Board of Directors

SUMMARY REPORT	Meeting Date:	26th July 2023
	Agenda Item:	16

Report Title:	**Patient Safety Report – Quarter 4 22/23**	
Author(s):	Vin Lewin, Patient Safety Specialist	
Accountable Director:	Salli Midgley: Director of Nursing, Professions and Quality	
Other meetings this paper has been presented to or previously agreed at:	**Committee/Tier 2 Group/Tier 3 Group**	Quality Assurance Committee
	Date:	14/06/2023
Key points/ recommendations from those meetings	The Quality Assurance Committee approved the report and were assured that governance of incidents is robust, action learning is in progress and embedding of learning or news ways of working is evident in a range of reporting.	

Summary of key points in report

Key points for this quarter:

- Racial and cultural abuse hate incidents were frequently reported by staff in quarter 4. A thematic review of these incidents indicated that they are most often 'flash point' incidents aimed at staff in the vicinity, as a result of frustration or volatility, rather than specific staff being targeted. A primary concern in this area is the potential for under-reporting and work is ongoing to promote the open reporting of all types of racial and cultural abuse. All incidents of this nature are reported directly to the inclusion equality and engagement lead.

- Violence and aggression toward staff were primarily reported as no or low harm incidents that, like racial and cultural abuse were thematically linked to 'flash points' rather than being premeditated acts of violence. As with racial and cultural abuse there is a potential for under-reporting in this area particularly in regard to patient-on-patient assaults where third party reporting to staff is required. Therapeutic engagement, observations and individual risk management were found to be key to preventing harm and encouraging reporting in this area.

- Whilst work to eliminate and mitigate the risks to patient safety through fixed ligature anchor points is impacting, there continues to be an increasing trend in self-harm incidents using non-fixed ligatures and headbanging. Non fixed ligatures are as higher risk as those from fixed anchor points, therefore work is in progress to improve collaborative planning and use of de-escalation techniques and de-escalation spaces rather than restraint to support patients who are self-harming.

- Reducing and mitigating the risks to the sexual safety of patients and staff remains a key focus in quarter 4. An improvement work plan aimed at increasing staff knowledge and awareness is underway and being closely monitored. During the quarter, actions previously identified in relation to sexual safety are being implemented and bite sized teaching sessions for mixed gender wards have been completed over a 2-week period to reach as many staff as possible.

Recommendation for the Board to consider:							
Consider for Action		**Approval**		**Assurance**	**X**	**Information**	

It is recommended by the author of this paper that the Board is assured that:

- Learning across patient safety incidents, complaints and safeguarding adults continues to be identified, triangulated and acted on to improve the safety, quality and experience of patients and staff.

- Quality improvement plans, developments and quality improvement projects are being undertaken to demonstrate robust improvement for patient safety and experience.

Please identify which strategic priorities will be impacted by this report:				
Recover services and improve efficiency	*Yes*		*No*	***X***
Continuous quality improvement	*Yes*	***X***	*No*	
Transformation – Changing things that will make a difference	*Yes*	***X***	*No*	
Partnerships – working together to make a bigger impact	*Yes*	***X***	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission Fundamental Standards	*Yes*	***X***	*No*		*CQC fundamental standards*
Data Security and Protection Toolkit	*Yes*		*No*	***X***	
Any other specific standard?	*Yes*	***X***	*No*		*Serious Incident Framework 2015*

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Service User and Carer Safety, Engagement and Experience	*Yes*	***X***	*No*		*This report and the learning lessons report focus on patient safety and improving experience.*
Financial (Revenue & Capital)	*Yes*	***X***	*No*		*There are financial implications of delivering the strategies aligned to this workplan. Currently no additional resource has been identified as Required.*
Organisational Development / Workforce	*Yes*	***X***	*No*		*There are training and development implications for the workplans aligned to both the Quality Strategy and Patient Safety Strategy. These will be articulated via individual implementation plans.*
Equality, Diversity & Inclusion	*Yes*	***X***	*No*		*Work has already identified the potential for racialised care delivery to impact on outcomes for both staff and servicer users, Clinical Quality and Safety Group consider the EDI implications within their workplan.*
Legal	*Yes*	***X***	*No*		*Failing to implement and embed quality improvement and assurance within SHSC will lead to regulatory issues, The patient safety framework is a contractual requirement and will be monitored via ICB/NHSEI.*
Environmental Sustainability	*Yes*	***X***	*No*		*Our aim is to innovate and transform to provide high quality care and support as early as possible in order to improve physical, mental and social wellbeing.*

Section 1: Executive Summary

1.1 The daily incident safety huddle reviewed 100% of all incidents reported within 24hrs of the incident being submitted. Several key themes emerged from the reviews including:

- Racial and cultural abuse in the form of verbal hate incidents, primarily toward staff members, but often in the presence of service users, was frequently reported in quarter 4. All such incidents are reported to inclusion equality and engagement lead for individual review and, where required individual follow up.

- The introduction of the Brøset Violence Checklist on Burbage ward (Following an independent review by Dr Paterson) continues to have a positive impact on reducing violent incidents. Whilst this tool is still in the pilot phase the data shows that there has been a continued reduction in the number of violent incidents reported by the pilot ward in quarter 3 and quarter 4 when compared against quarter 1 and 2. The tool is designed to be used at least once per day to assess the likelihood of aggressive/distressed outbursts at an individual patient level and enables staff to put preventative plans in place.

- There continues to be an ongoing rise in the number of self-harm incidents on acute inpatient wards. Dovedale 2 is the highest reporter of these types of incident. Quality Improvement work is in progress to improve collaborative planning and use of de-escalation techniques and de-escalation spaces rather than restraint to support patients who are self-harming.

- Medication management incident themes in relation to procedural task errors are the highest reported type of error rather than administration errors. No actual harm requiring medical intervention was caused to patients due to incorrect administration in Q4. The most common theme was failure to provide a second signature when administering controlled medication. This is an improvement from the past year since the introduction of the nursing medicine competency framework.

In this quarter there are several key themes across a range of patient safety monitoring and assurance mechanisms that tell us we continue to have risks to quality and safety and areas for improvement and learning which include:

- **Fall prevention**, whilst there is excellent work underway to reduce the number of falls in older adult inpatient mental health wards, falls in the two residential nursing homes continue to be frequently reported. Safety Huddle implementation is now underway in these areas and senior staff are also working collaboratively with the University of Bradford in a sharing of best practice capacity. This remains under review and reports to the Falls Management Group.

- **Sexual safety** is under significant scrutiny from the Director of Nursing, Professions & Quality (DoNPQ). A formal request for an improvement plan has led to planning in order to ensure that staff have to appropriate knowledge and training to mitigate sexual safety risks and implement preventative measures in accordance with the sexual safety policy. Sexual safety has been added as a standing agenda item at the Clinical Quality and safety Group for monthly reporting and quarterly reporting to the Quality Assurance Committee is underway. The DoNPQ has also suggested consideration of Sexual Health & Safety as a strategic approach across SHSC to fall within the auspices of the Quality Strategy.

- **Procedural errors** including search procedures, observation processes, incident reporting, communication with partner agencies and adherence to policy guidance. A range of improvement processes are underway that includes bitesize training, implementing learning from significant event analysis (SEA) findings and improvements to policy and procedure.

It is essential that SHSC has robust management plans in place and immediate risk reduction and improvement plans to address the issues in the medium term. We have clear evidence of learning that indicates where these situations continue (racial and cultural abuse, sexual safety issues and increased levels of self-harm) that the morale of staff is impacted, and cultural norms, values and behaviour can also be impacted leading to an increased risk to the safety of patients.

In quarter 4 there is evidence that Quality Improvement is beginning to have an impact on learning across teams. We can summarise therefore that risks and learning are identified within this quarter but there is still a need for improvement plans, developments and quality improvement projects to fully demonstrate robust improvement for patient safety and experience.

Section 2: Introduction

2.1 This report seeks to offer assurance that:

- Actual harm caused by SHSC and experienced by patients and their family is very low in regard to the severity of harm experienced.
- Where incidents of serious patient harm do occur learning is extracted, acted upon and shared in line with local and national guidance.
- Improvement actions are being undertaken that enable us to maintain and promote a patient safety culture in line with the quality strategy and our ambition to deliver outstanding care.

Section 3: Incident Key Performance Indicators

3.1 Number of incidents reported and reviewed in the previous 4 financial years and previous 4 quarters.

Financial year	**2018/19**	**2020/21**	**2021/22**	**2022/23**	
No. Reported	8605	8222	8440	8521	
4 Quarters	**Q12022/23**	**Q2 2022/23**	**Q3 2022/23**	**Q4 2022/23**	**Total**
No. Reported	2080	2170	2235	2036	⇧

3.2 Incident reporting has returned to near normal since covid 19 lockdown which reduced the overall number of incidents reported due to restrictions in service contact. A further reduction in the overall number of incidents reported since 2018/19 can be accounted for by the closure of Firshill Rise and Buckwood View. Monitoring will be undertaken to assess the impact of both disaggregation from the local authority and the loss of START services.

3.3 48hr reports, *StEIS and **SEAs identified in quarter 4 2022/23

- A 48hr report is requested from services when a significant risk or significant harm (or near miss) is identified in order to understand the facts and consider the type of follow up investigation required.
- A Significant Event Analysis (SEA) is requested following a 48hr report or following the initial incident report when local learning is identified that would mitigate further risk of harm to patients.

- A serious incident is an event where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that it warrants high level investigatory attention.

	January 2023	February 2023	March 2023	Total
48hr Reports	8	12	10	30
StEIS Reports	1	2	1	4
SEA's	4	5	4	13

**Strategic Executive Information System (StEIS). This is the national database where Serious Incidents are reported and monitored.*

***Significant Event Analysis (SEA). This document is used for team/service level learning investigations*.

3.4 Key points to consider from the data provided:

- The number of incidents reported over the last 4 financial years and the last 4 quarters has remained stable with a mean number of 8447 incidents each financial year.

- All incidents reported as having a catastrophic impact were in relation to death and 93% of these were either suspected or known to be due to natural causes. 6 expected deaths were reported by the two nursing homes respectively, all other reported deaths were reported by community-based services. All deaths from suspected suicide (4%) were subject to individual due diligence and where required a 48hr report was completed.

- 73% of all reported incidents can be traced to bed-based services. 75% of all incidents were reported by acute and community services. Rehabilitation and specialist services accounted for 23% of all incidents reported. 2% of incidents were reported by non-clinical services.

- 88% of all incidents reported were in the no harm (near-miss, negligible) or low harm (minor) categories of actual impact.

- 19% (6) of the 48hr reports requested went on to further incident Investigation (SI) All 48hr reports are reviewed by the weekly Serious Incident Panel.

3.5 Of the 6 Serious incidents subject to further investigation:

- 3 were suspected suicides in the community reported by Liaison Psychiatry, the Crisis Resolution and Home Treatment Team and the Recovery Team

- 2 were *S42 sexual safety incidents that took place on the decisions unit.

- 1 was a S42 patient to patient physical assault that took place on Maple Ward.

  Learning themes from these investigations will be presented in the Q1 2023/24 learning report. The Statutory Duty of Candour guidance was undertaken in regard to all incidents. Where required all incidents of harm were reported to South Yorkshire Police.

  **A section 42 enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. This happens whether or not the authority is providing any care and support services to that adult.*

Section 4: Incident reporting and Learning from Incidents

4.1 Incident reporting in NHS organisations is widely recognised as an important method for improving safety in healthcare settings. Organisations with a low threshold for reporting are indicative of an open and transparent learning culture. SHSC incident reporting remains consistent, and this is indicative of a low threshold organisation.

This is supported below in the following 2 tables which indicate that there has been no significant variation in reporting since quarter 1, 2021 and that 88% of SHSC incidents in Q4 are in the low patient harm (minor) or no patient harm (negligible) category.

Table 1 - All incidents reported since April 2021:

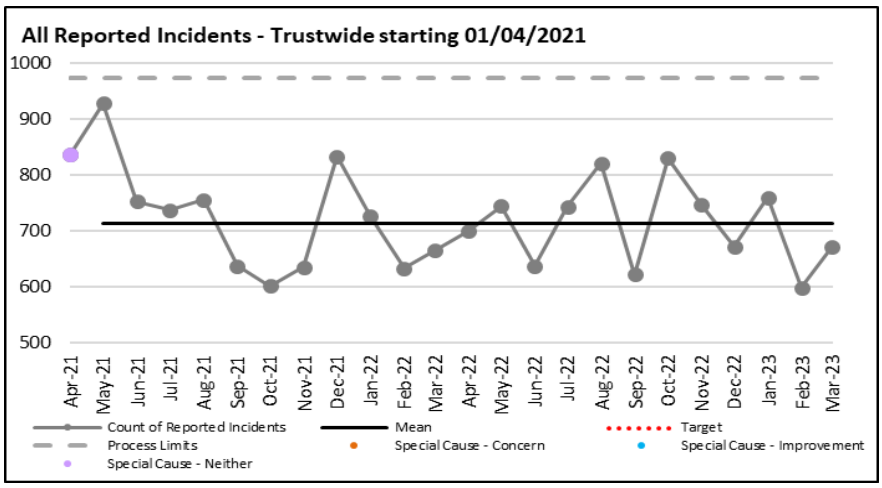
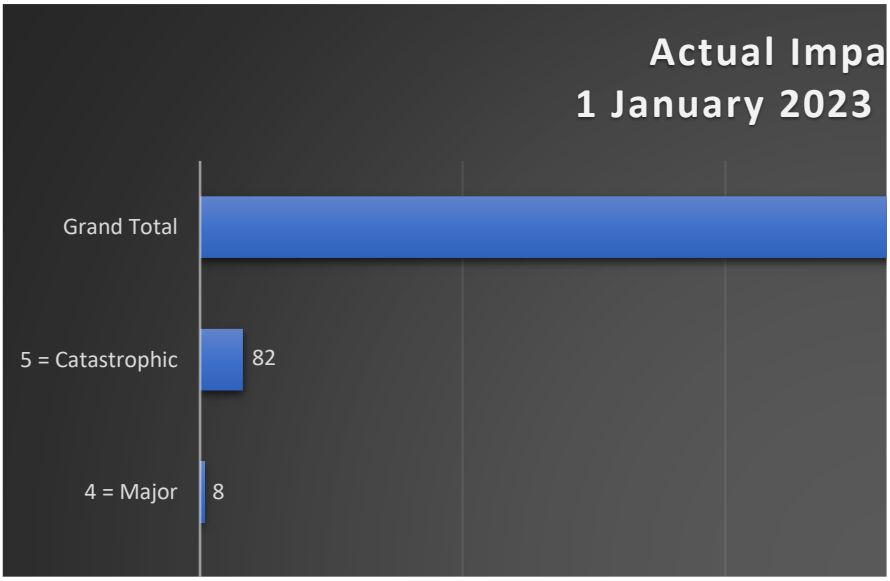


Table 2 - Actual impact of incidents being reported in Q4:



4.2 Daily Incident Safety Huddle (DISH) Learning Themes Q4

4.3 The DISH group, consisting of key individuals including the Patient Safety Specialist (chair), consultant nurse for Restrictive Practice, the Safeguarding team, the Health and Safety team, Physical Health leads and Pharmacy, reviewed 100% of incidents reported within 24 working hours in Q4. All incidents are individually reviewed, and quality checked in line with existing policy and standards.

Table 3 - Top 5 incidents since April 2021

Incident Type	April 2021 to March 2022	April 2022 to March 2023	Quarter 4 (Jan to Mar-23)
Exploitation Abuse	2963	2357	568
Medication	1234	994	203
Clinical Specific	902	1044	218
Moving & Handling	905	650	139
Slips Trips & Falls	810	696	184

4.4 Racial and Cultural Abuse incidents were primarily reported as patient to staff incidents in bed-based services (98%). The DISH noted an increasing trend toward offering staff and patients directly subjected to racial and cultural abuse debrief support and support to contact the police. Reported incidents are categorised by the DISH as either a potential hate crime or as a hate incident. All racial and cultural abuse is graded at minor (low harm) or above.

In Q4 92% of incidents were considered to be of a minor impact, suggesting they were primarily hate incidents rather than hate crimes.

A thematic review of these incidents suggests that very often racist language is used by the patient as a result of frustration due to their perception that they are being denied access to something material to them, such as cigarettes, section 17 leave or prohibited items that have been removed. In many other reported incidents racial and cultural abuse seems to have been associated with flash point circumstances where staff have been attempting to de-escalate aggressive or self-injurious behaviour.

The inclusion equality and engagement lead, in collaboration with the Directorates, held a series of safety huddles aimed at understanding how hate incidents and hate crimes can be tackled positively. Work has also been undertaken with the local community police team to ensure there is a joined-up understanding of when a police response to a hate incident or hate crime is required. Guidance on the management of hate incidents and hate crimes is now available for all staff on Jarvis.

4.5 Slips, trips and Falls accounted for 7% of all incidents reported in quarter 2, this increased to 10% in quarter 3 and reduced to 9% in quarter 4. 88% of the reported falls were from older people's services, with 65% of these being reported by the two older people's nursing homes. The current hotspot for falls is Birch Avenue Nursing home which reported 48% of all falls. In response to this, older people's services are engaged in a Quality Improvement project aimed at reducing falls in acute inpatients areas using the Huddling up for Safer Healthcare (HUSH) huddle methodology. The results and learning from this so far have been extremely positive and the Huddling up for Safer Healthcare (HUSH) huddle methodology is currently being implemented in the two nursing home services.

4.6 Actual Physical Assaults on patients accounted for 3% of all reported incidents in quarter 4 and this is a further decrease from the 5% reported in quarter 3. Actual physical assaults on staff accounted for 6% of all reported incidents in quarter 4.

The huddle continues to note a significant increase in the use of de-escalation techniques and staff and patient debriefs following these types of incidents. In addition, a Quality Improvement project is underway which is seeking to improve the process for debrief and formalise the reporting arrangements so that data can be more easily captured and monitored.

4.7 2% of all reported incidents were Sexual Safety incidents. 85% (35) of the incidents were reported by bed-based services. Where required sexual safety incidents resulted

in a safeguarding concern being raised. All of the incidents related to patient safety were categorised as negligible in their impact.

A thematic review of these incidents found that the most commonly reported incidents were related to sexualised comments, followed by disinhibited behaviour which required intervention to maintain the patient's dignity. There were two incidents of patient's reporting that they were sexually assaulted on the ward. These allegations were fully and robustly investigated and reported via the safeguarding adult's procedures. In both cases no evidence was found to support the claims.

4.8 Self-harming behaviour by patients in bed-based services has remained a consistent theme over all 4 quarters of 2022/23. In quarter 4 59% of all the Clinical Specific category of incidents were reported as self-harm. 54% of all self-harm incidents were reported by Dovedale 2 ward. A quality improvement project is underway to develop the 'response to self-harm risk' and this is being trialled on Dovedale 2 and Burbage Wards respectively.

4.9 The physical health and patient safety risk team continue to offer support in developing appropriate responses to patients self-harming by 'headbanging', including the development of a reduction safety plan for use with individuals. 99% of all self-harm incidents were reported as very low harm or no harm incidents but this does not account for potential psychological harm to the individual self-harming, staff and other patients.

4.10 Medication management incidents: as opposed to medication administration continued to be reported on a regular basis. As in quarters 2 and 3 the thematic trend reflects errors in procedural systems with only 9% of medication incidents overall leading to the patient being given the wrong dose or type of medication. Of this 9% there was no recorded physical harm to the patient and in all cases the basic requirements of the statutory duty of candour were implemented.

Section 5: Learning from Further Investigation

5.1 **Significant Event Analysis (SEA)**

SEA 1: Following a ligation incident on Maple Ward a patient had two seizures. Learning identified led to improved training and communication post ligation.

SEA 2: A resident at Birch Avenue sustained a minor head injury and fracture following a fall. The statutory duty of candour was followed. Learning identified a need for improvement in incident reporting techniques.

SEA 3: At G1 a potential Eliminating Mixed Sex Accommodation (EMSA) breach was reported. Whilst after further review the incident was found not to have breached regulations the team reviewed their approach to monitoring mixed sex areas and improved signage in the ward area.

SEA 4: During a Community Learning Disabilities home visit a client became aggressive with staff and family. A range of learning was identified that included:

- When clinical appointments are cancelled there will be an immediate communication cascade
- The role of Health Care Assistants in the service was reviewed and communicated to the team.
- Risk formulation was reviewed for home visits in order to ensure staff safety.

SEA 5: On Dovedale 1 a male patient entered a female only area and he looked in a female bedroom area via the viewing panel. The team reviewed their approach to EMSA, signage was improved and actions to make single sex areas more easily identifiable were undertaken.

SEA 6: The CERT reported that a patient was cared for in an out of city bed for an extensive period which limited the opportunity for family contact and leave to the home environment. Whilst ongoing bed pressure meant that the patient could not be immediately repatriated there is ongoing improvement work to reduce the number of out of area placements.

SEA 7: The flow coordination team identified that two service users were placed in out of area provision that did not meet SHSC's out of area guidance. As a result of the learning out of area guidance has been reviewed and fully updated by the flow coordination team.

5.2 **48hr Reporting**

5.3 Learning identified from the 48hr reports not taken forward for further investigation can be themed:

Theme 1: A resident living at Woodland View Nursing Home, was found on the floor injured. Woodland View is implementing HUSH huddles in order to reduce falls overall.

Theme 2: An email was sent to the SUN: RISE mailing list (54 members) with details of an upcoming meeting. As a result, work has been undertaken to gain individual consent for sending group emails and ensuring where consent is not given emails are sent individually.

Theme 3: A patient was transported with a secure transport provider and was wearing handcuffs. Learning identified that a less restrictive option for transport to the ward could have been negotiated in the community and that handcuffs should always be removed at the point of entry to the ward wherever practically possible.

Theme 4: A Safeguarding alert was raised by an ambulance crew arriving at Woodland View Care Home. When the crew arrived, they did not have access to a resident's care records. This safeguarding issue has been brought to the attention of senior managers within SHSC and we are now training agency workers in using insight to access and write notes.

Theme 5: Incoming shift saw an unidentified male on the ward. The male identified himself as a patients partner and said they had a booked visit. As a result, all of the team have been reminded of good practice guidelines for effective shift handover and potential safeguarding issues will be discussed as a standard item.

Theme 6: Staff on the unit received a telephone call informing them that their patient was in town at KFC walking towards the Park Square roundabout. As a result of this incident the leadership have formulated rules around observation which are consistent with Trust-wide policy.

Theme 7: A patient moved out of the city to take up residency in another area without an identified GP. Guidelines are being developed in order to mitigate this issue in the future.

5.4 **Learning from Serious Incident Investigations for Q3 2022/23**

5.5 Serious Incident investigations that were marked as completed and sent to the ICB from October 2022 to December 2022.

Notable Practice

5.6 In regard to notable practices the following was identified in relation to the Recovery teams the Liaison Psychiatry Team and the Crisis Resolution and Home Treatment Team:

- Good joint working between the teams involved in delivering care.
- The patient's wife contacted the Liaison Psychiatry Team expressing her gratitude towards the team for the care and treatment her husband received.
- The bereaved relative of a patient was placed under the Home Treatment Team and allocated a care coordinator before being referred on to the Recovery team. Individual risk following the suicide of a relative can significantly increase and immediate support, such as this, can be essential.
- It was clear that the care coordinator and both peer recovery workers involved were committed to working with the patient and were very supportive.

Lessons Learned and Actions

5.7 Themes, lessons learned and actions, investigations found the following:

- Investigation 1: Following the suicide of a patient receiving care from the Recovery Team and The Home Treatment the Home Treatment Team and related community teams are reviewing and formalising joint working processes and adequate handovers between teams.
- Investigation 2: Following the death of a patient from self-inflicted injuries the Older Adult Home Treatment Team have undertaken a range of learning actions to improve their communication processes.
- Investigation 3: Following the suicide of a patient receiving care from the Recovery Team reflective learning was undertaken to improve documentation and safety planning.

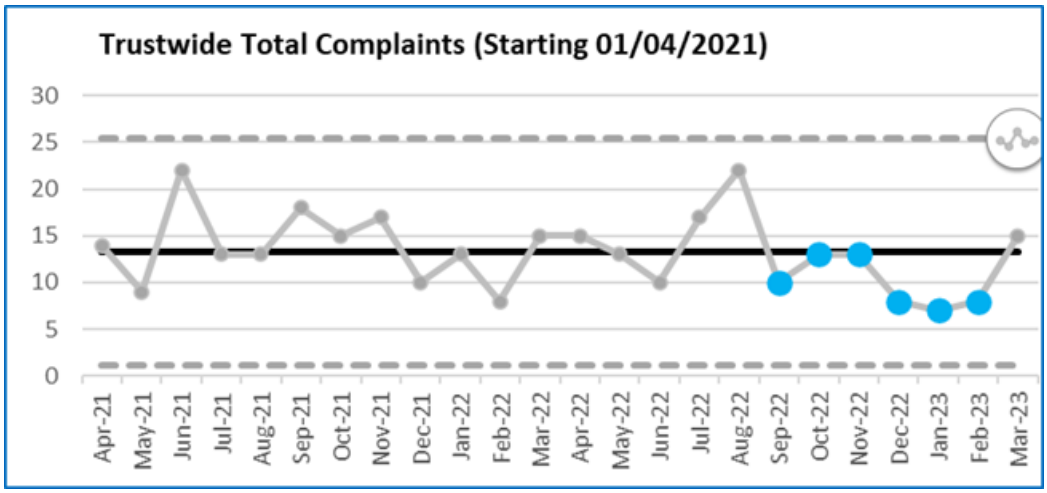
Section 6: Learning from Safeguarding Processes

- Two Domestic Homicide Review Overview Reports were submitted to the Home Office.
- In Q4 we raised a total of 4 Section 42 (2) Enquiries for SHSC service users and 7 enquiries have been closed. 1 enquiry was raised for service users in Out of City placement. 2 enquiries were closed with no further action required as the service user was safeguarded and no identified learning. 1 enquiry related to alleged actions of a staff member and that person has been supported through training and additional supervision.
- Two cases related to themes of alleged inappropriate restraint but after investigation and review by Respect colleagues, it was felt that necessary and proportionate restraint had been used by SHSC staff and transport staff had followed their own procedures, an after-action review was completed directly with the team.
- Other themes related to domestic abuse and risk assessments not being completed by staff following disclosure of abuse. Bitesize training has been delivered on domestic abuse and completion of the DASH risk assessment to the service area.

- During the quarter, actions previously identified in relation to sexual safety are being implemented and the bite sized teaching sessions for mixed gender wards have been completed over a 2-week period to reach as many staff as possible.

Section 7: Learning from Complaints

Table 4 - Formal complaints since April 2021



7.1 Twenty-eight formal complaints were received during quarter four (1 January 2023 to 31 March 2023), four less compared to quarter three (1 October 2022 to 31 December 2022). There were various complaint categories raised in quarter four. There was a backlog of complaints requiring quality assurance, due to Head of Nursing (HON) sign off being temporarily introduced as part of the quality assurance process during quarter four, and unplanned absence within the Complaints Team. The HON sign off process has since been removed. Twenty-eight complaints were closed in quarter four, eighteen less compared to quarter three, for these reasons.

7.2 The main complaint theme from quarter four relates to 'communications' (nine) and 'prescribing' (four). The key lesson learnt in quarter four is that we need to improve our communication with our service user's, their families and other services/teams. Examples of these are to clearly communicate decisions made regarding medication and treatment, explaining the out of city beds process when necessary and to return call-backs when requested or promised. Feedback has been provided to staff in question and bespoke training/support has been provided to help improve our service.

Table 5 – Complaints Themes

Complaint Categories	Q4 2022/23	Q3 2022/23
Communications	9 ↑	3
Access to Treatment or Drugs	6 ↓	11
Prescribing	4 ↑	2
Admissions and Discharges	2 ↑	1
Trust Policies	2 ↑	1
Values And Behaviours	2 ↓	4
Access to Records	1 ↑	-
Clinical Treatment	1 ↓	5
Other	1 ↓	2
Patient Care	- ↓	3

Section 8: Learning from Blue Light Alerts

8.1 Blue Light alert: The management of sharps processes. Rapid learning and action were undertaken following a recent increase in sharps incidents involving the passing of sharps between one individual to another which have resulted in sharps injuries to SHSC staff that were preventable.