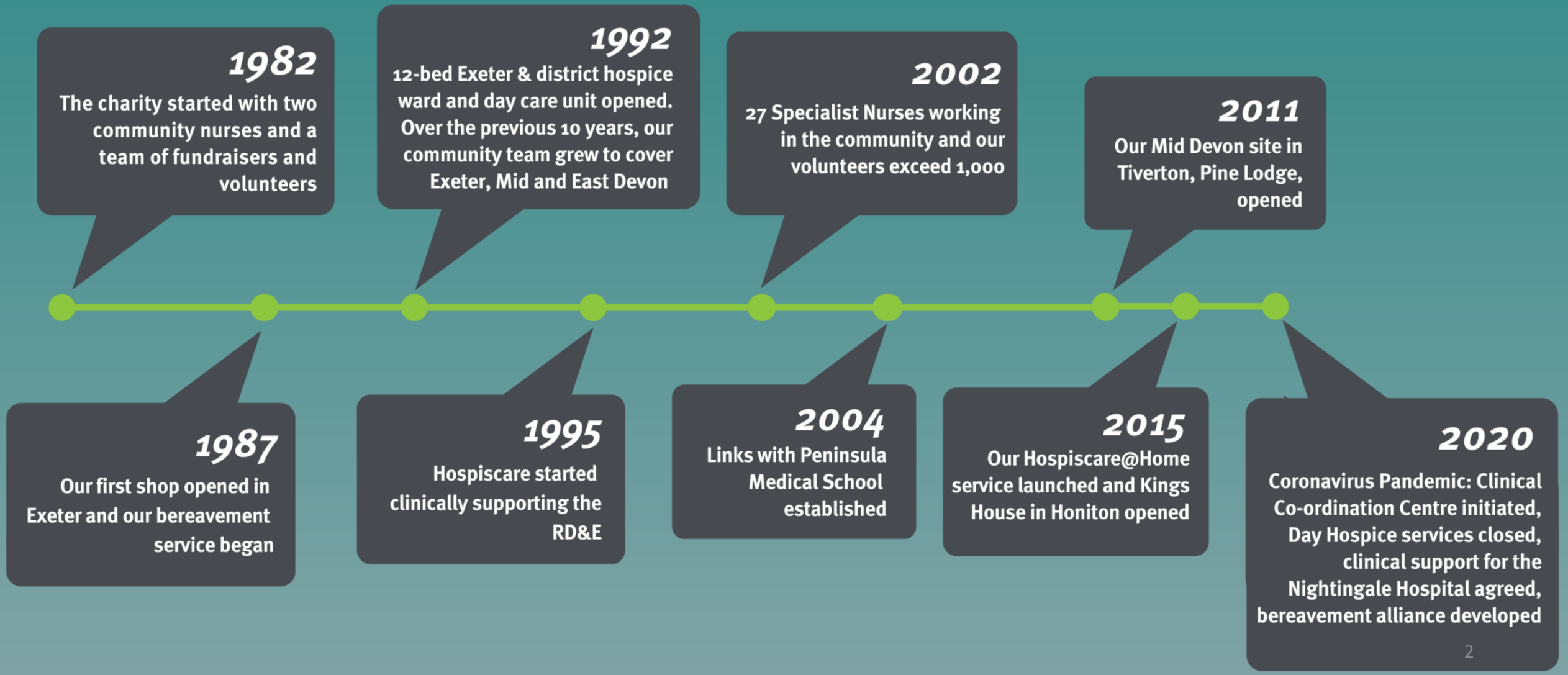
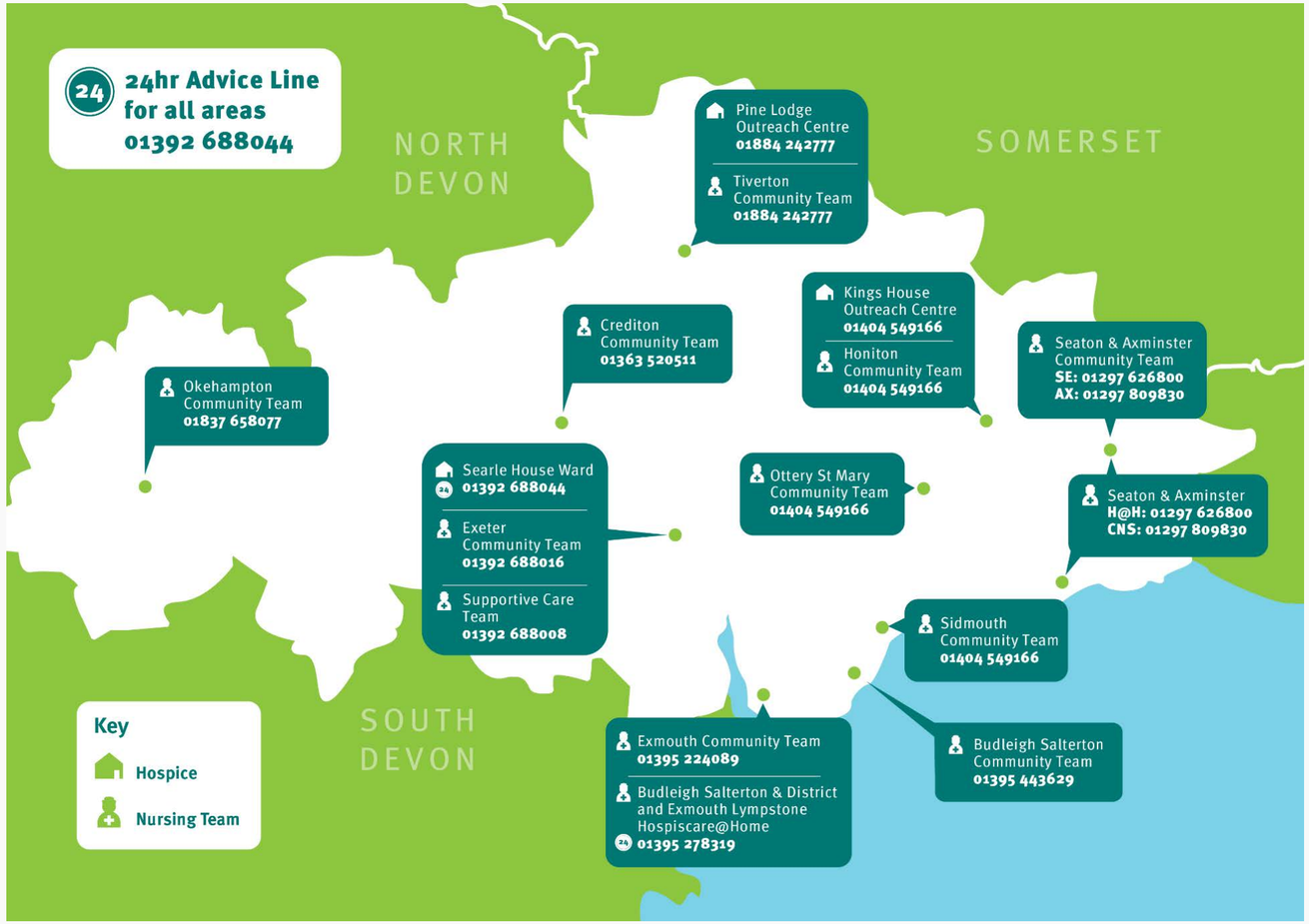
Hospiscare
Mind the Gab
SBAR Report

Hospiscare
Caring in the heart of Devon

The Hospiscare journey

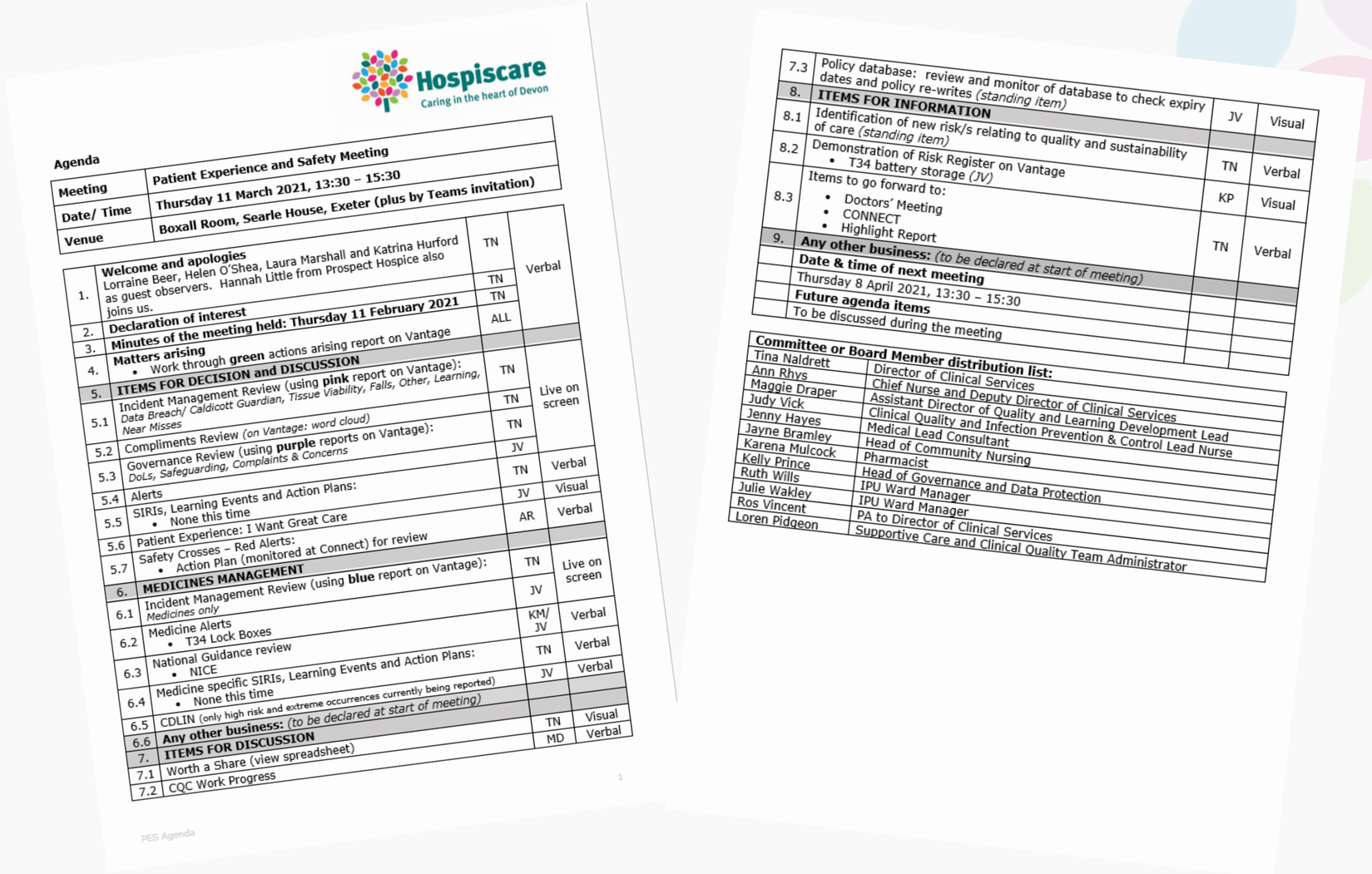


Hospiscare- our community



Hospiscare – Our Teams

Hospiscare –
Patient Experience and Safety Meetings



Hospiscare
Caring in the heart of Devon

Agenda

Meeting	**Patient Experience and Safety Meeting**
Date/ Time	**Thursday 11 March 2021, 13:30 – 15:30**
Venue	**Boxall Room, Searle House, Exeter (plus by Teams invitation)**

1.	**Welcome and apologies** Lorraine Beer, Helen O'Shea, Laura Marshall and Katrina Hurford as guest observers. Hannah Little from Prospect Hospice also joins us.	TN	Verbal
2.	**Declaration of interest**	TN	
3.	**Minutes of the meeting held: Thursday 11 February 2021**	TN	
4.	**Matters arising** • Work through **green** actions arising report on Vantage	ALL	
5.	**ITEMS FOR DECISION and DISCUSSION**		
5.1	Incident Management Review (using **pink** report on Vantage): *Data Breach/ Caldicott Guardian, Tissue Viability, Falls, Other, Learning, Near Misses*	TN	Live on screen
5.2	Compliments Review *(on Vantage: word cloud)*	TN	
5.3	Governance Review (using **purple** reports on Vantage): *DoLs, Safeguarding, Complaints & Concerns*	TN	
5.4	Alerts	JV	Verbal
5.5	SIRIs, Learning Events and Action Plans: • None this time	TN	Visual
5.6	Patient Experience: I Want Great Care	JV	Verbal
5.7	Safety Crosses – Red Alerts: • Action Plan (monitored at Connect) for review	AR	Verbal
6.	**MEDICINES MANAGEMENT**		
6.1	Incident Management Review (using **blue** report on Vantage): *Medicines only*	TN	Live on screen
6.2	Medicine Alerts • T34 Lock Boxes	JV	
6.3	National Guidance review • NICE	KM/ JV	Verbal
6.4	Medicine specific SIRIs, Learning Events and Action Plans: • None this time	TN	Verbal
6.5	CDLIN (only high risk and extreme occurrences currently being reported)	JV	Verbal
6.6	**Any other business:** *(to be declared at start of meeting)*		
7.	**ITEMS FOR DISCUSSION**		
7.1	Worth a Share (view spreadsheet)	TN	Visual
7.2	CQC Work Progress	MD	Verbal
7.3	Policy database: review and monitor of database to check expiry dates and policy re-writes *(standing item)*	JV	Visual
8.	**ITEMS FOR INFORMATION**		
8.1	Identification of new risk/s relating to quality and sustainability of care *(standing item)*	TN	Verbal
8.2	Demonstration of Risk Register on Vantage • T34 battery storage *(JV)*	KP	Visual
8.3	Items to go forward to: • Doctors' Meeting • CONNECT • Highlight Report	TN	Verbal
9.	**Any other business:** *(to be declared at start of meeting)*		
	Date & time of next meeting		
	Thursday 8 April 2021, 13:30 – 15:30		
	Future agenda items		
	To be discussed during the meeting		

Committee or Board Member distribution list:	
Tina Naldrett	Director of Clinical Services
Ann Rhys	Chief Nurse and Deputy Director of Clinical Services
Maggie Draper	Assistant Director of Quality and Learning Development Lead
Judy Vick	Clinical Quality and Infection Prevention & Control Lead Nurse
Jenny Hayes	Medical Lead Consultant
Jayne Bramley	Head of Community Nursing
Karena Mulcock	Pharmacist
Kelly Prince	Head of Governance and Data Protection
Ruth Wills	IPU Ward Manager
Julie Wakley	IPU Ward Manager
Ros Vincent	PA to Director of Clinical Services
Loren Pidgeon	Supportive Care and Clinical Quality Team Administrator

PES Agenda 1

Hospiscare SBAR Report

Situation:

In January 2020 Hospiscare's Patient Experience and Safety (PES) group noted a common drug error theme of the incorrect administration of Pregabalin and Gabapentin to patients on the Inpatient Unit (IPU).

Number of incidents 6 in 9 weeks.

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Background:

On becoming a schedule 3 controlled drug, Hospiscare IPU stored these medications securely within the wall mounted locked CD cupboard for safe storage and stock level checks/ordering.

They are entered into and checked out from the Controlled Drugs Record book and are a single person check for administration.

Hospiscare SBAR Report

Assessment:

Multiple errors have been made with themes; of administering the wrong medication (both ways) taking fewer tablets (i.e. 200mg prescribed and written in the CD book, but 100mg given - leaving stock level incorrect **and** recording in record book, but not taking out of the cupboard and administering to the patient (CD stock level high).

Hospiscare SBAR Report

Recommendation:

1. Each incident has been reviewed with Ward Manager and staff member and reflective practice completed
2. Incidents shared with the wider team to reduce risk of reoccurrence
3. When prescribed on hand written medication chart the drug name is highlighted to alert staff
4. Within the cupboard the two drugs are stored at separate ends i.e. not side by side
5. A poster created – ‘Mind The Gab’ and displayed within the clinical area
6. The Clinical Practice Facilitator will be doing some work-based learning with the team on error awareness
7. We will be sharing this leaning example with the CQC

Communication to Staff

- Shared by Line Managers at ward meeting
- Poster visible within the ward
- Shared by weekly communications by the Clinical Quality Team
- Poster shared electronically with Hospiscare Community Nursing team

2021

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MIND THE GAB

HIGHER dose e.g
300mg-900mg TDS

GABapentin

LOWER dose e.g
100mg-300mg BD

Pre**GAB**alin

Judy Vick - Hospiscare

Thank you