**GJF/2018/02/08**

**Approved Minute of Clinical Governance Committee**

**Held Tuesday 10 October 2017 @ 10.00 am**

**Level 5 Boardroom**

**Present:**

Mark MacGregor Chair

Phil Cox Non Executive Director

Karen Kelly Non Executive Director

Jane Christie Flight Non Executive Director

Anne Marie Cavanagh Nurse Director

Alistair Macfie Associate Medical Director

Theresa Williamson Associate Nurse Director

Laura Langan Riach Head of Clinical Governance

Paul Rocchiccoili Consultant Cardiologist

**Apologies:**

Stewart MacKinnon Non-Executive Director

Marcella Boyle Non-Executive Director

Jill Young Chief Executive

Hany Eteiba Acting Medical Director

Stewart Craig Consultant Cardiothoracic Surgeon

**Welcome and Apologies**

MMacG welcomed KK to her first meeting and did a round the table introduction. Apologies were noted.

**Review and Approval of Previous Minute**

These were approved as an accurate record of the meeting.

**Review of Actions**

**Cardiac Surgery**

LLR will forward a copy of the Consent Form to LC for circulation to Group.

**R&N Division: Update M&M Process**

MMacG explained the above to KK and our focus on improvement and aligning improvement methodology. It was noted that in MH absence, PR, HE and LA had started taking forward; LLR will link in. AMacf suggested speaking to JP to understand the different methods deployed within different areas.

**Agreed this should be tabled for the April meeting.**

**SAFE**

**2.1 Surgical Services Division Update**

TW explained the purpose of the report to KK and gave an update.

**Adverse Events:**

* Two falls with harm had been recorded as adverse events. The second fall did not result in patient harm.
* Pressure Ulcers: The focus on this area has resulted in a reduction quarter on quarter, but the last quarter was higher. It was noted that 57% were linked to devices (masks or tubing) but potentially due to the fact that the hospital was very busy during this period. This was discussed at SPSP and is being taken forward with the Tissue Viability Service and management in Critical Care.

**Significant Adverse Events:**

**DW2416:** This was briefly discussed. TW noted it was reassuring that the external panel members had not picked up on anything untoward. This patient had undergone several procedures and the swab was discovered when the heart was explanted.

**DW-2403:**  Patient fell and fractured new joint and required further surgery as a result. Noted this is an almost never event, but triggered a review of our systems to ensure our procedures are robust. TW explained the process for identifying when an RCA is required. Following an incident, a panel will score and any fours and fives are examined further. There is national guidance on what we should follow. Even if a RCA is not indicated, we will examine some near misses to identify learning; look at what failed and how it got to that point.

**DW-2280:** This incident resulted in an HR investigation prior to the RCA. Patient suffered no harm.

**DW-21542:** Following this incident, the Pain Management and Clinical Governance teams discussed and highlighted areas for improvement.

**DW-2072 & 2035:** This is due to be discussed at the next CGRM.

**DW-1848:** This was an interesting and challenging RCA. It was noted there were a number of Human Factors which led to this happening (staff felt rushed and hurried) and the feeling was this led to someone attaching the vent in the wrong position. There was lots of different interpretation and feedback from people on the team and this resulted in the report being written up differently. These factors indicate that we do not have a cut and dried case, but one which needs further scrutiny. It has also produced a lot of learning and feed-back, including human factors.

It was noted that a review was carried on the ward and the findings discussed at the Surgical Clinical Governance Forum. No further action was required.

**SPSP:**

Following a request by the Scottish Government to do work on deteriorating patients, this is now being undertaken in cardiothoracics and has been introduced to orthopaedics. It was noted that ICU requires different paperwork and methodology. Going forward, the colour coding on the chart will have an up or down arrow to indicate whether the area is on an upward trajectory.

**Complaints PCC:** Now generally resolved at Stage 1. The complaint around cataract surgery was a recognised complication of that procedure.

**\*LLR to update on cause.**

**Clinical Audit:**

A review and clean up of the data base has been undertaken. This was not resourced until recently; but now linking in with their clinical governance leads to identify anything for audit and satisfied any actions required had been carried out before closing the loop. KK suggested perhaps we should think about the wording around closing off as it was a bit misleading.

**2.2 Regional & National Division Update**

PR explained the purpose of the report and gave an overview and update on the Clinical Governance activity within the R&N Division from July – September 2017. During this period, one meeting had been held in September. He noted it had been difficult to have meetings which were quorate, but the day had now been changed so that more clinicians could attend. This looked positive moving forward.

**Adverse Events:**

The purpose of this report is to give an overview of adverse and significant events and the learning identified.

There has been an upward trend in adverse events, due in the main to figures reporting on complications. It was noted there were some consistent themes, for example flow of patients.

**Diagnostic Processes / Procedures:**

It was noted that the majority of events are related to either radiological/imaging/investigation/interpretations or laboratory investigations/interpretations.

**Documentation:**

One event related to RCA report where patient had ultrasound and result was not forwarded to their GP. This was part of the RCA which run in parallel with HR investigation.

**Falls:**

Only two resulted in harm, namely, minor head wounds. They were appropriately treated and monitored.

**Pressure Ulcers:**

As some patients have pressure ulcers prior to admission, TW confirmed checking for them is part of our admission procedure.

**Documentation:**

This RCA examined a failure to forward ultrasound report to a patient’s GP. This was reviewed as a Level 1 event, which was conducted in parallel with an HR investigation. It was noted that this was busy quarter in terms of RCA panels.

**DW-1658:**

This RCA identified the need for increased training of Fellows. Human factors were also considered as a factor in the decision to proceed. However, it was agreed this had not influenced the decision.

**DW-1307:**

Following the death of a cardiac patient awaiting surgery, the RCA considered how to escalate the process the flow of patients from cardiology to cardiac surgery. LLR confirmed this was a closed event which had been discussed in terms of learning.

**DW-2018:**

This related to the break-down of the hospital CT scanner. The main discussion point the RCA centred on the limitations of having only one CT scanner in hospital and the compiling of a business case for a second scanner.

**DW-2045:**

Following the death of a patient who had been discharged on a Friday morning when the ward was closing in the afternoon, an RCA was conducted to ascertain whether the ward closure was a factor in premature discharge. In addition, there was ongoing discussion around formalising procedures for Reception should a patient become unwell. It was agreed that this was a complex and challenging situation with hospital and family which was still unresolved.

**SW-2100:**

Ultrasound reports sent from e-mail instead of RIS system. Draft report will be presented to the next CGRM.

**DW-2312:**

This RCA investigated a missed aorta on MRI in 2010 which resulted in the patient presenting with a large aorta in the later stages of pregnancy. A review of the initial MRI confirmed the aorta was small but present. Had it been picked up at the time, the patient would have been successfully monitored and advised on pregnancy as the physiological changes during labour increase the risk factor. The patient delivered and went on to have surgery here in the hospital.

The Actions developed in relation to RCA outcomes were noted.

It was also noted that discussions with Leads on the five open actions were ongoing.

The SPSP At a Glance chart was discussed.

It was noted that some audits carried out by junior doctors had highlighted some interesting results and we were looking at opportunities to share the information wider. LLR stated that the information captured at RCAs informed discussions with the i-Steer Group on learning and organisational development. It also facilitated the sharing of information via L&D with other areas of the hospital.

AMacF commented that a lot of internal audits were carried out by trainees as part of their training. This information was shared at monthly CMEs and was viewed as useful for junior doctors in learning how to interact with the organisation and make use of central departments. LLR suggested this be included on the junior doctors induction to help take forward.

**2.3 Closed Events**

LLR stated there were two Closed Events (DW-1956 and DW-1658), both of which were mentioned within the Divisional Report. She echoed TW’s comments regarding the challenges around these and the learning process outcomes. AMacf stated that although these had been an emergency admissions, there had been sufficient time to conduct briefings; had these taken place things which contributed to the outcomes would have been identified. MMacG stated this reinforced that we should stop, think and discuss. It was agreed that a whole team approach was required and perhaps a champion appointed to ensure a briefing takes place and everyone has the opportunity to say they are happy with how things are. PR stated in Cardiology, briefings were a work in progress; they are done with electives but not emergencies. AMacf commented that we should target the highest risk and apply to emergencies, with core elements for the brief, bespoke to type of surgery with proper team with proper skill set. This was agreed.

**3. EFFECTIVE**

**3.1 HAIRT Report**

AMC gave a brief overview of the HAIRT Report until July 2017.

**SABS:** Peaked in 2016 but has returned to correct levels. Following investigation, it was identified that the SAB was associated with a chest drain. This was the first SAB in that particular area.

**CDIF:** Nothing to report.

**Hany Hygiene:** 94% compliance, but higher in the last few months. Training to improve this has now been put in place.

**SSI:** Currently within control limits.

**Mycobacterium Chimaera:** HPS are leading Scotland’s response to the Cardiopulmonary Bypass Heater Cooler machines. The emphasis is on getting this issue resolved and AMC confirmed discussions are now underway with other manufacturers.

**NSD Air Supply – Fan Failure:** It was noted the fan failure in NSD had not represented a significant risk to patients. Initially there had been concern around replacement parts, but these were sourced elsewhere and we now hold replacement parts in stock. Everything was up and running within four days.

**Cleaning and Healthcare Environment:** Housekeeping (98.4%) and Estates (99.17%). AMC confirmed there were no concerns around either of these figures.

**MRSA Compliance:** It was noted that the ten day compliance was not being maintained across the NHS, and a national piece of work is underway to examine the issues. We have looked at triggers and a list of improvements has been compiled moving forward.

**Orthopaedic SSI:** One deep infection noted, but good trend continues. AMC noted there would be more narrative around graphs in future.

**NHS Board Report Card:** AMC stated we generally compare well with other Boards, the only exception being last year during the increase in SABS when we were one of the higher Boards for the first time. The challenge is trying to compare like with like, but the Scottish Patients Programme is linking together to help shape good practice and identify drivers nationally to improve.

**4. PERSON CENTRED**

**4.1 Claims Report**

LLR gave a brief overview of the report and noted it would be produced bi-annually in future to provide an overview of claims with a view to identify risks and improve learning.

Two claims were highlighted which have been ongoing for some time. These relate to MRSA and we have been advised by the CLO that other Boards were re-opening such cases. However, no new robust evidence has been identified and the CLO is satisfied we do not need to carry out any further investigations. It was helpful to receive external assurance that any issues have been addressed.

Two claims have been closed since the last report and two new ones have been received. These have been identified following RCA investigation; one relates to a potential claim from the patient’s family following discharge issues, while the other relates to a retained swab. Although the swab was not the cause of death, we can improve and learn from this investigation.

There followed a discussion on informed patient consent and the challenges around how we ensure patients understand what is happening, even those who do not want to know, and how we evidence. LLR advised that a representative from GMC is coming to discuss patient information. MMacG stated that a UK wide approach is required, and it is the role of the colleges and societies to create national standard leaflets, identifying percentage risks. This would make evidencing clearer in a legal challenge. However, our main focus is to treat patients, maintain an open approach with families and learn from outcomes without influencing a patient(s) right to complain or claim.

**4.2 Seasonal Influenza**

AMC gave an update on the flu vaccine which was available to staff from last week. E-digest has published where and when this can be done and OH are available to go to different departments or make individual appointments. Our national target for clinical staff for this year is 50%; our uptake last year was 27%. It was interesting to note that uptake by non-clinical staff last year was greater. A paper is going to SMT about winning hearts and minds and managers taking responsibility for having conversations with their teams.

It was noted that Australia and New Zealand have seen an increase in flu and the information will be published as soon as it is available.

**5.0 AOCB**

There being to other business to discuss, the meeting closed.

The date of the next meeting is Tuesday 30 January 2018 at 10.00 am in Level 5 Boardroom.