South West Yorkshire Partnership NHS Foundation Trust

Learning from incidents

Quarter 2

Patient Safety Support Team

October 2024

With **all of us** in mind.

Our headlines

- 4,176 incidents reported
- **95%** 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
- Work on Poplars ward (slide 15)
- World Patient Safety Day event on 17th September (see slide 22 - 25 for more information)

Learning Responses

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.

- Managers 48-hour review (to understand)
- Debrief
- After Action Review
- Specialist Learning Review
- Thematic 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 and used as a tool to understand what has happened.

The team have taken a suggested to change the name from Manager's 48-hour review to Manager's Rapid Review. This was agreed at the patient safety improvement group.

The reason for changing is to class this review as a learning response for the care groups.

Debrief

A Debrief is a team-based discussion initiated as soon as possible after an incident with staff involved to ensure continued safety and support needs are met.

A debrief section has been created on Datix. The services are able to use this to directly input the debrief information.

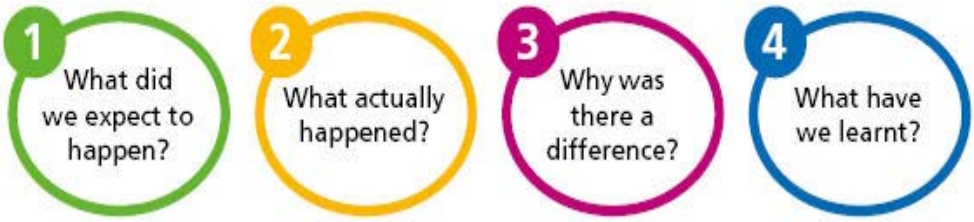
Further engagement and training for staff around the debrief learning response.

Debrief key themes

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

Debrief continued to be conducted for a wide range of incidents including violence and aggression and medication incidents.

Over Quarter 2 there has been an increase in using debrief for pressure ulcers.



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.

Incident summary	local improvement actions
Apparent suicide (not SWYT incident)	• discharge arrangements, staff should discuss with the service user, not just parents
Inpatient suicide (on leave)	• A transfer checklist template for internal ward transfers has been completed and is going through the review and approval process. • suicide prevention lead, will deliver learning and reflective sessions on removal of means to the Ward 19 (Male) nursing team.

After Action Review - Feedback

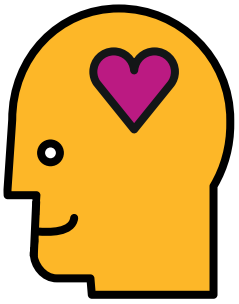
- "It was a highly emotive subject but dealt with in a very supportive way. I think it was a good opportunity for the teams to come together and look for ideas for improvements."
- "Felt like a relatively safe place to open up about patterns in patient deaths. The facilitators had a containing presence which the team appreciated."

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.

Incident summary	local improvement actions
Administration error	• Undertake an audit of unplanned visits to evidence an increase in demand. Use of SystmOne care plan drop down to capture this • Create a SITREP form • Commence safety huddles.
Patient fall	• Dip sample audits to monitor the use of bed alarms being turned on. • Continue with project work that is being carried out in relation to staffing pressures, and provision of bank/ agency/preceptorship work. • Purchasing of visible summary of NEWS2 laminated cards (similar to ID badge that can be carried by staff for quick access/visible prompt).

Patient safety analysis for learning



- Death by rail have been individually reviewed and a wider piece of work to bring together all the learning as started.
- Care close to home
- Enhanced pathway
- Barnsley service are completing a review on medication incidents (excluding insulin incidents)

Future work

- Incidents which have involved external healthcare professional incidents.

Patient Safety Incident Investigation (PSII)

An in-depth systems analysis review of specific patient safety incidents which are defined in the Trust's Patient Safety Incident Response Plan. Led by patient safety support team.

The lead Investigators have begun one individual patient safety incident investigations:

- Inpatient Suicide

These are in the early stages of development and further updates and feedback will be provided in the coming months.

PSII Projects

Clinical risk assessment (FIRM)

The primary focus being on care planning and embedding risk assessment more robustly into that process. A survey was developed with the aim of seeking an understanding of front-line colleagues' experience of FIRM in practice, including the barriers and reflections; 72 responses were received. Analysis of the results and learning will give a rich understanding of insights that will help shape future improvement workstreams and following the work being written up, this project will be concluded with work continuing separately.

Pressure ulcer

A day has been planned on 6 November 2024. It is envisaged that the process mapping with highlight the issues which can then be examined to explore where changes can be made to improve the experience for staff and streamline the process. The day involves front line clinicians, team leaders, managers, specialists, SystmOne, data and patient safety specialists.

Suicide prevention/self-harm

The scope was refined to focus on themes from serious incidents relating to self-harm and apparent suicide by inpatients (either on a ward, on leave, AWOL or within 2 weeks of discharge). A working group met in September to consider the focus with very good attendance. Further sessions are planned to take the work forward.

PSIRF priority improvement work updates

Updates will be received bi-monthly at the Patient Safety Improvement Group and updates provided on a rotating basis in this presentation

Medication safety

A highlight report was received in October 2024 which included updates on:

- Discussed in PSIG meeting the need for nursing support with actions – agreed nursing lead which will help with EPMA implementation and administration errors
- Monitoring common stock list for ward types
- Training package for out of hours leave
- Pharmacy KPIs to monitor previous improvement work around discharge medicines service, MaPPs
- Completed project with Unity Centre
- ADIoS system completed
- Green bag project rolled out across the Trust
- STOMP rolled out across the Trust
- Medicines 'other' categorisation

Other projects include:

- Forensic QI project regarding fridge temperature
- Neighbourhood nursing QI project regarding insulin errors

PSIRF priority improvement work updates

Self-harm and suicide prevention

A highlight report was received at the Patient Safety Improvement Group in October 2024 which included:

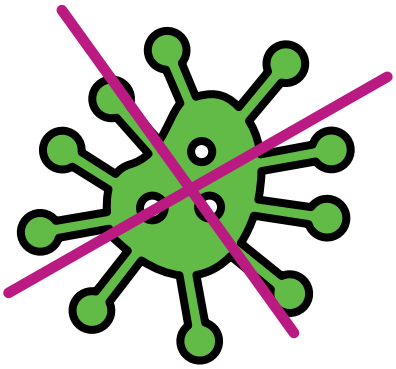
- Update on PSII thematic project for retrospective review of inpatient suicide/self-harm (as reported in section 2.3.6)
- Removing access to means guidance updated to align with national workstreams
- Updated SBAR which provides staff insights and awareness of removal of access to means including embedding online harms training on ESR
- SafeTALK training delivery
- Ongoing ASSIST training delivery
- Suicide prevention in the workplace when available.

PSIRF priority improvement work updates

Healthcare Acquired Infections

A highlight report was presented to the Patient Safety Improvement Group in October 2024 which included updates on:

- Continued work on IPC annual plan and quality improvement programme (audits, reviews)
- Delivery and monitoring of mandatory IPC and Hand hygiene training. Excellent training scores – above 80% threshold
- Preparing the Trust to prevent, protect, recognise and respond to infectious disease utilising data as evidence and highlighting trends.
- Outbreak management and control
- Completed a review of the practice and processes of Barnsley Neighbourhood Nursing Teams (NNT's), Tissue viability and Lymphoedema services when treating patients for leg-ulcer(s)
- Decontamination of equipment
- Environment monitoring report
- FFP3 fit testing training completed
- IPC toolbox talks
- Measles and supporting Q&A sessions
- Alcohol gel dispenser review
- Water hygiene training



Family Liaison Officer

The Family Liaison Officer and Trust Suicide Prevention Lead have resumed the bereavement standard work that was started in 2018.

- Bereavement group takes place monthly – new member of staff from Trauma Informed pathway has joined.
- A link worker role description has been developed and going through governance process
- PABBs training has taken place and reviewed well, with funding for further training

Currently developing an engaging and involving staff following a patient safety incident guidance.

Search for Engaging and involving patients and families on the intranet

Family Liaison Officer – Feedback

- "Just wanted to say thank you for all your support this past 9 months. You have been amazing."

Well done Poplars ward

"Poplars have been identified as a service demonstrating positive change and improvement in response to patient safety incidents, particularly through embedding practice in relation to family involvement. Families are notified immediately following an incident especially where there is a transfer of care to hospital required as a consequence. Previously there had been delays to this happening, which had been identified through a staff learning event facilitated by PSST in August 2024. The falls specialist advisor highlighted at the Trust PSOG meeting that she was impressed by the increased family involvement following falls incidents, alongside improved care planning and responding to patient's needs. This was highlighted at the Trust PSOG in October 2024 as a positive reflection of improvement from learning."

Learning and improvement

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

Learning Library

- Learning library Urinary Retention
- Domestic abuse nursing's silent epidemic article
- Elective home education
- Joint Agency Response & Child Death Review Meeting
- Example of using systems thinking tools to analyse an inpatient fall involving a medical device
- Learning Library summary for Translation and Interpretation
- Death of a community mental health patient following importing medications from America
- Transition of care between CAMHS and primary care services
- Voice of child
- Lethal means and online access April 24 update
- Child and adolescent to parent violence and abuse

Learning Network

24th July 2024

- Fall case study using SEIPS
- Reducing health inequalities LeDeR review

World Patient Safety day

Face to face Learning Network with a special focus on patient safety and falls prevention.

11th September in the large conference room in Fieldhead.

- Fall improvement work
- LD and falls risk/ prevention
- Creative minds - fall reduction work
- Patient Safety Partners
- PSIRF – Improvement

Face to face Learning Network staff feedback

- "Brilliant discussion and education"
- "Being face to face - nice to meet people from different teams / departments"
- "Information about relevant service, support and learning."
- "Overall I found everyone's presentations were informative and interesting from an inpatient perspective"

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

Week commencing 23rd September the patient safety team and fall coordinator supported creative minds with sessions for patients to promote patient safety. The art work created from the sessions have been displayed on the wards

Thank you for supporting a patient safety culture

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