether patient safety was compromised. The measures reviewed were:

- Hospital escalation and risk ratings
- Ambulances held and lost hours
- Hospital site position
- Site actions to deescalate

The incidents were all "front door" and it was recognised that the solution however is a whole system approach. The findings from the review have been used to assist with planning for Winter 2018/2019.

Bedside Oxygen

There have been a number of incidents where patients requiring oxygen at the bedside have been connected to the airport in error. The revised Never Event List for 2018 now includes connecting a patient to an air flowmeter when the intention was to connect them to an oxygen connector**.** The key learning from the events was identified and shared through the Learning Bulletin (see Appendix 1 – Learning Bulletin).

Redress Cases

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 have been in place for seven years. Under the Regulations the fundamental principle behind investigations into concerns, however they arise, is that those involved can expect to be dealt with openly and honestly and receive a thorough and appropriate investigation within an appropriate timescale.

In addition, the Health Board is obliged to consider whether there has been a breach of duty of care and whether any harm has been caused by as a result of the breach of duty of care. The judgement of a breach of duty is based on the legal test as set out in the case of Bolam i.e. "has the treatment fallen below a reasonable standard to be expected of a reasonably competent practitioner in the relevant field at that time".

Where it is judged that the breach of duty caused harm this constitutes a qualifying liability in tort and Redress needs to be considered.

Redress can mean:

- An apology
- Remedial action
- Explanation of the care given
- Assurances of the action taken to prevent/minimise the risk of recurrence
- Where appropriate, compensation.

Table 3: Cases Heard by Redress Panel in 2017/2018 by decision made

Number of Cases heard by Panel in 2017/2018	**57**
Of these :	
Qualifying liability was established	**48**
A qualifying liability was not found	**7**
The potential of a qualifying liability was found but due to potential value exceeding £25k it was taken out	**2**

Of the cases where a qualifying liability was established, offers of financial redress were made in 43 cases.

Table 4: Outcome of Panel Decision by Directorate

Directorate	Liability proven	Liability Not Established	Further Investigation Required	Breach of Duty established but value > £25k	Total
Blaenau Gwent	1	1			**2**
Caerphilly	2				**2**
Care of the Elderly	2				**2**
Community Gynaecology	1				**1**
Dermatology	1	1			**2**
Diabetology	2				**2**
Emergency Care	13	2		1	**16**
Gastroenterology	4				**4**
General Surgery	1				**1**
GP out of hours		1			**1**
Gynaecology	1				**1**
Infectious Diseases	1				**1**
Maternity	3				**3**
Medical Admissions	1				**1**
Mental Health	3				**3**
Newport	2				**2**
Physiotherapy				1	**1**
Radiology	2				**2**
Respiratory	2	1			**3**
Trauma & Orthopaedics	6	1			**7**
Total	**48**	**7**		**2**	**57**

Themes from Redress Cases

Whilst many of the breaches of duty were specific events there were several themes that emerged during the year, these included issues pertaining to documentation, medication, patient falls, pressure ulcers, investigations to aid diagnosis, clinical error etc.

Table 5: Themes from Redress Panel

Theme	Issue	Number of admissions of breach of duty of care
Documentation	Lack of robust management plans	2
	Lack of detail re examination	4
	Lack of evidence of procedures followed	1
	Lack of information re administration of drug	1
	Lack of clinical reasoning	2
Medication	Patient should not have been discharged home following administration of this drug	1
	Failure to document drugs administered	2
	Different drug and dose administered	1
	Failure to consider alternative route for medication	1
	Incorrect antibiotic prescribing	1
	Incorrect establishment of syringe driver line	1
	Failure to monitor levels of drug in blood	1
Patient falls	Failure to provide adequate 1:1 supervision	2
	Failure to complete/update risk assessments	2
	Failure to have clear plan in place	1
	Failure to complete bed rails assessment	1
Pressure ulcers	Failure to manage skin appropriately in line with Waterlow assessment	2
	Lack of documentation/evidence	2
	Failure to obtain pressure relieving mattress	2
	No Waterlow score	
Investigations	Failure to undertaken scan/x-ray	3
	Failure in/Delay in undertaking investigation	2
	Failure to report result	1
	Request should have been marked urgent	1
Clinical error	Failure to deliver baby earlier	2
	Failure to seek second opinion/refer to specialist	3

	Failure to perform observations Failure to remove plaster Patient not booked on CPOD list Too many attempts at procedure Wrong information given Failure to offer further treatment Failure to perform correct examination Unnecessary procedure Failure to follow protocol	1 1 1 1 1 1 1 1 1
Failure/Delay in diagnosis	Sepsis Cancer Fractures Dehydration	1 2 7 1
Incorrect vaccine administered		1
Consent	Patient not advised of risks of drug before discharge Given drug not consented to Didn't formally consent to procedure being undertaken	1 1 1
Patient assault	Failure to link behaviour with reasons for admission Observation levels didn't meet risk requirement Lack of robust management plan	1 1 1
Nursing care	Failure to perform observations Failure to follow correct checking procedure Patient should not have been redirected Failure to identify fracture on x-ray Failure to clean wound Patient not advised to attend hospital Incorrect assessment of oxygen requirements Wrong size equipment used	1 1 1 1 1 1 1 1

Lessons Learned from Redress Cases

As described above part of the Redress offered is to ensure that lessons are learned and action is taken to prevent and/or minimise the risk of such events occurring again in the future. When cases come before the Health Board's Redress Panel, there is a further opportunity to scrutinise

the action that is being taken to address the failings identified. In addition due to the membership of the Panel, opportunities arise to identify themes on a number of different levels e.g. cluster of events happening in one location, Health Board wide trends.

Cases emanating from incidents involving inpatient falls and pressure ulcers will often have been to their own scrutiny group where the focus is on the learning and the action that has been taken to address the events in question.

Whilst learning is often on an individual level with members of staff reflecting on the events that have occurred, cases are often anonymised and discussed in directorate/audit meetings and/or are taken to "Grand Round" for junior doctors to learn.

However some additional actions to note from cases heard during 2017/2018:

- Review of the Policy for Enhanced Care
- Teaching sessions undertaken on the Observation Policy
- Organisational review of EPAU
- Separate private area for women who receive bad news identified and bid made to League of Friends for furnishings
- WHO checklists now implemented for all caesarean sections across the Health Board
- Checking processes in respect of medicines managements have been reinforced throughout the localities within the Health Board
- COTE Directorate has introduced outpatient clinics for consultants which enables them to arrange a review where clinically appropriate
- Watch list for D2E has been set up
- Staff reminded of importance of care planning and updating of and reassessment for change of condition or following patient fall
- Changes in the way mattresses, pressure relieving mattresses ordered
- Drug charts have been made available in visiting GP care for GPs to write charts immediately
- Increased understanding of risk of dehydration within mentally ill patients who are refusing to eat and drink
- No medication/device to be administered to anaesthetised patients without prescription unless part of an emergency response.

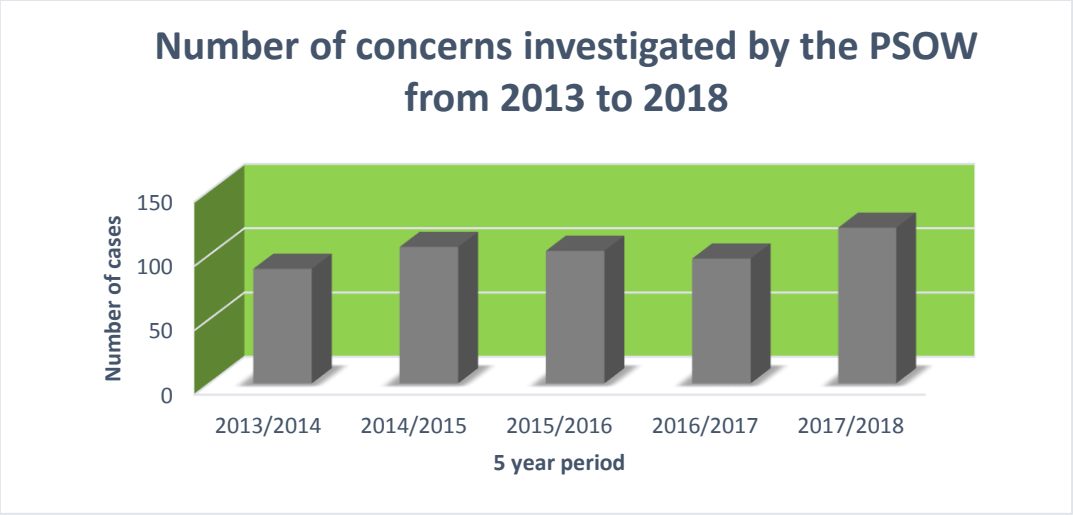
Public Service Ombudsman for Wales (PSOW) Investigations

The data for this financial year illustrates that there has been a 28% decrease in the number of upheld Formal Section 21 Reports received by the Health Board compared to 2016-2017.

There are a number of factors that has reduced the number of cases not being upheld:-

- the original investigation was appropriate.
- the Health Board staff have worked actively to liaise between the Ombudsman and Division to resolve the case.
- the Division took action to resolve the complaint once notified that they are with the Ombudsman enabling the service a further opportunity to resolve the concern. The report identifies that the Scheduled Care Division has made the most progress in this area.

The following shows a 34% increase in the number of news concerns investigated by the Public Service Ombudsman. A total of 121 cases were referred to the PSOW for 2017/2018, below is a bar chart comparing the number of concerns referred to the PSOW over a five year period.



There are close links with the Ombudsman and the Health Board, and the Health Board regularly attends the Ombudsman Sounding Board Meeting and the Ombudsman Liaison Network.

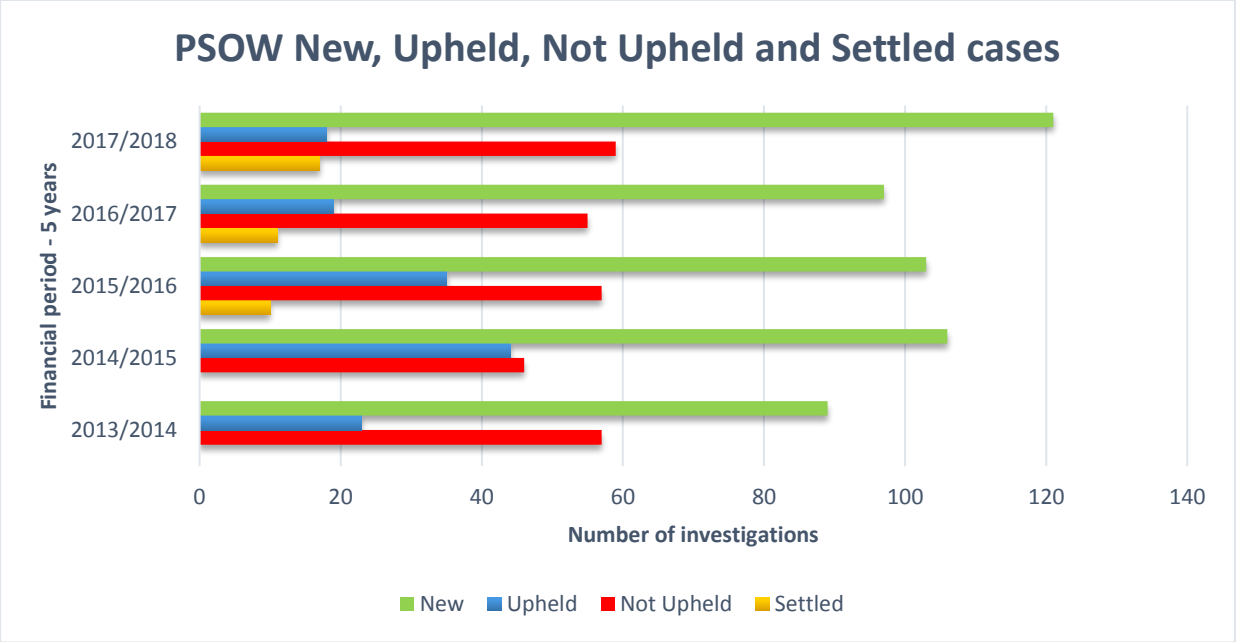
Please note that the table below includes Primary Care & Network Ombudsman cases and provide a positive increase in the number of cases being settled which has risen to 17 this financial year. The Health Board actively resolve/settle the concerns at Ombudsman stage. This action rebuilds relationships with the person raising the concerns, diminishes the number of cases formally investigated and thereby reduces the possibility of a public report.

The Health Board was informed of 26 cases which were anonymised, therefore these are not allocated to any Division.

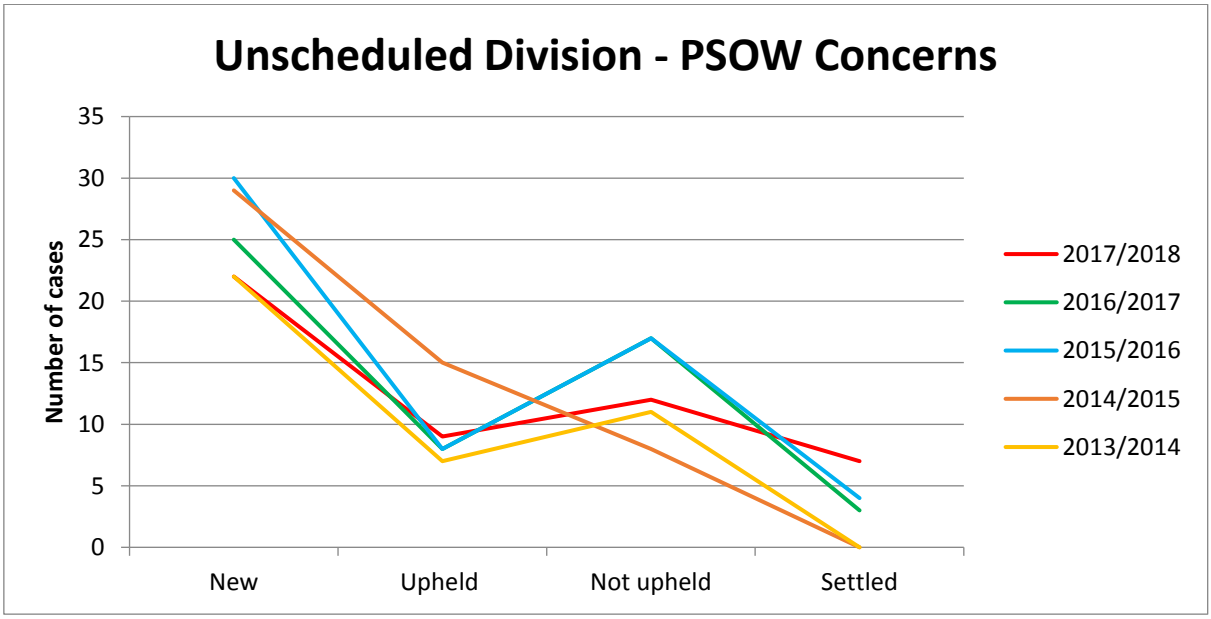
Below is the annual breakdown of Public Service Ombudsman cases by Division for 2017-2018

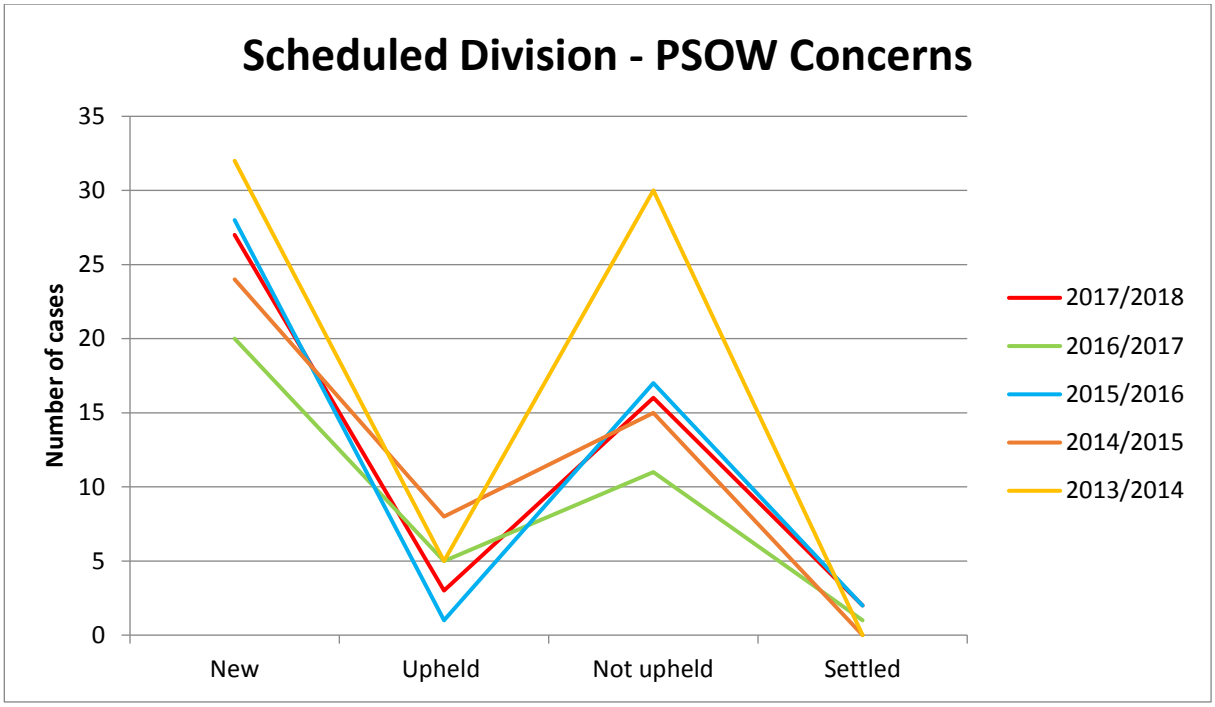
PUBLIC SERVICE OMBUDSMAN INVESTIGATIONS 2017/18 BY DIVISION			
Category	**Total**	**Division**	
Concerns Investigated by the PSOW	**121**	Unscheduled Care Division	22
		Scheduled Care Division	27
		Mental Health & LD Division	17
		Family & Therapy Division	14
		Community & PC Division	11
		Corporate Services	4
		Anon	26
Upheld Section 16 Public Reports	**0**		
Upheld Section 21 Reports	**18**	Unscheduled Care Division	9
		Scheduled Care Division	3
		Mental Health & LD Division	3
		Family & Therapy Division	2
		Community Division	1
		PC & Networks Division	0
Not Upheld Concerns & Section 21 Reports	**59**	Unscheduled Care Division	11
		Scheduled Care Division	16
		Mental Health & LD Division	7
		Family & Therapy Division	8
		Community Division	3
		PC & Networks Division	3
		Corporate	6
		Anon	5
Settled (concerns resolved by the HB at PSOW stage)	**17**	Unscheduled Care Division	7
		Scheduled Care Division	2
		Mental Health & LD Division	4
		PC & Networks Division	0
		Family & Therapy Division	3
		Community Division	1

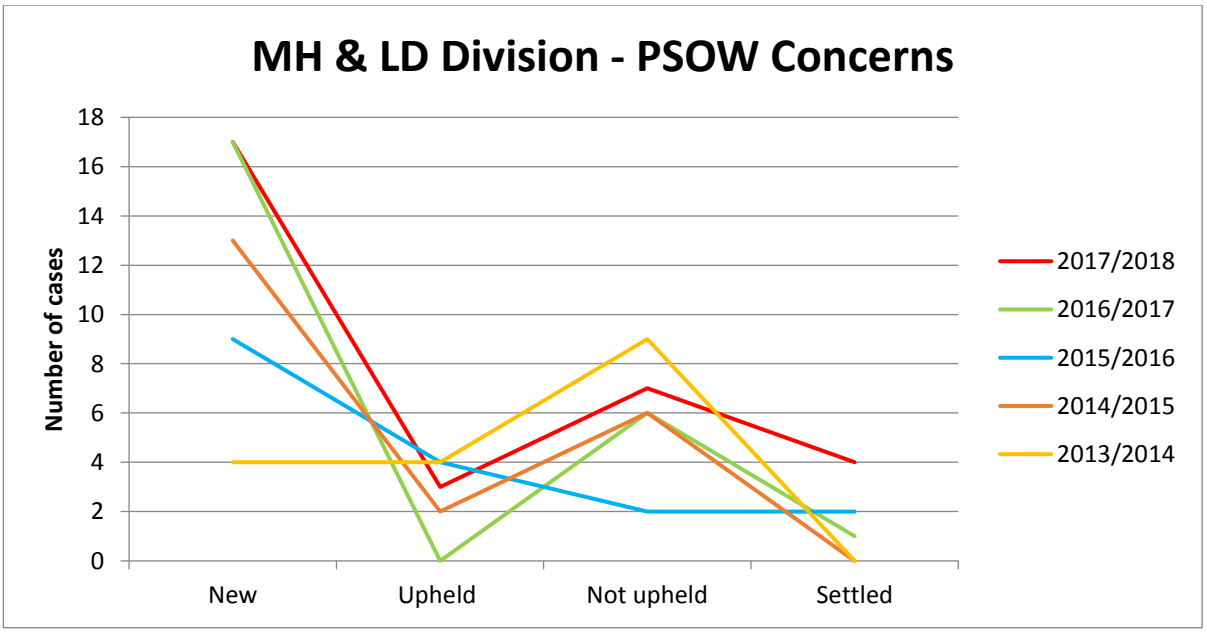
Below is a snap shot of the data over a five year period for new, upheld and not upheld investigations. There is an increase in new cases, settled cases and cases not being upheld. With a decrease in the number of concern investigations being upheld.

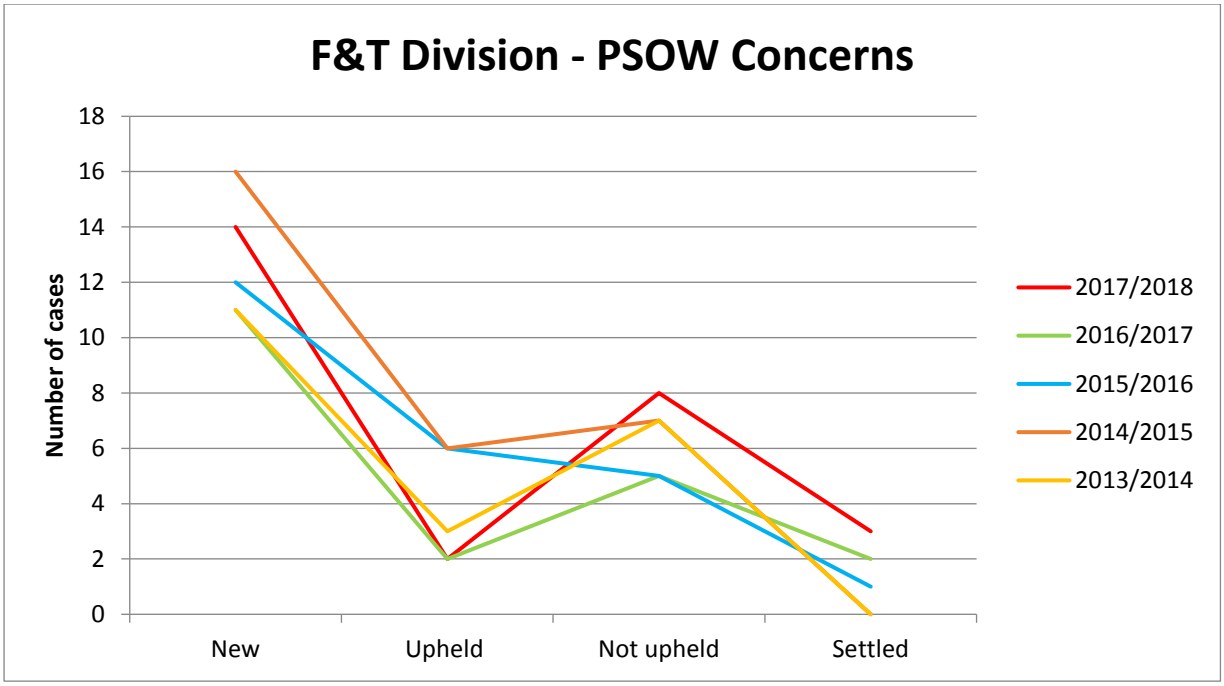


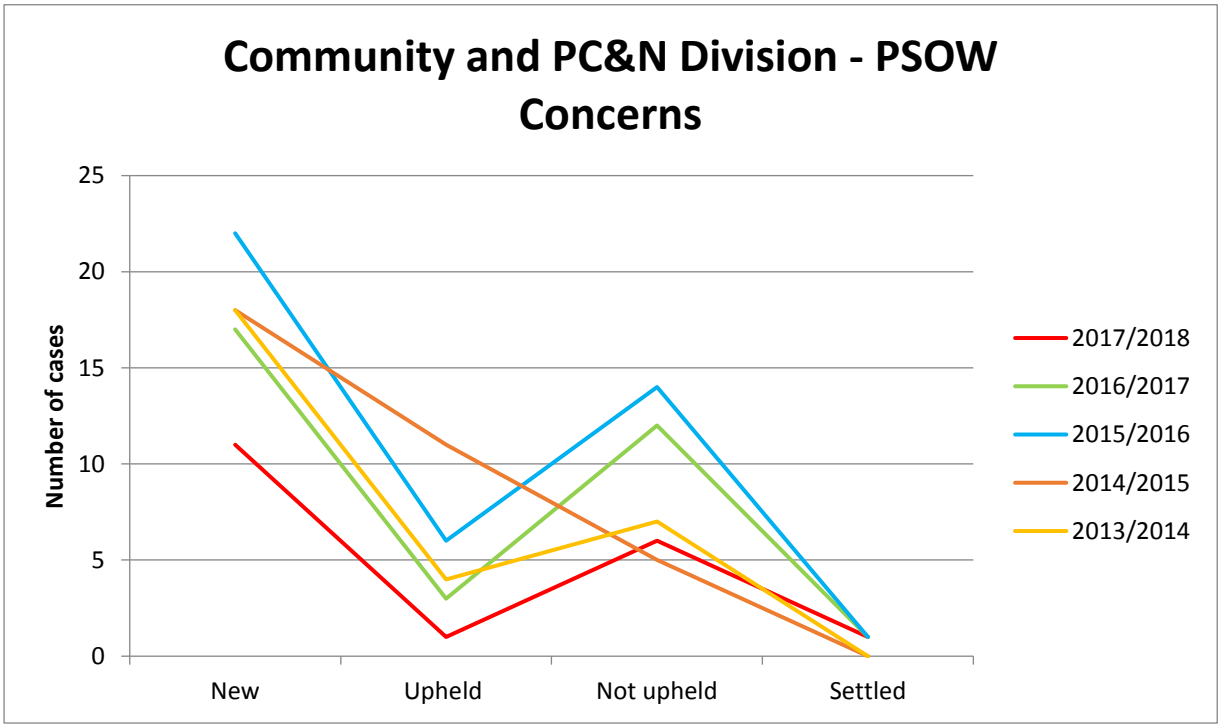
Also provided within this report is the Divisional snapshot of activity which is provided below and illustrates a five year breakdown of data.

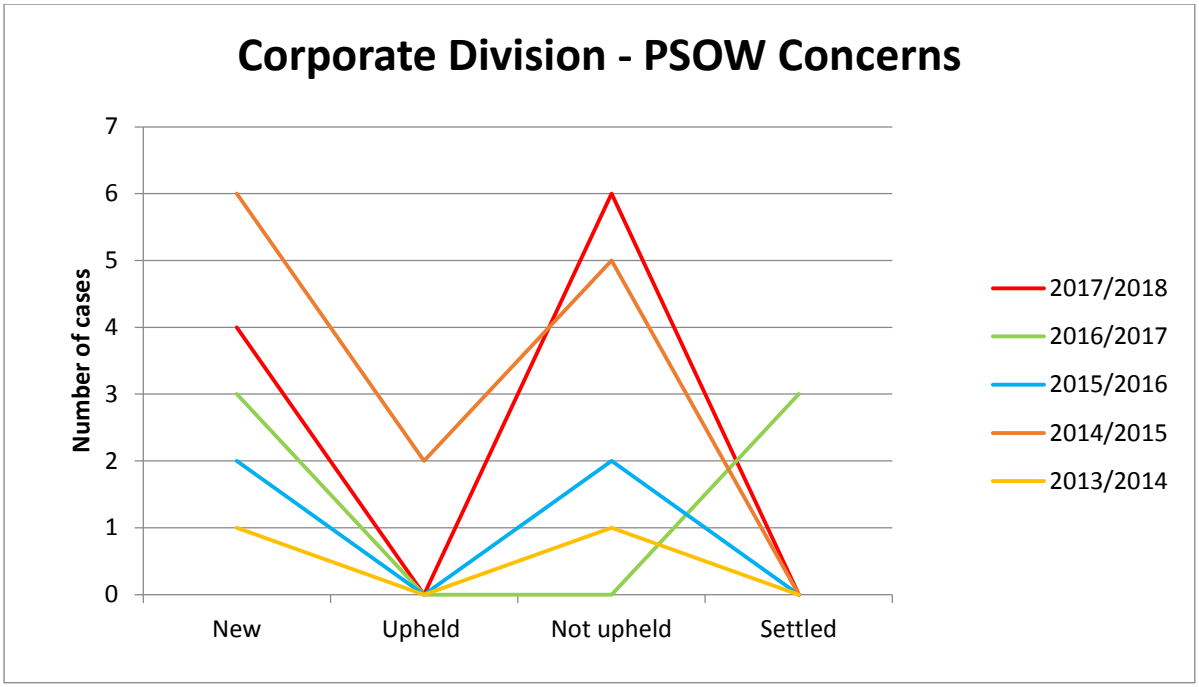



Scheduled Division - PSOW Concerns
Number of cases
35
30
25
20
15
10
5
0
New
Upheld
Not upheld
Settled
2017/2018
2016/2017
2015/2016
2014/2015
2013/2014


MH & LD Division - PSOW Concerns
Number of cases
18
16
14
12
10
8
6
4
2
0
New
Upheld
Not upheld
Settled
2017/2018
2016/2017
2015/2016
2014/2015
2013/2014

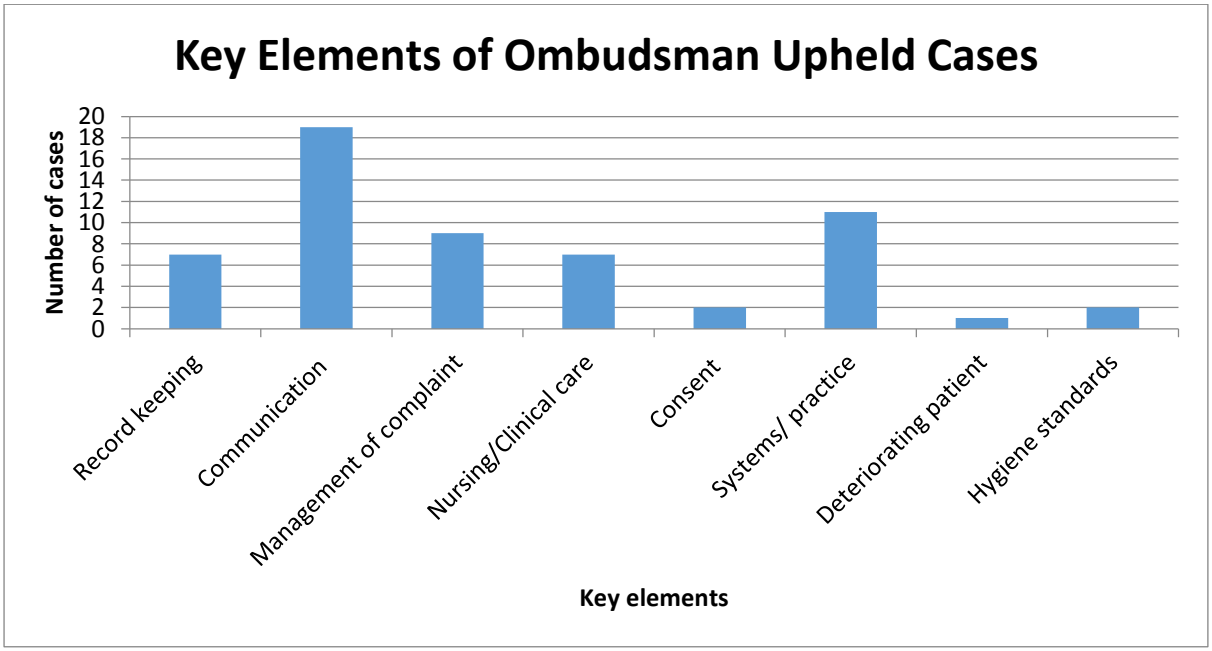

F&T Division - PSOW Concerns
Number of cases
18
16
14
12
10
8
6
4
2
0
New
Upheld
Not upheld
Settled
2017/2018
2016/2017
2015/2016
2014/2015
2013/2014


Community and PC&N Division - PSOW Concerns
Number of cases
25
20
15
10
5
0
New
Upheld
Not upheld
Settled
2017/2018
2016/2017
2015/2016
2014/2015
2013/2014



From the data above, the Divisions that has had an increased in the number of PSOW cases is Primary Care & Networks and Mental Health & Learning Disabilities. The remaining Divisions have seen a decrease in the number of cases received.

A review of upheld cases has identified that the lack of communication with the family is a core reason why a case proceeds to the Ombudsman. The bar graph below sets out the key elements of the upheld Section 21 Reports.



Learning from Ombudsman cases by Division

Listed below are the actions taken by each Division following an Ombudsman investigation.

Unscheduled Care Division has:-

- provided training to ensure that all staff members understand and are aware of the process to be followed in issuing death certificates on the Ward 2:2 YYF and how clinicians manage this. The Division has ensured that the Coroner's guidelines are now readily available to ward staff for their reference.

- reminded staff of the need for sensitivity and discretion when discussing matters with recently bereaved families and that, where possible, these conversations should take place in private.

- taken steps to further investigate and establish why no falls risk assessment was completed on admission.

- developed resource information, and a checklist, for all HCWs and nursing staff likely to have daily/frequent interaction with a patient on key inter faith points – covering the main cultures/faiths known from the ABUHB area's demographic profile.

- reviewed its referral process to the district nursing service on discharge from RGH.

- developed and introduced a mechanism which helps its heart failure clinicians to systematically and proactively identify any patients who may require palliative care.

- reviewed the considerable delay a patient was seen by a doctor in the ED, which amounted to service failure.

- support a Registrar in ED to have additional training on record keeping and discussed the complaint at their next supervision session.

- reviewed their referral process to ITU.

- evaluated whether its process for arranging follow up appointments is robust.

- recognised their failings to identify a qualifying liability in CEO responses letters.

- reminded ward staff that blood tests should be carried out when there are concerns to prevent acute kidney injury.

- reminded all urology physicians at all levels of the need to promptly arrange and conduct biopsies in cases of suspected urinary tract malignancies.

- reminded clinicians in the Urology Department of the importance of appropriate communication and engagement with patients and their families and of the need to ensure that diagnoses and prognoses are fully understood by families.

- shared the Ombudsman report with senior managers, drawing their attention the complaint handling failings identified and reminding them of the requirements of section 24 (2) of PTR Regulations.

- reminded clinicians of the importance of ensuring stool and fluids charts are fully completed in the presence of possible infective diarrhoea and vomiting, especially where the patient is at high risk of developing AKI.

Scheduled Care Division has:-

- reviewed the significant delays in arranging a meeting and providing a further response when managing complaints.

- reviewed the clinical and communication failings and its poor complaint handling.

- reminded relevant staff that when advising patients about the risks of proposed treatments, the discussions should be properly recorded in the patient's clinical notes.

- reminded relevant staff of the requirements of joint working under Putting Things Right and Regulation 17.

- shared the Ombudsman report with the nursing and clinical staff and provided them with the opportunity to reflect upon and discuss the shortcomings identified.

- reflected upon the failings highlighted which were not identified by its own complaint investigation and critically assess the level of scrutiny in (and the independence of) its investigation.

- Undertaken an audit of the quality of nursing records on ward C5, which should focus upon completion of observation charts, quality of

written entries and timeliness of escalation to/referral for medical review.

- undertaken an audit of patient records where the patient has additional needs and/or Learning & Disabilities Team have been involved, in order to (as a minimum) assess adherence to applicable policies and procedures surrounding referrals to and attendance of the Team and use of relevant tools (e.g. the pain assessment tool).

Mental Health and Learning Disabilities Division has:-

- apologised for the poor complaint handling and reviewed their processes and reflected upon the shortcomings in complaint handling identified by the Ombudsman's investigation.

- acknowledged the communication failings, which included inadequacies in the handover process from one CPN to another.

- reviewed their referral routes open to patients.

- reminded their staff of the importance of good record keeping, particularly in interactions with patients.

Family & Therapies Division has:-

- reminded the relevant clinicians of the need to provide full and meaningful explanations to patients when a birth plan has been amended and ensures that the patient not only understands the reason for the change, but is also assured that the decision is the safest for her and her baby.

- reviewed the care and treatment provided to Baby A in their next supervision sessions

- have created a guidance for clinicians on the transfer of babies to specialist units.

- taken action to improve processes for scheduling follow up appointments via the referral and booking centre, which have been audited.

- acknowledged that there was unnecessary examinations which would have caused increased pain and discomfort and the uncertainty about the possible link with the infection.

- provided training/updates in relation to NICE 2008 Induction of Labour, specifically in relation to spontaneous rupture of membranes and the choices for women.

- shared an anonymised version of the report with the Midwives to highlight the concerns over the number of vaginal examinations performed throughout the course of labour and staff have reflected on the use of VEs.

- undertaken an audit of record keeping on the relevant wards to include ensuring assessments of babies are fully completed and that observation charts are properly used. Also to confirm that medication charts are appropriately completed and recording is adequate for mothers.

Community Division has:-

- undertaken an audit of its individualised care plans to ensure that patients are being provided with personal patient care and to ensure appropriate and robust care of PEG sites.

- reviewed their processes for care plan or pathway specific for the management and treatment of patients with MRSA to support the provision of treatment and management advice at the point of notification.

Corporate has:-

- provided a pilot inter faith learning sessions to raise awareness, and to include such information within the induction training of all new HCWs and nursing staff.

- ensured such key cultural information is visible and clearly recorded in the patient's care plan.

- reviewed its Equality & Diversity training plan and included the wider Equality & Diversity training delivered for all staff to undertake within ABUHB's ongoing programme.

- implemented a process, as best practice whereby sufficient information is gathered about the specific needs of all dementia patients on their admission (especially those observing different cultures or religions) to include the following actions (save on acute admissions where this may not be immediately practicable).

- provided the "*This is me"* document on admission to families when a patient with a diagnosis of dementia is admitted (unless the

family indicates one has already been completed and can be provided).

- ensured Ward staff caring for the patient are given a verbal summary of any specific needs/requirements, once known, and as set out in "*This is me"*, and a written record made of any specific requirements in the patient's care plan.

- ensured a copy of the *"This is me"* document is placed and retained in the patient's clinical records (for immediate reference if there are future / multiple admissions.

Assurance, Learning and Closing the Loop

The learning from complaints and incidents has been identified throughout the report. The challenge for the Health Board is how to embed this in practice. There are various initiatives within Divisions for sharing good practice and closing the loop.

The Health Board Learning Committee has been reviewed and is being re-established with a focus on sharing good practice and implementing organisational learning.

The PTR team provide quarterly reports to the Quality and Patient Safety Committee and the plan is to provide bi-monthly reports to the Quality and Patient Safety Operational Group initially for further scrutiny and assurance.

The PTR team produce Organisational Learning Bulletins see Appendix 1.

Appendix 1

Issue 18

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

January 2018

Learning Bulletin

Bedside Oxygen

There has been an number of incidents where patients requiring oxygen at the bedside have been connected to the air port in error.

An Alert has been circulated informing staff that all medical air flow meters must be removed from wall ports when not in use.

Work will soon commence to cap off all medical air wall ports in most areas.

If medical air is required to administer nebulisers, air compressors can be obtained by contacting Angela Haley, Senior Nurse on 01633 238949, internal extension 48949.

Staff are reminded to be vigilant and monitor their areas to make sure the actions in the alert are carried out to make sure medical air ports are not in use in their clinical area.

Please be aware that the revised **NEVER EVENT list for 2018** now includes "a patient who requires oxygen is connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter".

Cultural awareness and hair cutting

A patient with cognitive impairment had their facial hair trimmed as part of personal care. The patient's religious beliefs were such that the cutting of hair is forbidden. This resulted in distress to the patient and their family.

Learning—Consent

There are many cultural and religious beliefs that staff must be aware of when planning and providing care. The patient's beliefs must be considered when giving personal care. The cultural and religious beliefs of each patient must be considered when completing individualised care plans, and staff must ensure consent is obtained. Where patients lack capacity, discussion with their family/carer should be undertaken to ensure the patient's dignity and respect for their cultural or religious beliefs is preserved.