Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Listening and Learning Sub-Committee
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Maria Battle, Health Board Chair
Cyfnod Adrodd: Reporting Period:	1st October – 4th November 2020

Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:

Since the previous exception report to QSEAC, the Sub-Committee has reviewed 23 individual cases, across the spectrum of redress; complaints; claims; serious incidents and public services ombudsman reviews, in addition to. 2 Health Inspectorate Wales (HIW) reports. The main issues arising from these cases and associated actions are as follows:

Missed/delayed diagnosis of fractures

A quality improvement collaborative meeting had been established, to look at the fracture pathway, particularly in relation to bony wrist injuries. A revised pathway for scaphoid fractures at the Minor Injuries Unit (MIU) at Prince Philip Hospital (PPH) has been developed.

Action and Follow up of Test Results

A quality improvement collaborative meeting has also been established, looking at the system for follow up and action of test results by clinicians.

Pathologist Involvement in Cancer Multidisciplinary Team (MDT) Meetings

This has been recognised as a priority and is being addressed by the Department. The Department is actively recruiting to a new post.

Acute Kidney Injury (AKI)

The case involved a failure to act on test results. The Sub-Committee received assurance regarding compliance with the action plan in respect of the ward involved, which will be monitored by the Operational Quality, Safety and Experience Sub-Committee (OQSESC). A new AKI bundle has been developed, with associated training provided to support the implementation across the Health Board.. The case also highlighted concerns regarding completion of the fluid balance chart and hydration of the patient. These issues have been addressed by the nursing teams involved. Learning from the case will be highlighted to the Nutrition and Hydration Group.

Thoracic Aortic Dissection

The case involved a delay in diagnosis of an aortic dissection. The Sub-Committee noted the progress made in relation to the action plan, in particular the 'Think Aorta' campaign. In

addition to the learning from events already undertaken, a summary of the case would be included in the Medical Director's newsletter.

Delay in Diagnosis of Deep Vein Thrombosis (DVT)/Pulmonary Embolism

In addition to delays in the diagnosis of the DVT, which was caused by a failure to undertake a full medical history from the patient and not acting on an abnormal ECG result. Concerns were also raised about the discharge planning process and records management/access to records. Discussion took place on the need for digitalisation of records and the significant benefits of having electronic access to a full set of combined hospital records. The Associate Medical Director for Quality and Safety agreed to take this forward and meet with colleagues as part of the transformation of services programme.

HIW Reports

Two very positive reports were received following visit to Cleddau Ward, South Pembrokeshire Hospital and Bryngolau Ward, PPH.

Public Services Ombudsman for Wales

The Sub-Committee noted one Ombudsman final report (12035) relating to the Health Board which had been received since the previous meeting. The report made the following recommendations:

- Remind relevant nursing staff of the importance of ensuring that all falls documentation, including care plans, risk assessments and discussions with patients around maintaining privacy and dignity are clearly and comprehensively documented in line with relevant guidance, including how to make appropriate amendments or corrections to records when necessary.

- Remind all radiology staff of the importance of ensuring that all initial radiological images should be fully and formally reported, including any incidental findings and any additional views.

- Share report with all the senior Orthopaedic Doctors and radiology staff involved in this case for them to reflect on the findings as part of their supervision, and provide evidence that they have undertaken a reasonable level of reflection with particular reference to the relevant themes set out in the analysis section of the report.

- Issue guidance on the importance of ensuring that patients are fully informed of, and involved in, decisions about their care and outline what steps should be taken in the event that a patient's ability to engage is compromised, or fluctuating, and ensure that it is shared with all staff who were involved in her care.

- Amend its discharge planning documentation to include a section for recording what ongoing management and post-discharge information has been discussed with and provided to the patient and remind relevant staff of the importance of completing this

documentation fully. Review its discharge planning process and take action to improve provision of a joined-up service, including clarifying who should be responsible for ensuring that care recommended by the Reablement Service is confirmed and will be in place when the patient is actually discharged.

Progress on the action plan was received by the Sub-Committee, with discussion focusing on the themes arising regarding discharge planning. A further analysis of the themes and emerging issues will be undertaken and fed into the Health Board review of the discharge processes to ensure all lessons learnt are considered as part of this review.

A second report (Section 23 Public Interest Report) was received which related to an Ombudsman's investigation into **Swansea Bay University Health Board (SBUHB).** The complainant was concerned that inadequate eye care was provided to her daughter in light of her known self-injurious behaviour (which included hitting herself on the head and face which were known to cause bruising). As a result, the mother expressed concern that her daughter's eye injury was not diagnosed sooner. The daughter has a diagnosis of Atypical Autism, Learning Disability – mild to moderate and mental health difficulties and was, at the time of the incidents, living in a specialist residential learning disability unit run by SBUHB.

The Ombudsman found that while the daughter received good care in terms of planning and delivery to meet her specialised learning disability needs, there were serious shortcomings in the care she received in June 2018 relating to her eye management. The Ombudsman found that the failings in the daughter's care engaged her Article 8 rights (a right to respect for one's private and family life) as the Health Board had not sufficiently demonstrated that it had ensured that the needs of an adult with learning disability, were sufficiently respected.

The report has been shared with the relevant services for consideration and will be discussed further by the Sub-Committee in February 2021 in response to any Health Board actions that may need to be taken.

Risgiau:
Risks (include Reference to Risk Register reference):

Actions are currently being considered to mitigate the risks of a lack of a) follow up and action of test results b) diagnosis and management of fractures, in the interim period, whilst the quality improvement work is being undertaken.

Gwella Ansawdd:
Quality Improvement:

The identified actions for quality improvement have been identified as:

- Follow up and action of test results,
- Reduction in the delayed diagnosis of fractures, particularly bony injuries,
- Digitalisation of hospital records,
- Communication – providing a single point of contact and digital first patient correspondence and communication,
- Review of MIU PPH patient and public communication,

• Electronic handover process.
Argymhelliad: **Recommendation:**
• The Quality, Safety and Experience Assurance Committee is asked to note the content of this report and be assured that the actions taken by the Sub-Committee to mitigate the risks are adequate.
Dyddiad y Cyfarfod Pwyllgor Nesaf: **Date of Next Sub- Committee Meeting:**
2nd December 2020