Learning Lessons UPDATE

August – November 2015

The Complaints Team and the Patient and Organisational Safety Department would like to share the learning from the Trusts incidents and complaints. Some of these points may seem obvious to you but they were all key features in recent serious incident clinical or complaint reviews.

The aim of these bulletins is to share the learning and good practice for every member of staff in your Team. Please circulate, discuss, and share, in staff areas or for staff that may not be able to access emails.

LEARNING FROM THE 1ST PATIENT SAFETY WEEK

Thanks to everyone who contributed to the first Patient Safety week 3-10 December 2015

- Several events ran during the week including Duty of Candour sessions, handwashing displays, falls awareness, a telephone survey on safety and an open art session with patients on *what keeps you safe.*
- Learning from the event aims that for 2016 all HCSWs will be trained to report incidents and all teams review their incidents regularly.
- ALL Staff need to know how to report an incident not just qualified staff - If you need Safeguard incident reporting training to report an incident, please contact POST on **FN 2080.**

- Click here to read a review of the week

MIND YOUR LANGUAGE ***???!!!!!!!!

This learning follows several incidents where staff have reported incidents and written the full language/expletives that they witnessed in the incident.

- ✓ Please can any staff who report details of any violent or verbal abuse incidents AVOID the use of actual swear words that were used during the incident. An account of the actual language used (if felt to be relevant) can be documented in the patients notes.

- ✓ On Safeguard please just report that the patient 'used profanities' or 'was using abusive language', there is no need to report exactly what this language was used.If you have received any verbal abuse or you have been involved in a violent incident and feel that you need additional support, please contact Workforce Safety, in the Workforce Safety Team on FN 1389.

LEARNING FROM COMPLAINTS

How many complaints has the Trust received in the last 3 months? We have received 13 formal complaints since August 2015.

How would you rate your introduction to your Ward? 10/10?

Themes of these complaints have been:

- A patient's experience of being admitted to a ward, and their induction onto the ward.
- Communication with a relative, from a community team.
- Communication about an appointment cancellation with a community mental health team. *(Patient felt was not timely)*
- Delays in funding panel process, for an inpatient on a ward. *(Patient said not kept informed of what caused delays)*
- Attitude of staff (Medical)

Learning from complaints:

- ✓ Patients who contact the Patient Experience Team are often intent on making a formal complaint, as they are often unaware of PALS and how it functions. Once explained, **most are happy to use the PALS process to try to resolve issues** raised at a local informal level. This is a **time limited opportunity** and can only be achieved if staff respond in a timely manner to any requests from PALS.
- ✓ Once the PALS process has been exhausted **the next stage is to formalise the contact into a complaint**, which is more time consuming for everyone, so if you are contacted by PALS for information please respond in a timely manner.
- ✓ Please **consider how you speak and interact with patients**, as it is very often not what has been said but the manner in which it has been said which causes patients to be upset. (Attitude of staff is one of the most frequent complaints.)
- ✓ Please ensure that if we agree to do or arrange something for a patient, that the **agreed actions are carried out and communicated**, and any deviation from what has been agreed is communicated to the patient as soon as possible.
- ✓ **When an appointment is cancelled please ensure that the patient is informed at the earliest opportunity**. Please consider that some of our patients are travelling via public transport, so if they ask for appointment times to be changed, then give due consideration to their request as this may help reduce DNA rates and improve patient satisfaction.

- **For more information about complaints & PALS contact Complaints Manager, FN 8471**.

LEARNING FROM AN INPATIENT COMPLAINT - GETTING THE FACTS RIGHT

"No care about me without me"

A patient complained about the information that was written in the Mental Health Act (1983) Tribunal report, stating it was inaccurate. The complaint review determined that information had been taken from a third person who was not available for the Tribunal, so another colleague supported the report writing. The review

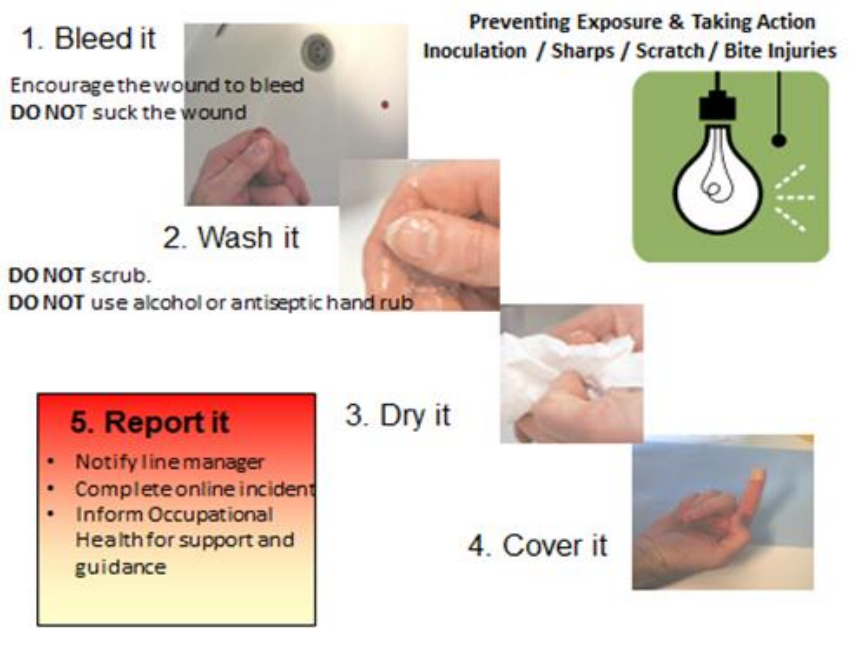
highlighted the importance of checking the facts with the patient if possible, in order to check the content as accurate.

In this case the patient highlighted that we had stated they were in debt and living in rented accommodation, whereas the patient was clear there was no financial debt and owned a mortgaged property. The patient acknowledged these inaccurate social circumstance details portrayed their life in a completely different way to what was accurate, for which we apologised.

LEARNING FROM INPATIENT INCIDENTS – ARE YOU GETTING THE POINT?

Following several incidents involving either the careless disposal of sharps, or injury sustained by a patient scratching or biting a staff member, please ensure you are aware of **SHARPS SAFETY** and the process to follow if an incident occurs.

- ✓ **Important,** if a significant exposure from high risk material with the potential to transmit a blood borne virus has occurred, complete the risk assessment document attached to the Infection Control policy.
- ✓ If the source is known or highly suspected to be a **high risk** and you have suffered an inoculation or splash injury resulting in the patient's blood entering your blood stream through your skin, eyes nose or mouth, contact the Consultant Microbiologist immediately (within one hour) for advice on the following numbers:
  - Office hours, 01782 674898, Microbiology Helpdesk.
  - Out of hours, 01782 715444 University Hospital of North Staffordshire Switchboard.
  - For any questions - contact Infection Prevention Nurse, 0300 123 1535 FN 2140.
  - Please click here to read Policy



RISKS WITH DRAWING PINS- WATCH YOUR SIGNS/DISPLAYS IN INPATIENT AREAS!

Following several patient safety incidents (in inpatient areas), please can any displays only use non-sharp methods to secure ward information, such as sticky dots or Velcro.

Please be mindful of access to paperclips and other sharp stationary and display items too.

DO YOU FACEBOOK? OR DO YOU TWEET?

There have been several recent incidents of patients utilising social media sites to gain access to Trust staffs personal information. Please take a moment next time you are logged on to see how much of your information is available online, you may be surprised!

The Trusts Social media protocol advises all staff that;

"It is important to remember when using social media that anything published online is instantly available across the Internet, and therefore the world, and will remain in the public domain. It is therefore vital that as a member of our staff, at all times and in all situations, you think very carefully about what you publish and the way in which you use these sites and you should bear in mind the codes of conduct and policies which are part of your professional and employment requirements"

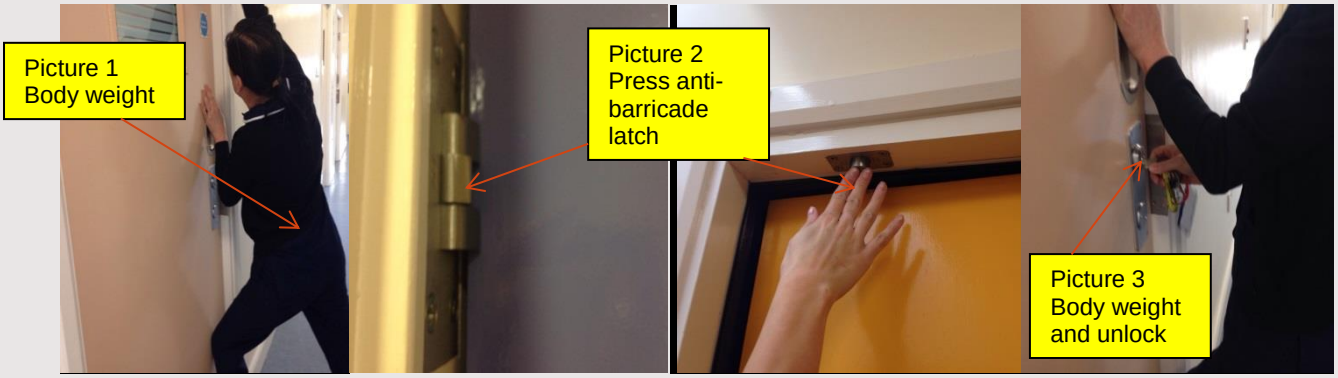
Please click here to read the Trust guidance on social media **If you have any questions or if you find something online which you believe breaches this protocol, please contact the Communications Team for advice on 0800 032 8728 or FN 2627.**

BEDROOM DOORS - INCIDENTS ON ACUTE WARD

Two recent incidents on a Harplands ward took place where patients locked the bedroom door and applied their body weight to the door. Staff were unable to open the lock. Fortunately the patient had come to no harm and moved from the door, so the staff were able to get into the room.

Please can you ensure that this incident and the related below guidance is:

- ✓ brought to the attention of **ALL INPATIENT STAFF**
- ✓ added to your wards local induction procedures.



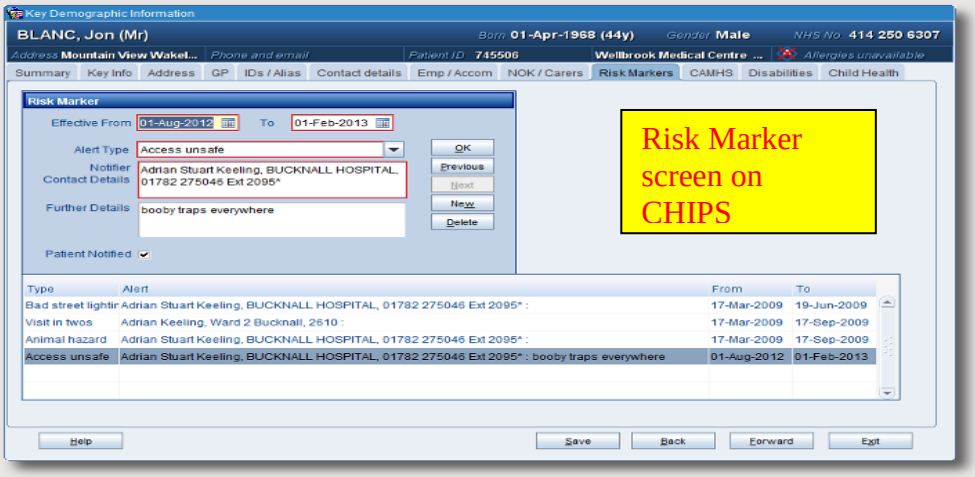
If there is a weight/person /barricade behind the door, to reduce chance of injury follow this procedure:

1.	Seek assistance from another member of staff before following this procedure.
2.	Assess what is behind the door by either looking through the glass or calling out to the patient.
3.	Apply body weight against the door (see picture 1)
4.	Press the anti-barricade latch inwards (see picture 2)
5.	If the door is not locked, pull the door towards you. Tell the patient you are opening the door, and the other member of staff will support the patient if required.
6.	If door is locked, tell the patient that you are opening the door, and the other member of staff will support the patient if required. Keep body weight against the door, use the key to unlock the door and pull the door towards you (see picture 3)
7.	Return door to closed position.
8.	Press the anti-barricade latch back to release it.

If you are unsure how to do this please ask the nurse in charge of your shift.

LEARNING FROM COMMUNITY SERIOUS INCIDENT - CHIPS RISK

- ✓ Please can any staff who use CHIPS, ensure that if you assess a patient that you know has been convicted of a violent crime/sentenced to imprisonment, you update the risk marker on CHIPS. You can state if you are no longer involved – but any key risk information is then still available for other parties.
- ✓ This also applies for patients who are no longer on your caseload during any sentencing, the CHIPS risk marker still needs to reflect this history if it is known, in addition to the risk assessment.



Risk Marker screen on CHIPS

HM PRISON SERVICE

PATIENT SAFETY ALERT - RISK OF HARM WHEN HOISTING

A recent patient safety alert has been circulated in relation to the "risk of death and serious harm by falling from hoists" – *NHS/PSA/W/2015/010.*

If you are involved in hoisting patients you **must** ensure that the following information is adhered to.

Ensure a suitable and sufficient written risk assessment is completed in accordance with the Manual Handling Operations Regulations 1992 and an up-to-date handling/hoisting plan is in place.

General guidance – good practice for all hoisting tasks

- Do not use the hoist/sling unless you have had the necessary training
- Read the handling/hoisting risk assessment/care plan and ensure it is current and relevant
- Familiarise yourself with the hoists emergency lowering systems
- All hoisting tasks must be performed with the minimum of two handlers
- Communication with all involved in the task at all times, including the patient
- Ensure safety and comfort of patient at all times
- Brakes **must** not be applied during the hoisting procedure
- Apply sling first and bring hoist in last
- Double check the sling – is it the correct sling for the hoist and for the patient
- Check sling attachments and sling is fit for use – not soiled/frayed etc.
- Ensure the support surface is ready to receive the patient
- Hoist just above the support surface to obtain sufficient clearance
- Do not use the hoist to transfer over distances
- Place hoist battery on charge when not in use
- Any concerns with the hoist/slings/equipment escalate immediately
- Report any incidents

Further support or guidance can be obtained from your cascade manual handling trainer or from, Health and Safety Advisor, FN 1353 or Training and Education Development Advisor, FN 2776.

LEARNING FROM INPATIENT SERIOUS INCIDENTS

It's not just older in-patients that can fall!

A female elderly patient fell whilst getting out of bed sustaining a fractured wrist, and then went on to later fracture her finger during another fall. The below actions were identified to reduce the possibility of this occurring again.

✓ **Confusion regards observation levels**. Education via handovers has been given to all ward staff regarding the correct use of the terminology in the observation policy, as there was some confusion with observation levels 1 & 2.

✓ Please **do not use shortened versions**/terminology for example Level 2 15/60. Write out in full what the parameters of the observations are to reduce ambiguity and confusion.

- ✓ Weekly audits to be devised to **check bed sensor alarms**, to ensure no faults have occurred.
- ✓ The Integrated Care Pathway includes the **osteoporosis risk assessment tool.**
- ✓ Managers please ensure you "**SIGN OFF" Reports** on Safeguard system within 3 days for 'Moderate' and above incidents.
- ✓ Older persons ward staff are to ensure that all incidents are discussed with the modern matron before discussion at the Weekly Incident Review Group.
- ✓ The Matron is to ensure that all **fractures are escalated** to the Patient and Organisational Safety Team.
- For more information on falls prevention please **contact Modern Matron and Falls Prevention Lead on 01782 441600, FN 2120 or Mobex 63753.**

NEW RISK ASSESSMENT TOOL GOES LIVE

The new Risk Assessment Tool was devised after consultation with staff across Directorates and forms the first level of assessment/screening that all services require. It is not intended to replace more specialist/modular assessments but can be built upon depending on service user and service needs.

The Risk Assessment Tool was developed with staff from all Directorates supported by Quality & Governance Leads. It is a validated tool and has been developed in partnership with Steve Morgan, Centre for Suicide Prevention Manchester University.

- ✓ The tool has been designed on CHIPS to avoid unnecessary repetition. Staff have the option to open the most recent assessment as a draft and simply update it with any new information.
- ✓ However, the assessment must be "published" on CHIPS to indicate it has been completed on that date. (Any assessment that remains in draft on the system cannot be considered as completed.)
- ✓ You can select "paper copy" of risk assessment if an online version has not been completed.

Please click here to see new risk assessment tool, also available on CHIPS.

LEARNING FROM DNA'S - COMMUNITY SERIOUS INCIDENTS

How do you manage your DNAS?

12,600 DNAS = Apx 6 years of time lost!

Did you know there were 12,600 missed appointments during the last 8 months?

Our Community services offer thousands of appointments in the community every month, although approximately 6% of patients Do Not Attend (DNA). There does seem to be some correlation between

patients who do not engage in services and DNA appointments, as they are more likely to be involved in incidents.

Total Community Contacts on CHIPS (April-Nov 2015)	190,856
DNAs	**12,600**
DNAs as a %	6.60%

12,600 Appointments of 1 hour each = apx 12,600 Hours
12,600 Hours = 320 working weeks
320 weeks = 6 years.
So…. that's 6 years' worth of appointments lost through **8 months of DNAs**.

12,600 DNAS = Apx 6 years of time lost!

- ✓ All service users where practicable should be reminded of their appointment date and time by either a letter or telephone call prior to the appointment date. If a mobile telephone number is available this could also be actioned via a text message.
- ✓ By reminding service users of their appointment there will be a reduction in the number of people that do not attend. If a service user fails to attend or decided to cancel their routine first (new) appointment/visit then the practitioner and/or clinical team must decide whether to refer the service user back to the referrer/offer a second appointment.
- ✓ It is recommended that the team contact the service user to find out why they did not attend and if possible liaise with the referrer before they make a final decision.
- ✓ Clearly document all decisions made and reasons for any decision to not offer a further appointment. Please click here to read the Trust Procedure re DNA

I CANDOUR, DO YOU?

The recent Patient Safety Week identified that not all of our staff were aware of what Duty of Candour (DoC) means for them, or what the process is following a DoC incident.

What does Duty of Candour mean? "It's the Quality of being open and honest"

The **Duty of Candour is a legal duty** on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to **help patients receive accurate, truthful information from health providers, and being open when errors are made and harm is caused.**

- ➢ Duty of Candour starts when there has been a 'notifiable safety incident'.
- ➢ This is an incident which has resulted in either:
  - a patient's death
  - moderate harm to the patient
  - severe harm to the patient, or
  - prolonged psychological harm to the patient

What do you need to do?

- ➢ Report the incident on Safeguard.
- ➢ The patient/next of kin is informed within 10 days of the DoC incident, by the team involved.

- A face to face explanation is offered by the team to patient/other with an APOLOGY and details of any investigation.
- Written APOLOGY letter is also completed by the team, sent to the patient/other and a copy sent to the Patient and Organisational Safety Team to be filed on Safeguard. (Template letters are available by calling FN 2096.)
- Document everything you have done in the patient notes and on the incident form.

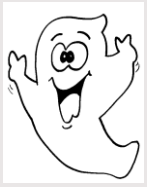
Please click here to read CQC guidance on Duty of Candour or click here to read the being Open Policy, which includes DOC

For information about DOC please contact Patient and Organisational Safety Team on FN 2096.

ARE YOU IN 'GOOD SPIRITS' AND 'BUBBLY'? LEARNING FROM RECORD KEEPING AUDIT

Good record keeping is an integral part of nursing practice, helping protect the welfare of patients. NMC guidance around record keeping states that there are some key principles that underpin good records and record keeping, one being the content and style. Within the guidance it states that patient records should:

- × Not include abbreviations, jargon, meaningless phrases, and irrelevant speculation, offensive or subjective statements.
- × A recent Audit of the Quality of Clinical Documentation has found that these are still evident in our patient records.
- × The most common meaningless phrases found were:



× A little unstable	× Calm and relaxed
× Low profile x3	× Calm and settled x 3
× Bubbly settled	× Fairly pleasant
× Good spirits	× More relaxed
× Pleasant and settled	× Pleasant and appropriate
× Settled x 2	× Mainly asleep

For more information about the audit results please contact Modern Matron, 01782 441600 or FN 2120.

SUPPORT AFTER SUICIDE – HELP IS AT HAND

Support after suicide

The Suicide Bereavement Support Partnership (SBSP) is the UK's national hub for organisations and individuals working across the UK to support people who have been bereaved or affected by suicide. Amongst the work the SBSP carry out, they offer access to both printed and digital copies of 'Help is at Hand' which is a booklet written by people who have lost someone to suicide.

It offers support, guidance and helps to explain that each person will be affected in their own way, and have different ways of expressing themselves. There are no set rules or stages, and no right or wrong way to be feeling.

- ✓ Visit the Support after Suicide website www.supportaftersuicide.org.uk for more information and to see an electronic version of the Help is at Hand booklet and a pocket guide.
- ✓ The Patient and Organisational Safety Team have ordered a number of hard copies of the booklet and pocket guide, which you can give to

people who have been bereaved or affected by suicide. See the contact details below to request copies.

- ✓ There are also a number of additional resources available on the Learning lesson page on SID

Living Well with Risk Group
The Trusts Living Well with Risk Group has recently been relaunched. The aim of the group is to shape practice in managing risk and learn from incidents.

If you would like to be involved with the work of this group or to request more information, please get in touch with the Patient and Organisational Safety Team **on FN 2080 or** safety@northstaffs.nhs.uk

CAN YOU READ BETWEEN THE LINES?

The 'Read Between the Lines' suicide prevention campaign calls on everyone to be alert to the warning signs of suicide in their friends, family and workmates. This year we have aimed the campaign towards men aged between 30-59 who statistically have the highest rate of suicide.

Here is a link to the high resolution version of three different campaign posters for you to print.

You will also see the campaign advertised around the city and on social media:

- Our City magazine
- Male washroom posters in Intu Potteries Centre
- Inside panels of local buses, partner newsletters – VAST, CCG, CYP, Healthwatch
- Facebook advert, Pitchero

If you would like some **Read Between the Lines** posters or flyers in your waiting areas please contact Patient Safety Manager on 01782 275096 FN 2260.

NEW LISTENING AND RESPONDING TRAINING AVAILABLE!

The Listening and Responding training has been revamped and is now available.

This session is suitable for all staff who have face to face contact with patients and covers up to date information on dealing with concerns and complaints. The session is just 1.5 hours.

To book a place please contact the Training Team.

OUT OF HOURS MEDICATION

DID YOU KNOW?
Staff have access to medication out of hours via an emergency drug cupboard which carries a stock of medications. In the event that the stock has already been used over a weekend, outpatient prescriptions are available for staff to secure medications from external pharmacies.

Please click here to read procedure for obtaining medicines out of hours

LEARNING LESSONS LEADS - WHO IS YOURS?

We are increasing the number of identified Learning Lessons Leads across the Trust; Managers please email Lesley Whittaker, Patient Safety Manager with the name of your nominated lead if you haven't already nominated someone from your team.

This is a “virtual “role and consists of email sharing and occasional comments about how your team manages complaints and incidents.

LEARNING LESSONS - NEXT SESSION

What’s on?
The Latest Learning from complaints and serious Incidents.

The Next Learning Lessons session date is:
Friday 29th January 2016
Harplands Hospital Academic 1 & 2
10-12 pm

Please email LearningLessons@northstaffs.nhs.uk to book your place; there are only 25 places per session now!

Learning Lessons has its own webpage, follow **this link** or find it under ‘Quick Links’ on SID homepage.

The page has some useful resources available for supporting patients and managing serious incidents.