Maternity and newborn, children and young people Newsletter

Working together to improve safety for women, newborns, children and young people

Welcome to the second edition of the Maternity and Newborn, Children and Young People Patient Safety Newsletter. This is a quarterly publication, keeping you up to date on the maternity, newborn, children and young people's work programmes.

We had a fantastic response to our first newsletter and are so pleased that you found it useful. We were delighted to have so many people join our Sepsis, Deterioration and Reducing Term Admission work programmes as a result of the newsletter. Many of you helped spread the word by distributing it to your own networks which is great.

FACTS

- **Term admissions rose by 0.9% between 2011 and 2012. ONS data on the number of live births used as a denominator has enabled a clear understanding of the scale of the increase.**
- **Between 1 April 2011 and 31 March 2014, there were 5,253 incidents relating to unplanned admission or transfer of newborns to a specialist care unit reported to the National Reporting and Learning System (NRLS).**
- **Of these, 398 incidents were reported as causing moderate or severe harm or death.**
- **4,925 were reported as a no harm incident and 1,750 as the patient suffering low harm.**
- **The UK Sepsis Trust estimate that 37,000 people die of sepsis each year in the UK and that 12,500 are avoidable.**
- **NRLS data for reported incidents in patients under 18 years for three years, April 2011 to March 2014, found that 225,676 incidents reported in newborns and 63,944 in children, making up 5.5% and 1.5% of the reports respectively in the NRLS for all ages.**

Harm relating to ingestion of Button Batteries!

NHS England has issued a Patient Safety Alert alerting healthcare professionals to the risk of death and serious harm from delays in recognising and treating ingestion of button batteries.

The alert was issued as a matter of urgency with the Christmas season approaching.

To read the Alert click here.

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The CYP work programme…….

DETERIORATION

- The deterioration platform on the Patient Safety First website is developing and traffic is increasing, especially in regard to our monthly webinars (which you can 'watch again' anytime—a great one on PEWS just up and e-PEWS being held in January), case studies from organisations and resources dropped in by you!
- Two working groups have been formed from the deterioration in children advisory group to create -
  - A curation of resources for staff to support the recognition and response to the deteriorating child (led by Dr Damian Roland, consultant in paediatric emergency medicine)
  - A film resource to support the active partnership with parents focussed on deterioration (led by Dr Bernie Carter, professor of children's nursing and with Kath Evans, head of patient experience)
- A meeting '**exploring a paediatric early warning system'** was held on 9 December. To be updated watch the deterioration platform or contact us.

We need your deterioration expertise!

- In March 2015 The deterioration in children advisory group would like to hold a virtual launch event of the work and resources shared and curated over the programme. Your ideas and volunteering for blogs, videos, case stories, improvements and other successes around this agenda would be gratefully received. We can link to work already completed but also plan to have the facility to video you presenting your work for the event! Please contact us to share.

SEPSIS

- Sepsis workshops have been held or planned for each region, gathering together clinicians, commissioners and those conducting research or improvement work to share knowledge and resources and to consider local improvements and drivers.
- The masterclasses, led by Dr Ron Daniels from the UK Sepsis Trust, are in full swing now. Small groups from organisations come together to consider improvements across their organisational systems for the prompt recognition and treatment for sepsis.
- The Patient Safety Alert on sepsis, issued in September, with links to the UK Sepsis Trust resources can be found here
- There is a webinar on sepsis on our deterioration platform and two more planned for next year, including one on maternal sepsis

Other news…..

- The National Patient Safety Alerting System issued several alerts relevant to our patients this year.
- The Sign up to Safety Campaign and Patient Safety Collaboratives are gathering momentum
- NHS Patient Safety Indicators can be viewed on NHS Choices
- The latest news on the next generation Patient Safety Thermometers can be found here
- Share your news or resources on patient safety for maternity or the care of newborns, children and young people on our Community of Interest area of the deterioration platform

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The maternity and newborn work programme…..

Reducing term admissions to NNU

♦A stakeholder event was held on 3rd November to present nationally collated data on term admissions from four different perspectives: NNRD, litigation, parents perspective and safety. This added to the expertise from front line clinicians, commissioners, researchers and strategic leaders attending the event. The afternoon workshop was designed to draw on expertise to influence where improvement work, needed to be centred. The event proved a powerful means of exposing the complexity and enormity of the work and highlighting that the solutions need to be levered at all levels of the system: provider and commissioner level as well as strategically. A document setting out the needs for successfully delivery of the work programme is currently being complied and will be disseminated early in 2015.

♦If you have improvement work you have done in regards to reducing avoidable term admissions or would like to join the interest group, please email: **michele.upton@nhs.net**

Reducing retained foreign objects in maternity

♦The Women's Health Patient Safety Expert Group are working together to learn from incidents and claims relating to retained vaginal swabs following a gynaecological or obstetric procedure. We have designed an on-line survey to gather useful information in order to determine possible interventions for reducing these Never Events. The survey will be sent to all maternity units in England to identify common issues to inform shared learning and capture examples of best practice. If your unit has already implemented improvements following such an incident, please share more with us at: England.maternity.patientsafety@nhs.net

Improving the safe use of Central Venous catheters in neonates

♦ Following reports of two recent incidents in neonates involving umbilical lines, a national survey of practice relating to insertion, management and use of umbilical lines was undertaken. The findings demonstrated three predominant themes:

- ♦ significant variation in practices
- ♦ That safety incidents involving umbilical lines are not uncommon
- ♦ That severe harm and death can result from the use of these.

A working party has subsequently been set up in collaboration with the British Association of Perinatal Medicine (BAPM) with the aim to develop a Framework for Practice to provide recommendations to promote safer practice. The full survey findings will be submitted for publication in the next few weeks. Thank you to all who responded to the survey which has helpfully provided clarity on national practice.

If you have any ideas or resources to share or would like to get involved in any of this work please contact us at: england.deterioration@nhs.net

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Harry's story

I know there is a lot of good care in the NHS, but I also know that there is poor care, particularly out of hours.

In 2008 I was a healthy 35 year old, married to Mike and, after a long wait, was very happy to be expecting my first child. I had no problems during pregnancy and did everything I could to be healthy and protect my baby. I went into labour at 10 days overdue, rang the hospital and went in when advised. We were taken to the delivery room and introduced to the midwife.

However, there was little communication or care throughout labour and we were left on our own even in the late stages of the labour, but we put our trust in the team: what else could we do? There were concerns about my baby's heart trace and I was put on a monitor, however, when the registrar was eventually called back to review the heart trace she looked exhausted. She then saw how bad the heart trace was and tried to deliver my son immediately, but it was too late.

My baby, Harry, was resuscitated and put on a ventilator. When Harry was four weeks old we were told he had profound brain damage due to the lack of oxygen at birth and were given the devastating news that he would never walk, talk or be able to feed normally. An investigation concluded that the CTG (heart trace) had not been read correctly and NICE guidelines for care in labour had not been followed.

After a difficult life of tube feeding, constant sickness, fits and discomfort, our son died of a chest infection aged 18 months. As a family we have been left devastated at the loss of our beautiful boy.

Research has shown that birth out of hours is associated with a significantly increased risk of death due to intrapartum anoxia. In our view, a major contributory factor was the lack of consultant presence. Since Harry's death, along with another bereaved mum, I have set up the Campaign for Safer Births to call for improvements in order to reduce the avoidable deaths and injuries of babies and mothers during labour. We are also contributing expertise to the RCOG Each Baby Counts project, using our difficult experiences to help inform future practice.

For more information on the Campaign for Safer Births click the link

https://www.facebook.com/campaignforsaferbirths?fref=photo