**Supplementary File 3: Final UK Included Practices**

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| **Category** | **It is a waste of time doing 'X' because it doesn’t make care safer. Please tell us what 'X' is.** | **Number** |
| Action Plans | Meaningless action plans or not being SMART with actions | 1 |
| Action Plans | Action plans to address increased falls rate in neuro rehab unit | 2 |
| Ad Hoc | Streaming certain calls to out of hours based on age factors just because they pass the initial safety questions. Sometimes there are other concerns that make putting them on a call back list inappropriate | 3 |
| Ad Hoc | Community pharmacists not being able to substitute unavailable medicines (or even brands) which are unavailable without referring to the prescriber which can cause delays of days to patients | 4 |
| Ad Hoc | Blue lights and sirens to a job that over 2 hours old | 5 |
| Ad Hoc | Relying on Agency staff (nursing) as they do not know our procedures, have inefficient/ineffective/non existant induction; | 6 |
| Ad Hoc | Red jugs/ trays/ nutrition- off radar of nursing. When done well, good but not often | 7 |
| Ad Hoc | Well-being activities in the office | 8 |
| Ad Hoc | Localised safeguarding | 9 |
| Ad Hoc | Making referrals requested by hospital consultants on discharge summaries, delaying care | 10 |
| Adding Tasks to Increase Safety that Create Other Tasks | Addition of additional reminder stickers to boxes of medications increases risks and impacts services, instead manufacturers should be fedback concerns regarding products so that additional supplementary info is on the packaging. | 11 |
| Adding Tasks to Increase Safety that Create Other Tasks | In our hospital we add extra stickers to the boxes of tablets that we dispense e.g. 'Not to be used for discharge'. it is supposed to prevent boxes of tablets without directions on being taken home by patients on discharge but this doesn't always happen and these stickers are a distraction for checkers and so sometimes focussing on the absence of these stickers when checking means that a major error such as the wrong strength can sometimes be missed. | 12 |
| Adding Tasks to Increase Safety that Create Other Tasks | Having to label medication in the dispensary. Ideally you should be able to dispense on the ward | 13 |
| Adding Tasks to Increase Safety that Create Other Tasks | I am clean stickers' (take up a lot of time). | 14 |
| Adding Tasks to Increase Safety that Create Other Tasks | Putting green in 'all clean' labels on things when you've already signed a cleaning compliance document. Its time wasting and not cost effective. | 15 |
| Adding Tasks to Increase Safety that Create Other Tasks | Falls prevention with restraining mobilisation | 16 |
| Administrative task | Obsessive Admin - it does not change patient care but does cover our backs - at the cost of time. | 17 |
| Bed Rails | Bed rails when not needed- cause other safety issues. | 18 |
| Bed Rails | Bed rails or cot sides | 19 |
| Bed Rails | Leaving safety sides down with patients at high risk of falls/agitated. | 20 |
| Bundles | care bundles that lead to no concrete action | 21 |
| Bundles | Skin bundles; | 22 |
| Controlled Drug Checks | Cd checks | 23 |
| Controlled Drug Checks | check cd drugs every night.. | 24 |
| Data Collection | Surveys | 25 |
| Data Collection | Surveys | 26 |
| Data Collection | Surveys. | 27 |
| Data Collection | patient surveys | 28 |
| Data Collection | Doing outcome measures to collect data that is NEVER used | 29 |
| Data Collection | collecting extensive data on nursing care hat does not reflect the real work as done | 30 |
| Delays in Care | Waiting for the team safety brief before sending for the first patient on the operating list | 31 |
| Delays in Care | looking for someone to help with transfers | 32 |
| Delays in Care | Escorting patients to theatre and spending time waiting with them until theatre staff are ready is unsafe - as ward is left short - need escort nurses! We (as the backbond of the NHS) (nurses) are genuinely concerned about the amount of vacancies in the profession. Despite so many campaigns and adverts we never seem to have enough! Discontinuation of the bursary for student nurses (when they work on wards is unjust and wrong). | 33 |
| Discredited Due To Lack of Evidence | interventions already discredited in peer reviewed studies (e.g. falls alarms) | 34 |
| Discredited Due To Lack of Evidence | Checking herbal interactions as there is no evidence or literature about herbal medicines so we can never definitively say one way or the other | 35 |
| Discredited Due To Lack of Evidence | Stop hiding behind safety without proper evidence base and risk assessment in relevant organisation stop assuming EU reg eg on safer sharps outweighs all logic on safety of medicin administration such as changing needles on insulin devices in hospitals. | 36 |
| Duplication | Some documentation still on paper and is repeated on EPR (online) for example, moving and handling care plans. Handing patients over when the ward receving patients has access to complete patient notes online and can read themselves --> EPR was brought in to exclude time wasting but this still continues. | 37 |
| Duplication | Duplicating documentation in several different places. IT systems are not compatable, and private providers can't access NHS systems. Result = we have to document the same information on paper private provider records, and on TPP SystmOne. | 38 |
| Duplication | paper and computer data same assesments for same things double work no sense | 39 |
| Duplication | duplicating processes in both electronic and handwritten formats | 40 |
| Duplication | Having tick lists for the post take ward round and electronic tick list to complete which ask the smae questions - it is duplication! | 41 |
| Duplication | Documenting both on computer and in notes. | 42 |
| Duplication | Completing handover in two different formats (paper and ward tracker), doing the CUR, | 43 |
| Duplication | Repetitive writing of notes - then putting it in the computer | 44 |
| Duplication | Printing out our assessments after completing them on our electronic record system, "just in case the computers crash" | 45 |
| Duplication | Writing the same information on Systmone in lots of different places e.g. incident report on Datix/ safeguard, then in risk assessment then in clinical records. | 46 |
| Duplication | Doing VTE assessment both in EPMA and seperately in CPD. | 47 |
| Duplication | Documenting safe information in different places as different systems use do not communicate- risk of errors and omission of information | 48 |
| Duplication | transcribing patients’ results into notes (an electronic solution with the option of ticking off a result which has been acknowledged and filed into the electronic health record) | 49 |
| Duplication | I also object to having to duplicate findings in multiple locations, handheld notes, computers and patient notes.l, this just increases my workload so that the ‘management’ can more easily find info during investigations, it doesn’t make care safer. | 50 |
| Duplication | Rewriting drug charts monthly (for the first of the month) | 51 |
| Duplication | hand writing transfusion forms and bottles twice | 52 |
| Duplication | Duplicating work done by other pharmacy professionals such as pharmacy technicians | 53 |
| Duplication | Double clerking of patients (patients admitted through A/E are clerked by A/E Team then clerked again by medical team- same questions asked over and over again); | 54 |
| Duplication | Double checking blood transfusions and IM injections | 55 |
| Duplication | Double nurse check for blood transfusion | 56 |
| Duplication | Second checking blood transfusions in acute. | 57 |
| Duplication | second checking IV fluids (NaCl etc) | 58 |
| Duplication | Double signature on IV/IM medications | 59 |
| Duplication | 1) 2nd check of IV fluids by nurses. | 60 |
| Duplication | double check intravenous medication | 61 |
| Duplication | Double checking drugs | 62 |
| Duplication | I would argue the 2 nurse checks of CDs don't improve patient safety as the quality of the 2nd checker is not always good. Evidence suggests single nurse checking is as safe if not safer. | 63 |
| Duplication | Second checking of controlled drugs in acute | 64 |
| Duplication | Double-checking most drugs | 65 |
| Duplication | Double checking medicines | 66 |
| Duplication | Cursory duble checks of medication administration that don't add anything safety wise, and may even decrease safety by diluting responsbility. I think double checks either need to be done properly with proper accountability, or not at all | 67 |
| Duplication | Second checking administrations; | 68 |
| Duplication | Requiring 2 members of staff to administer morphine. | 69 |
| Duplication | Double checking common oral meds. | 70 |
| Duplication | Double check with sign for abx and insuline | 71 |
| Duplication | Admission documents for previous patients that have been admitted to the unit | 72 |
| Duplication | The sign out at the end of surgical procedure. | 73 |
| Duplication | Remote Clinical validation process for NQPs for non-conveyed patients where ongoing care plan has already been discussed with another HCP directly involved in patients care | 74 |
| Duplication | Hospitals having to re-supply certain medicines because GPs feel 'unable' to prescribe in primary care eg cinacalcet, liothyronine | 75 |
| Duplication | Dealing with secondary care re-referrals - e.g. missed appointments, or secondary care wants secondary care but different specialists opinion and has to go back to GP to be re-referrerd | 76 |
| Duplication | taking transfusion samples twice | 77 |
| Duplication | Performing two sets of observations on minor injuries; | 78 |
| Huddles | The huddle | 79 |
| Huddles | Safety Huddles | 80 |
| Huddles | Mid shift safety huddle | 81 |
| Huddles | attending a daily pharmacy huddle at midday | 82 |
| Incident Reporting | Reporting pressure ulcers and falls | 83 |
| Incident Reporting | Reporting pressure ulcers and falls | 84 |
| Incident Reporting | reporting pressure injuries to CQC in our field | 85 |
| Incident Reporting | Focusing incident investigations on individuals, protocol driven root cause analyses, implementing systems which record incidents being reported as being 'bad' and no incidents reported being 'good' | 86 |
| Incident Reporting | Incident investigations | 87 |
| Incident Reporting | investigations around prescribing errors | 88 |
| Incident Reporting | Root cause analysis for medication incident investigations. Using protocols to escalate certain medication errors. Investigating every Hospital acquired thrombosis as a root cause analysis. Nursing completing long winded error reports | 89 |
| Incident Reporting | Investigating every fall with fractured NOF or pressure ulcer as an individual serious incident. We need the commissioners to support the SI framework recommendation of multi incident analysis and use scarce resources implementing research based improvements for prevention rather than investigating each one and finding the same root cause each time. | 90 |
| Incident Reporting | Reporting patient safety meeting incidents to the NRLS because nobody ever reads most of them and they never give any feedback to reporters. | 91 |
| Incident Reporting | Reporting safety issues - they aren’t acted on | 92 |
| Incident Reporting | Incident reports | 93 |
| Incident Reporting | Chasing investigations | 94 |
| Incident Reporting | Only doing post incident analysis to reduce risk | 95 |
| Incident Reporting | DATIXES - if nothing happens to them | 96 |
| Incident Reporting | DATIX forms | 97 |
| Incident Reporting | datix forms - unless after so many concerning same events - something is done to change practice. | 98 |
| Incident Reporting | Submitting Datix forms | 99 |
| Incident Reporting | Completion of Datix. | 100 |
| Incident Reporting | Reporting CD discrepancies/incidents to Accountable Officers. Reporting incidents to them is also a duplication of other reports we are required to make to NRLS | 101 |
| Incident Reporting | Near miss recording | 102 |
| Incident Reporting | Filling out a datix for pre-existing pressure ulcers | 103 |
| Incident Reporting | Completing concise SIRI for all individual pressure ulcers even if identified as no omissions. | 104 |
| Incident Reporting | fragmented approaches and reactive siloed responses to safety incidents | 105 |
| Incident Reporting | RCAS that dont pick out recurring themes and close the loop with meaningful intervention; passing blame from board/exec level (especially managers who are registered nurses but havent nursed for years) | 106 |
| Incident Reporting | Doing a root cause analysis after pressure damage in patients. | 107 |
| Infection Control | Bare below the elbows | 108 |
| Infection Control | Bare below the elbow in my area of outpatients. We are not doing any invasive procedures. | 109 |
| Infection Control | Bare below the elbows | 110 |
| Infection Control | Bare below the elbows | 111 |
| Infection Control | Wearing a uniform. Not being able to wear nail varnish or fake nails. | 112 |
| Infection Control | 1. worrying about silly uniform policies (e.g. black shoes, no died hair). | 113 |
| Infection Control | Wearing masks | 114 |
| Infection Control | Wearing gloves when not necessary (eg, making beds, serving hot drinks, personal care not involving bodily fluids) | 115 |
| Infection Control | Wearing aprons! I have no clue how that flimsy bit of plastic that only covers a small part of my body is protecting anyone!!! | 116 |
| Infection Control | wearing aprons | 117 |
| Infection Control | Closure of access between wards on the pretext of infection control | 118 |
| Infection Control | Cubicles for “CPE risk | 119 |
| Infection Control | taking emergency admission in same buildiing where theraputic treatment and assesment is taking place, | 120 |
| Infection Control | Admitting patients with quinsies to side rooms | 121 |
| Infection Control | Change non infectious patients bed everyday | 122 |
| Infection Control | Using alcohol hand gel | 123 |
| Infection Control | Getting people undressed into gowns when entering AED or even going to theatre | 124 |
| Intentional Rounding | Contact rounds | 125 |
| Intentional Rounding | Comfort round | 126 |
| Intentional Rounding | Houlry comfort rounding for eveyone. | 127 |
| Intentional Rounding | Hourly care rounds | 128 |
| Intentional Rounding | Hourly confort rounding for eveyone | 129 |
| Intentional Rounding | Hourly care rounds, for less paperwork. More time actually with patients. | 130 |
| Intentional Rounding | Hourly rounding | 131 |
| Intentional Rounding | Hourly or half hourly care rounds as it takes you an hour to do them and it doesn’t make it safer as you are already in the ward with the patients and they can ask you if they need anything. It’s just a paperwork trick to show we are physically doing our job. You spend half the morning going round to each patient and spending time with them and then going back again to do the paperwork which takes valuable time when you could be doing something productive for the patient like assisting with a drink or toileting etc. 2-4 hourly would be plenty arguably twice daily and once nightly unless the patient is critically unwell. Observations are different they need Charting as and when protocol states. I just find it a pointless tick box exercise!! We spend all day with our patients why do we need a bit of paper to say so. | 132 |
| Intentional Rounding | Nurse rounding | 133 |
| Intentional Rounding | Nurse roundings | 134 |
| Intentional Rounding | Nurse rounding checks every 2 hours. | 135 |
| Intentional Rounding | Nurse rounding every 2 hours | 136 |
| Intentional Rounding | Nurse rounding checks every 2 hours. | 137 |
| Intentional Rounding | Nursing wards every two hours because there is no staff can do it. If it is done its only a box to tick; not legit in acute setting like traume admission. Nursing rounds every 2 hours is inappropriate. We deal on emergency cases, broken bones that need surgery; which anaelgesia is the priority. Post-op care; rehabilitation. | 138 |
| Intentional Rounding | Doing nurse rounding - Staff waste lots of time daily in the computer instead to look after the patient properly. | 139 |
| Intentional Rounding | Nursing roundings - it is repetitive and does not give any information. All information is repeated elsewhere. | 140 |
| Intentional Rounding | Nurse roundings. | 141 |
| Intentional Rounding | Nurse roundings. | 142 |
| Intentional Rounding | Intentional rounding , sit rep | 143 |
| Intentional Rounding | Intentional rounding | 144 |
| Intentional Rounding | Intentional rounding - if already signed for something and documented evidence of patient care why do we have to tick a box? | 145 |
| Intentional Rounding | Intentional rounding on a watch bay | 146 |
| Intentional Rounding | Intentional rounding | 147 |
| Intentional Rounding | Intentional rounding. | 148 |
| Intentional Rounding | Intentional rounding audits | 149 |
| Intentional Rounding | Intentional rounding. | 150 |
| Intentional Rounding | Tickbox exercises on EPR as it takes us away from patient care i.e. nurse roundings | 151 |
| Local Operating Procedures | Local operating procedures | 152 |
| Local Operating Procedures | SOPs | 153 |
| Locking Medication | Locking emergency medication. | 154 |
| Locking Medication | Lock door with keys is unsafe in emergency situation | 155 |
| Looking for Equipment | Looking for products on the shelf that have been separated because of similar names, which means no longer alphabetical, and v difficult to find. | 156 |
| Looking for Equipment | searching for equipment | 157 |
| Medical tests, procedures and treatments | Performing a 12 lead ECG prehospital in FAST +ve patients that are within thrombolysis treatment window | 158 |
| Medical tests, procedures and treatments | Fluid balance that’s not charted at the end of 24 hours and measures input and output | 159 |
| Medical tests, procedures and treatments | checking bloods for high risk drugs; hospitals sometimes do it but it can be very time consuming to find out when (if) these were done and any results before doing a GP prescription for the medication. There needs to be a much easier way of all results being visible to the prescriber / HCP. | 160 |
| Medical tests, procedures and treatments | In the absence of national guidance and evidence, it may be a waste of time and resources to conduct annual Vit B12 levels in patients on metformin, as is the practice by some GPs | 161 |
| Medical tests, procedures and treatments | FBC in clozapine patients on it > 2 years | 162 |
| Medical tests, procedures and treatments | Prescribing PPIs for gastroprotection with corticosteroids in the absence of other risk factors. | 163 |
| Medical tests, procedures and treatments | Repeatedly monitoring LFTs in all terbinafine patients | 164 |
| Medical tests, procedures and treatments | imaging 24 hours after alteplase infusion | 165 |
| Medical tests, procedures and treatments | Monitoring pulse rate before administering digoxin for patients who are on stable doses in the community. | 166 |
| Medical tests, procedures and treatments | recommending annual HPV smears in patients on alemtuzumab for Multiple Scelorsis (MS) | 167 |
| Medical tests, procedures and treatments | urine leukocyte/nitrite/blood dip stick tests in adults who are over 65. | 168 |
| Medical tests, procedures and treatments | Taking control of people's insulin in hospital. | 169 |
| Medical tests, procedures and treatments | Prescribing opioids for \*chronic\* pain | 170 |
| Medical tests, procedures and treatments | ABG (arterial blood gas test) | 171 |
| Medical tests, procedures and treatments | Continued use of cervical collars | 172 |
| Medical tests, procedures and treatments | performing ECGs on patients where there is no reasonable cardiac differential | 173 |
| Medical tests, procedures and treatments | Surgical site marking for local procedures | 174 |
| Medical tests, procedures and treatments | parts of theatre documents... i.e. asking about "hair removal" immedialty prior to an anaesthetic, or asking at every pre-inciosn stop about tranexamic acid (which is only used in 1 surgical speciality). | 175 |
| Medical tests, procedures and treatments | Insistence of adrenaline for flu vaccine administration. It is low risk and creates a barrier to care homes accessing flu vaccine easily. | 176 |
| Medical tests, procedures and treatments | Marking the side before an angiogram of the lower limbs | 177 |
| Medical tests, procedures and treatments | Administering medicatoins to patients with capacity. Their medications can be given to themselves, by themselves. Especially closer to discharge. | 178 |
| Medical tests, procedures and treatments | not being traing to taking blood or putting cannulas so you have to wait for the doctor for pheblotomist (but you are Who has to have to administrate the IV drug), | 179 |
| Medical tests, procedures and treatments | Patients that are transferred on an operating taste into theatre (it’s a moving and handling issue) surgical view is we have allways done it this way and it can be an infection risk despite no documentated evidence to support it. | 180 |
| Medicine Reconciliation | Completing medicines reconciliation in hospital when the changes are not translated when the patient is transferred. | 181 |
| Medicine Reconciliation | Too many minor medicines reconciliation problems needing to be corrected by pharmacy staff | 182 |
| Medicine Reconciliation | Medicines are not reconciled at discharge from hospital either as a matter of course - yet huge resources are allocated to medicines reconciliation at admission to hospital (NB NICE recommend that medicines are reconciled at every interface - not just admission to hospital). | 183 |
| Meetings | Lengthy, daily multidisciplinary team meetings | 184 |
| Meetings | Key performance indicators. Attending certain meetings | 185 |
| Meetings | medicine rounds not allowing patients to self medicate | 186 |
| Meetings | automatically taking control of a patient's medication when they come into hospital i.e. let them do it themselves when they can | 187 |
| Organisation of medicines | Putting patients medication in multi-compartment aids for the benefit of care agencies | 188 |
| Organisation of medicines | compliance aids requested to make lives easier for staff rather than pts.........hospital pharmacy site dispensing medication........ | 189 |
| Organisation of medicines | providing dosette/blister packs; | 190 |
| Organisation of medicines | MDS trays/Dosettes | 191 |
| Organisation of medicines | Dispensing medicines in monitored dosage trays. Introduces more risks to dispensing process. Often supplied to patients without a clear explanation how to use. Can be viewed as a ‘cure-all’ for compliance issues but is often to make the job of social care providers easier, reducing responsibilities and training needs. | 192 |
| Organisation of medicines | Dispensing into monitored dosage system boxes for the majority of cases. | 193 |
| Organisation of medicines | providing dosette/blister packs; | 194 |
| Organisation of medicines | drug boxes | 195 |
| Organisation of medicines | Counting all the pills for every patients every round of medication when actually we do a medication audit for a patient every night | 196 |
| Out-of-hours | Spending a lot of time sourcing drugs because of supplier issues | 197 |
| Paperwork (assessments) | Vte assessments | 198 |
| Paperwork (assessments) | completing VTE risk assessment forms | 199 |
| Paperwork (assessments) | VTE assessment | 200 |
| Paperwork (assessments) | Completing the VTE assesment forms rather than actually providing treatment. | 201 |
| Paperwork (assessments) | AMTS | 202 |
| Paperwork (assessments) | AMT assessments | 203 |
| Paperwork (assessments) | AMTS on stroke ward (Pts get the MOCA cognative assesment) | 204 |
| Paperwork (assessments) | VIP Scores (just write the date it was inserted) | 205 |
| Paperwork (assessments) | cannula care plan/vip score | 206 |
| Paperwork (assessments) | Cannula vip score checks on vital pac | 207 |
| Paperwork (assessments) | The AKI CPD assessment. | 208 |
| Paperwork (assessments) | Bed rails assessments | 209 |
| Paperwork (assessments) | Bed rails assessments | 210 |
| Paperwork (assessments) | admissions assessments re: falls | 211 |
| Paperwork (assessments) | MUST on ICU | 212 |
| Paperwork (assessments) | Risk calls when people score 1 on PHQ9 Q9 as it is not indicative of immediate risk | 213 |
| Paperwork (assessments) | MCAs for patients with Polypharmacy is not a safety improvement for many patients including Care home residents - need clinical support. | 214 |
| Paperwork (assessments) | informing of allergies to agents that are not in hospital (eg cats) | 215 |
| Paperwork (assessments) | unvalidated falls or other risk assessment tools | 216 |
| Paperwork (assessments) | Falls prevention tick boxes exercises with no definite implementation of falls prevention measures | 217 |
| Paperwork (assessments) | Diagnosis for cpa documents. | 218 |
| Paperwork (assessments) | Completion of ward based fall forms, | 219 |
| Paperwork (assessments) | falls risk assessment | 220 |
| Paperwork (audits) | call bell audits | 221 |
| Paperwork (audits) | Daily ipad audit (safer). Multiple monthly audit --> many results available on EPR. | 222 |
| Paperwork (audits) | Safer audit when in charge. Safe care as staff are still moved although ward 21 has monitored bays with patients who are observed hourly and high news scores. | 223 |
| Paperwork (audits) | Completing MyCare audits three times a day | 224 |
| Paperwork (audits) | Paperwork audits mid shift. | 225 |
| Paperwork (audits) | Hand hygiene audit in an op department | 226 |
| Paperwork (audits) | Hand hygiene audit | 227 |
| Paperwork (audits) | Hand hygiene / infection control audits | 228 |
| Paperwork (audits) | Endless audits for hand hygient, catheetensation, venepuncture etc. It is open to so much interpretation of the person entering the data at the time of use, causing conflict at times if marked by other. | 229 |
| Paperwork (audits) | I don't think handwashing can be carried out remotely as often as it is recommended, and in my experience it isn't done. I can see the theory, and I agree with it. But I probably wash my hands more than most, and if I did it as often as specified, I think my hands would be raw meat by the shift end, to say nothing of the time cost. | 230 |
| Paperwork (audits) | Hand washing audits | 231 |
| Paperwork (audits) | Stop repeat audit where same findings eg storage / AMR & put effort into training to improve outcomes | 232 |
| Paperwork (care plans) | care plans instead of implementing them. | 233 |
| Paperwork (care plans) | Care plans | 234 |
| Paperwork (care plans) | Prescribed care plans. Just document the nursing care you have given. | 235 |
| Paperwork (care plans) | Writing care plans in the office to be taken at a later date, they should be written during the visit and left at the patients home | 236 |
| Paperwork (care plans) | repetitive nurse care plans (Models of nursing were research models and I don’t think Dorothea Orem ever intending us to use the detail in practice). | 237 |
| Paperwork (care plans) | Writing extensive care plans | 238 |
| Paperwork (care plans) | Falls care plans | 239 |
| Paperwork (care plans) | Falls care plans, | 240 |
| Paperwork (checklists) | doing a checklist and marking patients before inserting punctal plugs in outpatients | 241 |
| Paperwork (checklists) | Safety checklist for co-ordinator over staffing terms | 242 |
| Paperwork (checklists) | Checklists for clinical practice | 243 |
| Paperwork (checklists) | all the theatre pre-op/STOP checks. Signing in multiple places for the same process | 244 |
| Paperwork (checklists) | Some elements of the WHO checklist are outdated or irrelevant. The form should feel fresh and relevant or people just turn off. | 245 |
| Paperwork (checklists) | WHO checklist | 246 |
| Paperwork (checklists) | Most of the tick boxes on WHO checklists - but brief at start of list is useful | 247 |
| Paperwork (duplication) | Spreadsheets - same information kept in multiple places - only needs to be recorded once. | 248 |
| Paperwork (duplication) | Copying blood results onto the notes, Whoosh forms, and handover sheets in surgery. | 249 |
| Paperwork (duplication) | handover sheets in multiple places, | 250 |
| Paperwork (duplication) | Rewriting lits of medicines that patients take in multiple health records and connunication documents | 251 |
| Paperwork (duplication) | Rewriting drug charts: There is a move towards electronic prescribing in most trusts, but this has not been implemented nationwide. Rewriting drug charts can introduce errors such as copying the incorrect drug/dose, or omitting medications. Having an electronic system also enables the correct medications to be copied into discharge summaries, and allows review of medications if a patient is readmitted. Delays in information being relayed from hospital to the community: Despite improvements in transcribing clinic letters and electronic discharge summaries, there remains a delay in these documents getting to the GP surgeries or community care teams. If there are urgent messages that need to be relayed, this method is not reliable. Calling these community services prior to patient discharge is good practice but infrequently done and can be very time consuming. | 252 |
| Paperwork (duplication) | Same risk assessments in care plans. Must be done every 12 hours/ shift change but don't change every 12 hours eg. falls risk assessment for sedatred patient. Context is important but not considered by organisation requirements/ KPIs | 253 |
| Paperwork (duplication) | Re-writing handovers, re-typing info already available eg bloods,recording medication histories in multiple places, ordering medication | 254 |
| Paperwork (duplication) | Duplication of theatre checklists. | 255 |
| Paperwork (duplication) | Especially when the same information has to be completed numerous times, management ideas for better patient care hat are box ticking exercises | 256 |
| Paperwork (duplication) | It is a waste of time writing notes in separate physiotherapy files because nurses and medics don't look at it so it doesn’t make care safer | 257 |
| Paperwork (duplication) | Discharge letters after providing all the information in the clinicial notes | 258 |
| Paperwork (duplication) | Writing in the notes that you have washed your hands. It is correct to wash hands according to infection control policy, but why do we have to write and record that we have done this? | 259 |
| Paperwork (duplication) | repeating information in multiple places (excessive paperwork) | 260 |
| Paperwork (duplication) | Repeated transcribing of information on different bits of paper | 261 |
| Paperwork (duplication) | Duplication of documentation and assessment. | 262 |
| Paperwork (duplication) | Writing separate physio notes - we should just write in the medical notes otherwise we sometimes have to duplicate our writing | 263 |
| Paperwork (evidencing care) | Keeping logs of the errors pharmacy technicians make | 264 |
| Paperwork (evidencing care) | Inputting log data in can be time consuming when we go through patients every day who escalate as appropirate. Daily DQ checks - data should be more accurate to avoid errors requiring escalation. | 265 |
| Paperwork (evidencing care) | Recording nurse roundings on computer. | 266 |
| Paperwork (evidencing care) | Paper form filling to show care rounding | 267 |
| Paperwork (evidencing care) | Insulin passports | 268 |
| Patient Devices | Green band system. Anything additional. Green wrist band prior to surgery does not increase patient safety. | 269 |
| Patient Devices | The green band as patients are already checked on consent and to verbal confirm their procedure. | 270 |
| Patient Devices | The green band system for operations. | 271 |
| Patient Devices | I think the green band system is now obsolete as it has introducted before the WHO safety check system which has taken over as the format checking system - pre-op in the anaethetic room and pre-op in theatres. | 272 |
| Patient Devices | Green bands. Putting green bands on patients does not increase safety and is time consuming. | 273 |
| Patient Devices | Giving the patients yellow ‘Falls Risk’ wristbands. | 274 |
| Patient Devices | Falls alarms | 275 |
| Patient Observations | Hourly neuro observations | 276 |
| Patient Observations | 4hourly one on well people having elective procedures who don’t need them, | 277 |
| Patient Observations | 1)Routinely checking hourly on sleeping patients when there is no reason to think they will harm themselves during the night and shining a light on them just wakes them up. Patient Observations | 278 |
| Patient Observations | 15 Minute observation in mental health wards | 279 |
| Patient Property | having to go around the hospital to look for patients' properties | 280 |
| Patient Property | Property registration for patients belongings. | 281 |
| Patient safety ward round | Patient safety ward rounds | 282 |
| Referrals | Referrals to OT, Physio, SALT, specialist nurses, etc | 283 |
| Reporting | each time a patient chart is picked up, this needs to be logged onto the computer systemn as a 'tretament chart checked' . | 284 |
| Reporting | logging all insignificant interventions onto the electronic system. | 285 |
| Reporting | healthwatch reports | 286 |
| Reporting | consultancy reports on safety | 287 |
| Reporting | Numerous reports for committees, boards. | 288 |
| Reporting | Reporting concerns re staff shortages. In community --> the amount of visit and amount of milage in one shift. | 289 |
| Revalidation | Revalidation | 290 |
| Revalidation | Revalidation and almost all that goes with it - | 291 |
| Revalidation | Supervision | 292 |
| Revalidation | Frequency and depth of appraisals. | 293 |
| Routine risk avoidance care strategies | Checking pressure areas of independent patients | 294 |
| Routine risk avoidance care strategies | Turnarounds on independent patients | 295 |
| Routine risk avoidance care strategies | Doing pressure ulcer cares on mobile independent patients or skin checks. | 296 |
| Routine risk avoidance care strategies | Doing skin bundles / check pressure areas when the patient able to mobilse independently. | 297 |
| Routine risk avoidance care strategies | daily skin assessments for non risk patients | 298 |
| Routine risk avoidance care strategies | Checking pressure areas when the patient is able to mobilise independently and checked blood sugar QPS. | 299 |
| Routine risk avoidance care strategies | Doing skin bundles on patients who are mobile and independent four times a day. | 300 |
| Routine risk avoidance care strategies | Checking skin for patients who are independent and mobile. | 301 |
| Routine risk avoidance care strategies | Falls daily assessment for non risk falls patients | 302 |
| Routine risk avoidance care strategies | falls bundles for all over 65s, | 303 |
| Routine risk avoidance care strategies | Risk assessments for everyone | 304 |
| Routine risk avoidance care strategies | Focusing on the stuff we want to avoid (falls, pressure ulcers etc) instead of the good things we want to achieve (supporting people to live well and die well) by getting the fundamentals right. | 305 |
| Routine risk avoidance care strategies | Doing blood sugars four times a day for all diabetic patients | 306 |
| Routine risk avoidance care strategies | Rolling out blanket policies to wards that cater for different people, writing care plans that are irrelevant to the service user and team but have to be written due to some directive/ commissioning/ Cqc reaction | 307 |
| Routine risk avoidance care strategies | Testing patients carbon monoxide levels on every patient on admission to AMU | 308 |
| Routine risk avoidance care strategies | Full holistic assessment on patients recieving a one off brief intervention - for example wound dressing because GP practice closed, one off blood sample etc.. | 309 |
| Routine risk avoidance care strategies | falls bundles for all over 65s | 310 |
| Routine risk avoidance care strategies | Rigid 2hourly turns regardless of patient diagnosis | 311 |
| Routine risk avoidance care strategies | It is a waste of time unnecessarily rolling patients when they are sleeping as regularly as we do and disturbs their rest, especially when they are end of life care | 312 |
| Safety Thermometer | Safety thermometer | 313 |
| Safety Thermometer | Safety Thermometer in the community | 314 |
| Safety Thermometer | Safety thermometer | 315 |
| Screening | 18-25 year old safeguarding form | 316 |
| Screening | 2. Performing mental health 'clustering' - it purely exists as an exercise to fund the trust | 317 |
| Screening | Asking patients to complete 5 page equality monitoring forms for CCG Enhanced Services e.g. for patients having blood tests or injections and processing them and sending on to the CCG | 318 |
| Screening | Patient (Bristol) safety check list | 319 |
| Screening | Tick lists for child protection in A&E | 320 |
| Screening | undertaking unnecessary tests; | 321 |
| Screening | undertaking tests with a high probability of false negatives and false positives | 322 |
| Training | Spirometry external training for HCPs who have been doing this for an extended period of time | 323 |
| Training | Have all trainigs for skill such as canulation, change trust and not been able to do it as if you not competent enough. | 324 |
| Training | Observational trainings | 325 |
| Training | Statutory CPD eg fire training, lifting | 326 |
| Training | Statutory CPD eg fire training | 327 |
| Training | Statutory & Mandatory Training...one size does not fit all. I NEVER am in situations where child/vulnerable adult abuse awareness is relevant. | 328 |
| Training | blanket mandatory training on medicines safety as it appears to make no difference. | 329 |
| Training | some mandatory training eg child protection level 3 | 330 |
| Training | doing mandatory elaerning that is not relevant to specialty eg. having to complete a "no touch technique" elearning resource when I have been working in paediatrics for 10yrs and no one has found a way to cannulate using no touch technique in a toddler, or a module on dementia (outwith my patient demographic), or end of life care (separate protocols exist) | 331 |
| Training | Manual handling training. | 332 |
| Training | Spirometry external training for HCPs who have been doing this for an extended period of time | 333 |
| Training | Dementia awareness | 334 |
| TTO | Ensuring all TTO/TTAs are done at an appropriate time and delivered to Pharmacy at a time we are able to interrogate doctors who have not gone home. To allow this to happen al unnecessary training of doctors would take place after the work was done, post 16:30. This would 1) reduce the amount of interventions made by us and 2) improve patient safety by ensuring doses were given on time etc. and 3) get patients home early thus hitting discharge targets etc. | 335 |
| TTO | TTO's | 336 |
| TTO | oragnising the TTO packs and drugs to be taken home on discharge | 337 |
| Turning Patients | Turning patients every two hours for pressure care | 338 |
| Turning Patients | Two hourly turns/repositioning , shouldn’t be more frequent than four/ six hourly as it disturbs sleep | 339 |