South West Yorkshire Partnership NHS Foundation Trust

Learning from incidents

Quarter 3

Patient Safety Support Team

January 2025

With **all of us** in mind.

Our headlines

- Learning Response updates
- PSII projects
- Improvement works
- Family Liaison Officer updates and feedback (slide 13)
- Cheswold Park Hospital update (slide 15)
- Work on Willow ward (slide 16)
- Safety Huddles (slide 17)

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.

- 24 Hour review
- Debrief
- After Action Review
- Specialist Learning Review
- Thematic Review
- Patient Safety Incident Investigation (PSII)

Search for Learning Responses on the intranet.

Managers 48hr rapid review

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

The team have changed the name for 48 hour to managers 48hr rapid review. The reason for changing is to class this review as a learning response for the care groups.

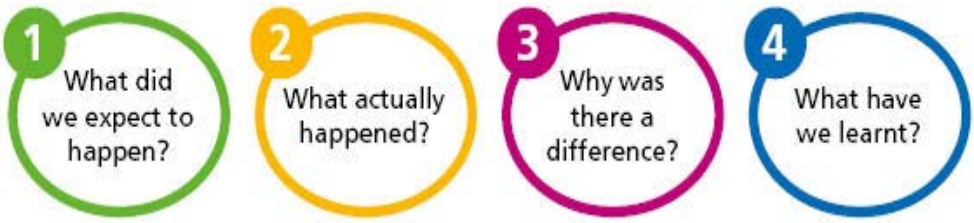
Debrief

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.

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



After Action Review - development

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

Currently trialing the care groups leading on after action reviews with patient safety team support. These are tended to be led by Quality and governance leads.

Learning Response update

In quarter 3 there where no new AAR and SPL responses approved by the care group. The team are currently working with the care groups to review the approval process

There will be an update in quarter 4.

Search for Learning Responses on the intranet

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 are working on three individual patient safety incident investigations.

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 gave insights that will help shape future work the Care Planning Risk Assessment Group.

This has now been concluded and share with the patient safety improvement group and closed.

Pressure ulcer

A group process mapping day took place on the 6 November 2024. The day involved front line clinicians, team leaders, managers, specialists, SystmOne, data and patient safety specialists. Out puts from the day are been taken forward in a task and finish improvement group in Barnsley physical health and wellbeing.

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). This work was paused in November/December but aims to recommence in February/ March 2025.

Patient Safety Improvement Group

The Trust Patient Safety Improvement Group has moved to a monthly frequency to operate alongside the Trust Patient Safety Oversight Group.

The agenda includes:

- Discussion to help understand variation, trends and themes. This will develop further in coming months and incorporate review of the data through an ethnicity lens
- Received highlight report with care group updates
- Oversight of the Patient Safety Incident improvement projects
- Oversight of improvement plans

Next steps: will include the introduction of monthly patient safety updates from care groups, corporate teams (e.g Customer Services, Quality Governance Team, Legal, People Directorate, Family liaison officer) and oversight of a sample of learning responses.

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

Pressure Ulcers

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

- A foot wound pathway has been developed and was implemented in August 2024. This has resulted in a reduction of Datix reports for foot wounds.
- There is a working group for a new pressure ulcer risk assessment – Purpose T pilot for the use of this new tool is planned to commence in January 2025 and will include the inpatient areas NRU and SRU and two neighbourhoods within Barnsley.
- A pilot has been completed in one nursing team to reduce the number of times a wound care assessment (WAC) is completed from weekly to monthly in line with the national wound care strategy. This is currently being evaluated.
- A review of the DHSC protocol for pressure ulcers and raising a safeguarding concern is underway, with a view to this being implemented into practice.

PSIRF priority improvement work updates

Inpatient Falls

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

- Update on completing daily **safety huddles** are: Ashdale, Beechdale, Elmdale, Ward 19, and Horizon Centre.
- **FRAT-18**: this has been fully reviewed and is now live on S1. Feedback from staff has been positive.
- **Bone Health Screening**: this is a Trust developed tool to support staff in understanding if the patient is at risk of osteoporosis and gives some guidance around treatment options.
- **Falls Champions**: there is some interest in having falls champions on inpatient wards, but the general consensus is that the wards are experiencing high acuity, and this could potentially add to the staff workload.
- **Training Needs Analysis**: This work is under way to improve access to falls awareness training on wards experiencing higher rates of falls. This includes bespoke sessions, and staff have access to falls eLearning

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 with wide range of members participating in the discussions
- The title link worker role has changed to bereavement link supporter following feedback from group members. The Comms teams are currently involved with minor changes to be made to the role description… watch this space
- PABBs training new dates across the Trust in Spring 2025
- A survey has been created for feedback on the family liaison officer role.

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

Feedback from a family member that the family liaison officer helped

Thank you so much for looking into this for me I really do appreciate it!! You don't have to apologise for anything you have gone above and beyond to help me!! I would like a hard copy if possible I feel if it's on email I'll read it once I receive it, however if it's an hard copy I don't have to open it and can lock it in the safe!Once again thank you so much for helping me get these records xx

Forensic Care Group

Themes and trends

- Policy & Practice, environment, violence & aggression, physical illness

Themes and trends – lower-level incidents

- Environment, violence & aggression, security, safeguarding

Areas of concerns/risks

- Observation & engagement, environment & equipment

Learning identified

- Choking related incident

Local improvement work

- Bluelight developed, debrief sessions, action plan & quality improvement work to improve awareness and implementation of observation & engagement policy

Learning responses being used

- Debrief, planned quality improvement work
- Sharing learning through Bluelight alerts

Cheswold Park Hospital

Cheswold Park Hospital transferred to the Trust from 1 October 2024 and they continue to use their existing risk management system, Ulysses for a period of time until transition to Datixweb can be implemented.

- Ulysses is not set up to report to LFPSE.
- To address this gap in reporting patient safety incidents to the national system, the PSST are working on transferring incidents into Datix so that essential reporting to LFPSE (and CQC via this route) can take place.
- The executive management team have given approval that the move to Datix will happen by March 2025 at the latest, with the expectation that it will happen earlier than this.

Well done Willow ward

These incidents highlight how reflecting, learning and engaging in learning works and makes everyone safer

- In July 2024 there was an incident on Willow Ward whereby a service user choked on a piece of food.
- In review of this incident, several areas of learning were identified and a facilitated debrief learning response was commissioned, supported by specialist advisors. There was a real positive attendance and willingness to learning from what did not quite go as planned.
- The service embedded the recommendations, and the staff involved in the learning response engaged well in the discussions. There was lots of conversation around being a leader, utilising ILS training as taught, and teamwork within the discussions.
- In October 2024, there has been a further incident on the ward whereby a service user has choked on a piece of food. Unlike the first instance, staff worked as a team, completing two rounds of back blows and thrusts, dislodging the food and ensuring a quick conclusion to this distressing situation. Staff took part in a debrief again, supported by specialist advisors, and the reflections were around how well the team worked together, the communication and how they had embedded the learning from the previous debrief.

Safety Huddles staff feedback

- **Consultant** 'It is a great way to meet up to discuss Datix's, Datix patterns and associated learning points to incorporate into future clinical practices.'
- **Housekeeper** 'keeps me informed of any environmental issues and safety risks.'
- **Physiotherapy team** 'The safety huddle is extremely effective in improving communication between the different disciplines in order for us to all work effectively as an MDT. It's a great opportunity to hand over salient information and to gain clarity from the team'
- **Matron** "The development and consistency of the safety huddle on Beechdale is a clear indication of a positive approach to communication within the ward team and supporting teams. This benefit of the safety huddle is reflected in the high standards of quality of care provided by the team to the patients and their carers. There is a constructive and encouraging approach to learning and working collaboratively as a team".

Learning and improvement

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

Learning Library

- Non-Contact Sexual Offences
- Political stickers
- Self Neglect section 42
- Datix Recording Final

Learning Network

- The next learning network is on;
- Tuesday 20th May 2025 at 13:00 – 14:30
- Tuesday 15th July 2025 at 11:00 – 12:30

Thank you for supporting a patient safety culture

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