South West Yorkshire Partnership NHS Foundation Trust

Learning from incidents

Quarter 1

Patient Safety Support Team

July 2024

With **all of us** in mind.

Our headlines

- 4,132 incidents reported
- **96%** of incidents resulted in no/low harm
- No Never Events
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

Patient Safety Incident Response Framework (PSIRF)

The Trust transitioned to working under the Patient Safety Incident Response Framework (PSIRF) from 1 December 2023.

- ✓ Developed learning responses resources and supported care groups to facilitate learning responses.
- ✓ Transitioned our former clinical risk panel meeting into the patient safety oversight group to ensure it aligns with PSIRF for the future.
- ✓ Updated our systems to reflect changes in care group organisational structures.
- ✓ Improved the collection of information for incidents to enhance the quality of information that supports decision making in the Trust.

Learning to inform improvements

Identifying new learning - where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.

- Debrief
- After Action Review
- Specialist Learning Review
- Patient Safety Incident Investigation (PSII)

Search for Learning Responses on the intranet

48 hour Review

This is completed on Datix for certain incidents. It is a first stage case note review.

As part of the PSIRF process the 48 hour review form was reviewed.

The learning disabilities service feed back to the patient safety team that the 48 hour review has improved the way they can provide information to LeDeR.

Manager bite size 48 hour training sessions are a regular Datix calendar event and bespoke sessions can be arranged

Debrief key themes

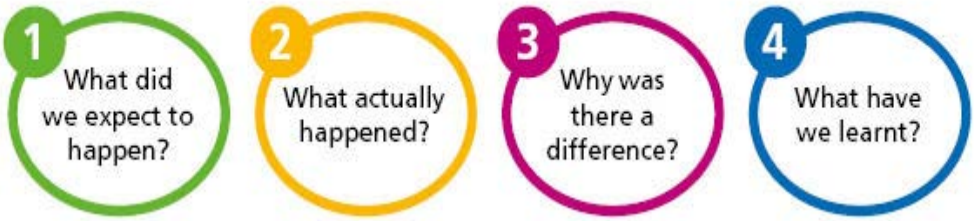
Main over all theme: Wellbeing check in for staff after an incident.

Violence and Aggression Type:
this includes incidents that are against staff and patients.

The main themes out the debrief is staff been able to have time for reflection after an incident. Managers also use this to check in for staff wellbeing.

Medication Incident Type:

Discussed immediate actions that could improve the dispensing error this was around human factors.



After Action Review

An after action review is a team based facilitated discussion of an incident which gives individuals involved the ability to reflect on and contribute to the understanding about what happened for learning

- The first Trust after action review was undertaken with the Barnsley Community teams in March and was in relation to a medication error. The team were very receptive to the process and fed back that despite this being a new learning response, it felt supportive, and meaningful as a way of capturing the learning.
- Staff have shown a shift in adopting a more systems thinking approach to learning and a positive cultural shift in the teams.
- Produced an after action review toolkit to support consistency of delivery.

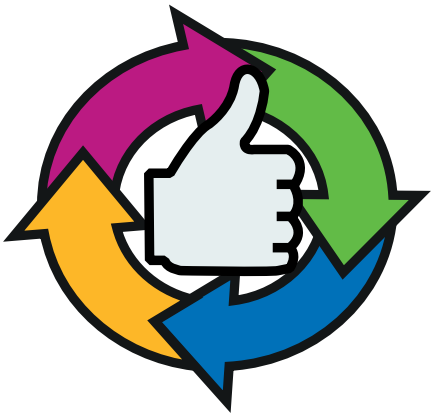
After Action Review - Feedback

- "Staff have a voice and were able to get there view and opinions across. "
- "Good discussion and everyone contributed to the discussion."
- "The facilitator was very engaging with the group. Listened to what the group was saying. Encouraged staff to be thought provoking."
- "It was a highly emotive subject but dealt with in a very supportive way. I think it was a good opportunity for the teams to come together and look for ideas for improvements."

Specialist learning review

A specialist learning review is used to identify learning from multiple patient safety incidents and explore a safety theme, pathway and process.

- The first Trust specialist learning review was undertaken with the Barnsley Community teams in February with a further four commissioned across the Trust since. It was in relation to a series of four incidents.
- Teams and staff were identified from the review, including stakeholders external to the Trust to analyse themes of the incidents, with the aim of applying systems thinking to identify areas of improvement. The session was well attended with 22 members of staff attending this exciting new learning approach.
- Staff responded well to the application of systems thinking using the Systems engineering initiative for patient safety (SEIPS) model and adapted well to a new way of thinking, with the focus on identifying the gaps between 'work as done' vs 'work as imagined', to support in the identification of areas of improvement and related safety actions.
- Throughout the commissioning of all the specialist learning reviews, the enthusiasm and buy in from care group colleagues to undertake these systems-based reviews has been positive.
- Produced a specialist learning review toolkit to support consistency.



Family Liaison Officer

The family Liaison Officer Yvonne Robinson and Trust Suicide Prevention Lead Naomi Sutcliffe

Have resumed the bereavement standard work that was started in 2018.

- Reestablish bereavement group membership
- Developing a link worker role description
- Roll out of PABBs training
- Updating resources of Trust intranet pages

Being open - engaging and involving service users, families and carers following a patient safety incident guidance is now live and has been shared with services through the headlines.

Search for Engaging and involving patients and families on the intranet

Family Liaison Officer – Feedback

"A huge thank you for all of your support over the last 7 months and for helping my husband and me navigate what has been a traumatic experience.

Your compassion for us throughout this whole process has been remarkable, I have never met someone so passionate about their job, However, I don't think this is just a job to you, it is clear you genuinely care about helping and supporting people through times of crisis! You have gone above and beyond with calls and visits outside of your normal working hours, as well as making time for us when we call or text.

Your knowledge of mental health has helped us with processing our emotions and personal battles, as you know my husband has gone through a difficult time with the flashbacks, without your support and guidance he would probably have had a breakdown, for this, I am truly grateful. Your ability to relate to us and other families is truly outstanding."

Forensic Services Care Group (including LD)

- The Forensic services have introduced a weekly incident monitoring group to support a review of amber and red incidents, and any other incidents that the care group have identified as needing discussion. Incidents from this group have been escalated to Trustwide Patient Safety Oversight Group, with recommended actions.
- The weekly incident monitoring group are in the process of establishing terms of reference. Consideration for how this can be done in collaboration with other care groups for consistent approach is underway.
- The care group have been receptive to embedding this new practice of incident review, and applying systems based thinking to the reviews in order to identify if further learning responses are needed.
- Ward managers and team managers attend the meeting and provide frontline updates around the incidents to ensure that all learning and actions taken are captured.

Learning and improvement

Some key examples of lessons learned and action outcomes from across our geographical areas, Care Groups and Specialists.

Learning Library

- Using the DASH (Domestic Abuse, Stalking and Harassment and Honour Based Abuse) Risk Assessment
- Home office document to support the concession for Migrant Victims of domestic abuse (June 2024)

Learning Network

- Family Liaison Officer role
- Learning lessons – Forensic care group
- Evaluating staff use of the trust frailty screening tool and their management of frailty
- Care Review Report

Preparing for World Patient Safety day

Specialist Learning Network for medicines safety and falls awareness. 11th September in the large conference room in Fieldhead.

Staff members are making their patient safety pledges on the intranet page

Week commencing 23rd September the patient safety team and fall coordinator are going into inpatient services to talk and raise awareness for patient safety and falls.

Learning from healthcare deaths

An overview of themes identified from reviews and investigations that have been completed during 2023/24 will be included in the next learning Journey.

Thank you for supporting a patient safety culture

Contact the patient safety team: **patientsafety@swyt.nhs.uk**