QUALITY & SAFETY MANAGEMENT GROUP
DATE: 11.08.2022 @ 10:00am
Chair: name redacted

Present:
Quality and Safety Manager (chair)
Velindre - Outpatient Nurse Manager
Velindre - Therapies
Welsh Blood Service, WBMDR
Velindre - Infection Control
Velindre - Medical Staffing
Velindre - Radiology
Patient Liaison Rep
Trust - Health & Safety Manager
Velindre - Pharmacy
Velindre - Radiotherapy
VUNHST - Digital Services
Trust - Head of Information Governance
Velindre - Medical Physics

Apologies
Head of Nursing
Head of Outpatients
Principal Pharmacist
Quality Lead, Radiology,
Head of Therapies
Education & Development

In attendance:
Velindre – Quality & Safety Officer

No	Item	Action
1	**Welcome and introductions** Introductions were made and the group agreed for the meeting to be recorded.	
2.	**Declarations of Interest** No declarations of interest were received.	
3.	**Notes of meeting held on: 23.06.2022 – FOR APPROVAL** The notes of the meeting held on the 23.06.2022 were agreed as a true reflection of the meeting.	
4.	**Current matters arising from Action Plan**	

	TL informed the group that the actions from the meeting held on 23.06.2022 have not been uploaded to the current action plan. TL confirmed the action log will be up to date by the next meeting in October. TL confirmed that all actions had been completed.	TL
5	**Consent Agenda**	
5.1	***New Membership of VCC QSMG*** The new membership of the VCC QSMG meeting was discussed further and subject to minor amendments was **APPROVED** by the group.	
5.1a	The chair welcomed both BT and CH to the meeting who were in attendance to seek agreement and approval on the following items: BT requested to attend this meeting in relation to two unsolved incidents and to seek guidance from this group as to whether there is a need to escalate further or whether there are any actions missed. BT went on to discuss the two incidents, in which she states have already been discussed at the Medication Safety Group and Medicine Management group: **Datix 5747** A dose of Fluorouracil was made within the pharmacy aseptic unit, it was made the day previous to when it needed to be administered. When the Fluorouracil (as part of OxMDG regimen) was sent to the RDU SACT unit, it was noted as part of an independent 2 nurse check that the volume within the syringe was incorrect. The correct volume was 22ml but there was approximately 31ml within a 30ml syringe. The dose was not administered to the patient but returned to pharmacy for investigation. The dose was re-made within the pharmacy aseptic unit and subsequently correctly administered to the patient. The patient came to no harm apart from a delay in treatment. BT reported that the following remedial actions were undertaken. • Introduce tamper proof bags within pharmacy at point of release. • RDU treatment rooms to have magnetic access set up. • Commend the 2 nurse independent checks which is standard practice. Reiterate that this is standard practice. • Close monitoring of any further issues with all SACT. • Learning if a similar event occurs, to not destroy the SACT and consider testing. Pharmacy SOP to be updated to include that all products that are returned to pharmacy in case of suspected error /incident are quarantined and held until decision by senior pharmacist that they can be appropriately destroyed. • Learning by junior staff that escalation to senior staff should have been carried out at point of the error occurring. The Chair commended BT and their team on the thorough investigation. The Chair stated that no further actions were necessary and the datix can be closed as there are good mitigating actions. This was **AGREED** by the Group.	

	Datix: 5764 A resus trolley on the corridor by radiotherapy had no Oxygen cylinder present. This was identified fortuitously by a staff member on passing. It is unknown how long the medical gas cylinder was absent from the resus trolley. Initial investigation was carried out by the chief pharmacist to enquire with all clinical departmental managers to see if they had removed the oxygen cylinder. No positive responses were received. Operations was contacted to see if any 222 (emergency) calls had been made on the 25th or 26th May which could have led to the Oxygen cylinder being used. It was confirmed that no emergency calls had been made on these days, and also clarified that Operations holds an emergency pager and didn't recollect any calls made. CCTV of the surrounding corridors were also examined, again with no findings. (The area in which the resus trolley is held does not have CCTV as it is a patient area). To mitigate against this incident being repeated: • **Name redacted** lead ANP has been contacted to establish if the oxygen cylinders can be secured to the resus trolleys and will include that a check of the medical gas cylinder is incorporated as part of the routine trolley check. This is being discussed with the Resus Practitioner link for VCC. The Chair agreed that a robust investigation was undertaken, and measures are being implemented to prevent this happening again. The Chair requested all members report any extra-ordinary incidents to the quality & safety team, to enable the quality and safety team to monitor themes. This was **AGREED** by the group	
5.1b	**WBMDR PGD Justification Paper** The chair welcomed BT and CH to the meeting to seek approval for the SBAR which proposes that the prescription required to dispense at collections be replaced with a patient group directive (PGD). BT informed the group that the VCC Medicines Management Group supports the approval of the PGD's for the delivery of this service at VCC. CH stated both haematology consultants as directed by WBS regulations oversee the care of the donor while they are under those collections. Unfortunately it is a real struggle to get the prescriptions signed by the consultant due to capacity issues, so in turn nurses are being sent out to track the consultants down for them to sign the prescription. CH went on to inform the group that WBS has approached some collection centres in England and Scotland and are currently using the PGC because the drugs for the donors are standard each time and low risk. The Chair found this way reasonable and will pass to corporate colleagues for inclusion on the Trust QSP Committee in September. This was **APPROVED** by the group.	
5.3	**National Review into the Prevention of Venous Thromboembolisms (VTE) in NHS Wales** This was **APPROVED** by the Group.	

5.4	**HIW Review of Patient Discharge from hospital to general practice** This was **APPROVED** by the Group.	
6.0	**STANDARD AGENDA ITEMS**	
6.1	**Divisional Risk Register** TL presented the divisional risk register to the group highlighting that some risks are now due to be updated. TL informed the group that SLT were impressed by the efforts made by all to ensure all risks on the register were now being reviewed in a timely manner. The Chair reported that the Interim Director of Cancer Services is keen to identify themes of risks, which will be tracked by the Quality and Safety Team. This was **APPROVED** by the Group.	
6.2	**Health & Care Standards Q1 2022/2023** TL informed the group that the Health & Care Standards for quarter 1 are now due. TL stated that she doesn't envisage much change from Q4. TL requested that members take this action back to the relevant department. This was **NOTED** by the group.	
6.3	**Highlight Report – Patient Experience** The chair stated that the current patient experience manager is leaving imminently and will be advertising for a new Concerns and Feedback Manager, but until then the service sits under quality & safety team. The chair stated that Civica is now live and in all areas. DMH asked how we collect the equivalent information for patients that have passed away. The Chair confirmed that all inpatients' deaths are reviewed by the Medical Examiner Service (MES) and part of that review is gathering feedback from the next of kin about the care they received. This was **NOTED** by the Group	
6.4	**Highlight Report – VCC Infection, Prevention Control from 08.06.2022 & 13.07.2022** HJ informed the group that hand hygiene figures have improved. **The group NOTED both reports.**	

6.5	**Highlight Report – Operational Services** No paper received. No representative at the meeting due to misunderstanding about timings. This was **NOTED** by the Group.	
6.6	**Highlight Report – Clinical Audit** Due to annual leave, SW has requested any questions to be directly sent to her and will endeavour to reply as soon as she returns from leave. This was **NOTED** by the Group.	
6.7	**Highlight Report – Radiotherapy** CD presented the report and highlighted key issues below: • Radiotherapy Capacity is an issue within the department and with the digital health record being implemented soon, unsure how it's going to affect how the radiotherapy department receive referrals. • A concern was raised regarding an attitude of a doctor in the radiotherapy dept. It was dealt with by the Quality and Safety (Q&S) Manager and closed as an early resolution. The Q&S Manager thought the response was very good. This will be passed to the Interim Radiotherapy Manager. • A number of incidents have been reported via DATIX. Some of them do take a little while to assess and get signed off, but they all need to be looked at in relation to our guidance. When an error has been discovered before the treatment has been delivered and it's has been rectified in the treatment plan, it will still need to be investigated. • No serious incidents reported to HIW over the past two months. • Engaging with patients in relation to providing feedback. • Training compliance has slightly decreased. Encouraged staff to book onto the recently advertised sessions for Fire Safety • As part of service improvements, a new software system has been introduced called QA Tracker which records routine daily machines quality assurance, which enables the staff on treatment unit and physics staff to use it remotely. • Due to an incident regarding a fall in radiotherapy outpatients one action is to incorporate a check on the chairs within the health and safety review. The check will be on an adhoc basis. This was **NOTED** by the Group.	
6.8	**Highlight Report – Outpatients** JM presented the report and highlighted the key issues: • Issues with staffing levels and no senior support. • Reviewing processes around blood. Data needs to be collected but will feedback to a future meeting. • Training compliance is low because the competencies didn't match with the staffing. M&S training has been stripped back to basics. • Major increases in Phlebotomy appointments. • Outpatients' clinic rooms are being reviewed as part of a project.	

	• Difficulty in accessing QR code on mobile phone for patient experience. Work is ongoing with the Digital Lead Nurse. This was **NOTED** by the Group.	
6.9	**Highlight Report – Digital Services** DMH apologised for not providing a paper and verbally highlighted the issues below: • National Cyber Incident has no impact on Velindre University NHS Trust. • Working towards an implementation date of November for DHCR. Estimating 90% of the time is dedicated to ensuring that the transition runs smooth. • Issue around the timeliness of opening emails could be down to the fact that a lot of the organisation is still using an old version of Microsoft 2016. If you are a DMS user which particularly applies across of all health boards, there has been an incompatibility between DMS and Office 365 for a while. This has now been fixed and will implement a roll out to upgrade staff who are currently on an older version. This was **NOTED** by the Group.	
6.10	**Highlight Report – Pressure Ulcers** The Chair informed the group that due to the timings of meetings, there is no highlight report to present due to both scrutiny panels meeting later today, SO provided a verbal update from the previous month. TL to circulate when completed. • 1 velindre acquired pressure ulcer, which was found to be avoidable because it was a pressure ulcer on the ear underneath oxygen tubing. The Chair stated there is no evidence of checking underneath the oxygen tubing. There was not any guidance in the policy around checking any medical devices and how often it should be undertaken. This will now be incorporated into the policy and will be fed back to the ward. • The patient was complex and a high risk of developing more pressure areas, but due to the hard work by staff meant that this patient didn't develop anything more. This was recognised in the meeting. RH to take feedback to the ward. This was **NOTED** by the Group.	TL SO RH
6.11	**Highlight report – Falls** SO reported that there is nothing of significance to report here. A highlight report will be written after both panels have met. **T**his was **NOTED** by the Group	SO
6.12	**Highlight Report – Therapies** SP presented the report and highlighted the following issues: • Two risks on the register, one relates to the risk of harm for staff who haven't received violence and aggression training, which is about the breakaway techniques. The department have agreed that only lone workers will have module c training. Second relates to departmental covid-19 risks, which has been updated on the 30th of June, but still remains open.	

	• No complaints or concerns to note • No therapy incidents since the last meeting but an incident was reported but it was investigated by a different service. The incident relates to a metal object falling and nearly hitting a member of domestic services, fortunately no harm to staff member. Investigation has been undertaken and closed. This was **NOTED** by the Group.	
6.13	**Highlight Report – Radiology** GG presented the report and highlighted the following issues: • The department have extended days which are Tuesday, Wednesday and Thursday and open from 8am until 6pm. No impact as of yet. • A fire, security and safety inspection has taken place, awaiting report from HJ, Trust Health and Safety Manager. • The ISO standards are up to date. They were revalidated until May 2025. • Mandatory training is at 70½ compliant overall, • 40% of the radiography staff are now ILS trained. This has increased the safety standards in line with the CT and MRI radiographer standards. This was **NOTED** by the Group.	
6.14	**Concerns Update** SO provided an update for June and July and highlighted the following: • 21 concerns received for the Cancer Centre, 15 of them were managed as early resolutions, which means that we were able to resolve them within 48 hours and 5 of them were put through putting things right process. Common theme was relating to care/ treatment and communication with consultant. • Discussions around face to face vs virtual consultations were had. • One breach of duty where missed opportunities to identify a comorbidity which meant the patient couldn't have chemotherapy. Patient consented and attended for their chemotherapy before it was picked up. No harm came to the patient because the treatment. • No serious incidents to report. • A SCIF was held recently to discuss a concern about medical cover on first floor ward when there was an acutely unwell patient. Patient was ready for transfer because they were acquiring a high amount of oxygen to maintain their sats. Paramedics arrived and they were worried about transferring the patient to the Grange because they were so unwell. The paramedics didn't want to drive past UHW so wanted to discuss it with the SHO. Nursing staff struggled to get hold of SHO. Patient was admitted directly to Rhosyn day unit because the assessment unit was full. The patient didn't receive a senior review for 18 hours after admission. An action from SCIF is for the SHO's to speak to Ward Manager for disseminating information. This has now been incorporated into induction. • One point to raise is the possibilities of staggering lunch breaks to make sure that there's always a senior medic available. • There is a need to review the appropriateness of patients who are admitted to the assessment unit. That would free up space on the assessment unit for these patients who are acutely unwell. This was **NOTED** by the Group.	

7	**LEARNING**	
7.1	**Serious Incidents (SI's)** Nothing to report.	
7.2	**National Report Incidents (NRI)** Nothing to report.	
7.3	**Claims – Learning Brief** **Outpatients fall in Radiotherapy** The learning brief is relating to the fall in radiotherapy which happened 18 months ago. This is now going through as a claim. Mitigating actions in place with a review of the chairs being included in the health and safety review.	
7.4	**Complaints/Incidents/Compliments** Nothing to report.	
7.5	**Claims** Nothing to report.	
7.6	**After Action Review** The Chair explained that this relates to breach of duty where Patient received curative radiotherapy for colorectal cancer in 2013. Patient has sadly since developed a radiotherapy related secondary tumour. The patient was not fully consented to the risks of the radiotherapy. A number of actions have been identified and will be monitored via this group. This was **NOTED** by the Group.	
8	**FOR NOTING ONLY**	
	Legislative Regulatory Compliance Register Update for Nursing, Quality, and Safety will be monitored through this group. This was **NOTED** by the Group.	
9	**ISSUES TO ESCALATE TO SLT**	
	No urgent matters to escalate to SLT.	
10	**PAPERS RECEIVED AT TRUST COMMITTEES – FOR INFORMATION ONLY**	
	N/A	
11	**ANY OTHER BUSINESS**	

	No further business to discuss.	
	Next meeting details below:	
	13/10/2022 @ 10:00am via Teams **Deadline for agenda items: 30/09/2022** **Deadline for papers: 05/10/2022**	