NHS
North West
Ambulance Service
NHS Trust

LESSONS LEARNT

MAY 2020

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INTRODUCTION.

There is a strong culture in the NHS of learning lessons when things don't go to plan clinically, to ensure that patients continuously receive the best possible care and that we're never complacent about the quality of care we provide.

Identifying lessons that can be learnt from the experiences we have, either positive or negative, within our working environment, is extremely important in our goal of becoming the 'Best Ambulance Service in the UK'. They help us in preventing unwanted reoccurrences and in continuing to improve the services we provide.

"Some things cannot be taught; they must be experienced. You never learn the most valuable lessons until you go through your own journey"
Roy T. Bennett

The aim of this publication, produced by the trust's Non-Clinical Learning Forum, is to share some of the lessons NWAS has learnt, over time, with the wider workforce to ensure that NWAS continues to place the safety of our patients and our staff as the top priority within our ambition of providing the 'Right Care at the Right Time, in the Right Place, Every Time'.

NEIL BARNES
Deputy Director of Quality
Chair of the trust's Non-Clinical Learning Forum

In NWAS, we believe that non-clinical teams can also benefit from continuous learning and sharing best practice and so we have taken a step further and introduced a non-clinical learning forum. These lessons which the group focuses on could be the result of an incident that had the potential to influence patient care, identifies where there are inefficiencies, or could be specific to a team's work such as a requirement for better software to improve the services they provide.

The non-clinical learning forum meets frequently to share knowledge and is attended by leaders from across the trust. Directorate representatives, who are members of the forum, obtain lessons learnt from their directorate and add these to their respective 'Learning Tracker' prior to the meeting. Following discussions with colleagues at the forum, these relevant lessons learnt are then disseminated throughout the organisation through colour co-ordinated bulletins, training and other groups posted for all staff to view via the trust's intranet and internet sites (the Green Room).

Summaries of the forum meetings and key points are presented to the Quality and Performance Committee and then a summary paper from the Chair of this Committee is presented to the trust Board.

We value all lessons shared, both positive and negative, as these help us to improve in all areas of our work. Sharing lessons with others helps to take them into consideration and, where applicable, put into practice and demonstrate best practice.

What follows in this publication is a summary of a selection of lessons learnt, identified since April 2018.

The publication is a mixture of lessons learnt from the following departments within the trust, Clinical Safety, Communications, Estates and Fleet, Freedom to Speak Up, Governance, Health and Safety, Legal, Patient Transport Service (PTS), Programme Management Office (PMO), Quality, Resilience, Risk, Safeguarding and Safety and Security.

If you would like to see the latest lessons learnt bulletin for your department, please ask your manager or view them via our Green Room.

The trust also has a Learning from Experience Policy which can be found at;
www.greenroom.nwas.co.uk/library/learning-from-experience-policy/

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NWAS IS COMMITTED TO AN OPEN AND FAIR LEARNING CULTURE WHERE EMPLOYEES ARE CONFIDENT TO REPORT ADVERSE EVENTS AND/OR NEAR MISSES; KNOWING THAT THERE IS A SUPPORTIVE PROCESS TO ENCOURAGE LEARNING AT BOTH INDIVIDUAL AND ORGANISATIONAL LEVELS.

COMMUNICATIONS.

The Communications team took a call from the media about a stabbing incident resulting in a question from the police as to why the name of the hospital was in the media.

Serious incident information sharing with the media needs to be limited to protect the patient, especially where a crime has been committed and someone’s safety could be at risk.

Guidance was issued to the team as to what information is appropriate to share.

A campaign was launched by the Communications team to recruit volunteers to be community first responders, as requested by the Community Resuscitation team.

Due to an overwhelming response from the public, the planned campaign activities were unable to be implemented.

A note has been added to campaign plan templates to ensure teams internally anticipate demand following a public launch and are resourced to deal with it.

As the use of social media becomes more prolific, the Communications team recognised the increasing number of out of hours Facebook messages from individuals stating that they were feeling suicidal and asking for medical advice online.

The trust’s social media sites are only monitored during office hours so the team were concerned that these people had not had a response, resulting in a need to follow up the message to ensure the individuals were safe.

As time had elapsed since the original message, this was not only distressing for the team but also meant that the individual might not have gotten the urgent help that they needed.

The team has now put in a place an automated message which the sender immediately receives when posting a message. This clearly explains when the social media site is manned and gives advice on where the individual can go for help. The message also advises the public that the site administrators cannot despatch an ambulance or give medical advice.

ESTATES AND FLEET.

On review of activity from previous winters, it was identified that additional downtime was being incurred due to crews travelling to workshops for minor repairs. A trial was run placing a mechanic at Stockport Ambulance Station to perform running repairs for vehicles across the south side of Manchester. A review of the benefits demonstrated it worked well, reduced a significant amount of travel time and increased the availability of vehicles be able to respond.

Prior to the procurement of the new premises cleaning contract in 2018, staff were given the opportunity to feedback on their understanding and experience of the service, along with the option to provide suggestions for service improvements. The results were analysed and where applicable incorporated into the tender specification. They were then shared with the incoming contractor in order for them to comprehensively understand staff view and develop their plans accordingly. Giving stakeholders the opportunity to input is a key factor in delivering a successful outcome.

FREEDOM TO SPEAK UP.

A number of bullying and harassment allegations have been raised with the Freedom to Speak Up Guardian.

The trust is due to launch an anti-bullying and harassment campaign to ensure that staff know how to raise an issue in the right way.

Bullying and harassment can also affect patient safety; a person suffering from the effects of bullying and harassment can suffer stress, anxiety and sleep deprivation.

Many of the cases the trust receives are passed to the Freedom to Speak Up (F2SU) team as staff do not feel comfortable going to their line manager with their concerns.

F2SU will sign post staff to the relevant policy in order to address concerns or raise matters on a person's behalf.

Staff were reminded of the trust's Be, Think, Do leadership framework and asked to seek feedback from trusted colleagues about perceptions of their behaviour.

HEALTH AND SAFETY.

Track chair failures were identified but there were issues with locating these chairs, as serial numbers had not been detailed on our Datix system. This raised concern that not all chairs were being regularly checked which potentially could put the safety of our staff and patients at risk.

To ensure that all track chair failures are logged, equipment managers now regularly check the chairs to make sure they have all have a serial number and are regularly inspected.

A Datix report has revealed that in 11 months there had been 42 incidents (including five incidents involving patients) linked to vehicle related injuries of which six were RIDDOR reportable.

We identified that the figures appeared to be high and that they primarily included slips, tips and falls from vehicles.

Good reporting enabled the Health and Safety team to identify these issues and basic reminders were sent to staff to check their surroundings before exiting vehicles.

INCIDENTS.

When incidents have been reported on DATIX, some were not categorised or sub-categorised correctly. With information missing it was difficult to determine harm or the potential for harm.

Lack of information causes difficulty in determining the frequency of these incidents and whether they are nationally reportable.

It is vital that staff remember the importance of completing the correct fields for an Incident Report Form, when reporting or managing an incident. The category of incident is equally important to make the information as useful as possible.

INFECTION PREVENTION AND CONTROL.

Staff were observed with poor compliance in relation to handwashing techniques.

A new handwashing observational checklist was produced, so that senior paramedic team leaders and their colleagues could work together to improve handwashing compliance. Ultimately this will protect staff and patients from harm.

The purpose of handwashing is to remove dirt, viruses and bacteria from hands. This stops diseases being spread in the environment and from person to person, which can lead to illness.

The trust is committed to its uniformed staff complying with 'Bare Below the Elbows' principles. This includes not wearing wrist watches, other jewellery and/or painted/false nails at work while in uniform.

LEGAL.

Decisions to settle claims made against the trust had to be taken as a result of poor record keeping/evidence of investigations/inspections.

Our ability to defend claims relies heavily on the quality of our documents and records ie patient report forms and incident report forms. If it is not written down its difficult to evidence that it did/did not happen as alleged.

Staff were reminded of the importance of keeping records/investigations factual and without giving opinions.

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LEARNING FROM EXPERIENCE IS FUNDAMENTAL TO SERVICE IMPROVEMENT BOTH FROM ADVERSE INCIDENTS AND ALSO FROM DEMONSTRABLE EXCELLENCE, AND SHARING LESSONS LEARNT ACROSS THE ORGANISATION ALLOWS COLLEAGUES TO NOTICE THEMES AND APPLY THE LEARNING TO THEIR OWN AREA OF WORK, IF APPLICABLE.

PATIENT TRANSPORT SERVICE.

A volunteer car driver collected a patient from their home address to take her to a hospital appointment for radiotherapy. The patient was walking down their driveway towards the car when she tripped over a brick and fell. Sadly, she hit the ground and sustained lacerations to her face.

If the environment had been assessed for potential risks before the patient left her house, her injury could have potentially been avoided.

Following the incident, we identified that it may be necessary to give volunteers additional training on how to undertake an appropriate environmental assessment in order to identify any potential risks to the patient. As a result, a session on environmental assessments has been added to our volunteer car driver induction course and an awareness book for existing drivers has being developed.

A patient who was sat in his own wheelchair in the NMI Millennium seat became trapped when the seatbelt webbing became stuck in the ratchet. In order to free the patient excessive force was required to dislodge the webbing that was ratcheted too far in, resulting in cuts and scraps of both the staff members’ arms. A similar incident also occurred where the webbing had to be cut in order to free the patient.

A change in design, combined with some skill erosion, has meant that some staff haven’t been using the adjustable adapter beam on the NMI Millennium seat back where appropriate. This creates the potential for the seatbelt to become jammed if the adjustable adapter beams are not used correctly.

A bulletin has been issued reiterating the correct procedure for using the NMI Millennium seat and team leaders have been asked to ensure all staff are aware.

A patient was discharged to their home address. Upon arrival at the property the crew had safeguarding concerns about the patient but they refused to give consent and had capacity.

It was raised that there is currently no method of recording where a safeguarding concern has been attempted but consent has not been obtained.

A procedure has been implemented whereby staff call into control so that a record can be made to show that safeguarding was attempted.

An incident review group was undertaken looking at slip, trip and falls incidents within a three month period within all areas of PTS.

From this review it was identified that PTS staff encounter a number of patients who either fall whilst in our care or we find fallen within their own home and may reveal to us that they are frequent fallers.

By failing to refer these patients to the appropriate care pathways available, the opportunity for early intervention with these patients may be missed leading to a potential patient injury.

A bulletin has to be issued to all staff highlighting the ‘Raising Concerns for Patients Scheme’ which can be utilised to refer the patient to the appropriate care pathway and so getting the patient the support which they may require.

PROGRAMME MANAGEMENT OFFICE (PMO).

All projects must have a Senior Responsible Owner (SRO), someone who is accountable for the project. The SRO provides the direction and vision for the project, their strong leadership and clear accountability are key elements of successful project delivery. The requirement to appoint a SRO for a programme or project is now established within the trust and required in order to initiate a project. The SRO is the individual who is ultimately answerable for an activity or decision. This includes 'yes' or 'no' authority and the power to stop a project. The SRO is accountable for ensuring a programme or project meets its objectives, delivers the projected outcomes and realises the required benefits and are accountable to the trust Executive Leadership Committee and trust Board.

Identifying the correct governance for projects at the outset is of critical importance. This is to ensure that projects can operate effectively with the correct guidance, clear escalation routes and enable clear decisions to be made at the right level. Where clear governance exists, projects are more likely to meet their identified and measurable outcomes. Projects with unclear governance and ownership tend to drift, lose momentum and either fail in their delivery, or fail over time, thus their benefits are not achieved.

To ensure appropriate governance is provided, the trust has implemented a Corporate Programme Board (CPB) to govern all projects and programmes. CPB will provide scrutiny and challenge for all projects to ensure change is implemented effectively and that outcomes and benefits identified at the outset of a project are realised.

QUALITY.

A potential myocardial infraction (heart attack) patient was taken to a specialist heart centre on an alert. Upon arrival it was evident that the patient had no ECG monitoring throughout the journey.

The receiving staff at the centre immediately requested the patient be brought into the unit in order to recommence monitoring quickly. Luckily on this occasion no further developments had occurred on route to the unit.

It is important that all cardiac patients presented to any receiving hospital have continual ECG monitoring to ensure that any ECG changes are not missed and can be acted upon appropriately.

Discarded used sharps were being found in response bags without the safety feature being engaged. This posed a sharps risk to staff and risk of cross contamination.

Feedback was shared with staff on how to correctly disengage a sharp and how to dispose of them correctly.

It is important that staff ensure, that on disposing of a sharp following failed cannulation, that the needle is withdrawn fully from the catheter so that the safety mechanism can engage and reduce the risk of a sharps injury.

RESILIENCE.

A reoccurring recommendation from incident debriefs was recognised. Staff working in noisy environments reported difficulty in hearing audio from Airwave hand terminals.

To overcome this, the Executive Management Team agreed to support the proposal to issue all Airwave hand terminal users with their own earpiece for use in noisy environments. A procurement process was undertaken and sufficient funds were identified to support this issue.

Safety critical messages could have been missed if not heard clearly on Airwave. If this issue had not been raised during debriefs, the problem would have persisted causing danger to staff and patients.

Responders in police and fire services regularly wear identification tabards at the scene of incidents involving other emergency services in accordance with JESIP Principles. But in NWAS, only on-call commanders had previously carried these.

Our Resilience team arranged for the procurement of tabards for all ambulances and rapid response vehicles with a range of role title sliders, so that the first attendant on scene at a multi-agency incident can easily be identified as the operational commander until relieved.

RISK.

We were experiencing some problems with Datix incident notifications as they were being sent to a large cohort of local and specialist managers. This resulted in poor ownership, investigation and staff response.

To prevent the issue from re-occurring, the system was modified so only a small number of responsible managers receive initial incident notifications, to allow them to assign responsible investigators who progress the management of the incident to closure.

SAFEGUARDING.

A crew were called to a lady who had bruising on her abdomen. The bruising was documented however there was no explanation how the bruising occurred.

The lady was subject to domestic violence by a family member. Unfortunately over time this escalated leading to her death from the injuries sustained.

It is essential that staff use professional curiosity and ask questions in relation to the presenting injuries.

Domestic abuse can be stopped and victims can be helped. Safeguarding is everyone's responsibility.

SAFETY AND SECURITY.

It became known that emergency operations centre staff were not passing details to operational staff information about violence and aggression flags held on the system, unless they were responding to the individual who was the subject of the flag.

These actions were contrary to procedure, which explicitly states all violence and aggression information must be passed to operational staff.

Control staff were reminded of the procedure.

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