Appendix 1

The following slides show statistical process charts of incidents that have been reported by our staff during April and May 2021

Any detail that requires further clarity please contact the Patient Safety Team

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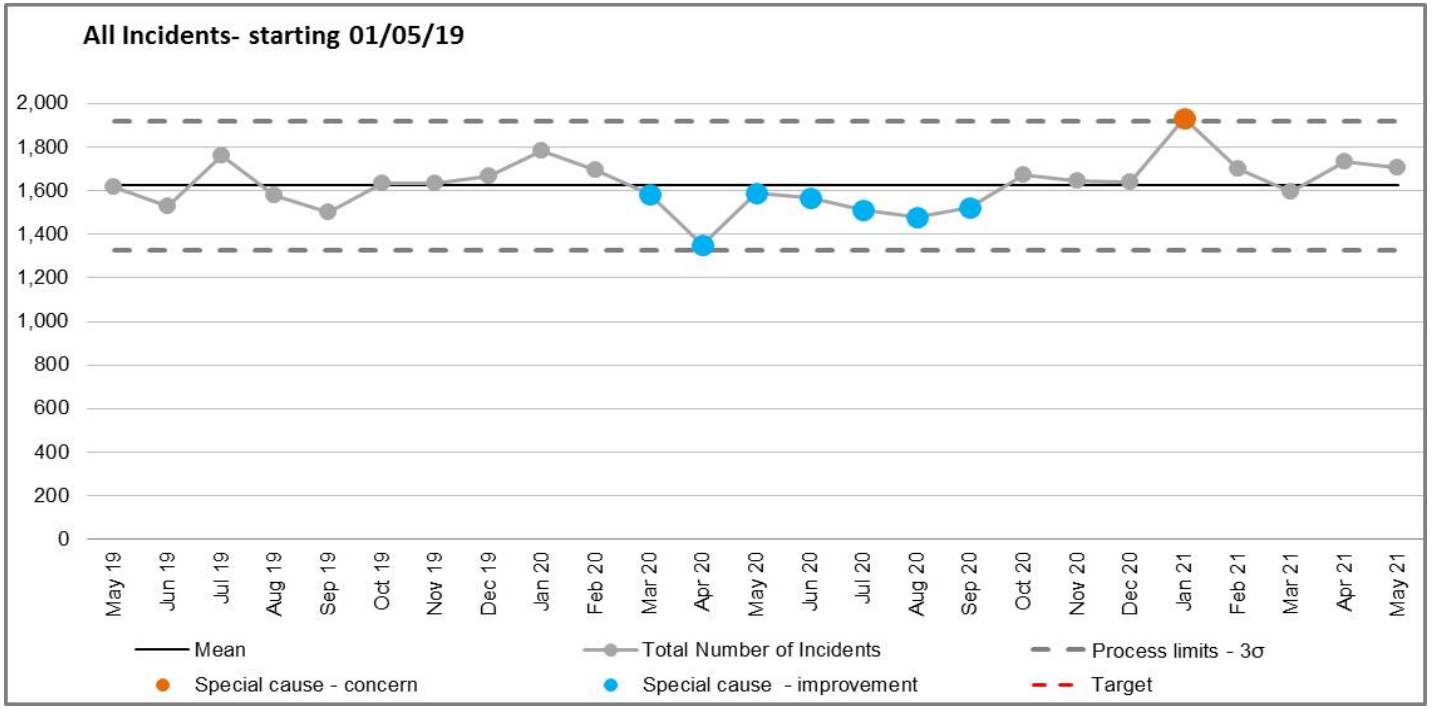
1. All incidents



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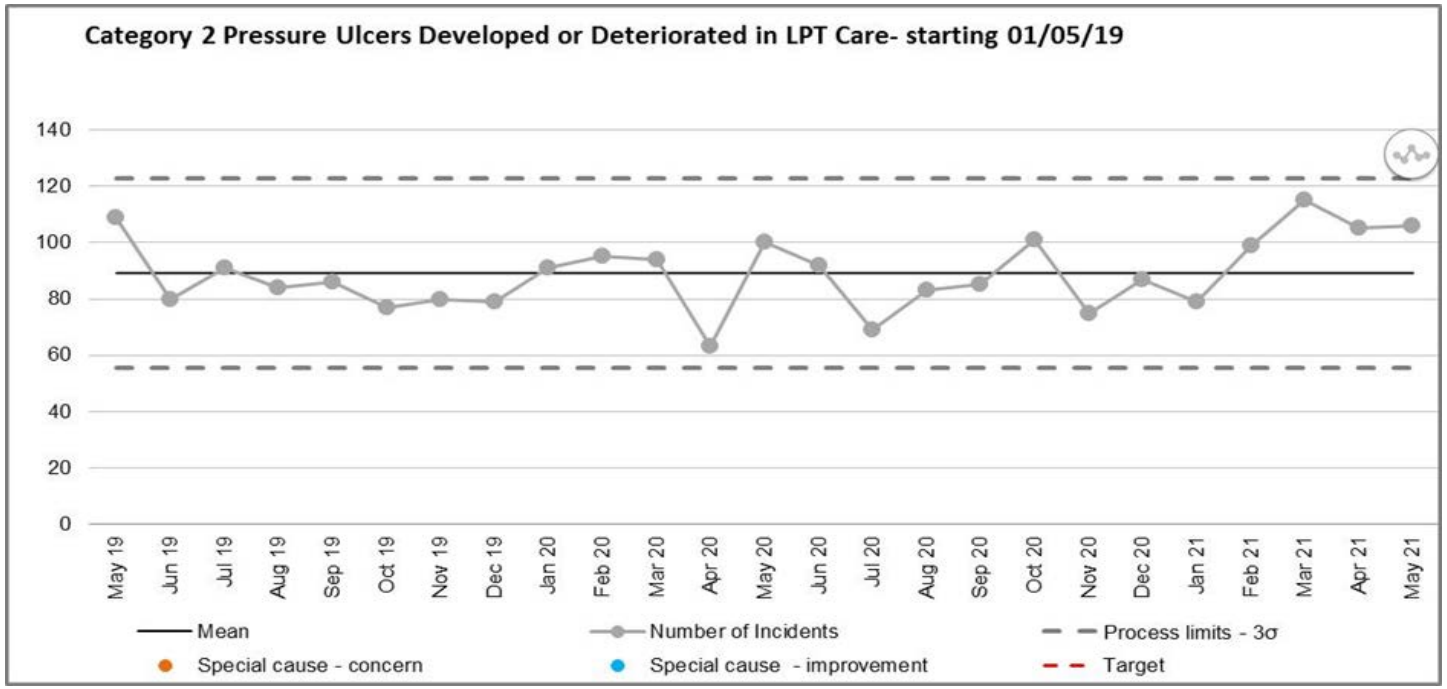
2. Category 2 pressure ulcers developed or deteriorated in LPT Care



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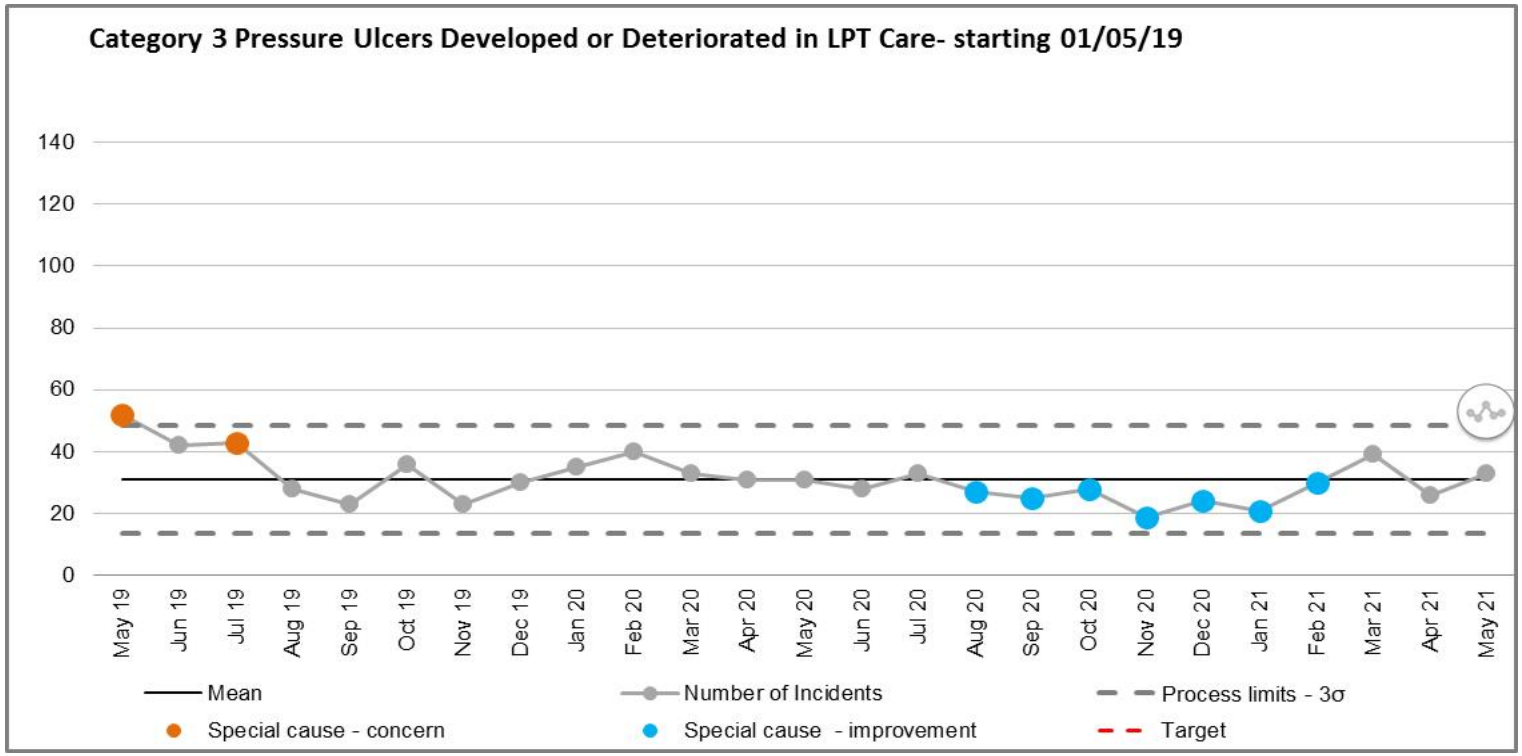
3. Category 3 pressure ulcers developed or deteriorated in LPT Care



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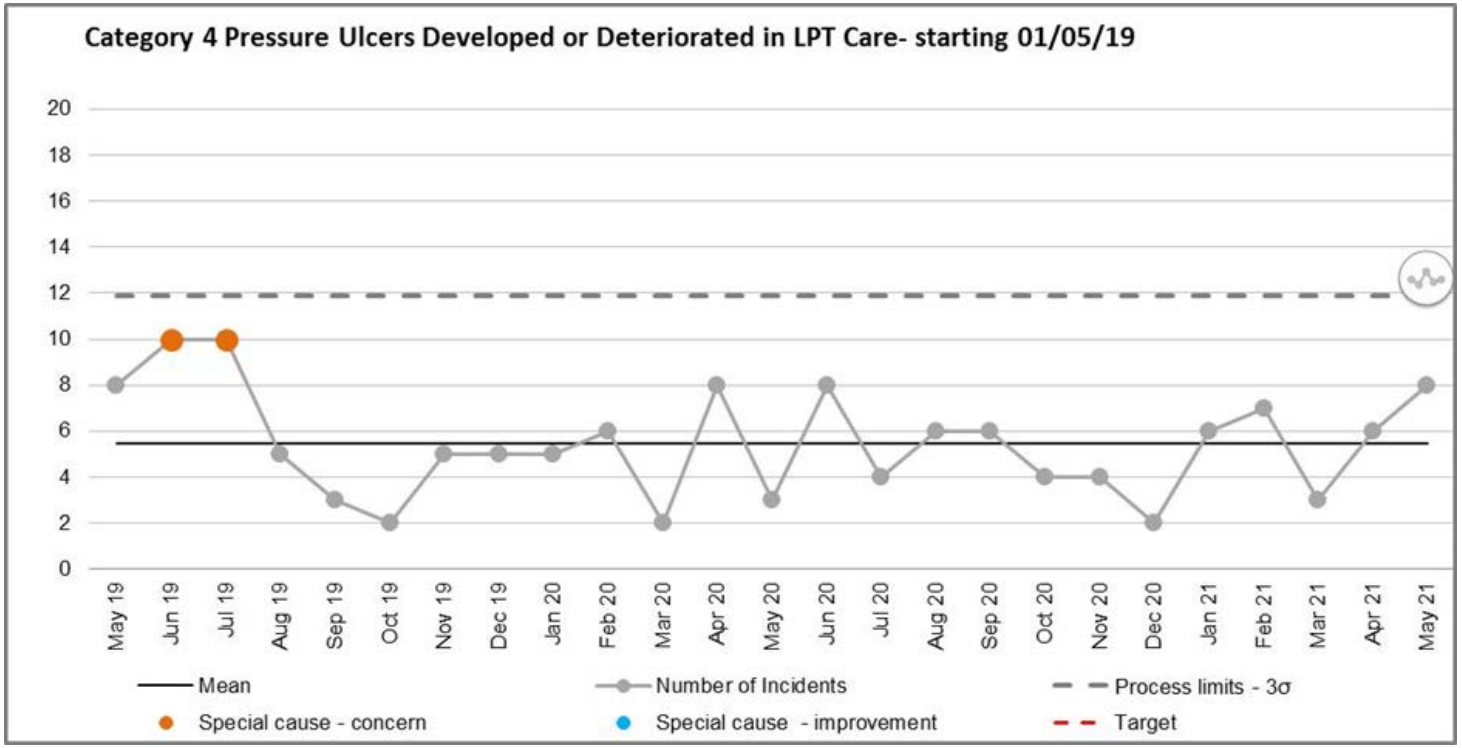
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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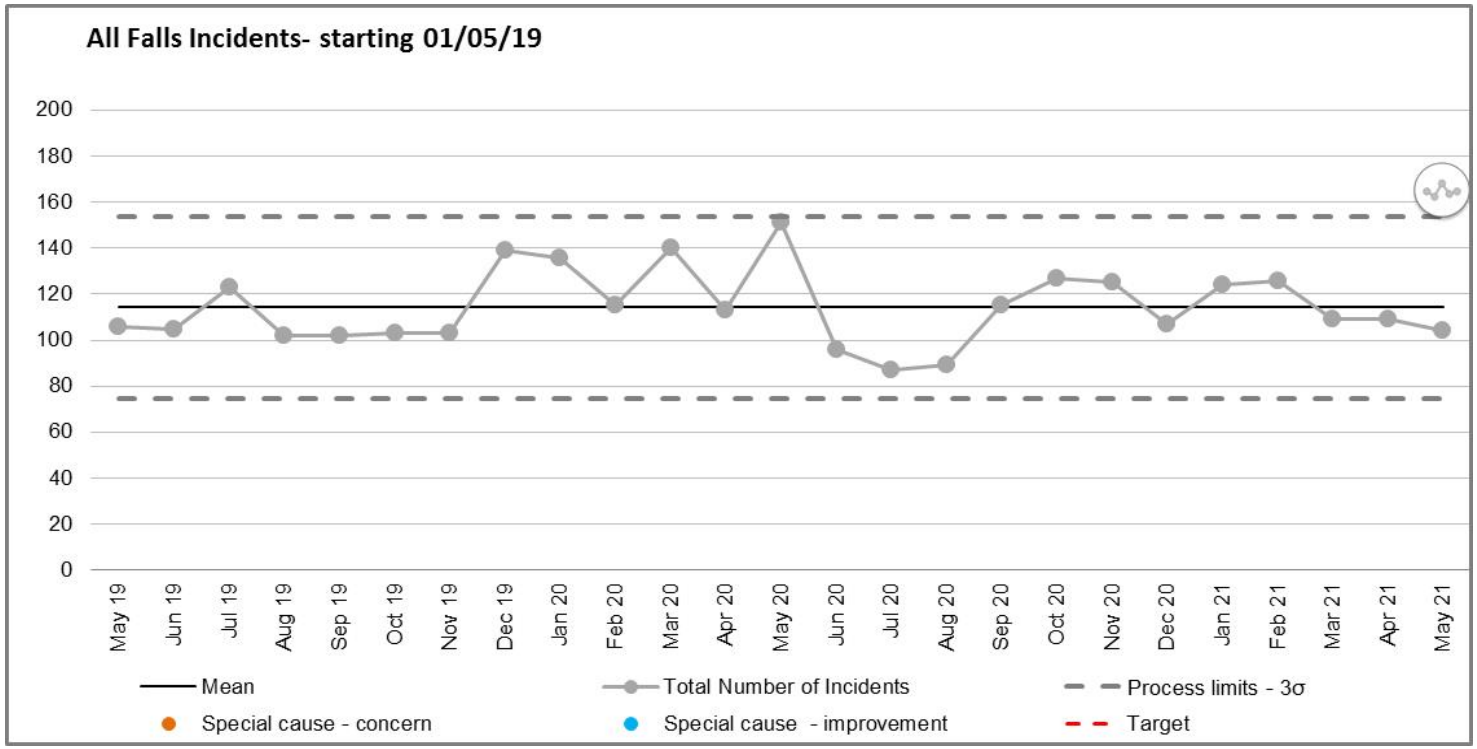
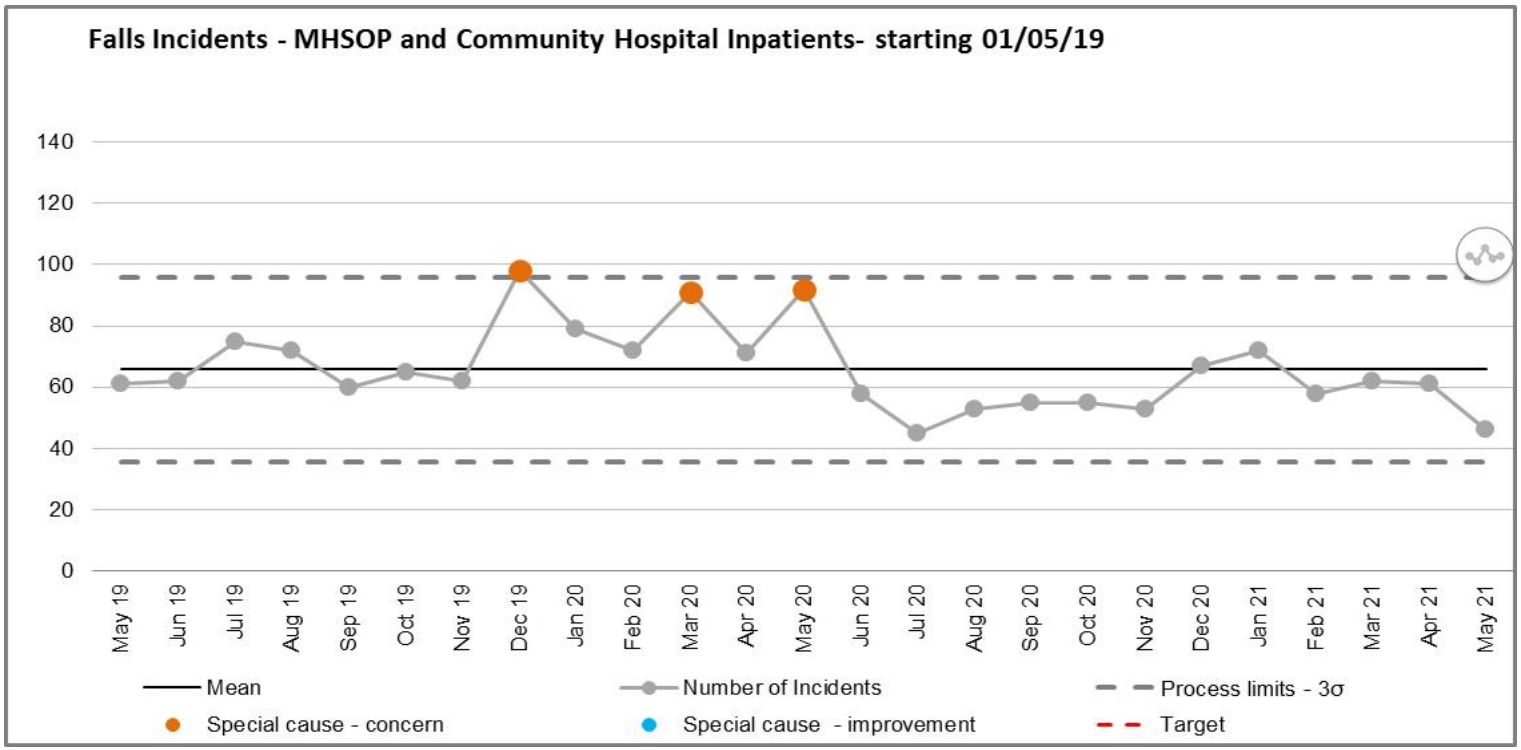
5. All falls incidents reported



6. Falls incidents reported – MHSOP and Community Inpatients



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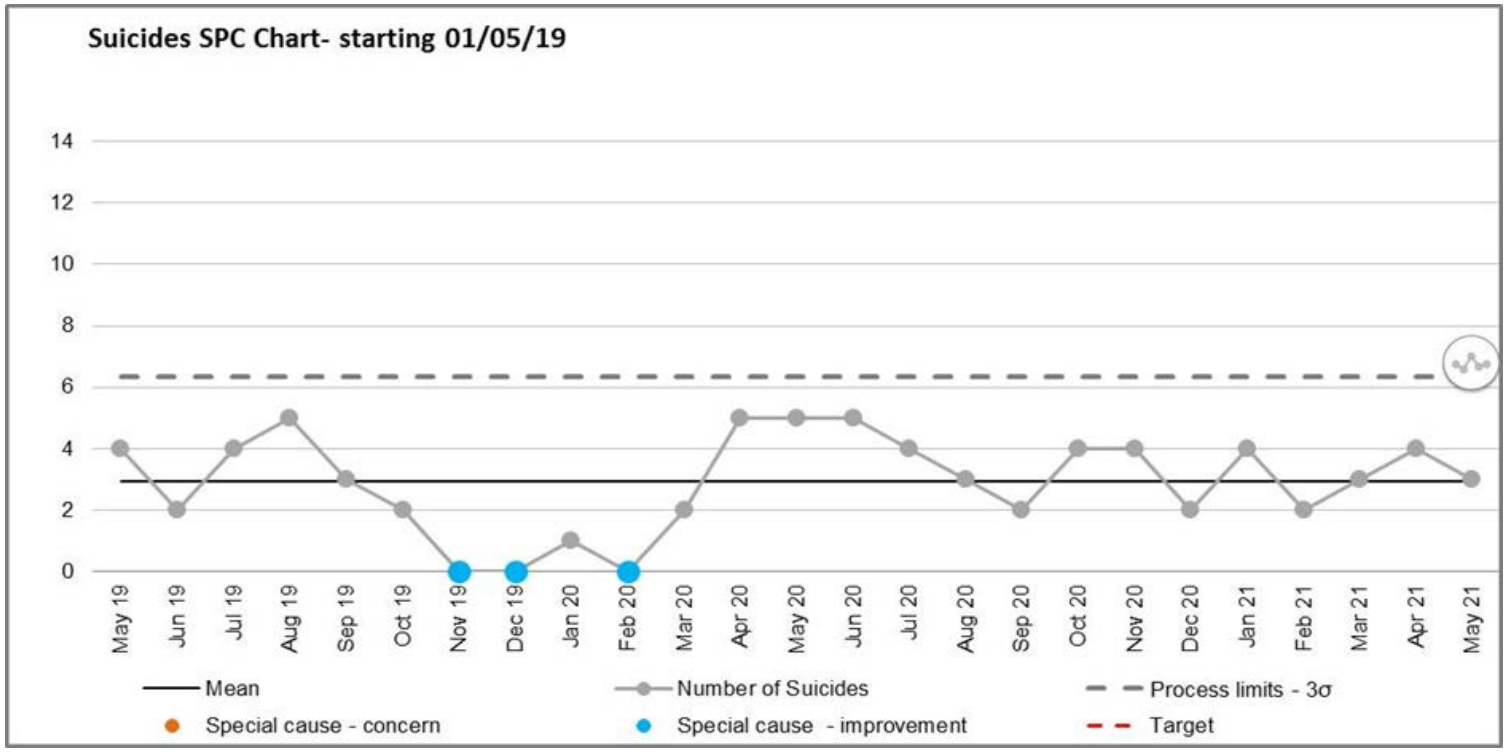
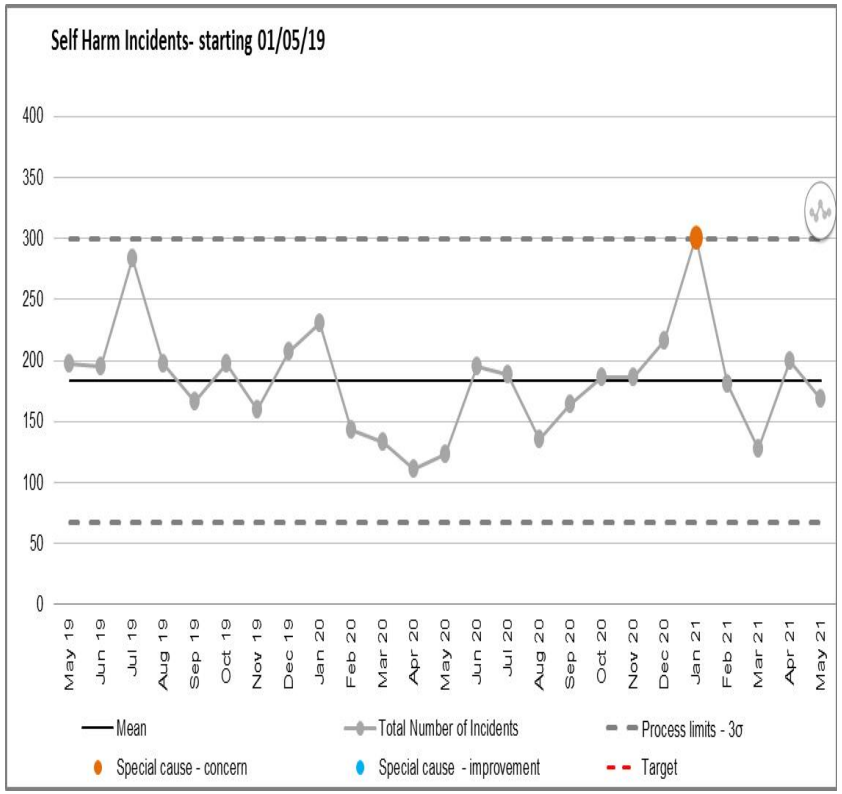
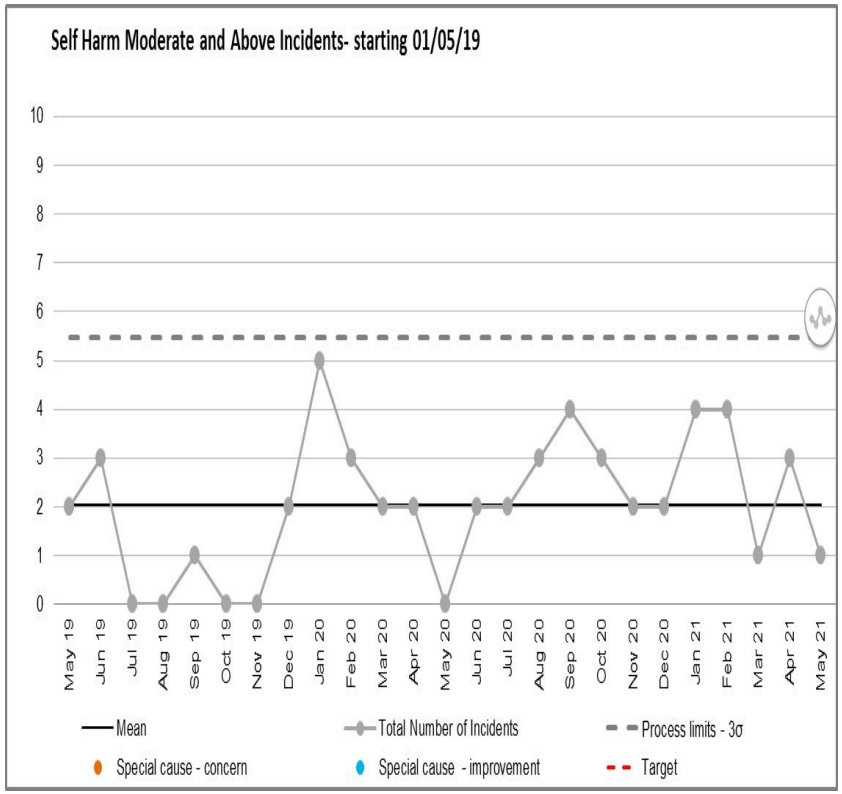
7. All reported suicides



8. Self harm reported incidents





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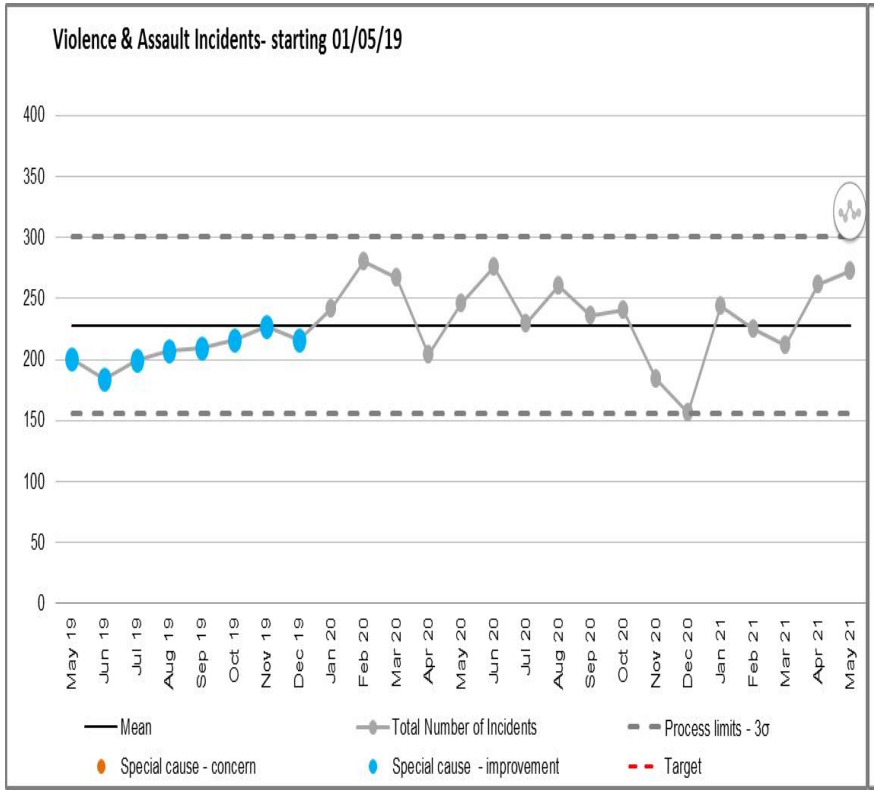
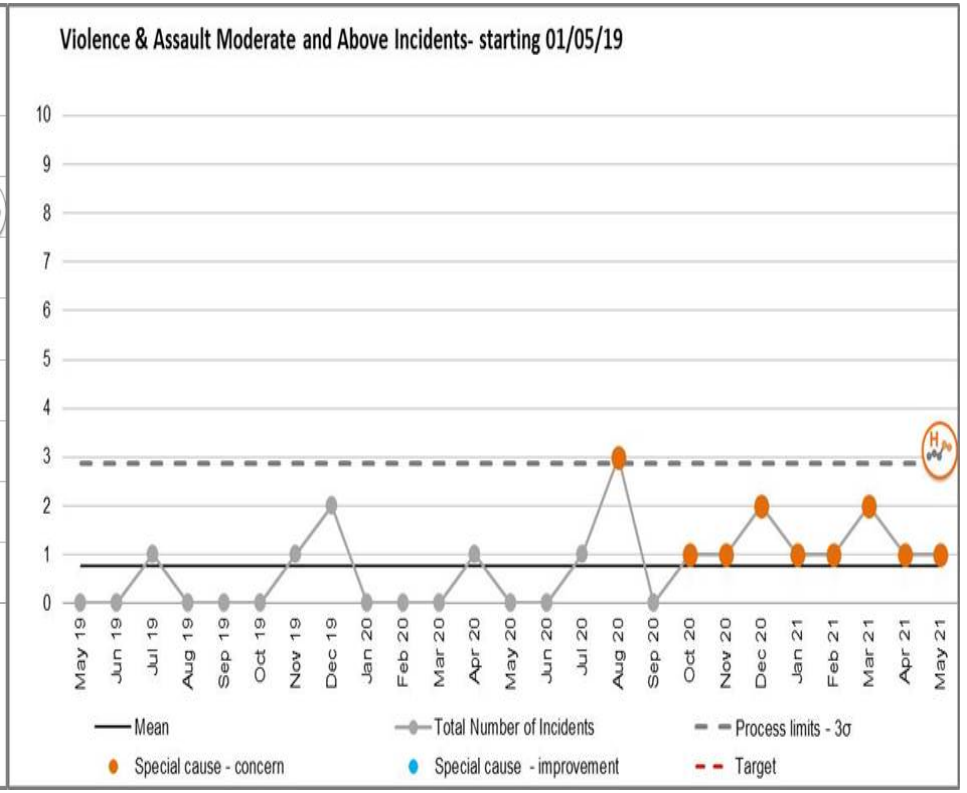
9. All violence & assaults reported incidents





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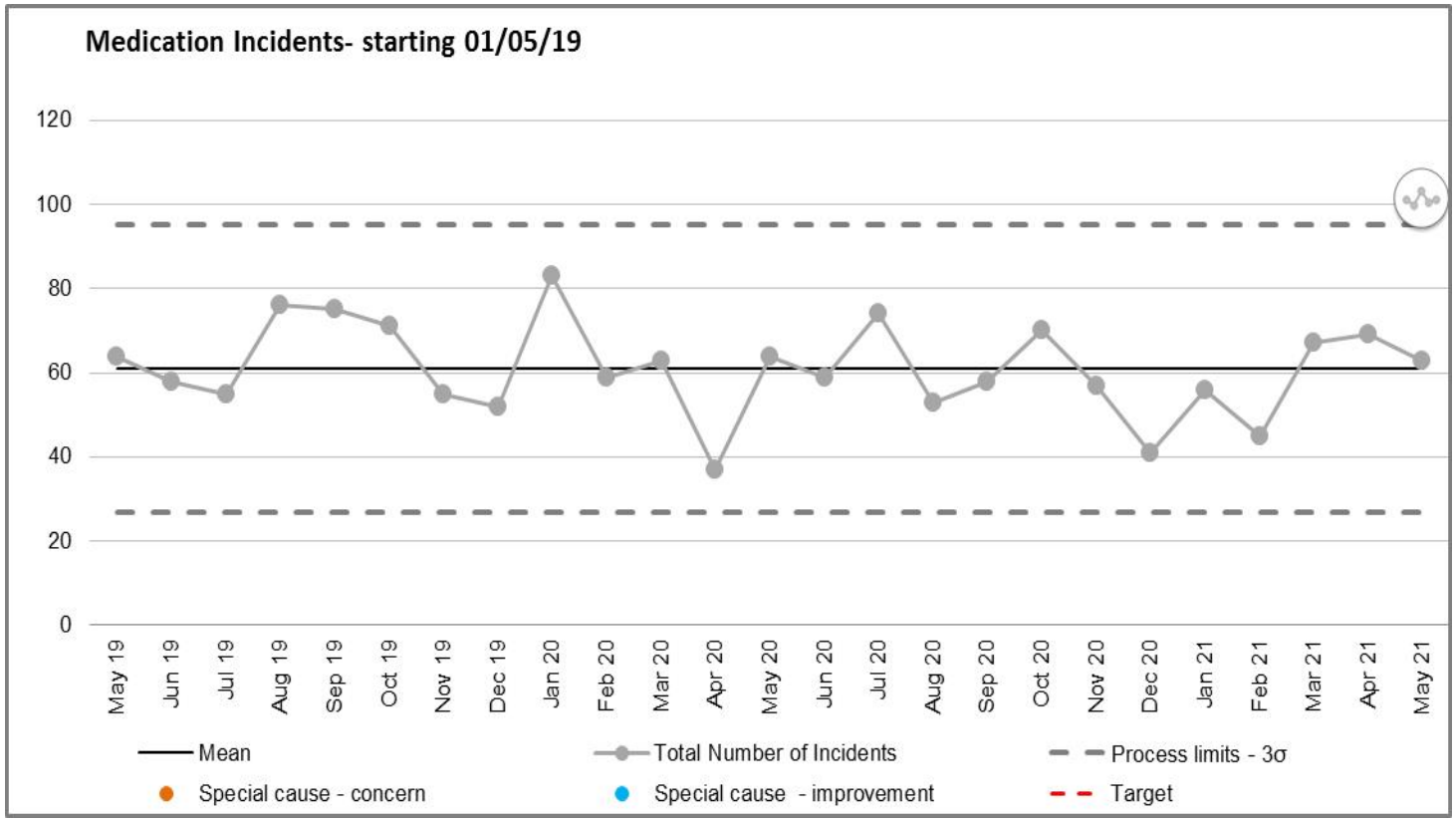
10. All medication incidents reported



11. Directorate specialities describing top 5 incidents

Table 1: Mental Health: Inpatients

Mental Health Non MHSOP Inpatient - April	
Cause Group	Total
Violence/Assault	151
Self Harm	60
Patient Falls, Slips, And Trips	33
Security	19
Clinical Condition	17

Mental Health Non MHSOP Inpatient - May	
Cause Group	Total
Violence/Assault	163
Self Harm	52
Patient Falls, Slips, And Trips	42
Security	35
Clinical Condition	18

Table 2: Mental Health Community

Mental Health Non MHSOP Community - April	
Cause Group	Total
Self Harm	50
Violence/Assault	28
Case Notes & Records	9
Clinical Condition	8
Safeguarding (Adults)	7

Mental Health Non MHSOP Community - May	
Cause Group	Total
Self Harm	40
Violence/Assault	31
Safeguarding (Adults)	16
Safeguarding (Children)	9
Patient Death	8

Directorate Specialities describing Top 5 Incidents

Table 3: MHSOP – Inpatients

MHSOP Inpatient - April	
Cause Group	Total
Patient Falls, Slips, And Trips	28
Violence/Assault	16
Medication	7
Clinical Condition	6
Tissue Viability	3

MHSOP Inpatient - May	
Cause Group	Total
Patient Falls, Slips, And Trips	20
Clinical Condition	10
Violence/Assault	10
Accident	8
Medication	5

Table 4: MHSOP – Community

MHSOP Community - April	
Cause Group	Total
Patient Death	7
Safeguarding (Adults)	5
Self Harm	3
Communication	2
Infection Control	2
Violence/Assault	2

MHSOP Community - May	
Cause Group	Total
Patient Death	13
Self Harm	4
Case Notes & Records	2
Communication	2
Patient Falls, Slips, And Trips	2

Directorate specialities describing top 5 incidents

Table 5: Learning Disability – In-Patient

LD Agnes Unit - April	
Cause Group	Total
Violence/Assault	60
Clinical Condition	5
Self Harm	5
Allegations Against Staff	2
Clinical Assess. (Diag, Scans, Tests)	2
Hate/PREVENT Incident	2
Safeguarding (Adults)	2
Security	2

LD Agnes Unit - May	
Cause Group	Total
Violence/Assault	72
Hate/PREVENT Incident	4
Patient Falls, Slips, And Trips	3
Self Harm	3
Accident	2
Medication	2

Table 6: Learning Disability - Community

LD Community - April	
Cause Group	Total
Safeguarding (Adults)	9
Self Harm	8
Violence/Assault	7
Patient Death	3
Safeguarding (Children)	3

LD Community - May	
Cause Group	Total
Self Harm	9
Violence/Assault	9
Case Notes & Records	5
Safeguarding (Adults)	5
Communication	4

Directorate Specialities describing Top 5 Incidents

Table 7: FYPC Inpatient CAMHS

FYPC CAMHS Inpatient - April	
Cause Group	Total
Self Harm	81
Violence/Assault	11
Security	6
Missing Patient	3
Allegations Against Staff	2
Unsafe Environment	2

FYPC CAMHS Inpatient - May	
Cause Group	Total
Self Harm	60
Staffing	5
Allegations Against Staff	4
Clinical Condition	3
Violence/Assault	3

Table 8: FYPC non LD Non CAMHS

FYPC Non LD Non CAMHS - April	
Cause Group	Total
Case Notes & Records	2
Security	2
Self Harm	2
Violence/Assault	2
Confidentiality	1

FYPC Non LD Non CAMHS - May	
Cause Group	Total
Security	3
Safeguarding (Children)	2
Unsafe Environment	2
Access, Admission, Appts, Xfer, Discharge	1
Accident	1

Directorate Specialities describing Top 5 Incidents

Table 10: CHS In-Patient

CHS Inpatient - April	
Cause Group	Total
Tissue Viability	36
Patient Falls, Slips, And Trips	33
Patient Death	16
Medication	10
Infection Control	7

CHS Inpatient - May	
Tissue Viability	50
Patient Falls, Slips, And Trips	26
Patient Death	6
Non-Medical Equipment	5
Infection Control	4
Staffing	4
Violence/Assault	4

Table 11: CHS Community

CHS Community - April	
Cause Group	Total
Tissue Viability	489
Medication	11
Safeguarding (Adults)	11
Non-Medical Equipment	7
Patient Falls, Slips, And Trips	7

CHS Community - May	
Cause Group	Total
Tissue Viability	479
Medication	19
Case Notes & Records	11
Access, Admission, Appts, Xfer, Discharge	9
Safeguarding (Adults)	9

12a. StEIS Reported Serious Incidents (SI's)

2021/2022 - STEIS Notifications and Internal Investigations

		StEIS Notification	SI INVESTIGATIONS					Internal Investigations		
		Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	Confirmed DoC breaches	DMH	FYPC/LD	CHS
2021/22 Q1	April		11	2	2	5	3	4	2	6
	May		4	0	1	4	3	2	1	3
	June									
2021/22 Q2	July									
	August									
	September									
2021/22 Q3	October									
	November									
	December									
2021/22 Q4	January									
	February									
	March									
YTD			15	2	3	9	6	6	3	9

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12b. Directorate SI Action Plan Compliance Status 2020/21 to date

	Overall Trust Position						
	Total SI (Other) Action Plans due to be Implemented	Total SI (Other) Action Plans Implemented	Total SI (Pressure Ulcer) Action plans due to be Implemented	Total SI (Pressure Ulcer) Action plans Implemented	% Total SI Action Plans Implemented by Month	% Total SI Action Plans Implemented YTD	% Quarterly
Apr-21	5	1	0	0	20.00%	20.00%	
May-21	14	2	0	0	14.29%	15.79%	15.79%
Jun-21	0	0	0	0	-	15.79%	
Jul-21	0	0	0	0	-	15.79%	
Aug-21	0	0	0	0	-	15.79%	#DIV/0!
Sep-21	0	0	0	0	-	15.79%	
Oct-21	0	0	0	0	-	15.79%	
Nov-21	0	0	0	0	-	15.79%	#DIV/0!
Dec-21	0	0	0	0	-	15.79%	
Jan-22	0	0	0	0	-	15.79%	
Feb-22	0	0	0	0	-	15.79%	#DIV/0!
Mar-22	0	0	0	0	-	15.79%	
Total YTD:	19	3	0	0	15.79%	15.79%	

12. Learning

Serious Incidents Emerging Themes

Patients with complex Learning Disability

For patients with complex learning disability and being cared for by multiple teams it is sometimes difficult for staff to recognise that the situation may have deteriorated sufficiently to need additional support. **Action** –reflection and learning is taking place to ensure that there is adequate supervision and ensure escalation to appropriate support.

Deteriorating Patients

NEWS 2 protocols are not always adhered to and therefore sepsis screening not always considered early **Action** –trust wide task and finish group is meeting to strengthen NEWS 2 training with oversight by the resus and deteriorating patient group

Management of diabetes

There have been some incidents where patients recorded results have not resulted in appropriate action to manage their diabetes. **Action** District Nursing teams are strengthening their responsibility to act on abnormal results and ensuring they have guidance from GP's re parameters. DMH have also shared very helpful guide for staff in relation to recognising when to escalate

12. Lessons Learned

Management of venous thromboembolism risk (VTE)

- There has been positive evidence that learning has been embedded in relation to the risk of patients having reduced mobility in relation to their mental health rather than a physical reason and this is being considered by staff. This has been evidenced in unrelated SI reports describing re assessment when reduced mobility noted and by a reported increase in the use of prophylaxis.

Patients use of bedrails and low beds

- There has been a noticeable shift in the decision making to use low beds or bedrails for patients which has been seen in investigation reports coming through. Staff have documented their assessment of risk and rational for decision making.