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Leicestershire Partnership NHS Trust

Trust Board Patient Safety Incident and Incident Learning Assurance Report January 2024

Purpose of the report

This report for November and December 2023 provides assurance on LPTs incident management and Duty of Candour compliance processes. The process reviews systems of control which continue to be robust, effective, and reliable underlining our commitment to the continuous improvement of keeping patients and staff safe by incident and harm reduction. The report also provides assurance on 'Being Open', numbers of incident investigations, themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the issue

Teams are working together to continuously improve our ability to review and triangulate incidents with other sources of quality data with the data we have available.
The quality of our data and the ability to triangulate this data is essential to the culture of continuous improvement. Opportunities are being explored to both internally and externally consider options to improve this data and provide more sensitive and easier to use data that is available closer to teams.

The culture move is towards a 'problem sensing and not comfort seeking' mind set, characterised by actively seeking out weaknesses in the system from multiple data sources and seeking any evidence that there is an incipient risk of complacency. This culture is supported through inviting staff to share concerns and ideas to improve rather than waiting to feel they need to 'speak up'; this will also support staff to feel psychologically safer.

It is proposed that future reporting will include a deep dive review into one of the key areas of patient safety improvement work – this will provide the opportunity for six deep dives across the year. The falls group have commenced this process.
The proposed subjects are

1. Falls
2. Pressure Ulcer prevention
3. Suicide and self harm prevention
4. Least restrictive practice
5. Violence and Aggression
6. Medicines safety

Patient Safety Strategy (NHSE 2019)

Patient Safety Partners (*involving everyone*)–
Partners are undergoing their induction phase, including understanding current patient safety priorities and meeting teams Our patient safety partners will also support our embeddedness of the Strategy through representation in our safety committees. This will initially be the Patient Safety Improvement Group (PSIG) and Quality Forum (QF). This will enable an overview of the QI improvement work and offer opportunity to volunteer to be involved in work where they feel they can add value.

Change Leaders – (***importance of culture***)
The first meeting with our change leaders in relation to our psychological safety work has supported discussions about the first piece of work to undertake, which will be to agree a definition for psychological safety within the Trust.

Patient Safety Incident Response Framework (PSIRF) –

Progress since implementation on the 1st November:

- Continue to build on processes and agree the detail of new policies
- Working to build capability and confidence in relation to 'thinking system'
- Preparing those with oversight responsibility for their new role

Investigation compliance with timescales set out in the current serious incident framework – Challenges continue with compliance with timescales; this is however an improving picture (see graphs in slides). Now reporting on this data weekly to demonstrate progress.

Analysis of Patient Safety Incidents reported - Appendix 1 contains Statistical Process Control (SPC) charts utilising the NHSI Toolkit to support the narrative and analysis and local speciality incident information. The overall position is also included for all investigations and action plans.

All incidents reported across LPT - Incident reporting should not be seen as a good single indicator of safety in the clinical environments; however, these can provide an early indication of incident change in specialities or even across the Trust or a wider healthcare system.

Review of Patient Safety Related Incidents - The overall numbers of all reported incidents continue to sit just above or on the mean and can be seen in our accompanying appendices.

Pressure Ulcers - Patients affected by pressure ulcers developed whilst in LPT care – Normal variation continues in the number of Category 2, 3 and 4 pressure ulcers developed or deteriorated in our care. An overview of the Quality Improvement programmes to date and outcomes to be reviewed and presented to the Trust Strategic Pressure Ulcer Group in February 2024. Building on Pressure Ulcer Prevention NICE quality standards/metrics and learning, the group will redefine pressure ulcer prevention quality metrics and patient outcomes for measurement by Trust, Directorate, and community nursing hub for launch in quarter 1 2024.

Falls Incidents - The falls group have provided a deep dive (please see attached slides)

Deteriorating Patients - Work continues on finalising the DPRG policy and directorates addendums for sign off. Stimulated from early learning from investigation work being undertaken from one incident, , there has been conversations and meetings looking at better partnership working with the UHL cardiac arrest teams to aid access and easy of passage through the unit during emergencies. These conversations have enabled a focus on trying to find solutions between the two organisations. Work continues with the VTE policies for each directorate, alongside the early learning from the current investigation. There has been an appointment of a new consultant nurse in CHS who has agreed to take the lead with the Trust sepsis work. Collaborative work with NHFT around NEWS 2 improvement has also progressed and initial surveys and baseline studies are being commenced.

Groups related to self-harm and suicide prevention:

The trust self-harm and suicide prevention group- The group have considered the key priorities and developed a matrix to assess areas of further work by self-assessment against the recently published NHSE Suicide Prevention Strategy and NCISH self-harm toolkit. A new suicide and self-harm prevention lead has been appointed who will lead, report and evaluate this plan.

MH Safe and Therapeutic Observations Task and finish group

The group consists of 5 work streams:

1. Learning from Incidents / SI's / CQC enquires / Complaints.
2. Engagement and co-production – patients, staff and carers.
3. Training and competency Assessments
4. Recording incidents.
5. Creating Best Practice Guidance

During October 2023, the Recording Incidents and Creating Best Practice group agreed a revised handover guidance including the role of the nurse in charge in assessing the skill mix of staff on duty to carry out observations competently. The Engagement workstream presented the finding from the staff, patient and carer surveys/ focus groups which will feed into other workstreams. The group is closely linked to the NHFT/LPT MH Observation Improvement Collaborative, and 3 areas have been identified for quality improvement projects:

- Inpatient pathway review – acute care
- Nighttime observation – safety vs therapeutic relationship and sleep hygiene
- Training and competences/use of technology

The projects will be developed in a session in November 23 with change ideas being commenced in January 24.

Medication incidents and Medication Safety - Work is ongoing to align the model with the patient safety strategy and to ensure there is appropriate oversight of data and reporting in from Directorates. Key areas for review are management and administration of controlled drugs and 'critical drug' omissions. The role of Medicines Safety Officer (MSO) is being progressed which is is essential to build on the improvement work in relation to medicines safety.

Review of attendees at the three key medicines groups, risk reduction, Audit and Quality Improvement and Medicine Management has been completed, with a considered review of each group terms of reference.

Integrated Care Boards/Collaboratives/Commissioners/Coroner/CQC – Continue to update Commissioners and CQC with any significant incidents that have occurred even though they will not be formally reported as an SI and ongoing work with all commissioners to appropriately update on our transition to PSIRF. This includes understanding how trust will algin assurances, as we move away from relying on the review of Serious Incidents.

Learning from Deaths (LfD) – Ongoing work to improve access to patients Equality and Diversity data and validation of data received in relation to deaths that are in scope for review. Family feedback is key to learning from deaths and our bereavement specialist nurse is providing rich information for learning in relation to the aspects of our care that families are appreciative of and areas that we can improve. Further work is ongoing exploring ways we can proactively hear from patient's relatives.
The Medical Examiner process is being extended to Primary Care, this extension of the

process will provide improved access to the data for our patients cause of death and therefore opportunity for learning.

Patient Stories/Sharing Learning - Patient stories are used to share learning and it is important that we learn from both when things go well and not so well Trust-wide to ensure focused learning is part of our culture and new way of thinking. Evidence suggests that staff learn better from patient stories, and we are working to ensure our stories are based on system thinking and human factors. The appendices illustrate stories provided by directorates which have been shared within Improvement Groups for cross trust learning, based on human factors and therefore transferrable.

Decision required.

- Review and confirm that the content and presentation of the report provides assurance around all levels and categories of incidents and proportionality of response.
- Be assured systems and processes are in place to ensure effective investigations are undertaken that identify appropriate learning.
- To enable sighting of the Senior Trust team of emerging themes, concerns through incident reporting and management and patient safety improvements.

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward, Head of Patient Safety	
Date submitted:	January 2024	
State which Board Committee or other forum within the Trust's governance structure.	PSIG-Learning from Deaths-Incident oversight	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	Assurance of the individual work streams are monitored through the governance structure	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust Wide QI	X
Organisational Risk Register considerations:	List risk number and title of risk	1. Trust's systems and processes and management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient. 2. Trust may not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

Appendix 1

The following slides show Statistical Process Charts of incidents that have been reported by our staff during November & December 2023

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

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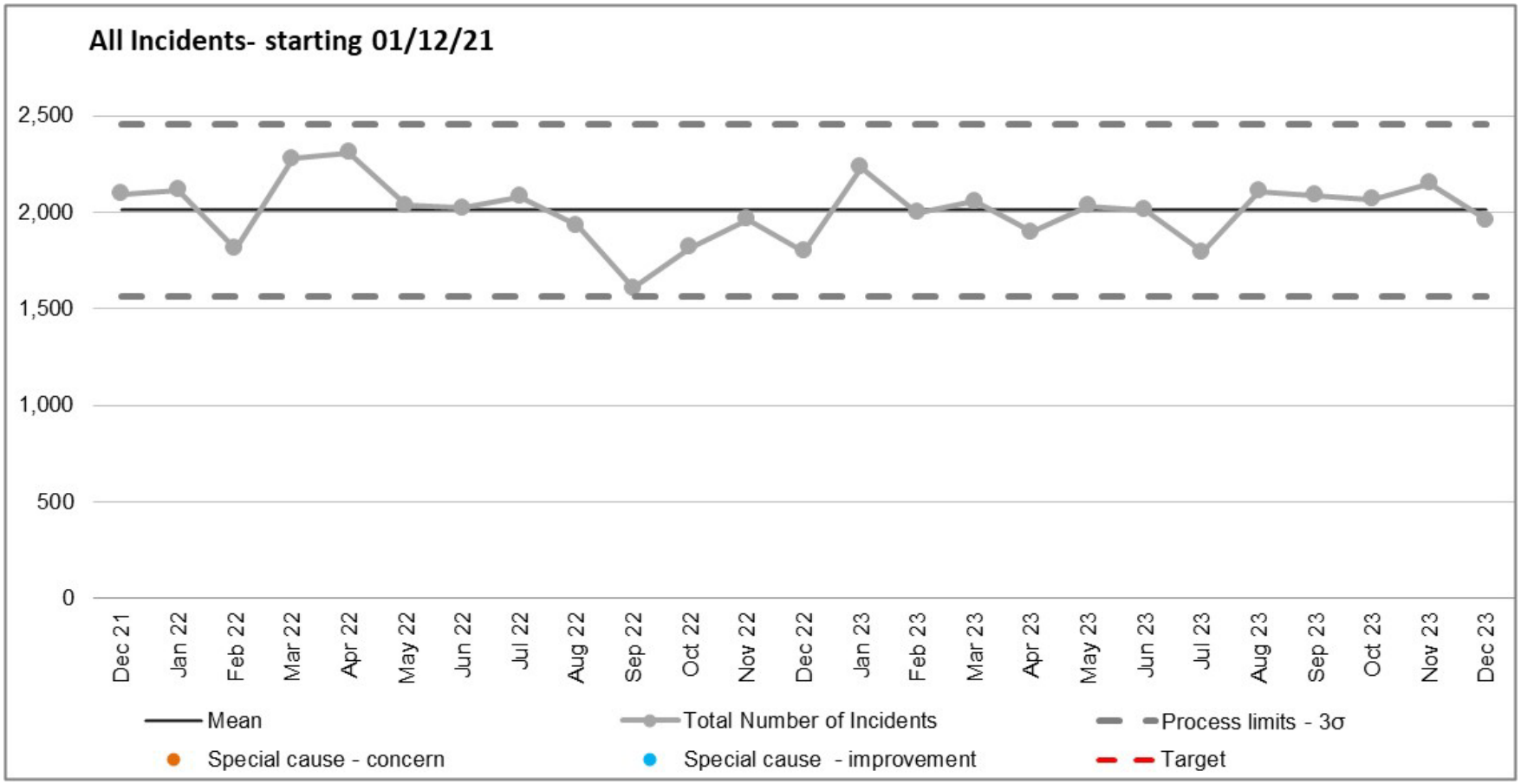
1. All incidents



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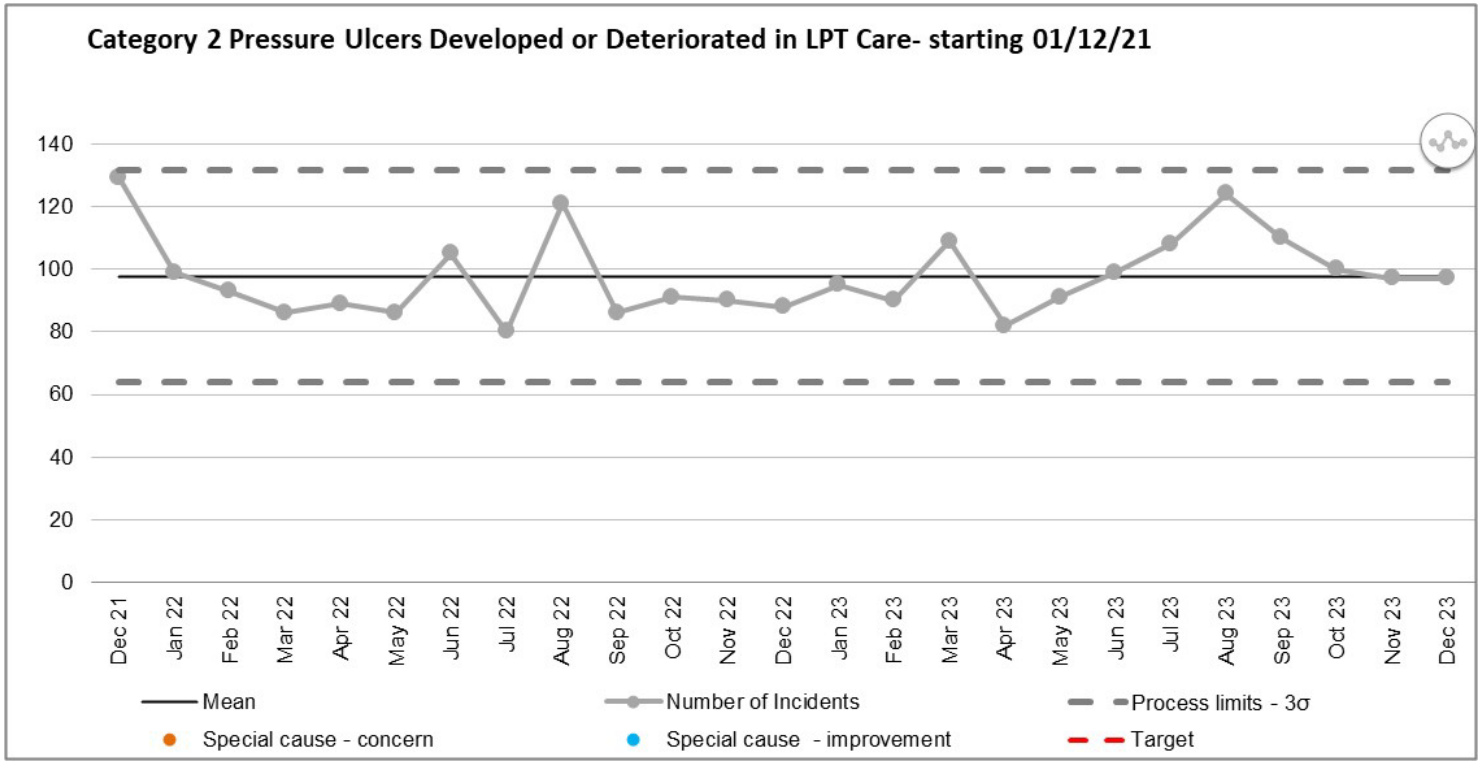
2. Category 2 Pressure Ulcers developed or deteriorated in LPT Care



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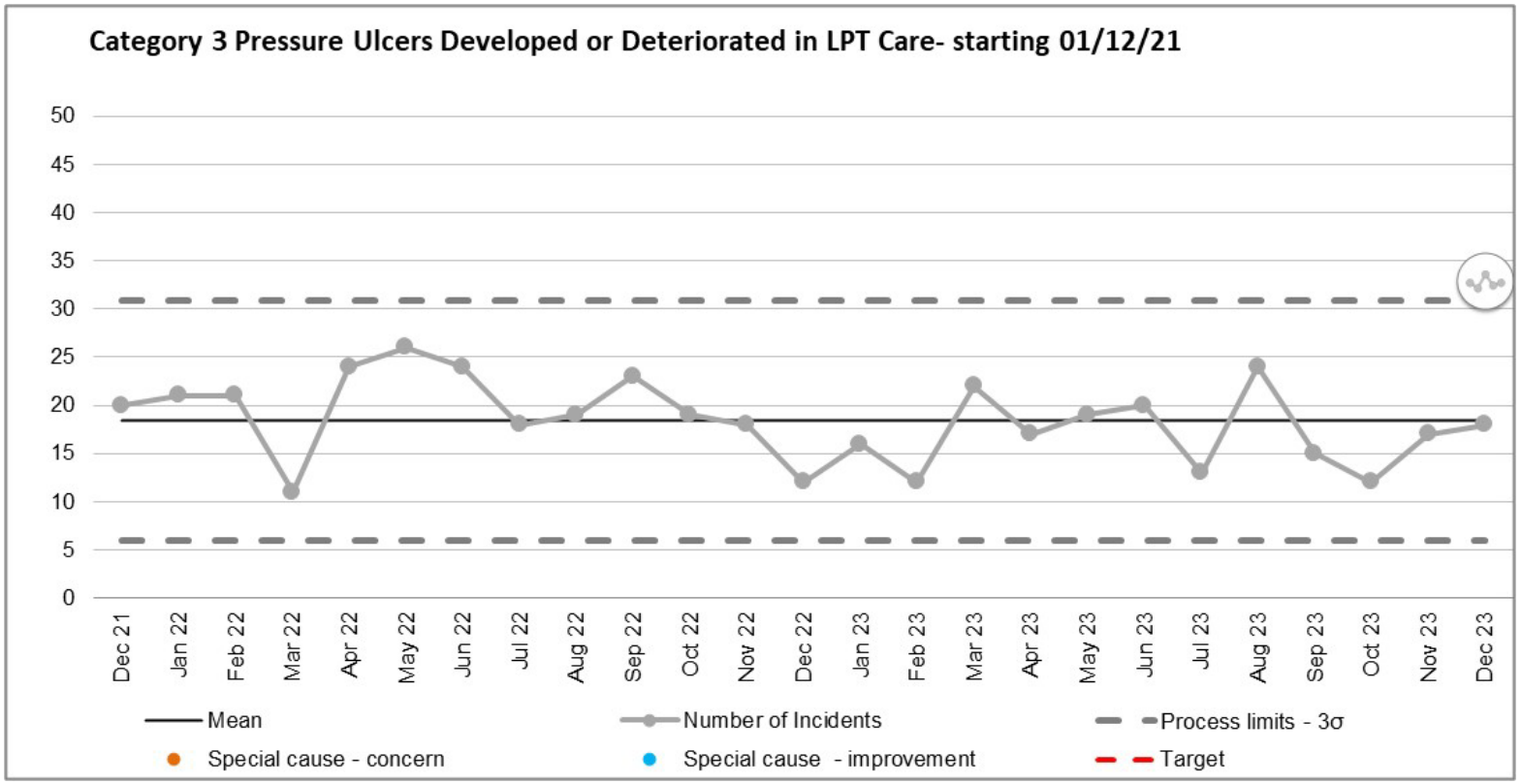
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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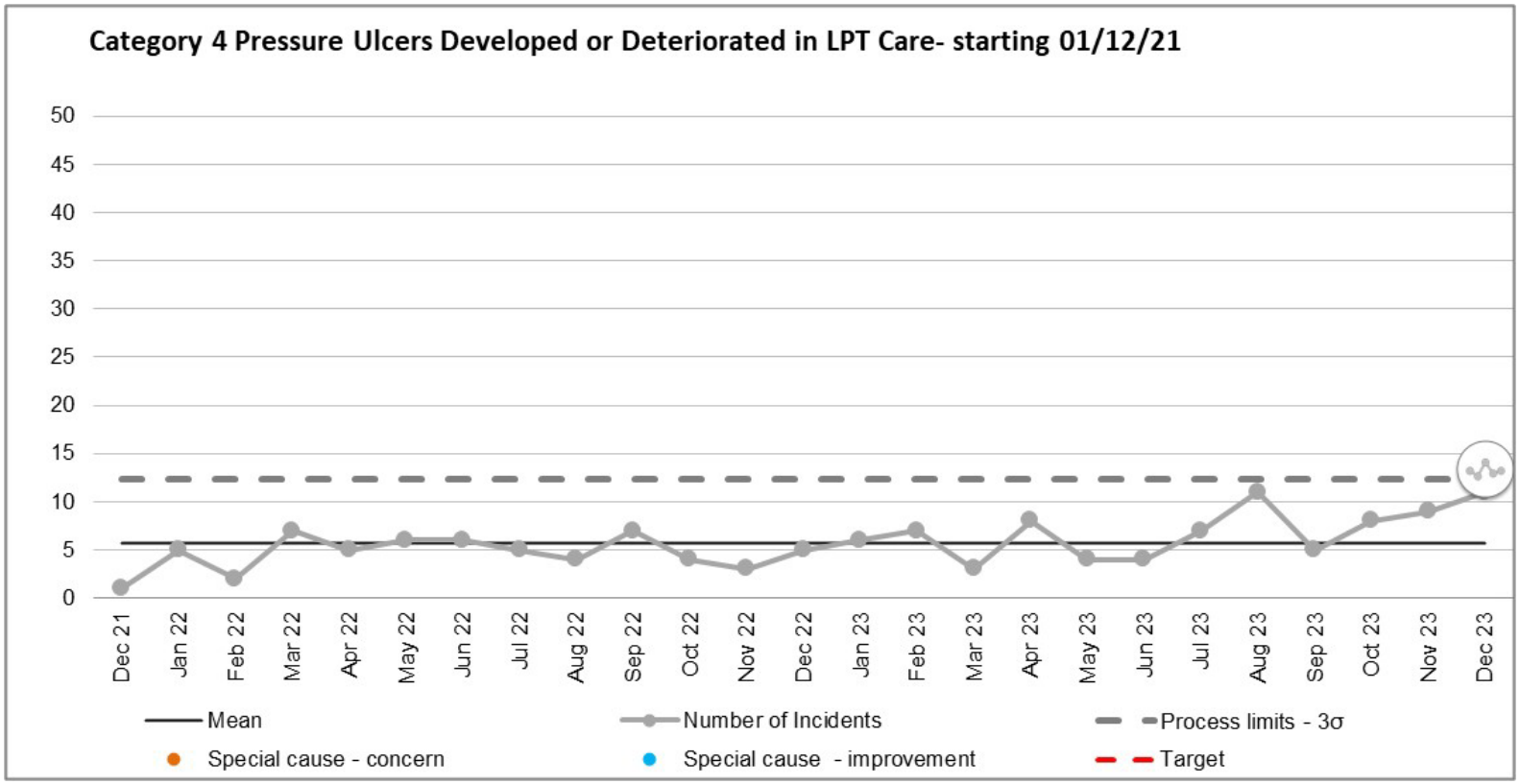
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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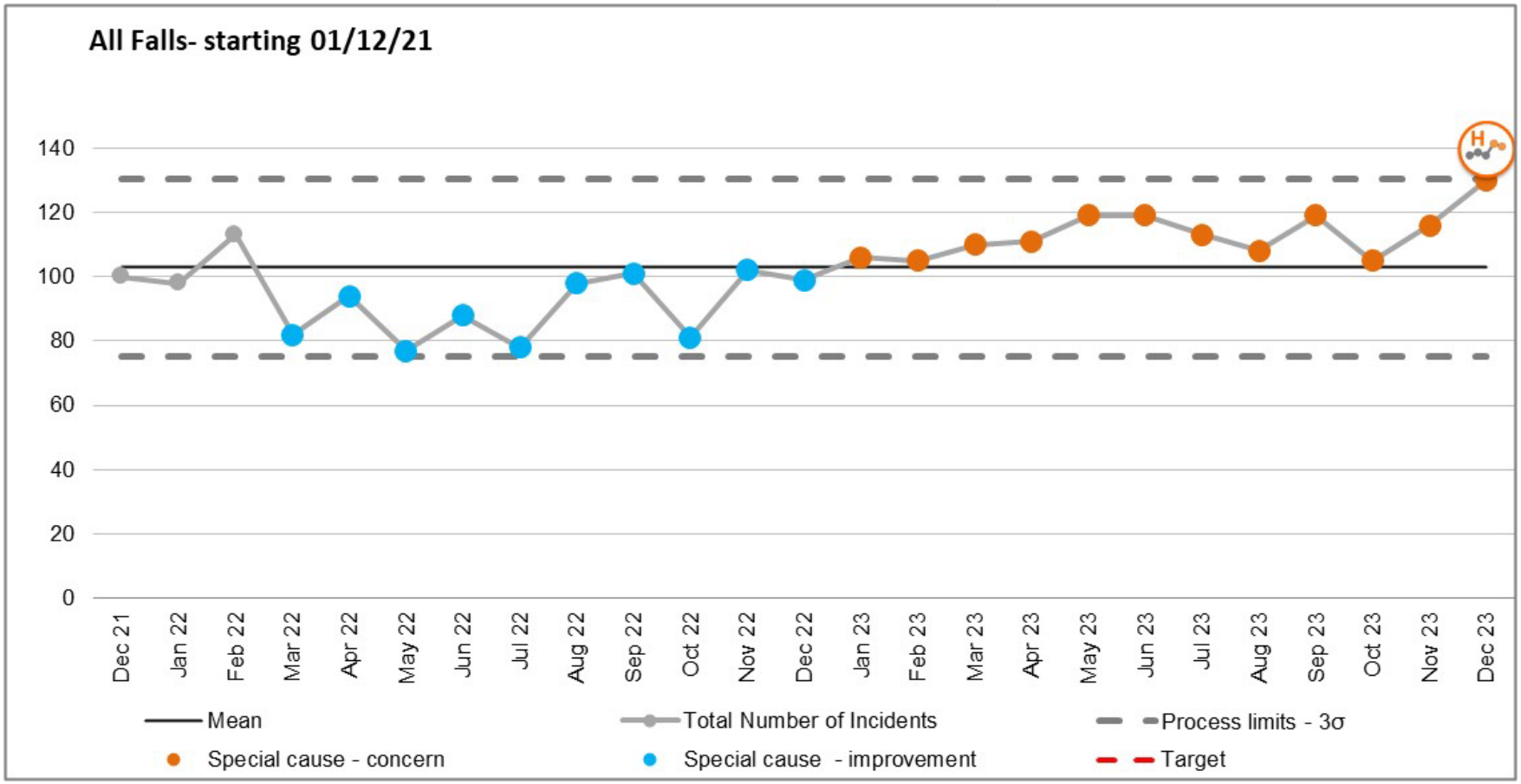
5. All falls incidents reported



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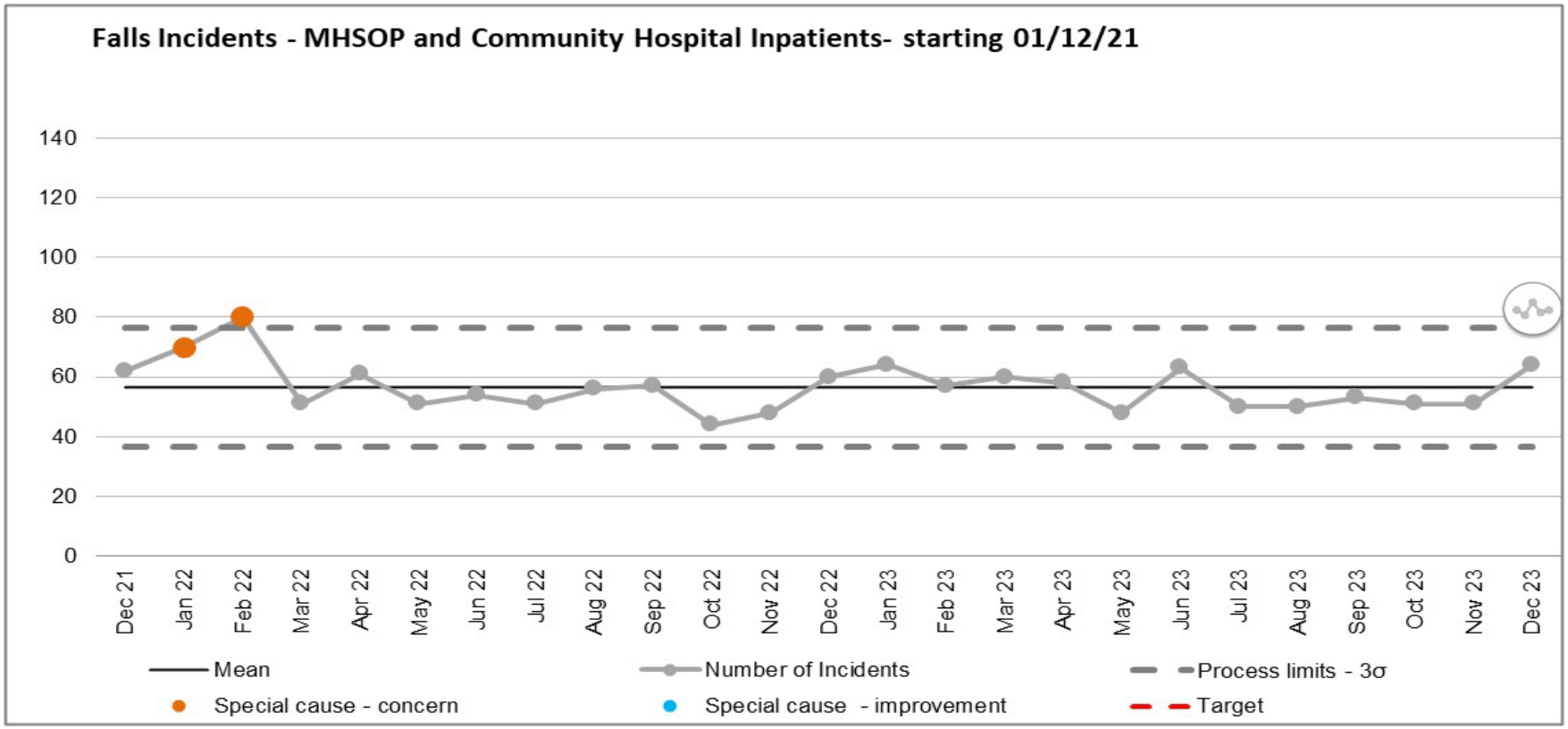
6. Falls incidents reported – MHSOP and Community Inpatients



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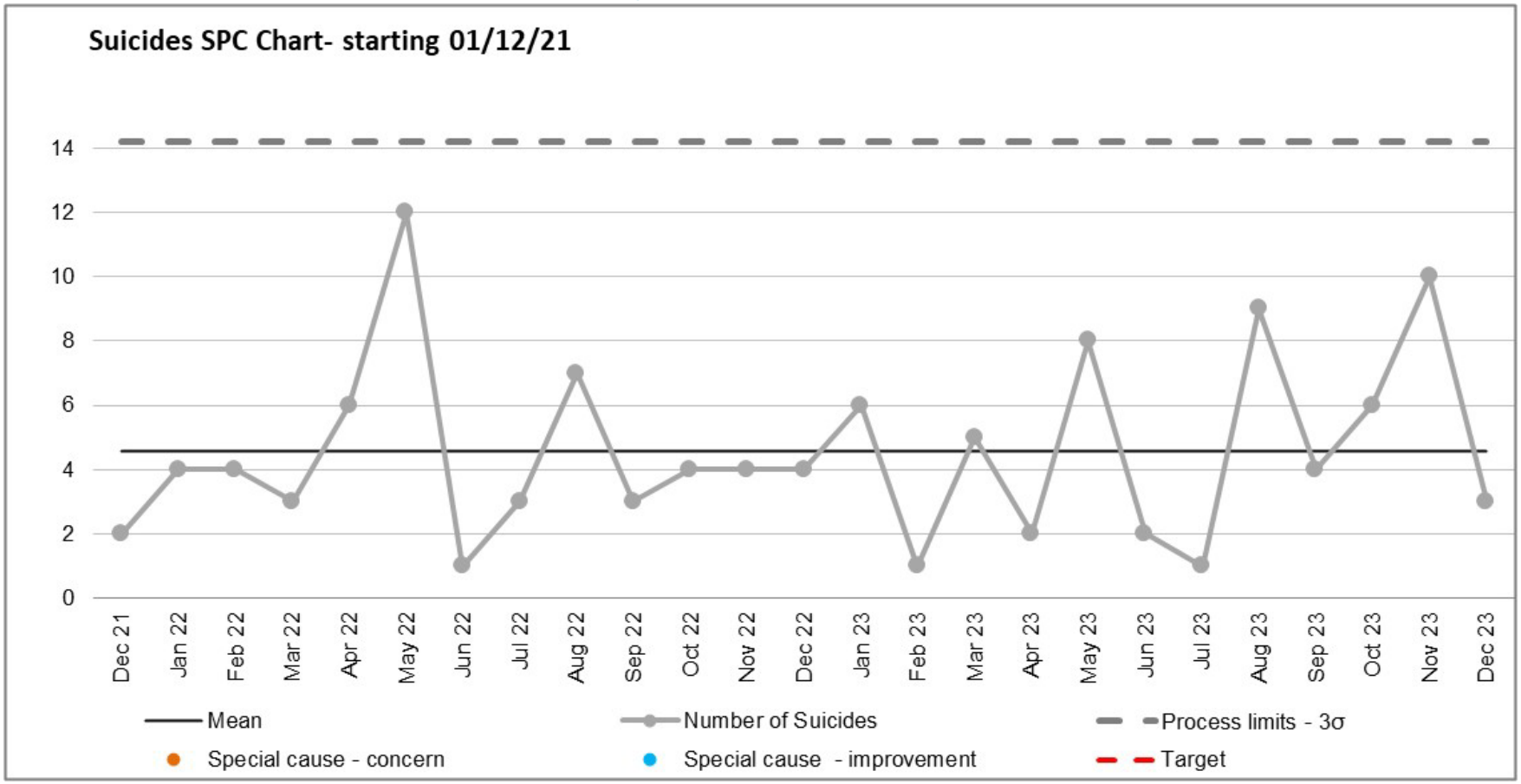
7. All reported Suicides



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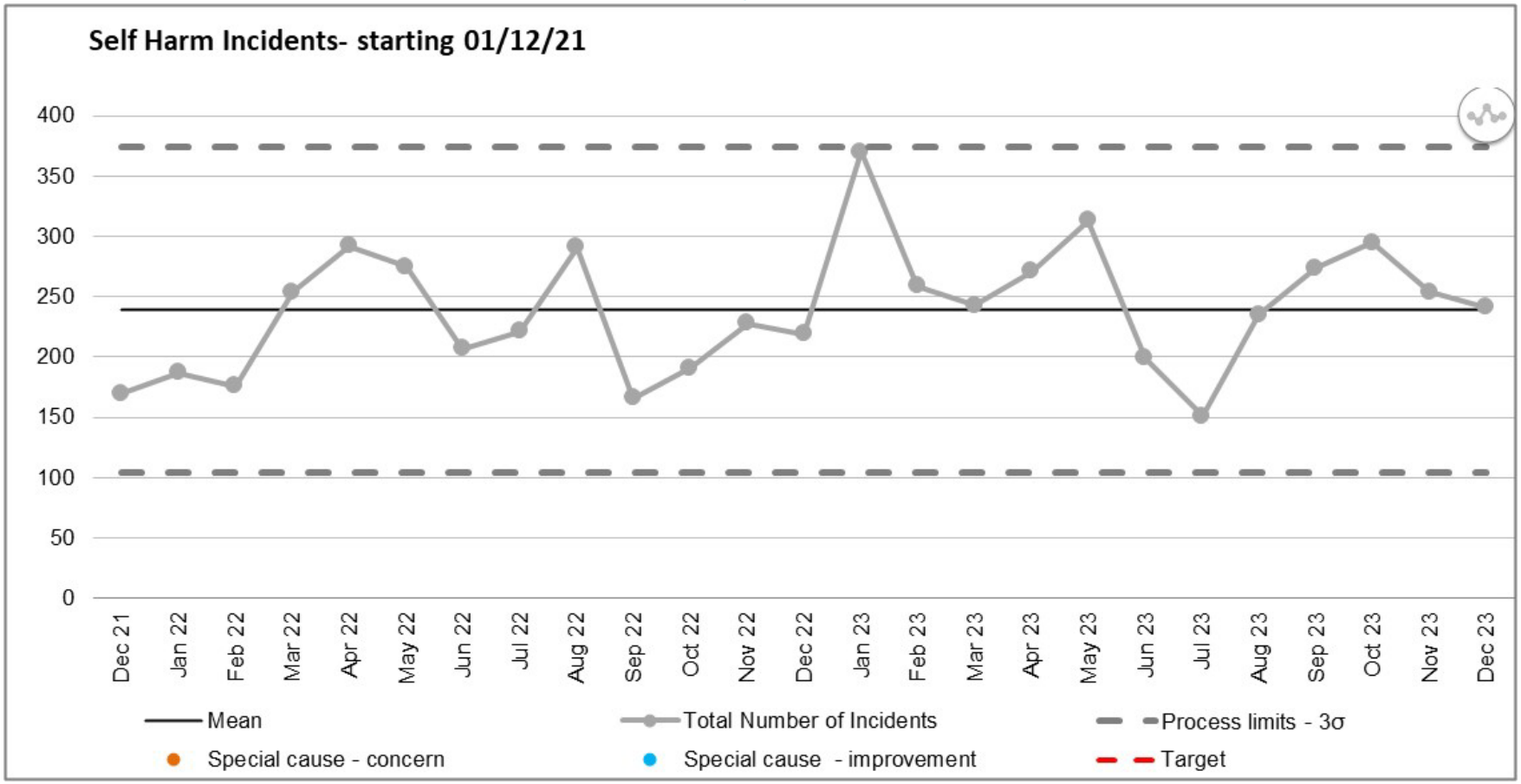
8. Self Harm reported Incidents



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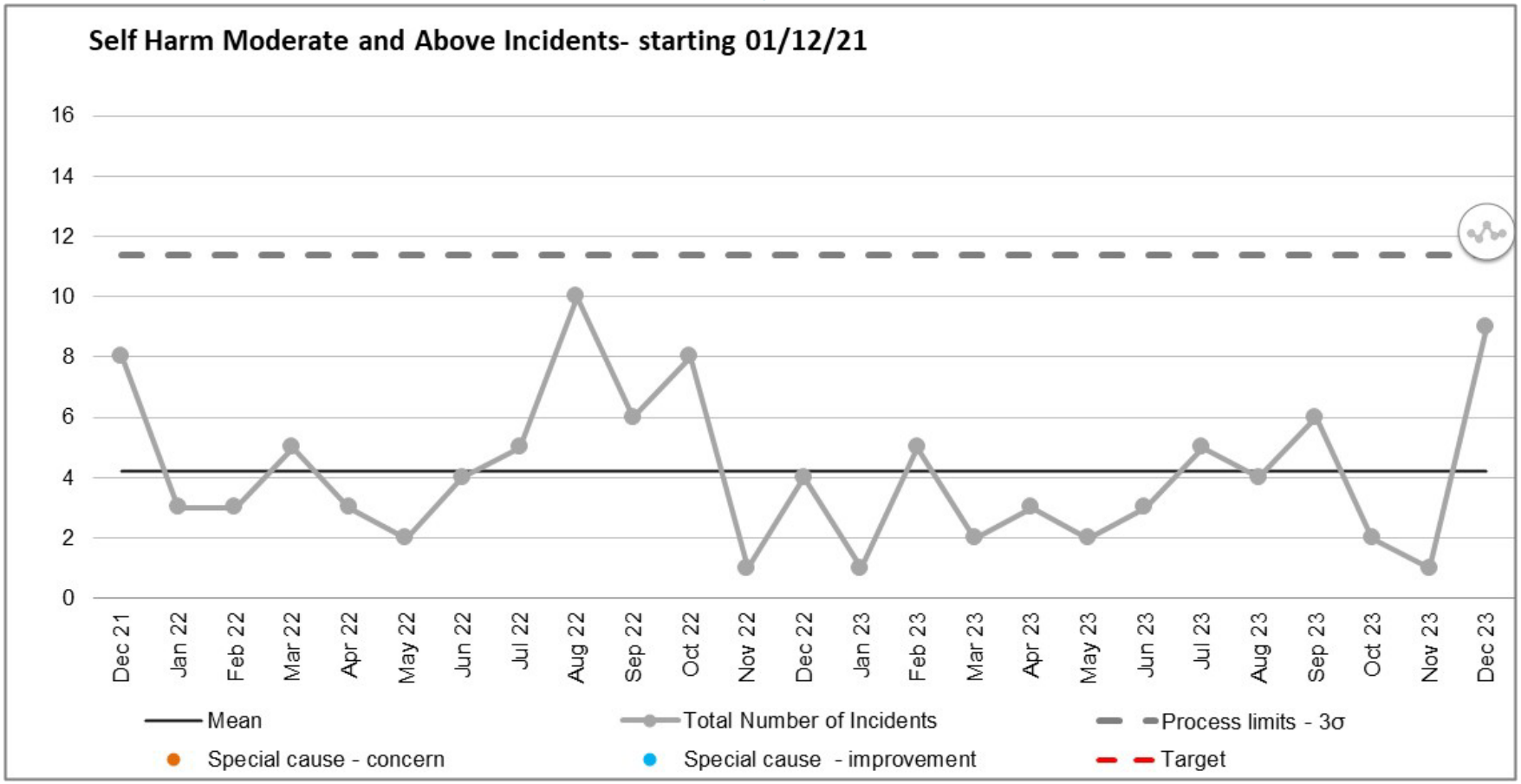
8a. Self Harm reported Incidents



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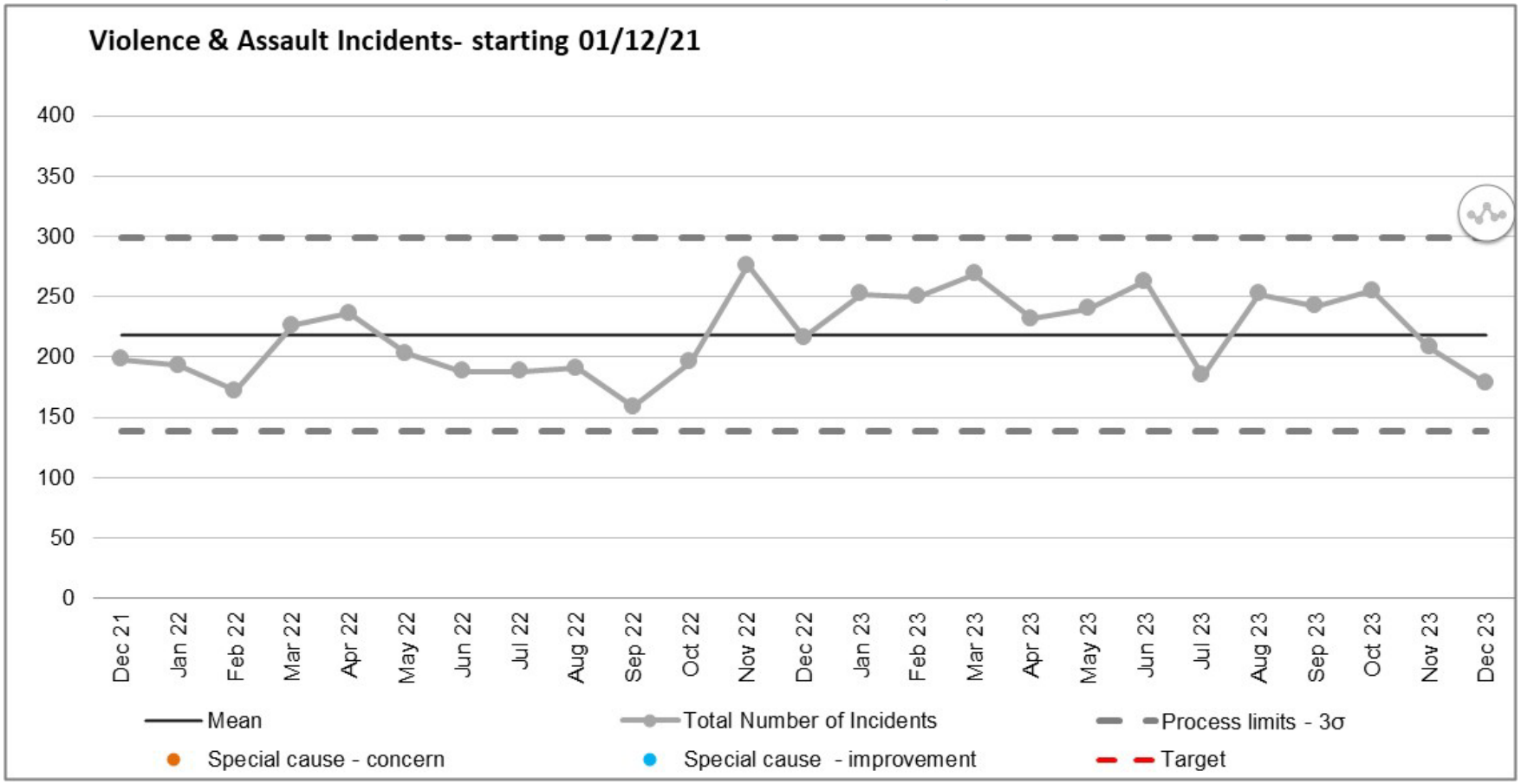
9. All Violence & Assaults reported Incidents



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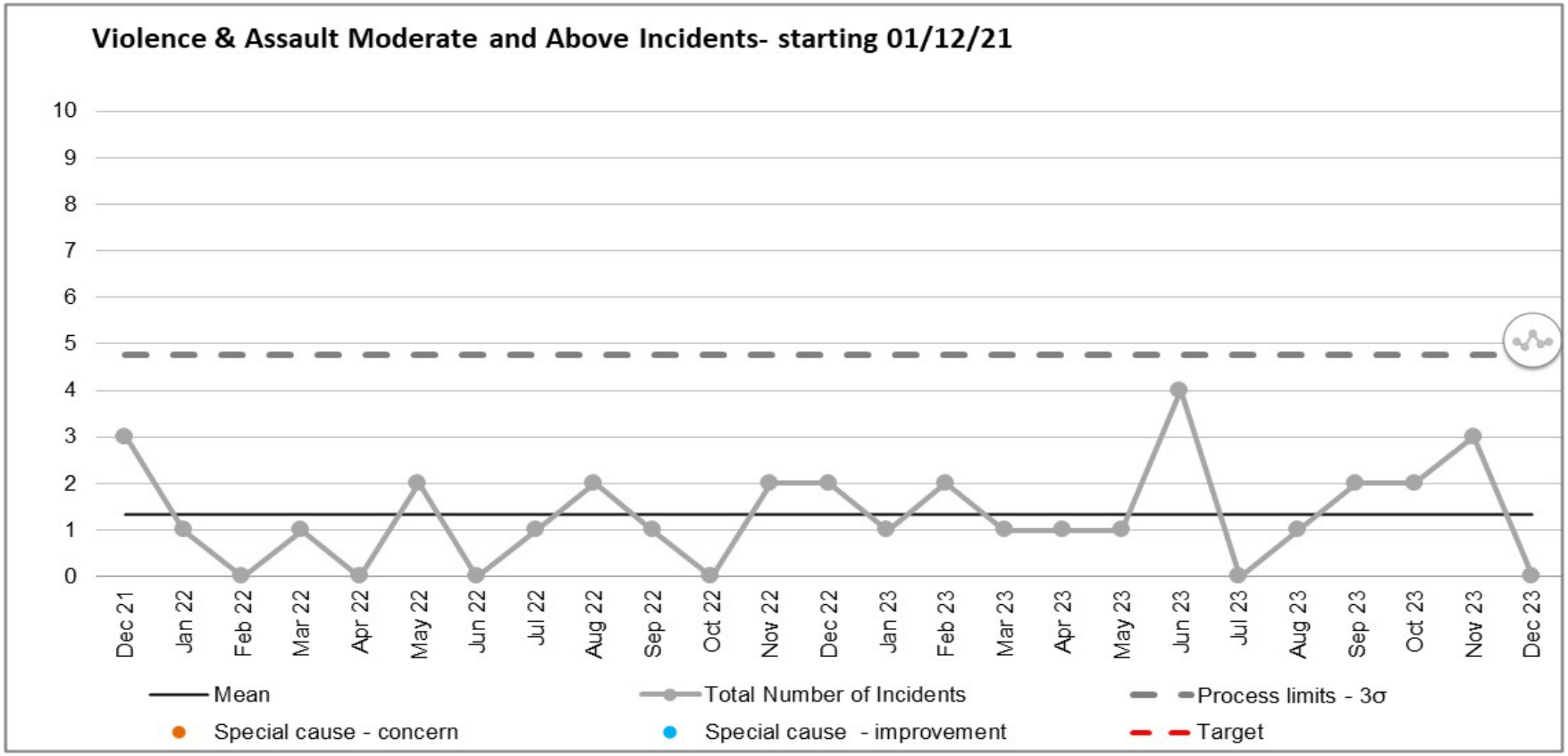
9a. Violence & Assaults moderate harm reported Incidents



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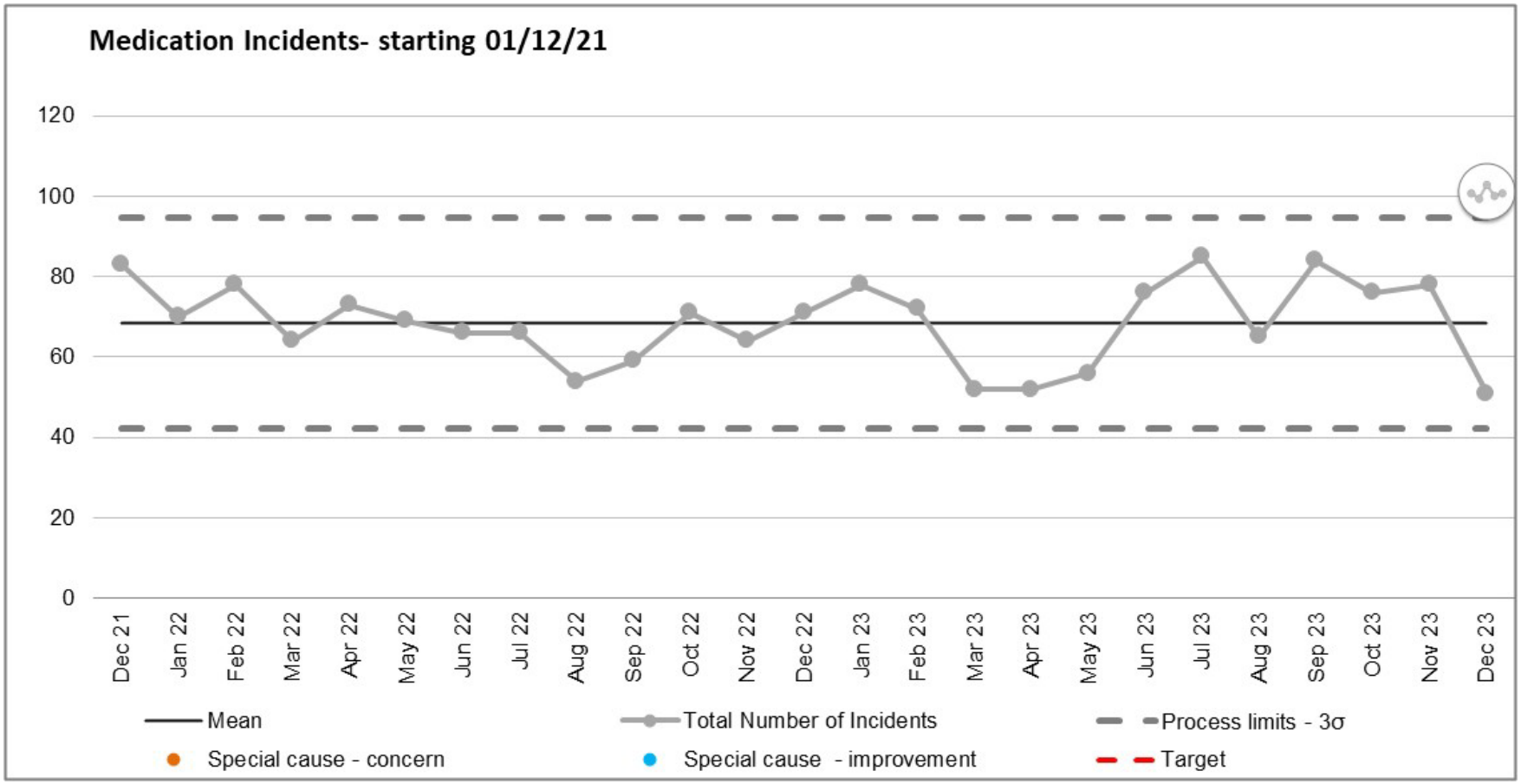
10. All Medication Incidents reported



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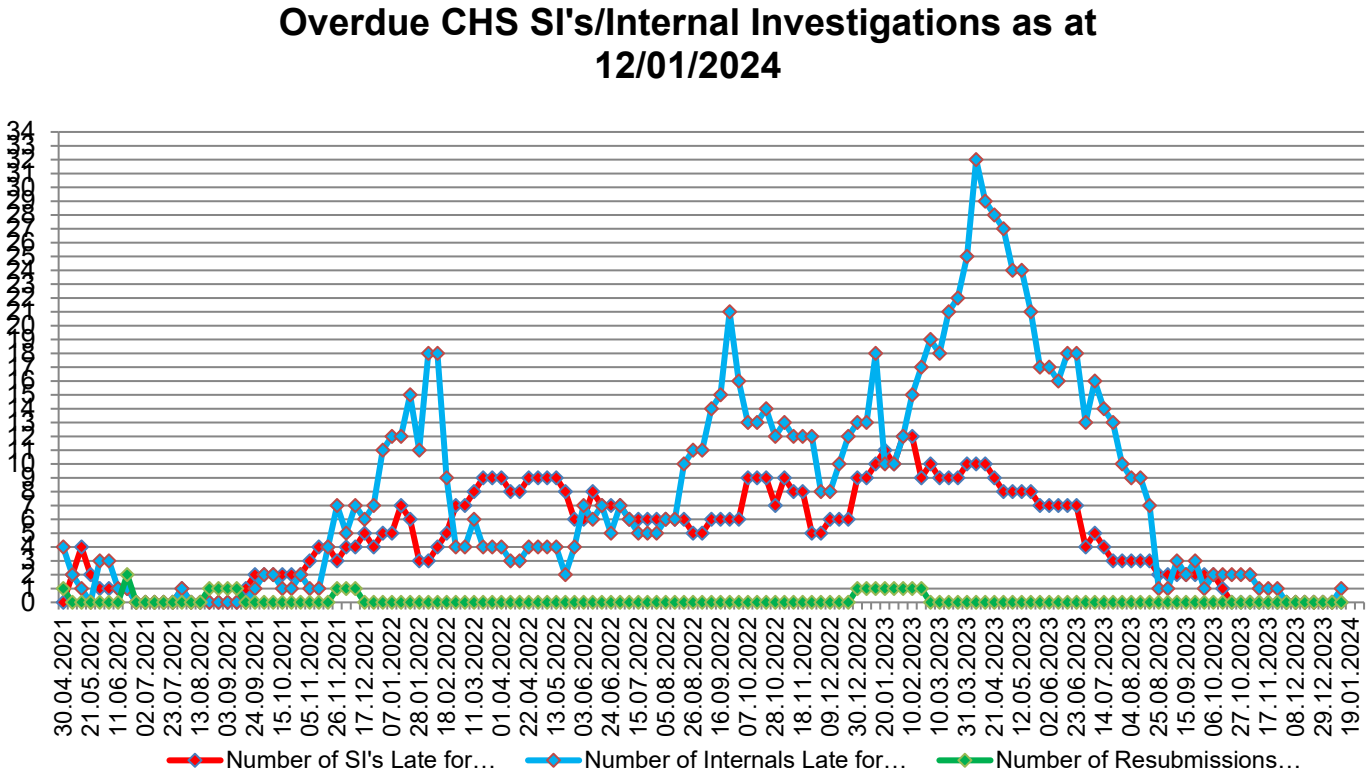
11. Ongoing - StEIS Notifications for Serious Incidents

2022-2023 StEIS Notifications and Internal Investigations								
	StEIS Notifications	SI INVESTIGATIONS				Internal/SEIPS Investigations		
	Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	DMH	FYPC/LD	CHS
2022-2+5:17023								
April	0	2	0	2	10	3	3	3
May	0	3	0	0	12	5	0	4
June	0	4	1	2	7	2	1	3
July	0	4	1	4	8	4	1	6
August	0	7	1	1	7	5	2	2
September	0	3	1	3	10	8	2	9
October	0	4	0	3	4	4	4	11
November	0	6	0	1	4	6	0	8
December	0	7	1	2	4	6	2	10
January	0	2	0	1	9	3	0	10
February	0	4	1	1	9	7	2	6
March	0	1	0	0	11	9	1	5
2023-2024								
April	0	3	1	1	4	8	2	2
May	0	4	0	2	4	7	2	3
June	0	2	1	1	9	2	4	6
July	0	1	0	0	10	3	1	5
August	0	1	0	0	4	6	4	13
September	0	2	0	0	6	3	1	9
October	0	1	0	0	4	5	2	10
November	0	0	0	0	5	2	2	1
December	0	0	0	0	7	8	3	5
	0	61	8	24	148	106	39	131

12. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) – CHS as at 12/01/2024



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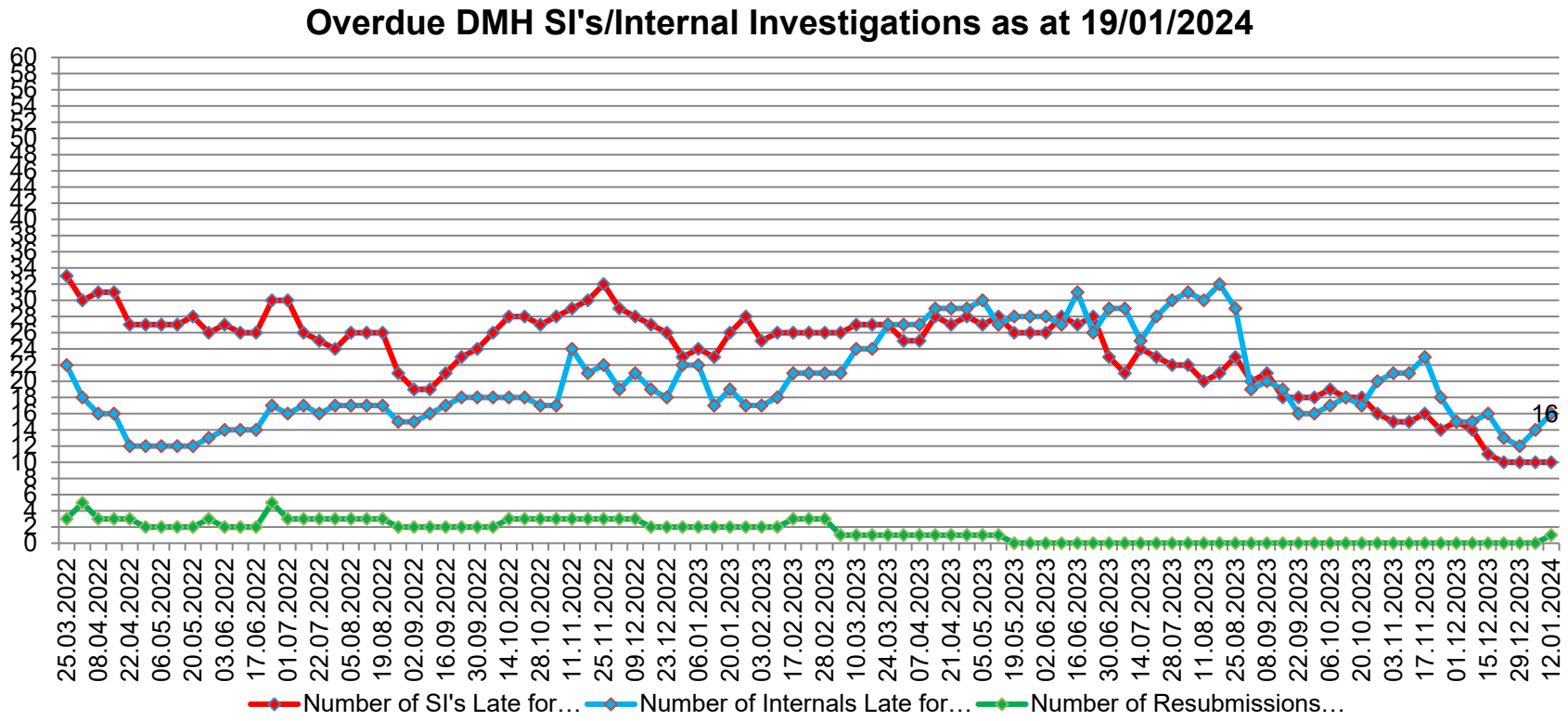
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH as at 12/01/2024



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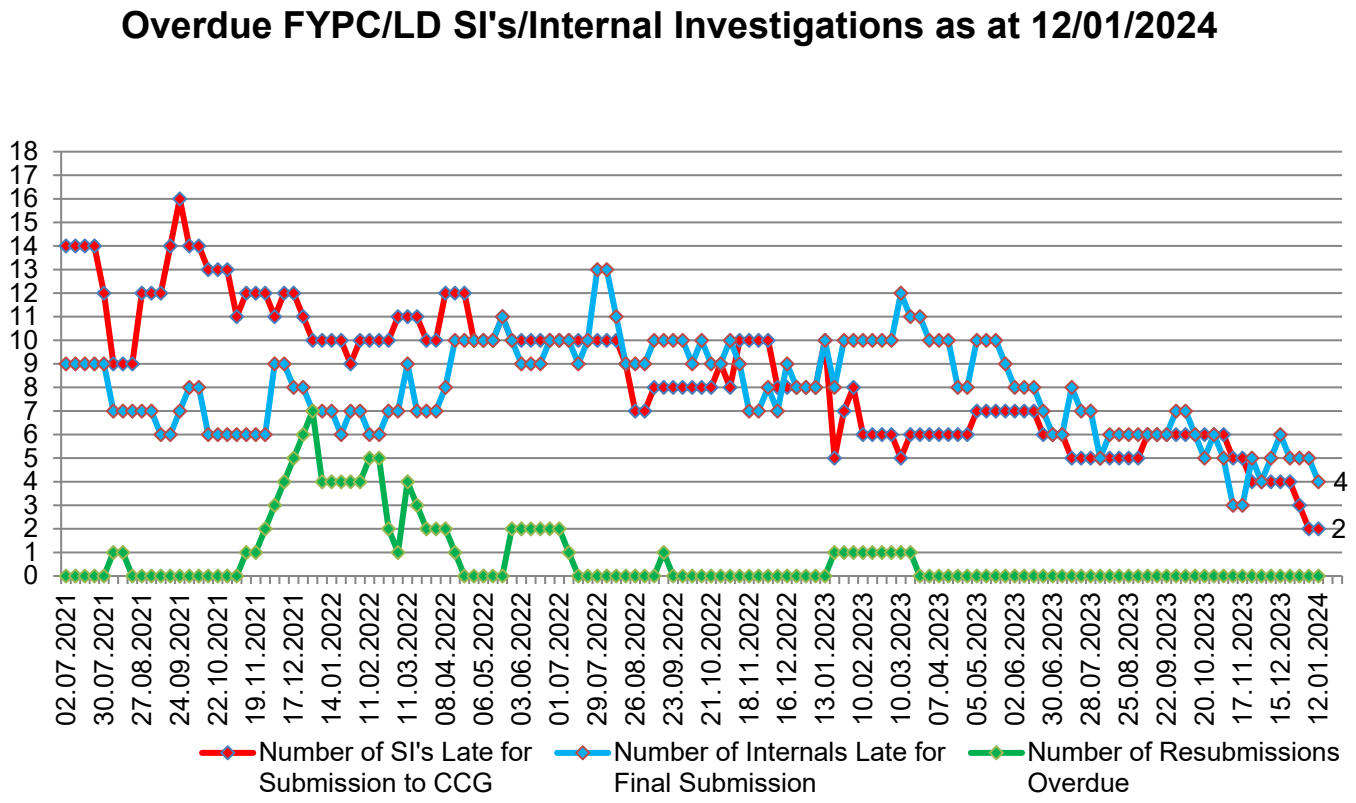
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) – FYPCLD as at 12/01/2024



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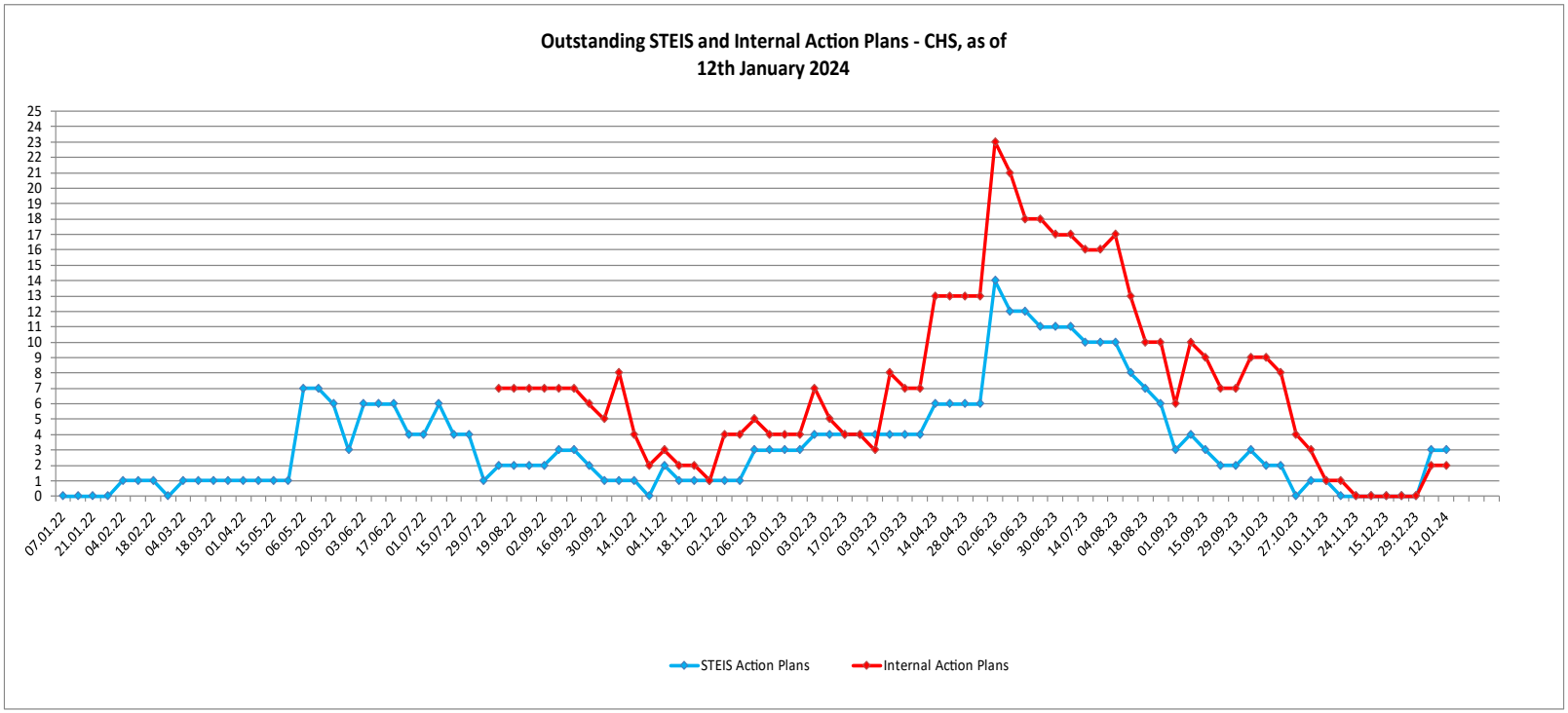
12b. Directorate SI Action Plan Compliance CHS Status 2021/22 as at 12/01/2024



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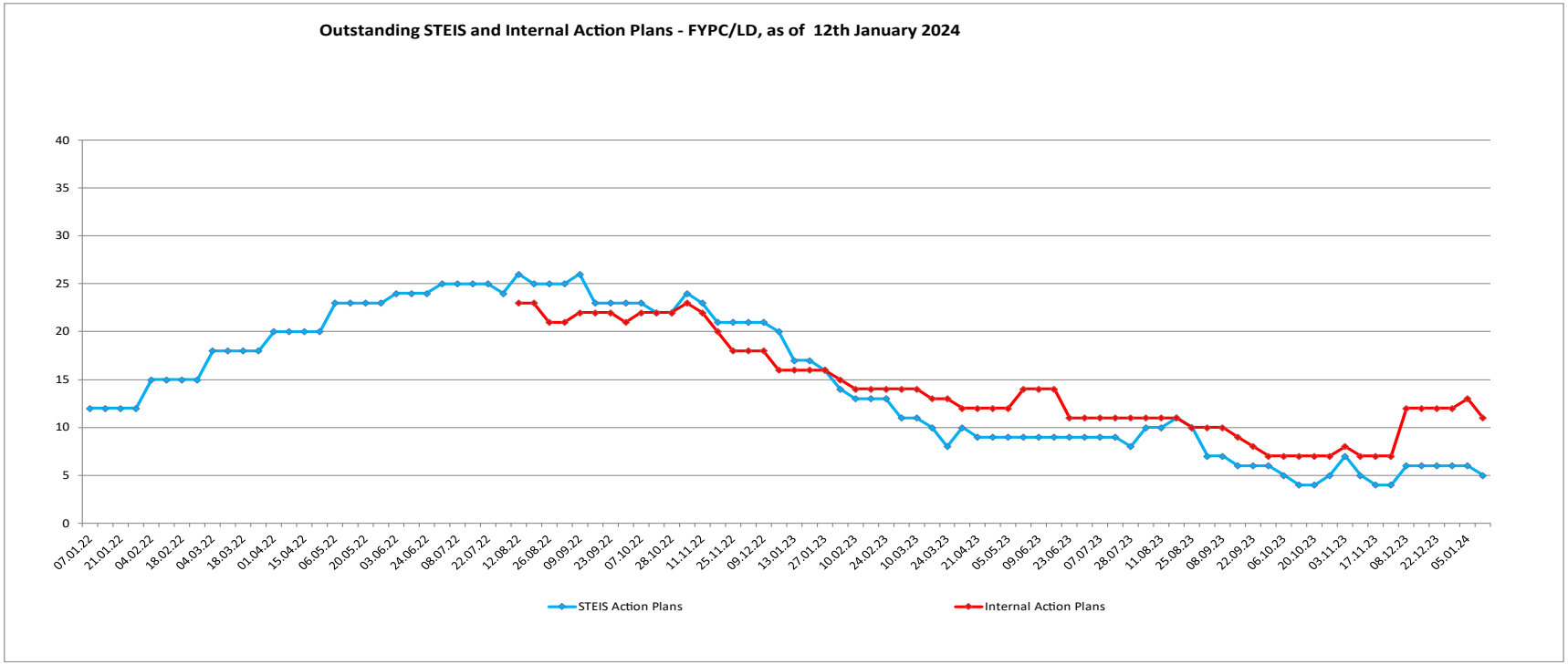
12b. Directorate SI Action Plan Compliance FYPC/LD Status 2021/22 as at 12/01/2024



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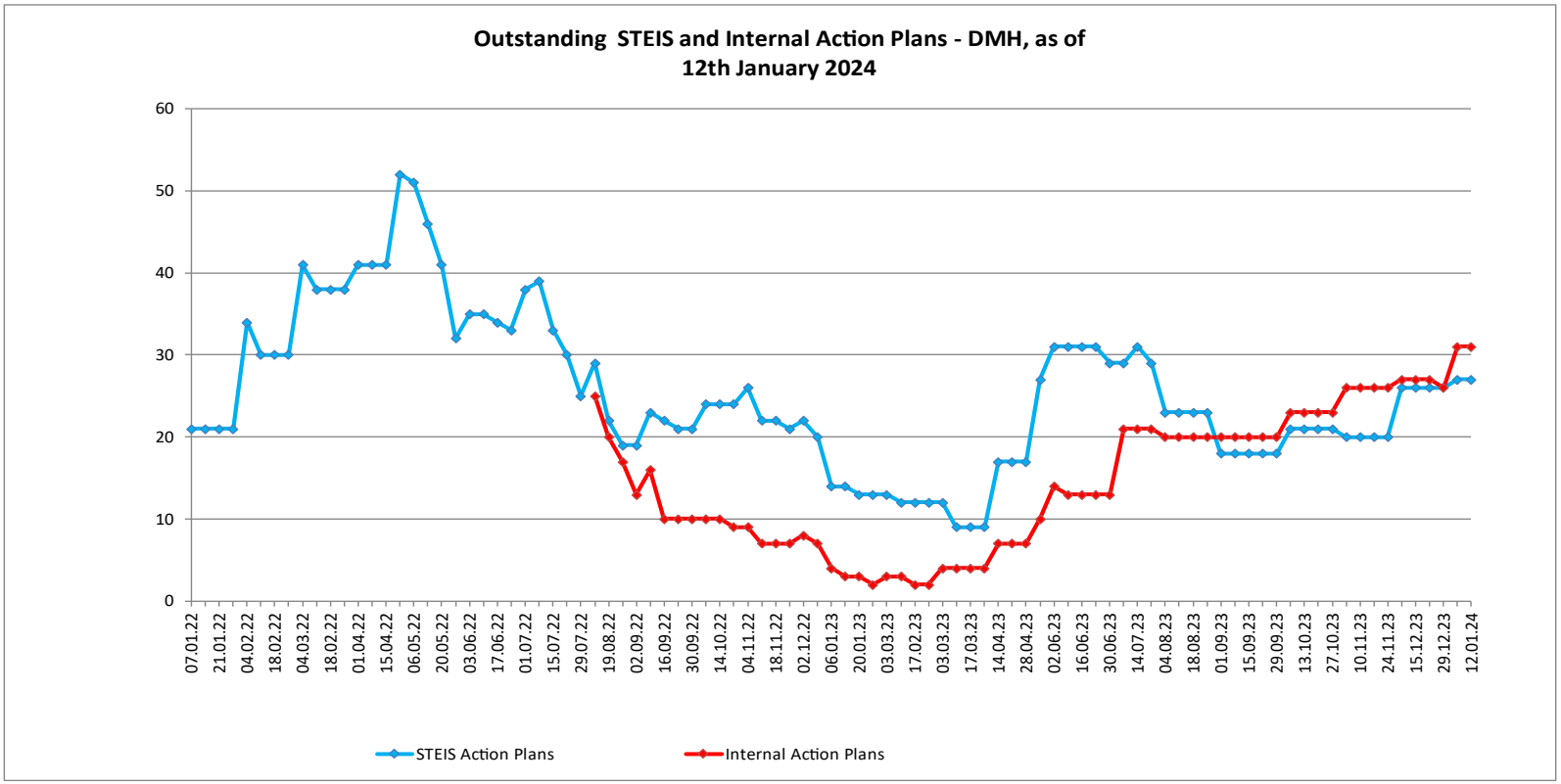
12b. Directorate SI Action Plan Compliance DMH Status 2021/22 as at 12/01/2024



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13. Learning from our learning response process

We have now transitioned to PSIRF (November 2023) we are working to skill wider groups of staff to use system thinking to consider incidents.

- Teaching methodology for System Engineering for Initiative for Patient Safety (SEIPS)
- Encouraging confidence to talk together about system learning and less focus on writing reports
- Working with Commissioners to agree how we can work together differently for them to receive assurance outside of reading SI's

14. Learning November/December 2023

Incidents/Complaints Emerging & Recurring Themes

There is a theme around the accurate monitoring of patient's physical health and the identification of deterioration and appropriate re planning of care and escalation as appropriate.

Action; There is work to understand the barriers to staff escalating this There are multiple work streams looking at this

- deteriorating patient group are refreshing their policy
- The PU prevention group are looking at their QI schedule
- The nutrition and hydration group are considering how this is accurately monitored in patients

LPT FALLS STEERING GROUP

Slides prepared by
Steph O'Connell,
CHS AHP Lead and Clinical Director
Chair of LPT Falls Steering Group

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Falls are a symptom not a diagnosis

- Reasons for falls are multifactorial and are an issue in many pathways
- LPT policy and practice is based on national guidance and evidence base

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LPT Falls Steering Group

(Level 3 reporting into PSIG)

Purpose of steering group

- To promote best practice
- To reduce the number of falls and the harm from falls through
    - monitoring of incidents, data and analysis of themes
    - identify and instigate actions to improve patient care
    - offering support for staff through provision of training and resources.

LPT Falls Steering Group

- Promotes ownership of group aims at team and directorate level
- All actions underpinned by personalisation of falls management and prevention for individuals
- Established principles of good practice for inpatient and community teams (following 2 slides) against national guidance and evidence base
- Directorate reports received in meeting with analysis of incidents and actions
- Cycle of Directorate Deep Dives presented in meetings for wider reflection, check + challenge and support for wicked problems.
- Use of learning from incidents and benchmarking to inform improvement actions

PREVENTION AND MANAGEMENT OF FALLS in INPATIENT SETTINGS
PRINCIPLES OF GOOD PRACTICE

1. PREVENT

- All potential falls risks identified using
  - Multifactorial Falls risk assessment
  - Incl. lying + standing BP, meds reviews, continence, consider mental capacity
  - Assess for equipment to reduce risks (bed rail, low bed etc)
- **Patient/carer involved in identifying action to reduce risk of falls**

2. MANAGE RISK

- Evidence of the management actions visible in the patient records.
- **Patient /carer's contribution should be visible in the care plan**
- Review of Falls risk weekly or more often if there are changes in the patient's condition
- Evidence Care Plan reviewed/updated with change in patient condition

3. RESPONSE TO FALL

- Post fall actions evident in line with Falls policy
- Incident recorded on Ulysses
- **Duty of candour completed**
- **Patient engagement re incident**

4. REASSESSMENT

- Falls Huddle carried out, with **staff and patient involved in identifying causes of fall and contributing factors**
- Risk assessment is reviewed and changes to care plan made
- Learning and actions identified and shared within MDT and wider

5. LEARNING

- Learning shared through ward and wider team meetings, via learning boards, clinical networks, falls champions
- Evidence of change in practice through audit and evaluation
- Relevant learning shared and monitored across services, directorates and at organisational level

PREVENTION AND MANAGEMENT OF FALLS in COMMUNITY SETTINGS
PRINCIPLES OF GOOD PRACTICE

1. PREVENT

- All potential falls risks identified using
  - Multifactorial Falls risk assessment
  - Patient/carer involved in identifying action to reduce risk of falls

2. MANAGE RISK

- Interventions to reduce identified risks clearly evident in Care Plan
- Evidence of the management actions visible in the patient records.
- **Patient /carer's contribution should be visible in the care plan**
- Evidence Care Plan reviewed/updated with change in patient condition

3. INTERVENTIONS

- **Exercise and balance – evidence shows improving strength and balance can reduce falls risks**
- **Education re falls prevention strategies and lifestyle to reduce risks**
- **Home hazards and safety interventions in home**
- **Identification of equipment to reduce risk of falls**

4. REASSESSMENT

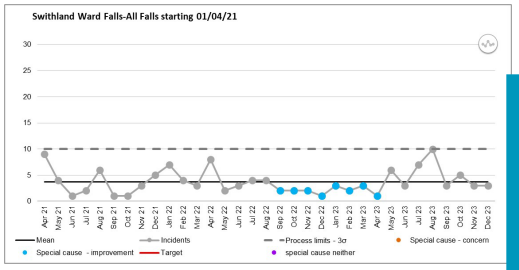
- If a falls occurs **staff and patient involved in identifying causes of fall and contributing factors**
- Risk assessment is reviewed and changes to care plan made

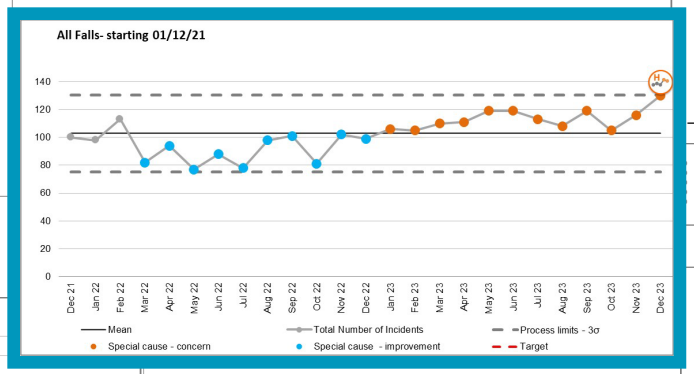
5. LEARNING

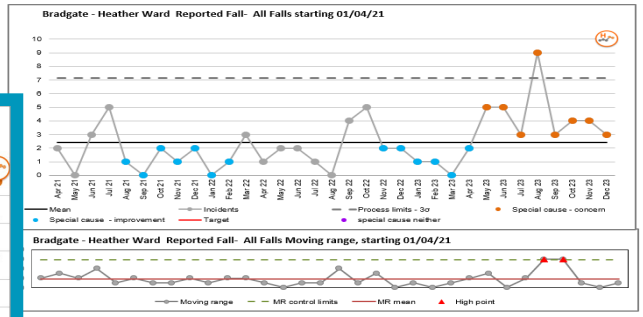
- Learning shared through ward and wider team meetings, via learning boards, clinical networks, falls champions
- Evidence of change in practice through audit and evaluation
- Relevant learning shared and monitored across services, directorates and at organisational level

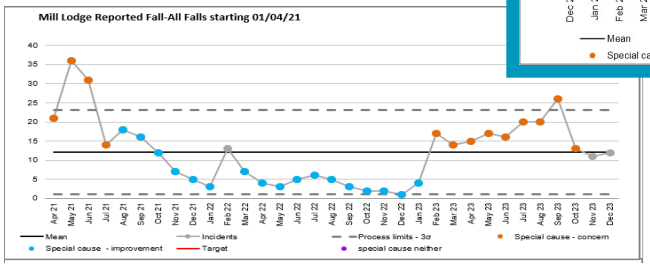
LPT Picture – No. of incidents

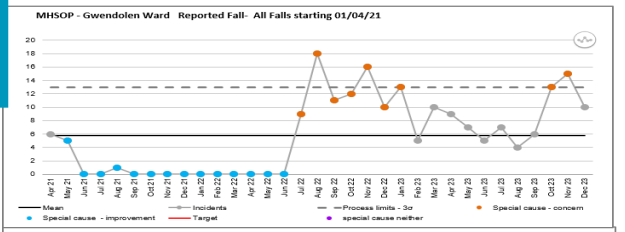
LPT overview data does not reflect nuances in incident occurrence on different wards in different directorates. Local analysis of incidents identifies where incidents relate to patient presentation or common themes.

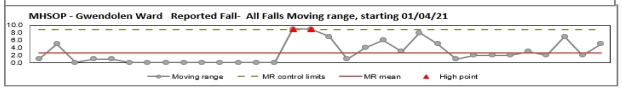












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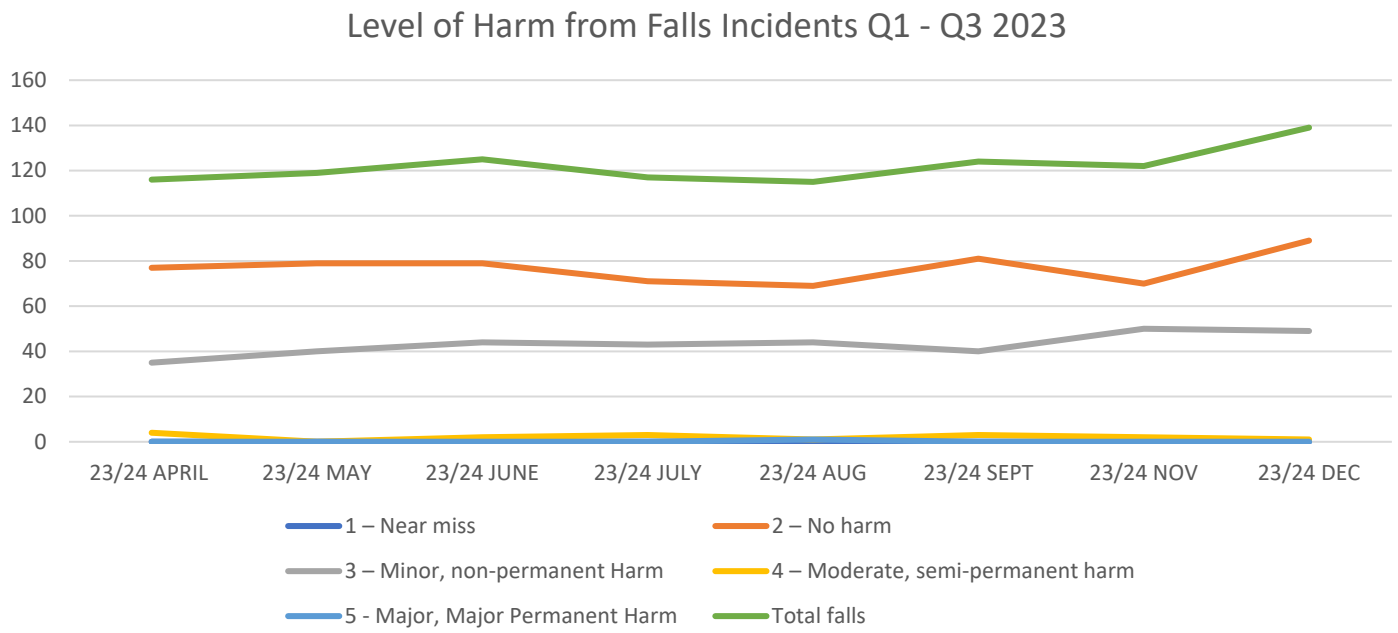
LPT Picture - Level of Harm

The pattern of harm levels has remained consistent for some time



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Overview Analysis

- Patient cohorts in different areas present specific issues – Need to adapt principles to ensure personalised care – good examples in Mill Lodge
- Important to promote holistic approach – addressing mental and physical aspects in all cohorts, eg continence, vision, cognition and capacity
- In monitoring compliance with policy need to,
    - Understanding impact of systems and processes on compliance
    - Improve staff engagement to embed good practice
- Support 'Professional Curiosity' and triangulating risk, interventions and outcomes
- Recognise challenge of promoting patient independence whilst maintaining safety
- Reviewing staff skill sets and capacity – impact of vacancies + agency on safe care

2023/24 ACTIONS

1. PREVENT
2. MANAGE RISK
3. RESPONSE TO FALL
4. REASSESSMENT
5. LEARNING

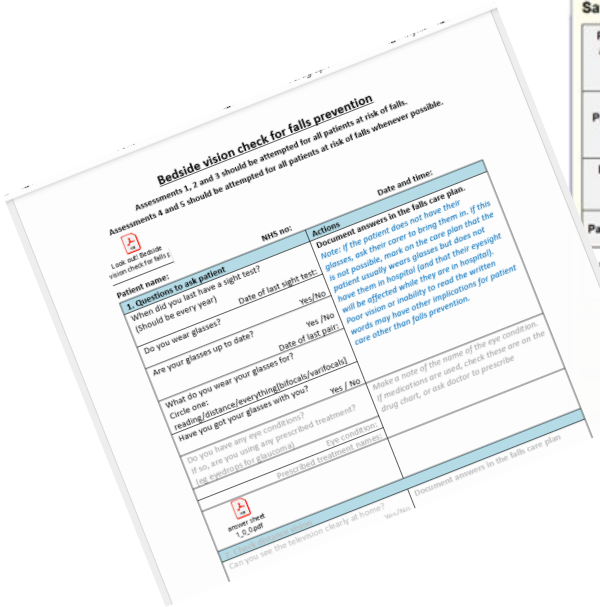
- Staff education and support – Falls Champions
- Benchmark Multifactorial Falls assessment process against NICE + NAIF (e.g., ensure understand impact of vision, ly+st BP, meds reviews, delirium, mobility, continence on falls risks)
- Updated Prevention and Management of Slips, Trips and Falls Policy
- Developed specific tools to support decision making re managing risk and personalising care plans including redesign of post falls management tool
- Promote Post Falls huddles on wards
- All wards now have access to Flat Lifting Equipment – training role essential and for inpatient staff. Eliminated long lies wating for EMAS and reduced risk of exacerbating injury through hoisting
- Scrutiny of data at all levels team, directorate and organisation, use of SPC. Identification of themes and actions. Promote ‘professional curiosity’, Falls Champions networks

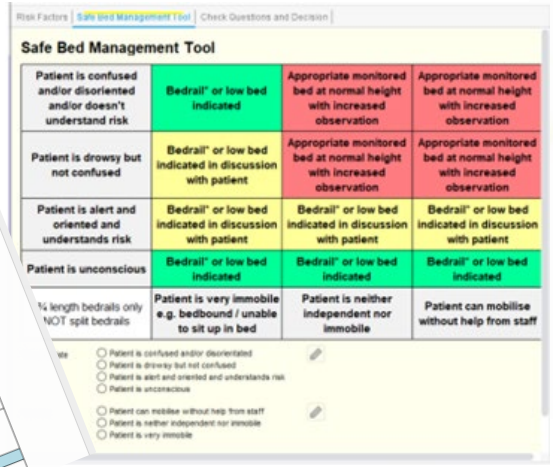
2024/25 PLANS

1. PREVENT
2. MANAGE RISK
3. RESPONSE TO FALL
4. REASSESSMENT
5. LEARNING

- Continue Staff education and support – develop role of Falls Champions
- Update Falls Mandatory training to align with policy updates
- Continue scrutiny of data at all levels, team, directorate and organisation, use of SPC. Identification of themes and actions. Promote 'professional curiosity' and involve Falls Champions networks
- Support use of Patient Stories to share learning from incidents
- Develop case for best practice seating following seating audit
- Evaluate use of Vision Assessment in each directorate
- Deep Dive on falls within community services
- Review audits against Falls policy in each directorate
- Improve communication with teams – resources, newsletter etc
- Develop Flat lifting options for safely retrieving a patient who falls outside

Any Questions?





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Patient Story 308231– Jade

About Jade:

Jade was an informal patient on Langley Ward (not detained under the Mental Health Act) with a history of self-harm. Jade has a diagnosis of ASD and is deaf with cochlear implants but lip reads well. She presented with a history of extreme dietary restriction and exercise, following a period of weight restoration while in medical assessment at the LRI. Jade was initially considered for discharge to outpatients, however Jade and her family felt it would be safer for her to continue their weight restoration and management of risks as an inpatient.

Following an initial period of anxiety, Jade had a period of being more engaged with others however went on to experience a lowering of mood.

At the time of the incident, her care plan and risk assessment detailed high risks in relation to self-harm in the context of emotional dysregulation. Her eating had stabilised.

What Happened:

Two days into an agreed 7-day period of leave, Jade returned to the ward and was reviewed by a member of staff. This was on her request as she was struggling with home leave. Jade presented as tearful and reported that she did not wish to take her medication. She was given the opportunity to return from leave early but declined this.

3 days after later, Jade's mum rang the ward to advise Jade was at the Leicester Royal Infirmary (LRI) Hospital after having been found having seizures at the bottom of the stairs for a prolonged period of time. It transpired that Jade had taken an overdose of medication, following her storing her medication at home rather than taking it. Jade maintained that she did not intend to kill herself with the overdose.

Jade was discharged from the LRI following treatment and returned voluntarily to Langley Ward where she remained until a robust discharge plan was put in place.

Good Practice:

The ward had a good understanding of Jade's needs and sound clinical decisions were made based on all available resources at the time. The pros/cons of discharge versus a prolonged inpatient stay on Langley Ward were clearly considered.

On speaking with Jade, she told the investigator in general she knew the staff were trying to keep her safe physically and the 1-1 was a good thing even though she didn't like it at the time.

Learning:

The Standard Operating Procedure for the Adult Eating Disorders Ward has been updated to ensure there is clear guidance for staff on risk assessments being:

- *updated following significant events and prior critical decision making in collaboration with patients*
- *includes clear risk formulation based on patient's risks and needs*
- *clear crisis and contingency plans are in place for high risk patients going on leave*

On speaking to staff, they reflected with the investigator that they would benefit from some wider awareness on management of self-harm regarding patients with complex trauma. A training schedule has been put in place for 2024 to include EUPD/complex trauma and management of self-harm. LPT also offer a training package on personality disorders.

A reminder was sent to staff regarding uploading minutes of critical meetings onto patients records. This has also ben included in the updated SOP.

NHS
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Patient Safety - Learning from incidents 1

David's Story

David was a gentleman aged 77 who lived at home with his wife. David had been diagnosed with Motor Neurone Disease and penile cancer. As a result of penile cancer, David had a long-term urethral catheter.

What happened to David?

Since May 2023, David has experienced blockages in his catheter which have resulted in community nurses visiting six times to unblock his catheter. Three of those occasions took place in the week leading up to the incident, where David had been visited by two different community nurses. Nurse A visited twice due to catheter blockages. The first time finding old blood which required no intervention, and again two days later to find haematuria present, but preforming a bladder irrigation to unblock the catheter was unsuccessful. Therefore, Nurse A needed to change the catheter.

When the catheter was removed and before inserting the new catheter, frank (fresh) blood was draining and a cold compress was applied until the bleeding stopped. David's observations were checked, and his NEWS2 Score was 3. Nurse A did not escalate the incident but did give advice to David and his wife before they left.

The following day when another call was received from David's wife regarding catheter issues, the community triage nurse gave advice to carers over the telephone, advising to change the leg bag to the catheter and monitor David's urine output. Additional advice was given to David's wife to contact their GP to request the GP refer David to Urology due to ongoing catheter issues.

Patient Safety - Learning from incidents 1

On the 4th call-out, Nurse B visited and described David as grey in colour, clammy and visually unwell. David's NEWS2 Score was 8, therefore, an ambulance was called via 999. Nurse B re-catheterised David again before the Paramedics arrived and frank haematuria drained into the leg bag. When the Paramedics arrived, they administered intravenous fluids to stabilise David before safely transferring him to hospital.

David experienced blood loss and required admission to hospital and David consequently required a blood transfusion due to anaemia as his Hb was 30 on admission. David was tested and diagnosed with a urinary tract infection. Therefore, he was administered intravenous antibiotics additional to intravenous fluids. A 3-way catheter was inserted during admission to continuously irrigate David's bladder and prevent blood from blocking his catheter.

Patient Safety - Learning from incidents 1

The impact on David and his wife

The whole experience was distressing for both David and his wife. David sadly died on 8th November 2023.

Our Learning Focus

- The triage nurse should always assess a patient's medical history to identify if there have been frequent calls for the same issue and/or intervention required. Any previous concerns during catheter interventions, a history of recurring issues or an existing acute contingency plan in place and highlighting this to visiting nurses to be aware of.
- The importance of Collaborative working and MDT discussions to ensure all disciplines are involved in highlighted issues so that the wider team involved in each patient's care is aware to recognise onset of deterioration, take action and potentially prevent undesired symptoms and anything reversible could be actioned at onset to prevent acute hospital admission.
- Sourcing senior community nurse support when anything untoward occurs from the norm on interventions or when recognising a NEWS2 Score is to be checked, requesting for advice from the senior nurse and potential follow up.
- A catheter passport needs to be put in place and checked.
- Education is required for nurses to be aware of the LPT catheter policy to correct pathways of who they should contact and to safety net with a follow up, prior to visiting patients with catheters.
- Education is required for nurses involved with management of catheters to not remove or insert a catheter if haematuria is a concern. And to know the LPT pathway directs to contact Urology for advice, as

Patient Safety - Learning from incidents 1

the nurse can provide vital information for Urology to assess and identify urgency of transfer, review or, if appropriate, direct advice for the nurse to action at the time.

Changes made following this incident.

- ✓ Nurse B followed the correct escalation process when concerned about David by requesting paramedic support via 999 when David's NEWS2 Score was 8 which was the appropriate action.
- ✓ The catheter care plan for David was updated to ensure all his catheter changes going forward were to take place at Urology and not in the community. This was also an alert on David's SystmOne home page for anyone unknown to David should be allocated to visit. David and his wife were also aware of the plan going forward.
- ✓ Learning from this incident has been shared with LOROS in response to the concern they raised.
- ✓ David's wife and daughter had been visited by the Senior District Nurse who has apologised for their distress and that actions from the team lead to an avoidable hospital admission. They were assured that his care would be reviewed and the findings with be shared with them. The family had raised no other concerns.
- ✓ There will be a link to the catheter policy and pathways within the catheter care plan on SystmOne **https://www.leicspart.nhs.uk/wp-content/uploads/2020/04/Urinary-Catheter-Policy-for-Community-Health-Services-Inpatient-Facilities-and-Primary-Care-Exp-Feb-24.pdf**
- ✓ Refer to pathways during visits i.e. Haematuria and 'Stop Think' is recommended.
- ✓ Nurses are advised to stop and call a senior nurse or triage nurse for advice. As this allows time for clear thinking and joint decision making.
- ✓ Access to newly launched continence training is suggested if a recap of

Patient Safety - Learning from incidents 1

knowledge is required.

- ✓ Clinical incidents are to be reported in a timely way to allow for earlier review of care, learning and engagement with patients and families.
- ✓ The findings will be shared with his wife and family.
- ✓ The Learning Board and David's story will be shared with staff involved, to support further reflection and to support improving practice by also sharing with the wider community team.