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Leicestershire Partnership NHS Trust

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

Purpose of the report -

This report for January and February 2024 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 incident 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.

This is a very challenging time across the NHS; as well as working to improve the safety data and intelligence within the organisation, the Patient Safety Improvement Group are reviewing learning from across the NHS in the UK.
There have been several recently published National reviews which we have considered to ensure we are drawing out all the learning and applying this across the Trust.

Currently there are pieces of work underway to ensure that we learn from the recent publicised Norfolk and Suffolk Foundation Trust in relation to their learning from deaths process and an action plan is being developed based on their learning. There is also a review of the learning from the recently published report into the failings at Greater Manchester Mental Health Trust. The national review took place after Panorama broadcast undercover filming exposing abuse on the organisation's inpatient wards. The focus of the review was to seek to understand how the conditions were created in which this behaviour could happen and could go unchecked and unnoticed.
The detail of the national review is being considered within our Trust and the findings and recommendations cross referenced for our local context and learning identified and developed.

We also continue to work with our change leaders to progress our psychological safety work. We have a passionate and enthusiastic group of change leaders who are keen to work with us. They have come together to agree our local definition of psychological safety and their next meeting is arranged to progress the changes required to ensure that staff feel able to raise concerns and that they will be listened to and responded.

Patient Safety Incident Response Framework (PSIRF) -We transitioned to PSIRF four months ago and we continue to build on our processes as we learn and develop these collaboratively. The premiss of PSIRF allows organisations to design and learn from their incidents in line with their local context. This is the largest scale change in Patient Safety in the last twenty years and therefore there is not an expectation that these changes will happen immediately. This change in thinking requires a level of safety maturity and expertise and we are continuing to build capability by providing awareness of the human factors models used to consider complex situations and identify wider system changes to support our staff to do their best work.

Investigation compliance with timescales set out in the current serious incident framework –This is an improving picture (see graphs in slides) as we complete the backlog of incidents and transition to our new processes.

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 –
We continue to see normal variation in the number of Category 2 and 3 pressure ulcers developed or deteriorated in our care. Special cause concern has been noted for the month of December 2023, with 9 category 4 pressure ulcers developed in our care. The CHS pressure ulcer delivery group are completing a deep dive review to analyse and identify learning, actions, and assurance to be shared to the Trust strategic pressure ulcer group.

The Trust strategic pressure ulcer group have completed an annual review of data, patient outcome measures, learning from incidents and current quality improvement projects in line with the NICE Quality Standards for Pressure Ulcer Prevention.

Whilst there has not been an overall reduction in pressure ulcers developed or deteriorated in our care Trust wide, it is recognised that there have been some service or hub areas of special cause improvement and improvement in performance measures for several quality standards including pressure ulcer risk assessment, advice on repositioning, information on preventing pressure ulcers.

The group recognise that areas of special cause concern, improvement or quality improvement programmes have not previously been linked to outcome measures that aid assessment of impact. The group have identified a suite of outcome measures linked to the quality standards and have mapped current Trust position and identified gaps in reporting with an aim to develop a dashboard to support improvement work and assess impact of interventions going forward.

The following priorities have been identified for the groups work plan in 23/24:

- Repositioning
- Wound photography – use of the ISLA app
- Moisture Associated Skin Damage
- Equipment

Pressure ulcer prevention training has also been reviewed for all clinical staff and roles and the group are proposing a tiered approach:

  - Level 1 – Basic - Not role essential but available for clinical staff not specified as role essential
  - Level 2 – Intermediate – Role essential for specific clinical staff working in DMH, FYPC/LDA
  - Level 3 – Enhanced – Role essential for CHS staff, all nursing roles, specified AHPs

Falls Incidents - Numbers of falls incidents remain static, although number of falls at Mill Lodge have dropped due to profile of current patients in the ward being less mobile, additionally we did not report any moderate harm falls in January 2024 or February 2024. However, a spike in numbers of falls reported at the Beacon Unit in February 2024 is being investigated and reflections and learning will be reported in the April 2024 Falls Steering Group. In the Falls Steering Group d in March 2024 FYPC LDA presented their performance against Falls Prevention. It was agreed that whilst all the national evidence base for falls prevention is based on people over 18, LPT need to clarify the approach and expected standards for under 18s in CAMHS and Eating Disorder services, where falls occasionally occur, this work will start in April 2024.

Incident data shows that last month Flat Lifting was consistently used as an appropriate method of lifting patients who have fallen and there were no incidents where a hoist was used for this purpose. Work is also underway to evidence the improvement in safe patient handling that the introduction of flat lifting has made.

Deteriorating Patients - The DPRG policy is now in draft form and is being finalised PSIG have shared a summary of the key actions related to DPRG from significant incidents and learning events which have occurred. DPRG will utilise this to form our work plan for the coming months. Some of the recommended actions have already been highlighted as potential issues by the relevant working groups within DPRG and via the collaboration work with NHFT and in some cases, there has been some initial work begun already. updates will be reported through to PSIG.

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. A key area of work over the next few months is to look at omissions of 'critical drug' omissions. This work will initially look to understand the system issues that may be contributing for example by reviewing stock drugs in relation to the current context.
The role of Medicines Safety Officer (MSO) is being progressed which is essential to build on the improvement work in relation to medicines safety.

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) –
The group are continuing to review the learning from the review of the Norfolk and Suffolk learning from deaths process and strengthening our processes. A workshop is planned to take place in April with LPT stakeholders to consolidate and progress the plan.
The Medical Examiner process is now being extended to Primary Care, this extension of the process will both provide improved access to the data for our patients cause of death and therefore greater opportunity

for learning. As well as greater opportunities to work with ICB colleagues where potential learning across and between the ICS is identified.

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:	March 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	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning		
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	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 January and February 2024.

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

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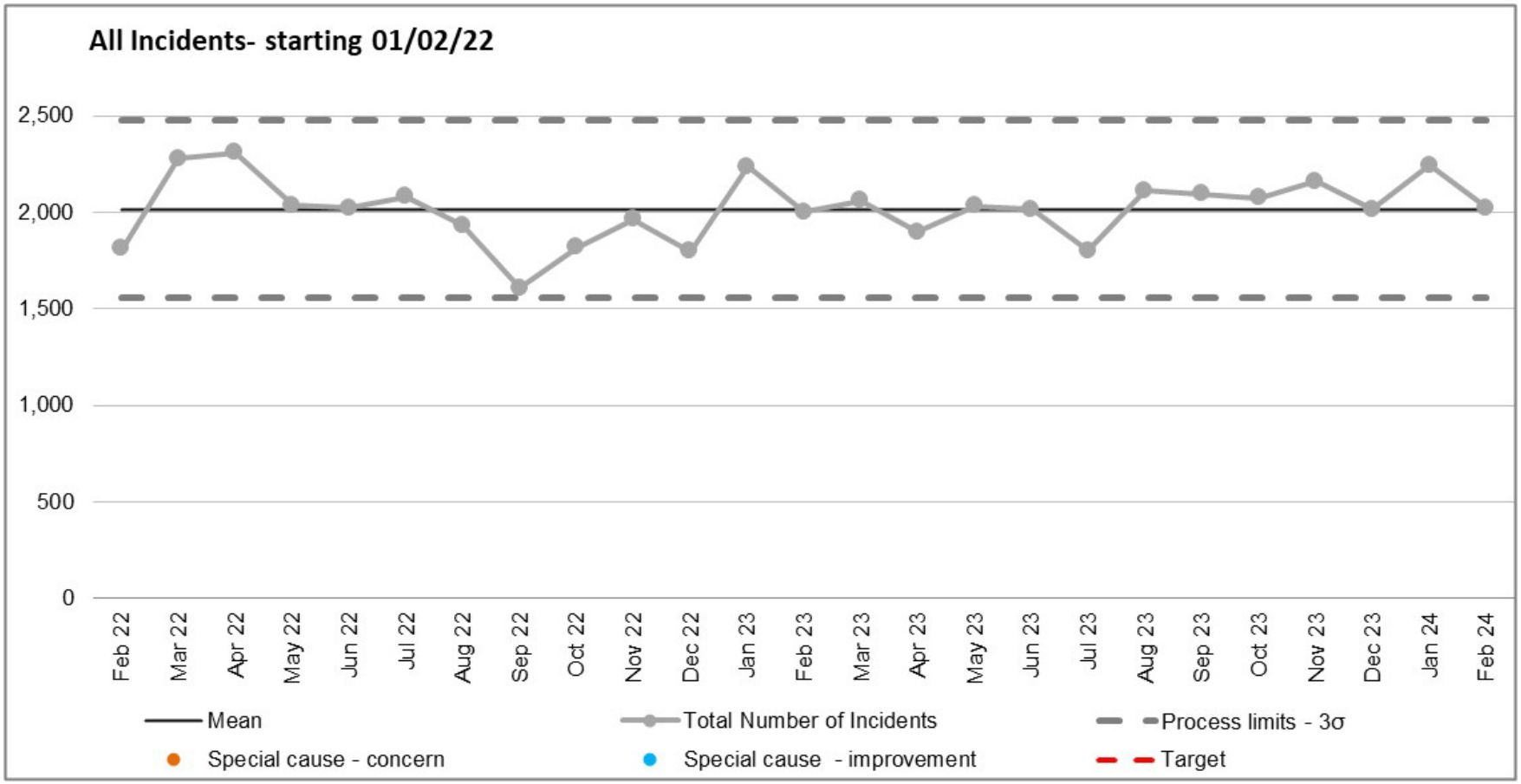
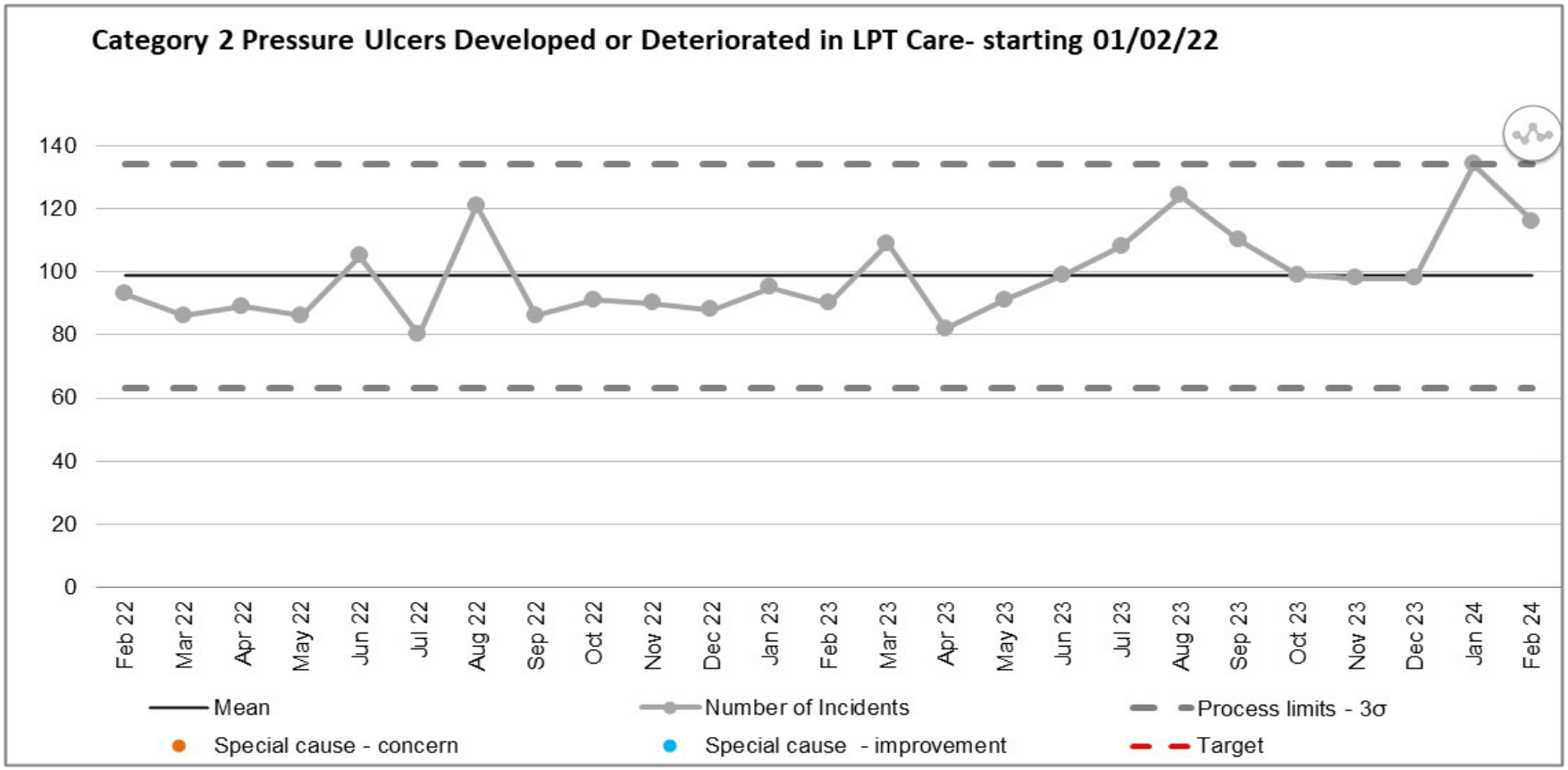
1. All incidents



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



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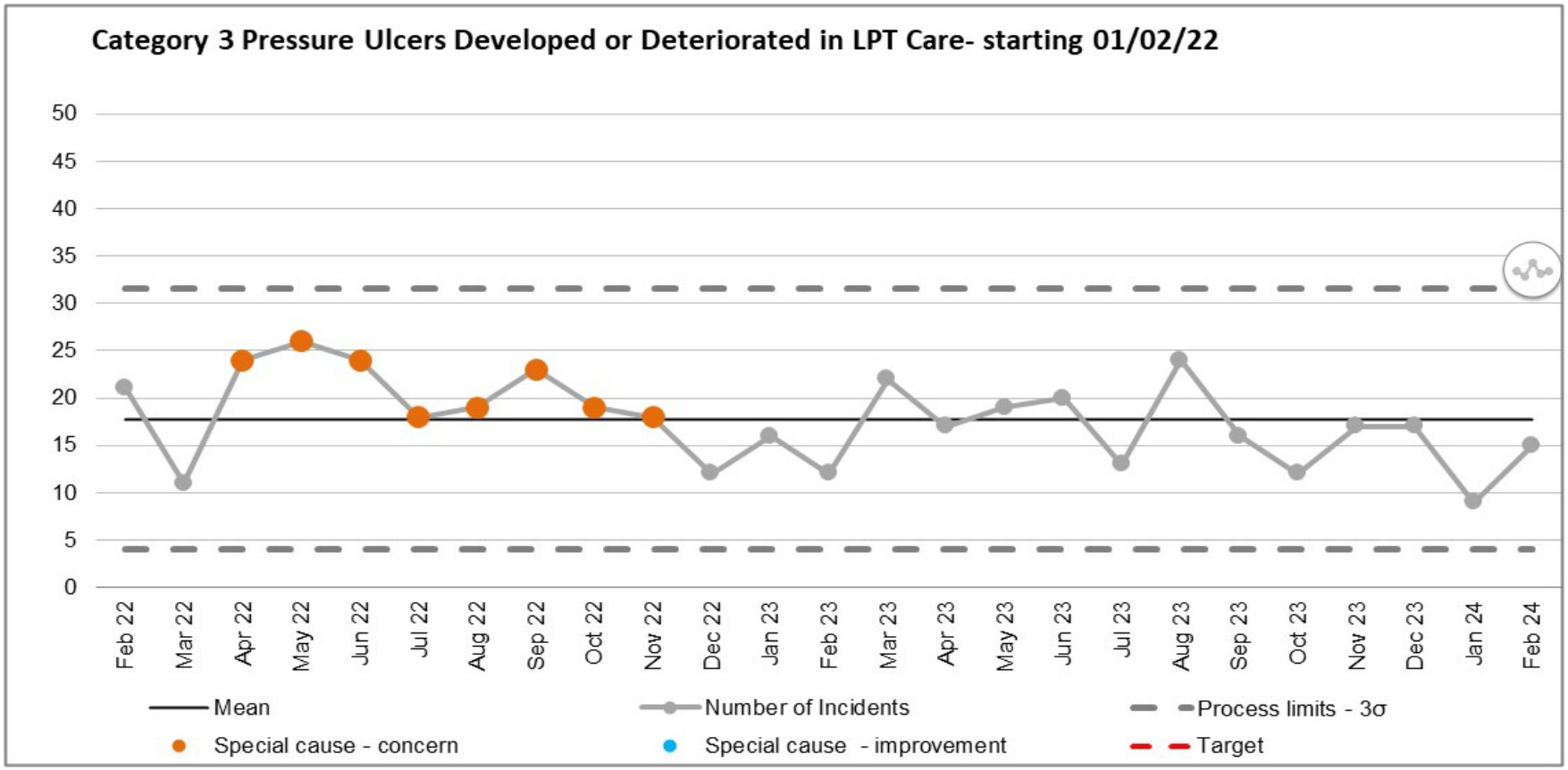
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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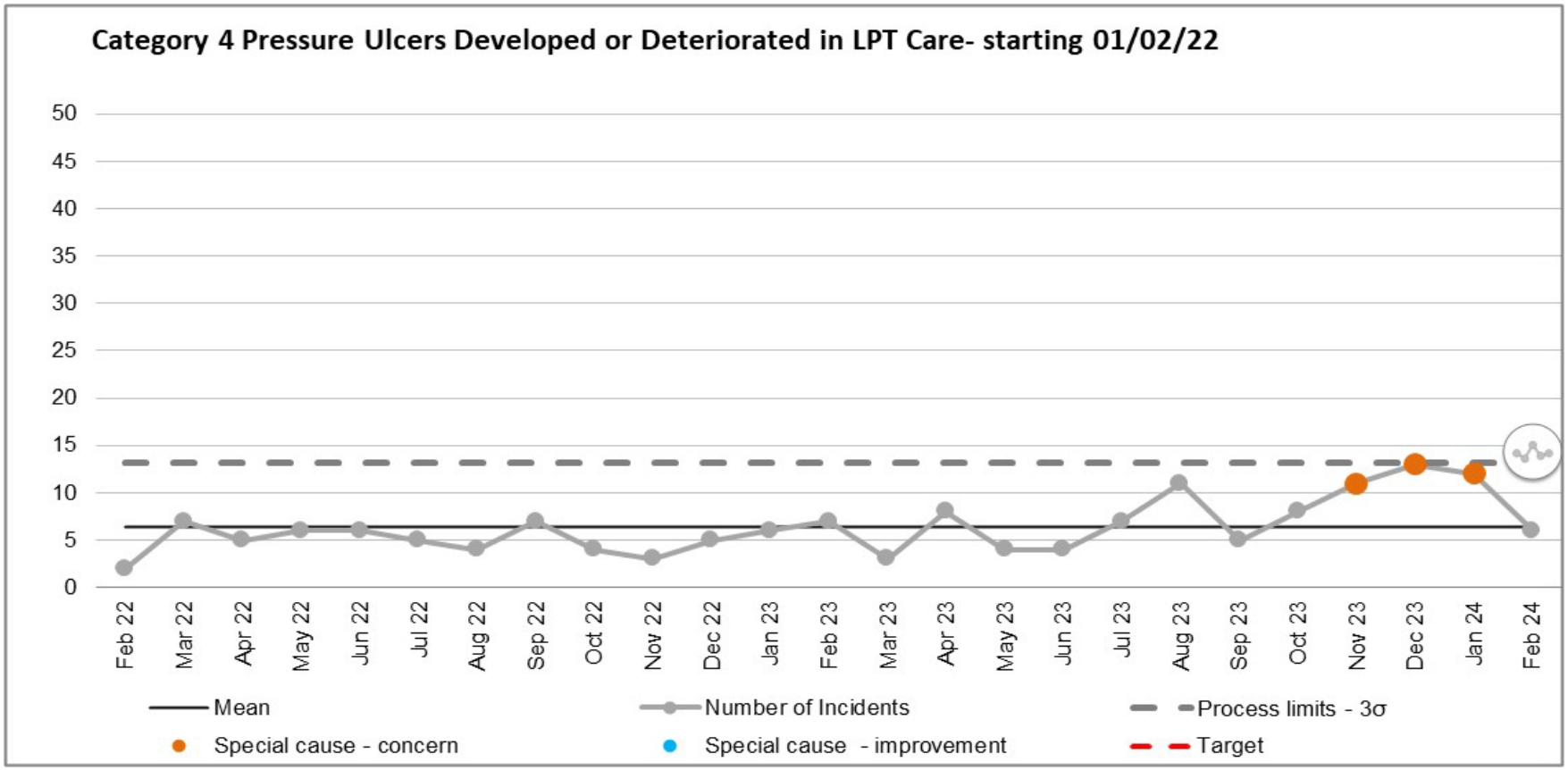
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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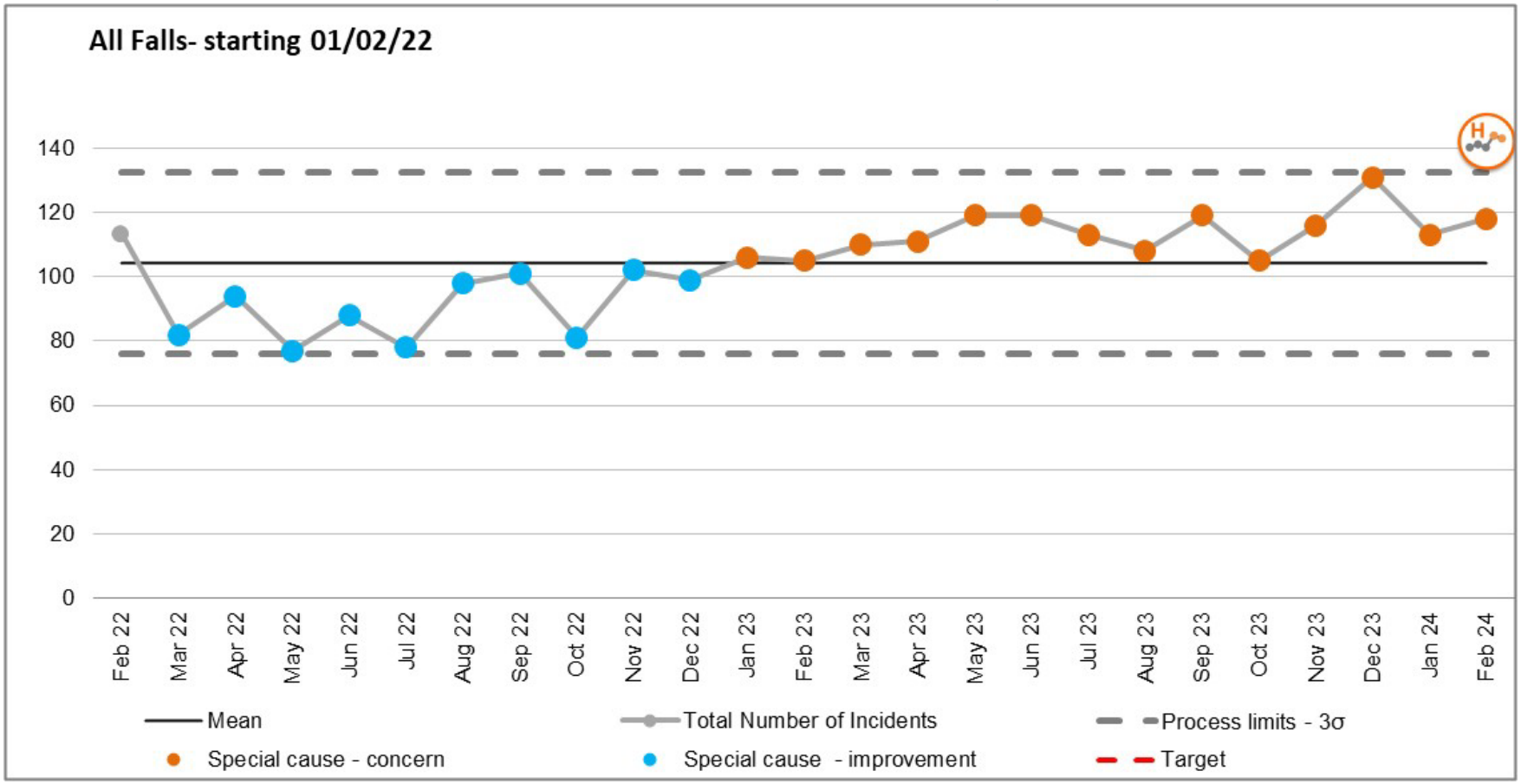
5. All falls incidents reported



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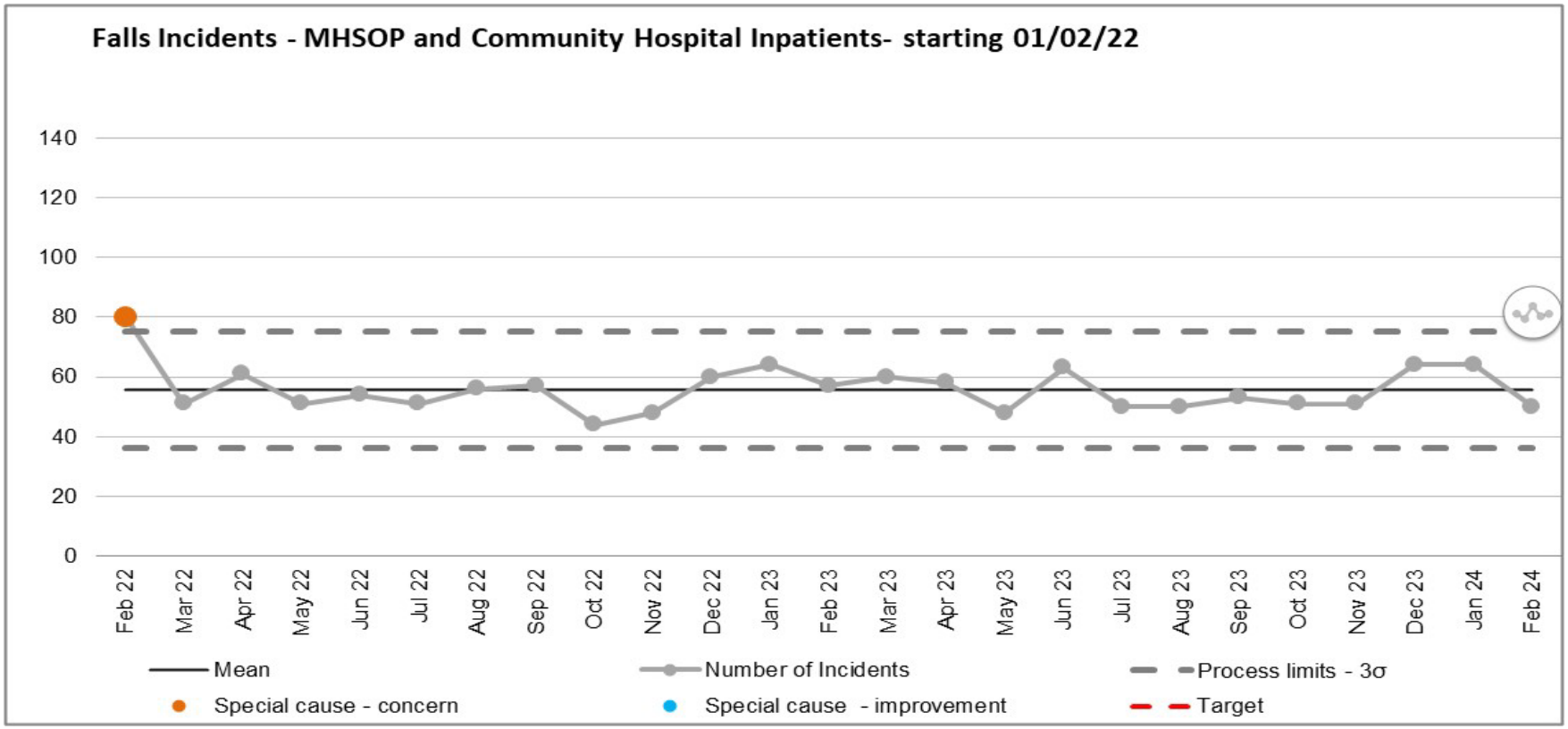
6. Falls incidents reported – MHSOP and Community Inpatients



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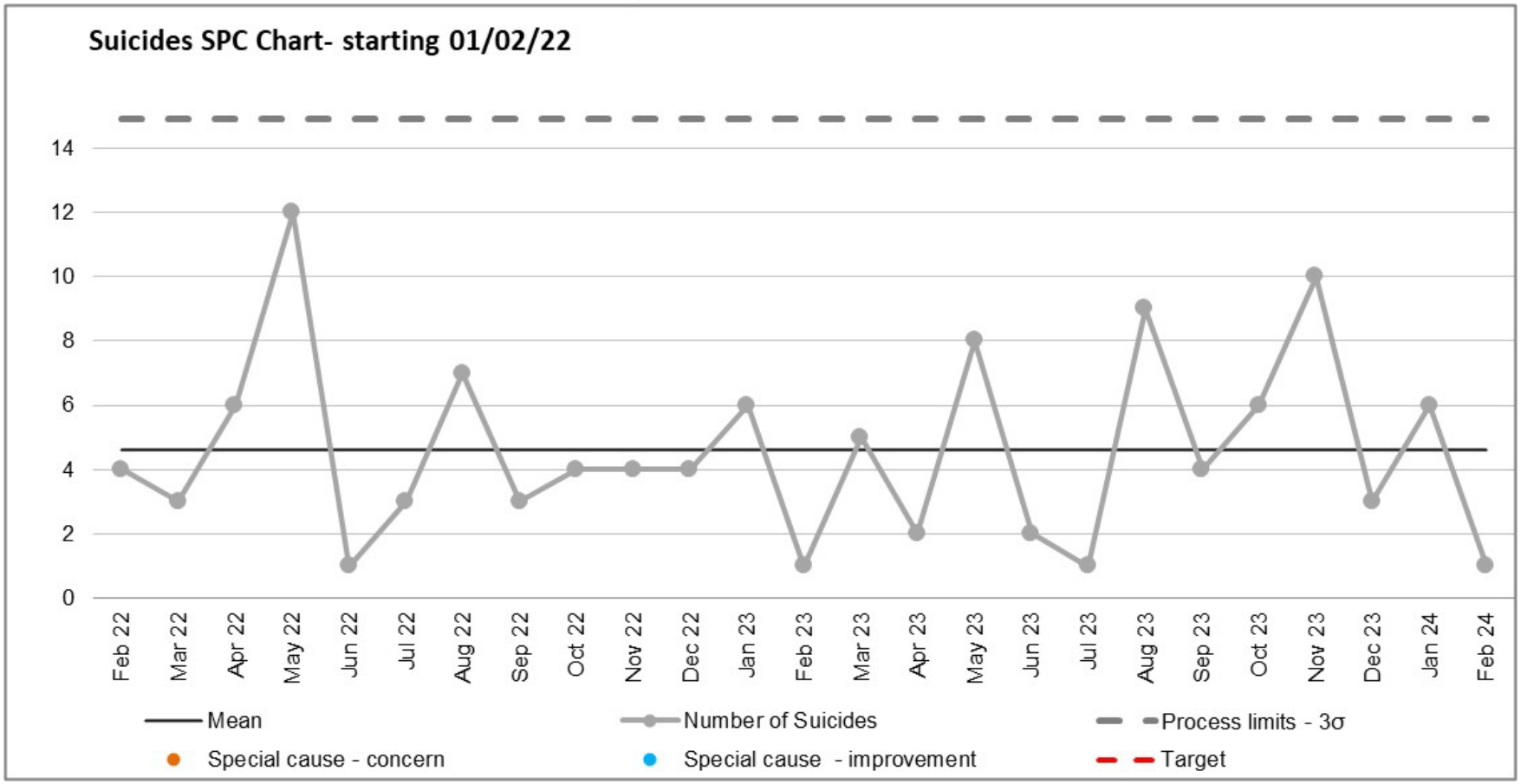
7. All reported Suicides



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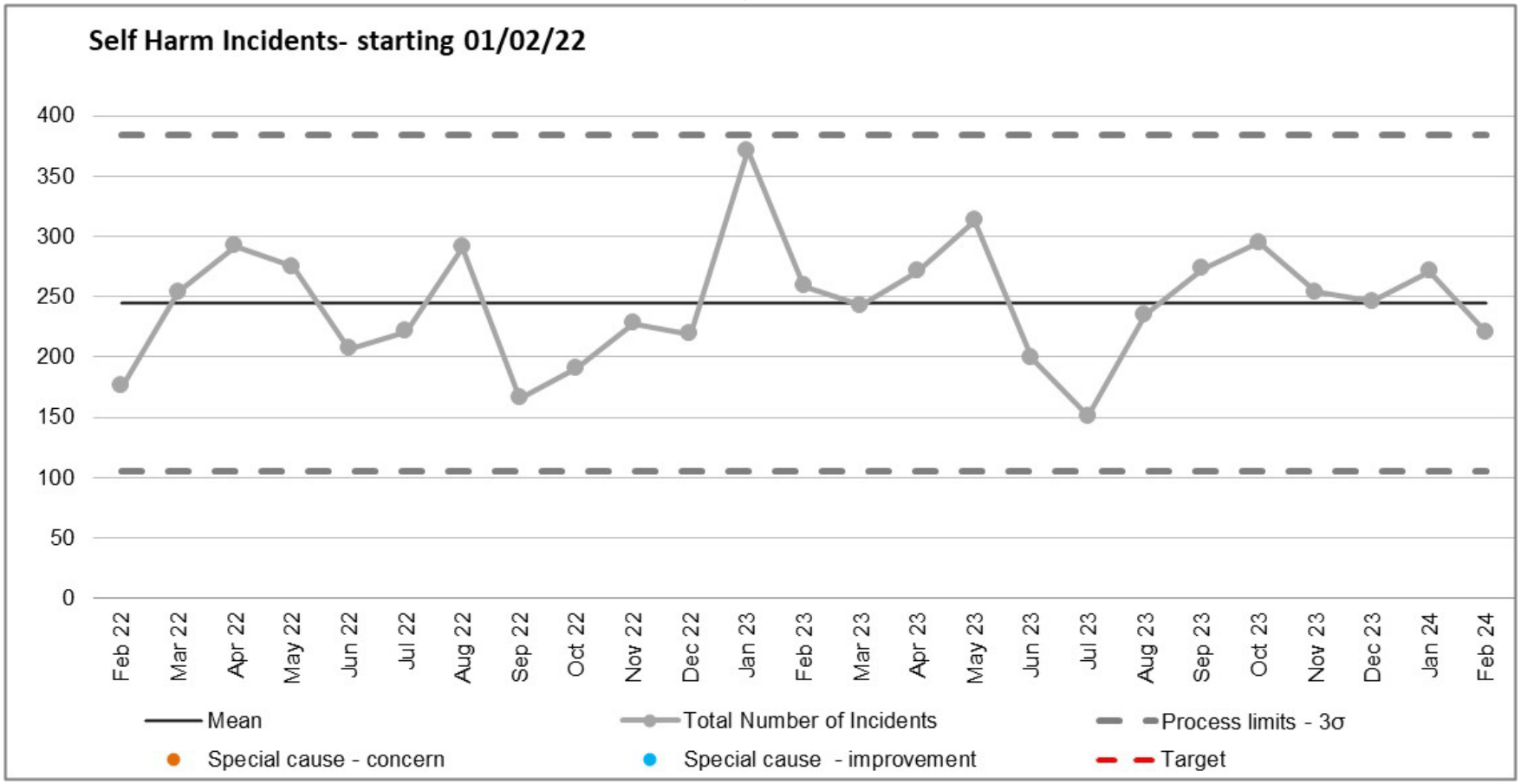
8. Self Harm reported Incidents



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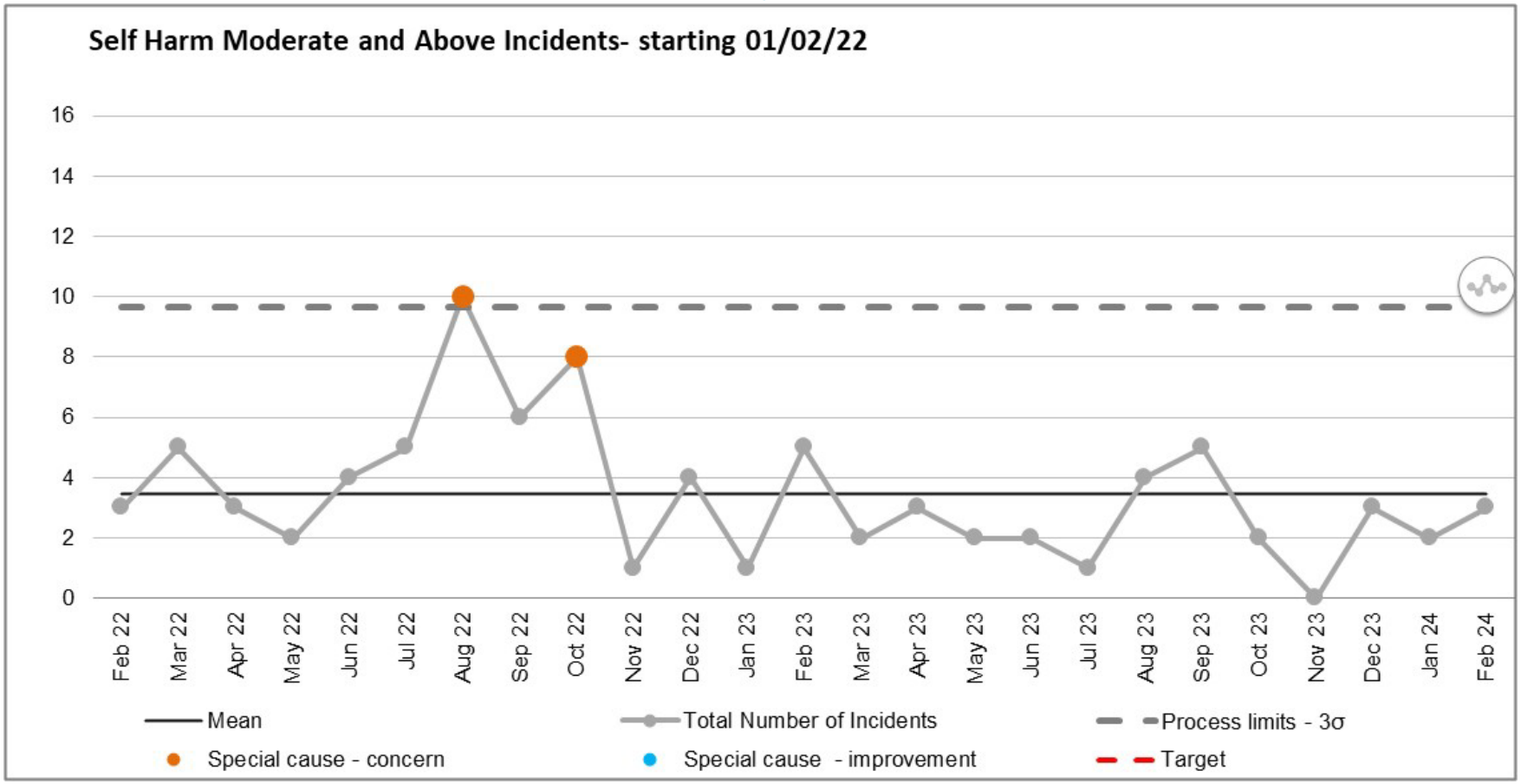
8a. Self Harm reported Incidents



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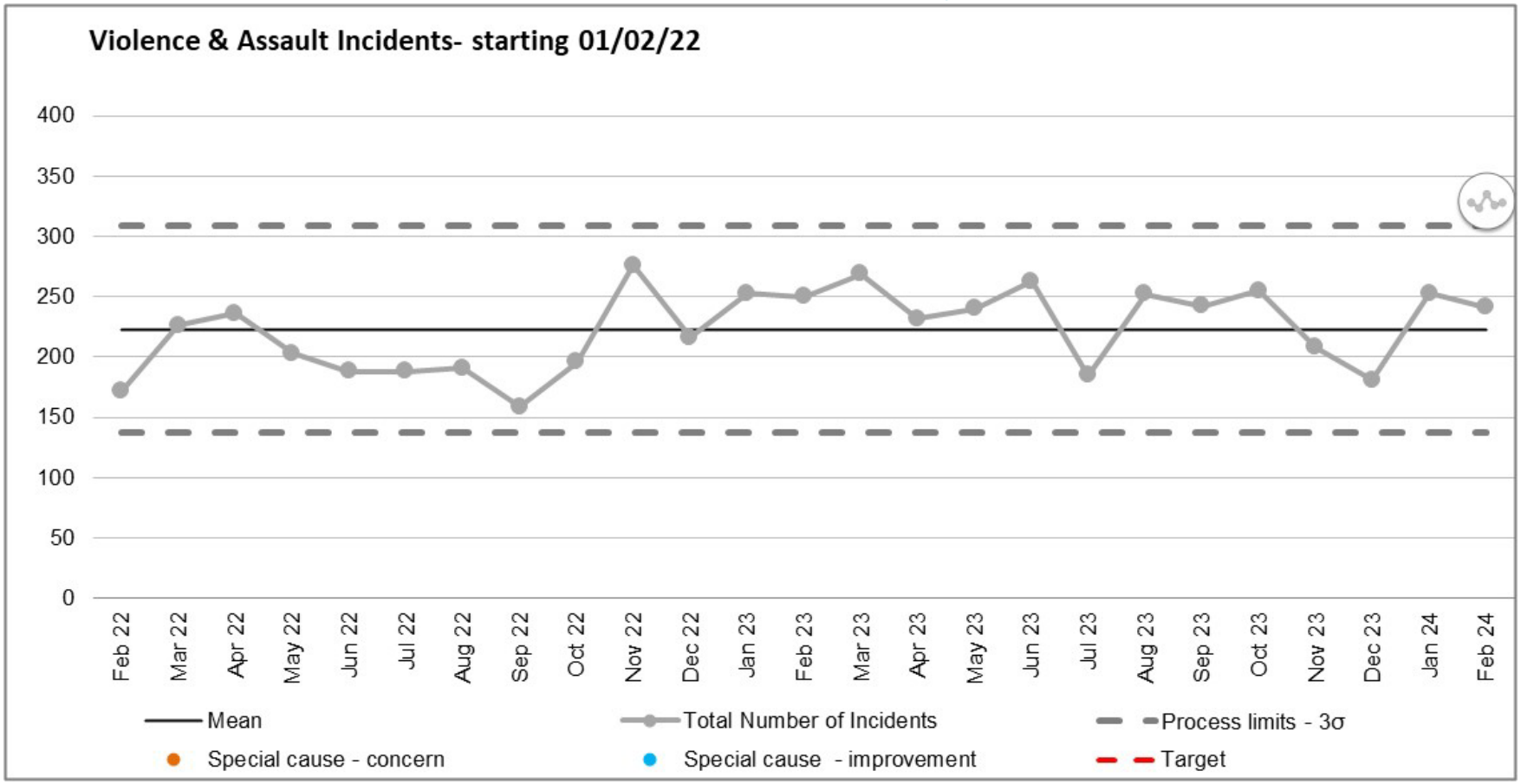
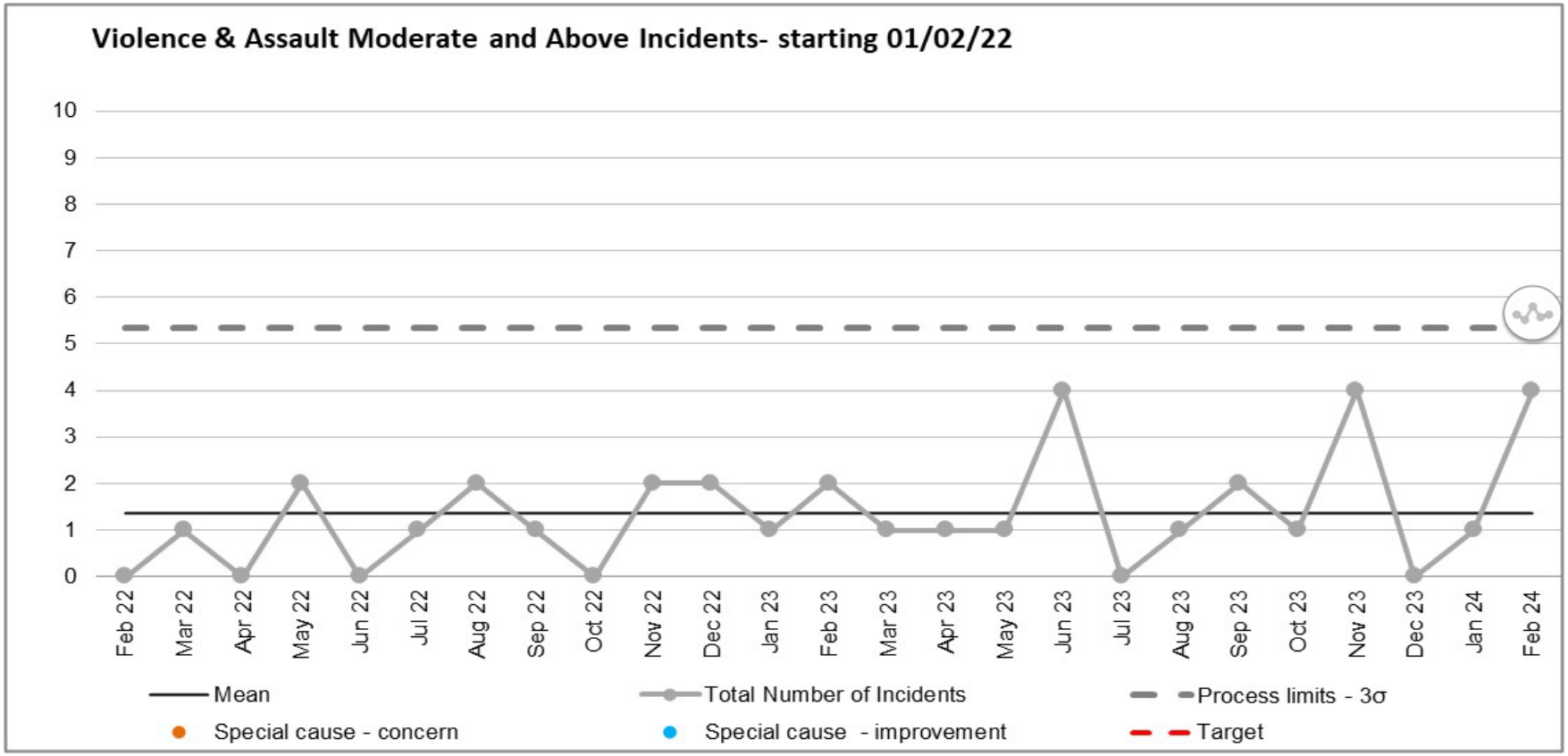
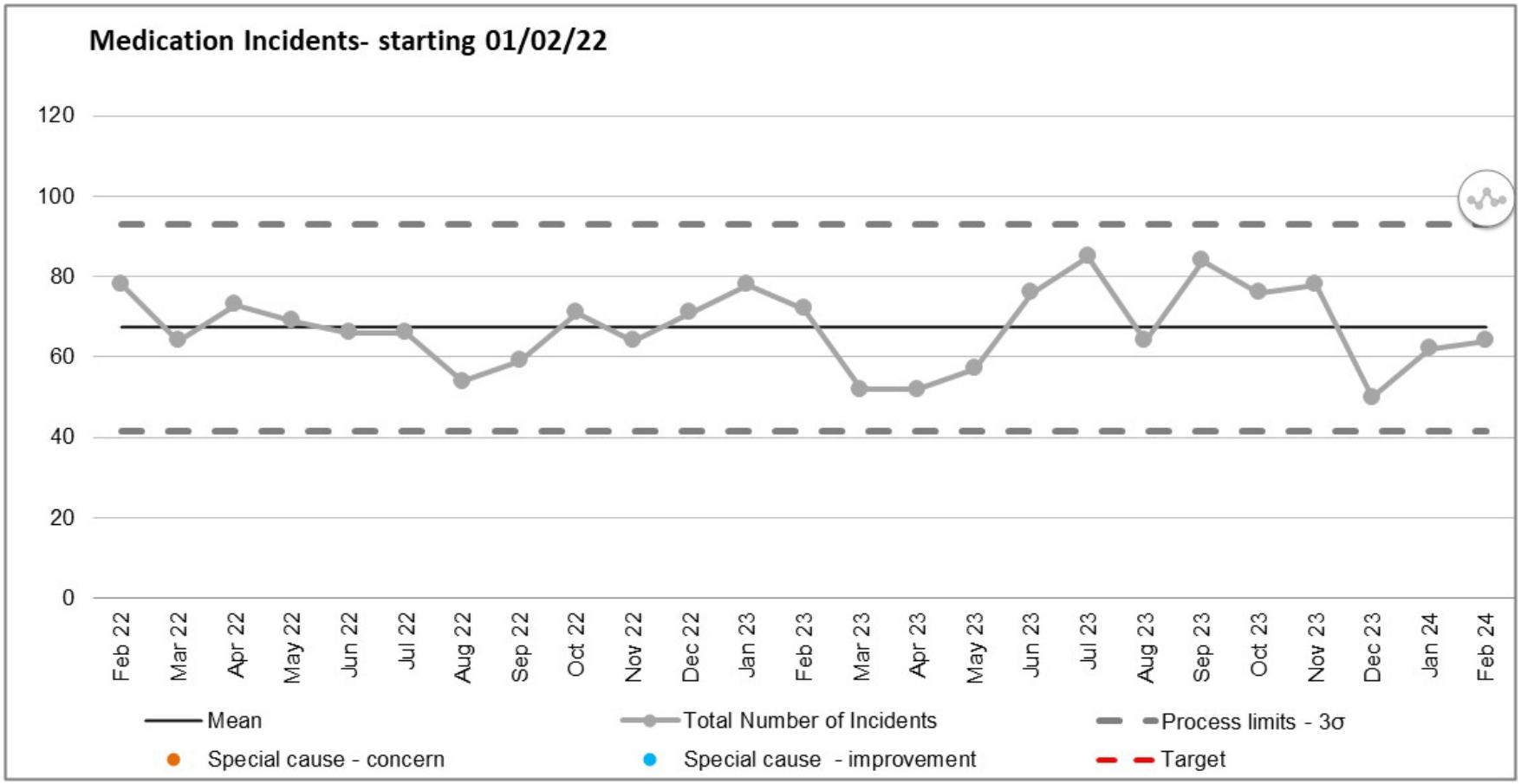
9. All Violence & Assaults reported Incidents



9a. Violence & Assaults moderate harm reported Incidents



10. All Medication Incidents reported



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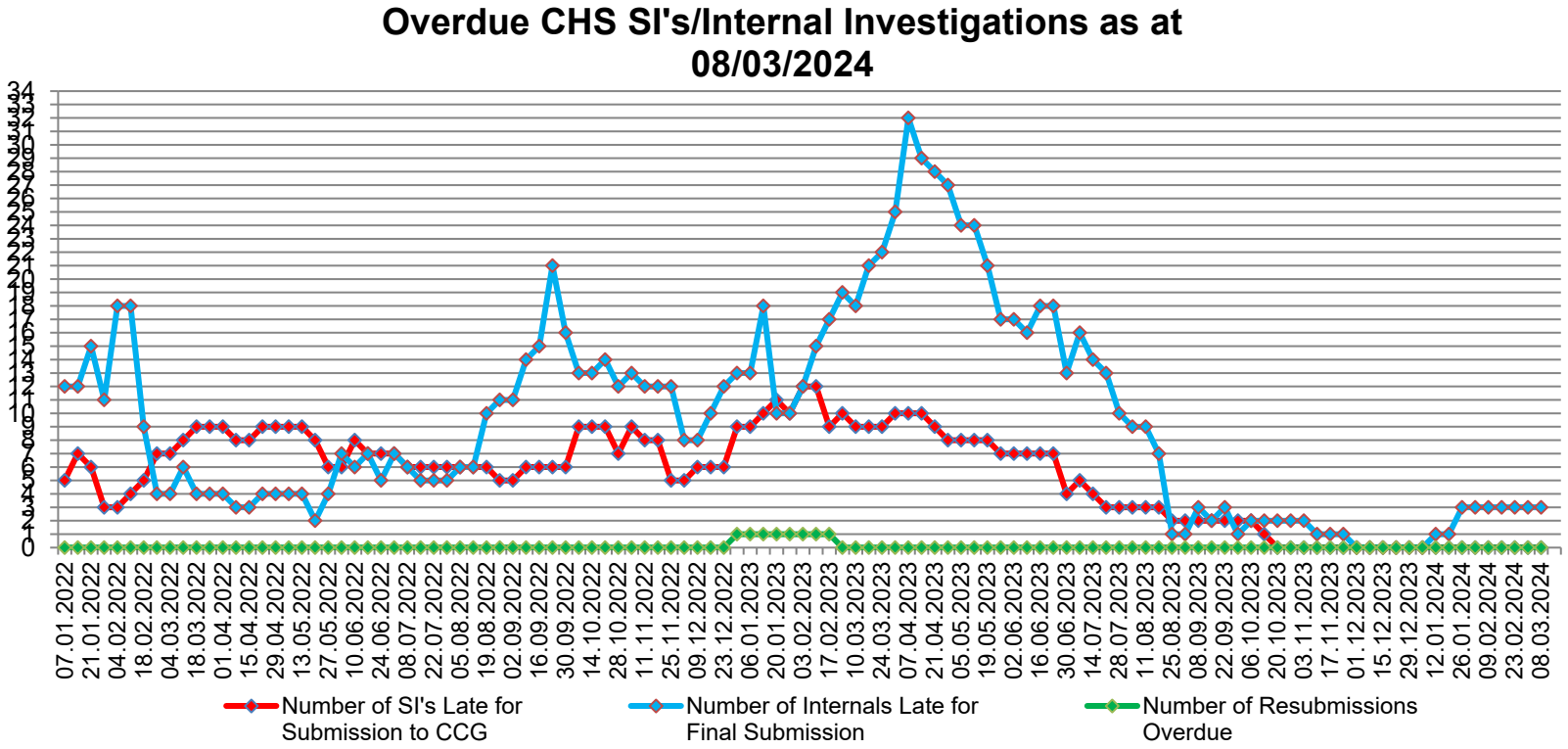
11. Ongoing - StEIS Notifications for Serious Incidents

2022-2024 StEIS Notifications and SEIPS Investigations											
	SI INVESTIGATIONS				PSII MEETING NATIONAL CRITERIA				Internal/SEIPS/PSII Meeting local criteria Investigations		
	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Closed in month	PSII declared DMH	PSII declared FYPC/LDA	PSII declared CHS	Closed in month	DMH	FYPC/LD	CHS
2022-	Not Applicable due to PSIRF				N/A	N/A	N/A	N/A			
April	2	0	2	10	N/A	N/A	N/A	N/A	3	3	3
May	3	0	0	12	N/A	N/A	N/A	N/A	5	0	4
June	4	1	2	7	N/A	N/A	N/A	N/A	2	1	3
July	4	1	4	8	N/A	N/A	N/A	N/A	4	1	6
August	7	1	1	7	N/A	N/A	N/A	N/A	5	2	2
September	3	1	3	10	N/A	N/A	N/A	N/A	8	2	9
October	4	0	3	4	N/A	N/A	N/A	N/A	4	4	11
November	6	0	1	4	N/A	N/A	N/A	N/A	6	0	8
December	7	1	2	4	N/A	N/A	N/A	N/A	6	2	10
January	2	0	1	9	N/A	N/A	N/A	N/A	3	0	10
February	4	1	1	9	N/A	N/A	N/A	N/A	7	2	6
March	1	0	0	11	N/A	N/A	N/A	N/A	9	1	5
2023-2024											
April	3	1	1	4	N/A	N/A	N/A	N/A	8	2	2
May	4	0	2	4	N/A	N/A	N/A	N/A	7	2	3
June	2	1	1	9	N/A	N/A	N/A	N/A	2	4	6
July	1	0	0	10	N/A	N/A	N/A	N/A	3	1	5
August	1	0	0	4	N/A	N/A	N/A	N/A	6	4	13
September	2	0	0	6	0	0	0	N/A	3	1	9
October	1	0	0	4	0	0	0	N/A	5	2	10
November	0	0	0	5	0	0	0	N/A	2	2	1
December	N/A	N/A	N/A	7	0	0	0	N/A	8	3	5
January	N/A	N/A	N/A	3	2	0	0	N/A	7	3	1
February	N/A	N/A	N/A	1	1	0	0	N/A	3	2	7
	61	8	24	152	3	0	0	0	116	44	139

12. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) – CHS as at 08/03/2024



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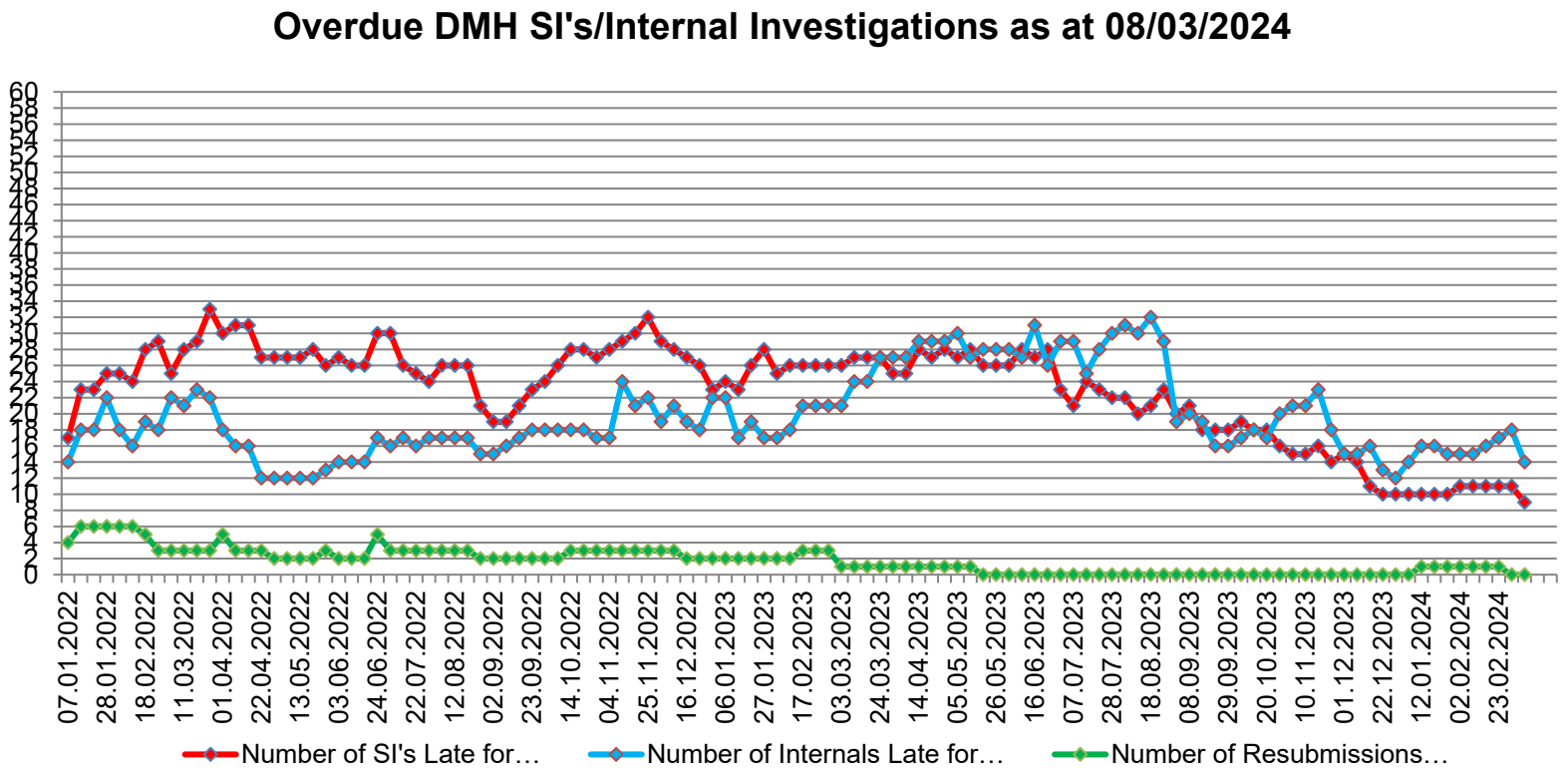
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH as at 08/03/2024



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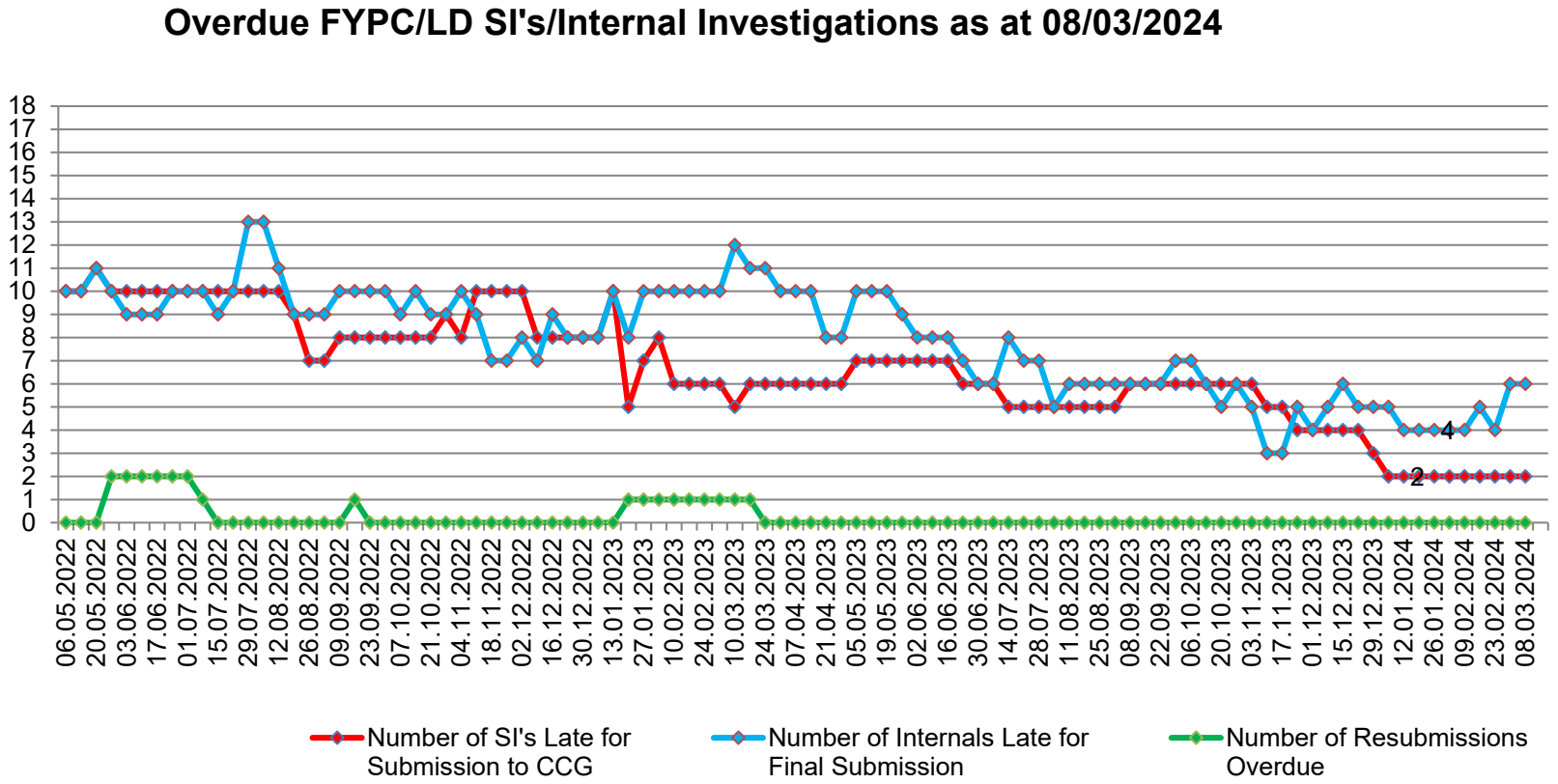
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) – FYPCLD as at 08/03/2024



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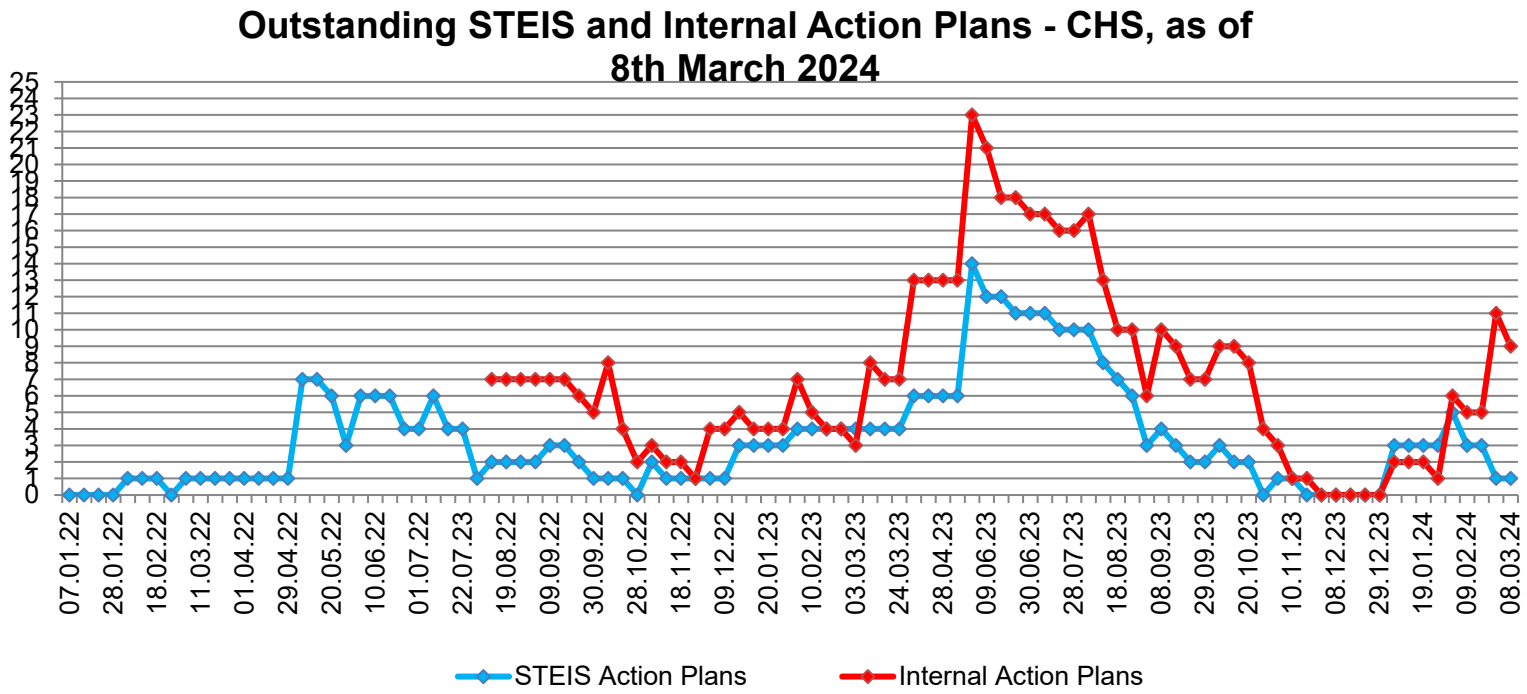
12b. Directorate Action Plan Compliance CHS Status 2021/24 as at 08/03/2024



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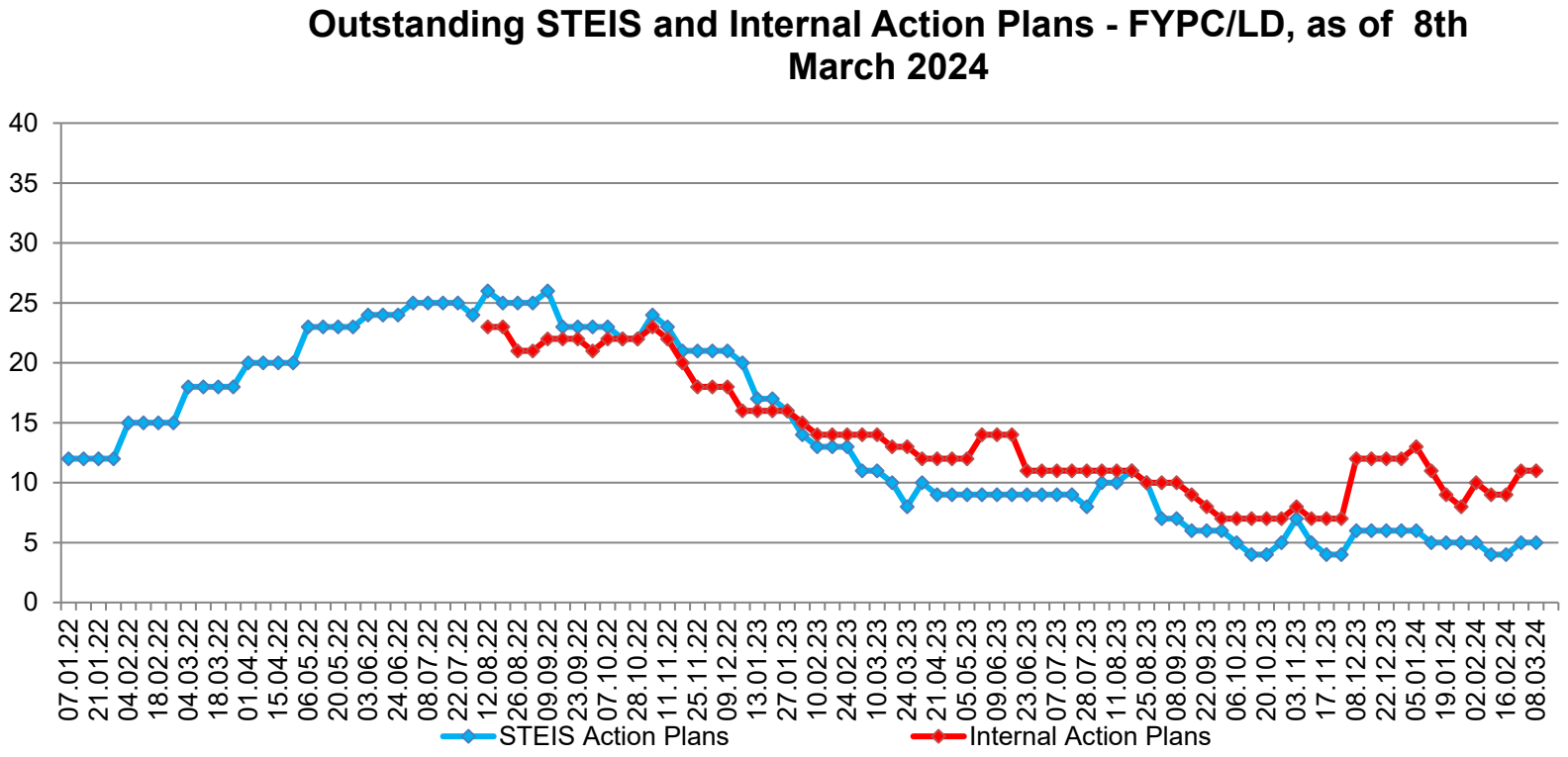
12b. Directorate Action Plan Compliance FYPC/LD Status 2021/24 as at 08/03/2024



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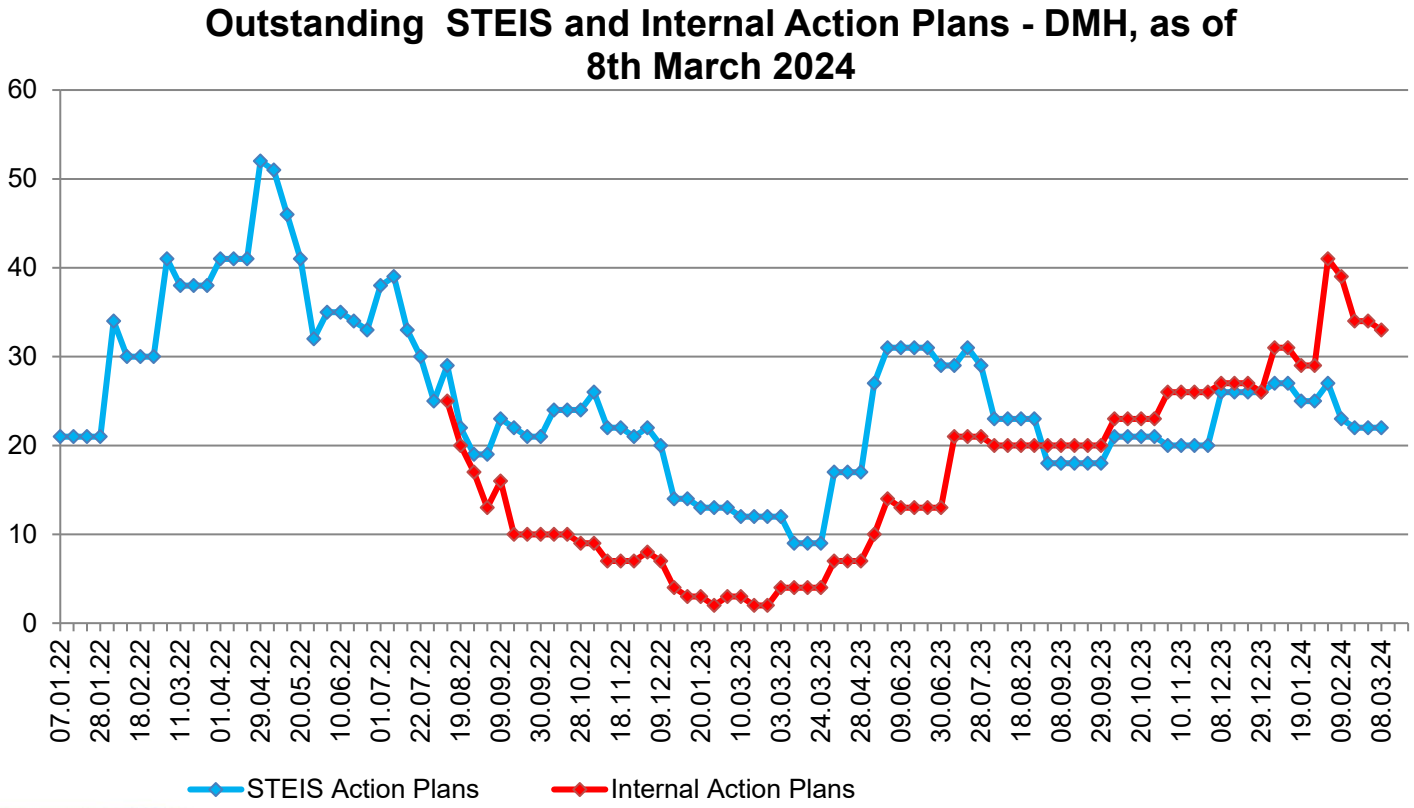
12b. Directorate Action Plan Compliance DMH Status 2021/24 as at 08/03/2024



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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 Initiative for Patient Safety (SEIPS)

- Encouraging confidence to talk together about system learning and less focus on writing reports

- Patient Safety investigators are spending time out with teams to work with them to think about robust actions

14. Learning January/February 2024

Incidents/Complaints Emerging & Recurring Themes

There has been a recurring theme around staff feeling confident and able to engage with patient's families at the same time as maintaining the patient's confidentiality.

Action; Guidance has been written around 'caring confidentiality' and this work is being linked into the triangle of care work stream.

A community of Learning event has been planned to explore with staff the barriers and to identify the support they need

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NHS Trust

Patient safety – Learning from Incidents

Tom's story

Tom was a 54-year-old gentleman who was estranged from his family and lived independently supported by private Mental Health Care support workers who visited him weekly. He had experienced serious mental health problems since the age of 25 and had not been in employment for 16 years. He had been stable on medication since 2019 and was transferred from Assertive Outreach (AO) team to the Community Mental Health team (CMHT) in June 2022, although stable at this time it was recognised he was at high risk of relapse, previously relapses had resulted in substance abuse, self-neglect and interactions requiring police involvement. When he was stable Tom was able to have good social interactions and was independent in all of his activities of daily living. A Community Psychiatric Nurse (CPN) continued to review Tom and administer his monthly depot injections, at the time of the incident Tom was not under any Mental health Act section or Community Treatment Order (CTO) and no concerns had been raised regarding his capacity.

What Happened before the incident?

Tom was reviewed by a Consultant Psychiatrist in August 2022 at this time he appeared stable, taking his medication and had good social interactions and a plan was made to review him in a years' time.

In November 2022 Tom experienced signs of a relapse of his mental health and from December 2022 he began to disengage with his CPN and to refuse his depot injections, he was last been seen by his CPN In January 2023 when he declined his depot injection. On the 31/03/2023 Tom was found in his home by his private carers having died by suicide.

What were the events leading up to the incident?

- In October 2022 Tom completed an LPT service user online questionnaire about his service provision. He wrote he was 'fairly dissatisfied' with his interactions with mental health care professionals.

- In November 2022 Tom told his GP he was having problems sleeping and didn't attend a planned GP appointment and cancelled some of his planned support visits, this was unusual for him to do.

- There was a lack of verbal and written communication that resulted it being unclear who had responsibility for Tom's ongoing care and oversight.

- There were concerns regarding how Tom was managing his finances in the months before his death and further concern he may have been a victim of a financial scam as he previously had managed his own finances well, however

prior to his death had not been paying some of his bills and debt agencies were involved. Tom was also not sharing any of this information with his support worker who he had previously trusted and engaged with in discussing his finances.

- Tom did not discuss and communicate in any detail with his CPN, and they reported that they had not established an effective therapeutic relationship where the CPN felt that Tom was fully able to express his thoughts and feelings.

- Tom's depot injection was due on the 23/12/2022 on the 28/12/2022 he left a note saying he was not at home and would be back the following day, the following day a CPN visited, and Tom was not at home and a note was left asking Tom to contact to arrange to receive his depot injection. Lack of a communication plan with Tom resulted in it being unclear if Tom was receiving notes and messages left for him by staff, no escalation of this was completed to senior staff in line with the DNA policy for patients who are at risk of relapse.

- On the 04/01/2023 Tom told his CPN he didn't need his anti-psychotic medication anymore and had thrown it away and felt 'great' without it. The following day Tom was visited by his CPN and was presenting as quiet, giving short answers and stated he was not taking any medication, it was also noted he had not requested his repeat prescription from his GP since December 2022.

- On the 16/01/2023 Tom was visited by his CPN and declined his Depot injection, and a plan was made to review him in 4 weeks. The CPN escalated for Tom to be reviewed in an MDT forum and 3 days later Tom's disengagement and declining of medication was discussed and a plan made to continue to visit Tom every 4 weeks and to continue to offer him the Depot injections, he was noted to be at risk of his mental health deteriorating due to him declining his depot injections.

- Due to Tom declining his depot injection in January communication of what service was going to be involved in Toms's ongoing care was not clear on the

SystmOne records resulting in Tom being discharged from the service and therefore not being offered his depot injection in February, not reviewing his relapse indicators and having no plan for Tom to receive any further reviews.

What's our Learning?

- Tom's risk factors in relation to him declining his medications were not fully explored and the significant behaviours he had previously experienced during his relapses considered and the effect that not taking his medication would have on the possibility of a further relapse and potential harm to both him and others recognised.

- Changes in Tom's behaviours were not explored and there was a lack of recognition of early relapse factors.

- Reviewing Tom collaboratively with the CMHT, his GP, Consultant, AO team and mental health support workers would have allowed everyone who knew Tom to discuss together and agree a plan of how best to support him and due to the change in his mental health establish if his care needed to be transferred back to the AO team.

- Ensuring all of the relevant detail of health care professionals' interactions with Tom was recorded may have supported staff to review previous entries and decide if any escalation for further support was needed. Ensuring that CPN's routinely review the SystmOne records prior to visits may have highlighted that Tom had telephoned the service and reported he was having problems sleeping.

- It was not recognised that as he was not being managed under a legal framework and was disengaging from services Tom's individuals risk factors and early relapse factors were not recognised and escalated and it appeared that the team had felt everything was being one for Tom.

- There was no evidence that staff had taken the opportunity to discuss with Tom the information he had shared that he was dissatisfied with the mental health services he was receiving may have allowed open communication and

an opportunity for Tom to talk about what he felt he needed in regard to additional support.

- The MDT reviews and documentation did not recognise the level of Tom's risk or the Severity of his SMI or explore safeguarding pathway options during these forums. This may have allowed discussions to establish if escalation were required and rationales to be recorded.

- Escalation by the CPN when it was recognised that Tom was not feeling that he was able to fully discuss his thoughts and feelings with him may have provided an opportunity for a colleague to be involved in Tom's care to establish if a rapport could have been established with another health care professional.

What has been completed since the incident?

- An LPT DMH Transfer checklist has been developed (template for transfer information) to ensure all areas are included needs to be formulated for every transfer between services e.g., AO to CMHT and a new transfer checklist made for any subsequent transfers between services – this is designed to support relevant, current and potential risks to be managed appropriately.

- Risk training has been updated to included discussions surrounding discharge due to DNA being supported by needs led decision making. Update to the Trust Policy in relation to the ensuring decisions are needs led and that all risk assessments must be updated prior to patients being discharged to evidence that it is safe to discharge under the management of non-attendance policy.

- An audit of the standards of patient care record keeping within the Team and relevant actions taken in response to the audit findings.

- A review and audit of the MDT process is taking place across all CMHT's with particular attention to record keeping and rationale for decision making. clearly visible and documented.

Leicestershire Partnership NHS Trust

Patient Story – Learning from Incidents

310322 Jade

About Jade

Jade is a 21-year-old lady who has had a lengthy admission on Langley Ward since September 2021 as an informal patient - a patient in hospital but not detained under the Mental Health Act (MHA).

Jade has an A-typical Eating Disorder which manifests itself as part of her self-harming. She has been diagnosed with Autism Spectrum Disorder (ASD), Emotionally Unstable Personality Disorder (EUPD) and is deaf with cochlear implants. Jade lip reads well and staff wear visors instead of masks when interacting with her as per agreed plan of care. The incident occurred when mask wearing was mandated for inpatient settings.

Jade has had multiple incidents of self-harm during her admission on Langley Ward, including several admissions to hospital (LRI) for assessment and treatment of wounds. Due to the severe level of self-harm, Jade is risk assessed to be on level 3 observations 24 hours a day.

What Happened

On 22nd September, Jade was on an escorted walk around the grounds with two members of staff. She began to power walk in front and away from staff. Numerous attempts were made to tell Jade to slow down but with she did not respond. She eventually stopped and appeared very tearful. Jade stated that she feels she isn't listened to, and she has no freedom because she is on constant observations. Support was given to Jade by staff and the reasons and risks were explained to her as to why she is on constant observations.

Two weeks later, when Jade was on another escorted walk, she again proceeded to walk ahead of accompanying staff and began to headbang causing harm to her forehead. Staff escorting her called for assistance from the ward who responded. Jade then started to walk quickly and staff kept close to monitor the situation.

An ambulance was called to take Jade to the LRI for assessment and treatment of her forehead, however the wait was long so staff decided to take her in a taxi. Jade was escorted by two staff to the LRI where she disclosed to LRI staff that she had burnt her arm on a radiator. Burn wounds from the oil heater were undetected by Langley Ward staff as Jade hid them until she disclosed information at LRI.

On return to Langley Ward during a conversation with staff, Jade expressed anxiety about her discharge planning and covertly self-harmed when feeling unsupported and "trapped" using a radiator.

Good Practice:

A multi-professional discharge meeting was held on 10th October; this was well attended by representatives across the Trust and Jade's voice was captured and evidenced within the meeting minutes.

Evidence of the meeting taking place was documented well within the progress notes.

Learning:

Oil heaters are used on Langley Ward to additionally heat rooms as low weight patients will feel cold and can encourage lowering temperatures by opening windows as shivering will cause further weight loss. Patients are often seen with hands/arms on these portable heaters to keep warm with no previous incidents or risk of burns. It was unclear if the temperature was turned up whilst Jade was resting her arm on it. This incident triggered a full radiator audit of all wards across the Trust by the Health and Safety Team.

Jade should have been encouraged not to sit close to an oil heater and hold her arm against it, as per her care plan dated 2nd October. Staff did not recognise the potential harm from sitting close to an oil heater and placing arms on the heater.

The risks and what to observe for had not been clearly explained and understood by temporary staff who were undertaking the level 3 observations. Staff should have recognised that Jade's arm was on a portable oil heater which was causing her significant burns during the level 3 observations.

In response to these areas of learning, a process has been developed for the ensuring staff (including temporary staff) cannot book a shift unless they have completed the supportive observation and engagement training. Expectations for observations and patient risks are also clearly communicated to staff in handover.

Jade's risk assessment/care plan should have clearly detailed the potential risk of covertly self-harming with a portable oil heater, as well as radiators that has the potential to cause burns. A process has been put in place that if oil heaters are required, there must be a clearly documented risk assessment to understand the potential risk to self-harm. Risk assessments are updated as required and this is being audited. A definitive list of how many and where the oil heaters are positioned has also been completed.

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Patient Safety - Learning from incidents 1

Sylvia's Story

Sylvia is an 85 year old lady who lived in a bungalow with her husband. They received twice daily package of care to help with Sylvia's husband, due to him having dementia.

Other than this they managed quite well and Sylvia maintained her independence, despite previously having two falls at home and had multiple diagnoses of Systemin Lupus, Erythematosus, Myocardial Infarction, Chronic Kidney Disease, Parkinson's Disease and Hypertension.

What happened to Sylvia?

On the 19/10/23, one of the care providers found Sylvia on the floor with a left sided facial droop and left leg weakness. Sylvia was admitted to University Hospital of Leicester where she was diagnosed with a stroke.

Sylvia was then transferred to St Luke's Hospital for rehabilitation 14/10/2023, with the goal to being discharged home as Sylvia was making good progress. When admitted to St Luke's, Sylvia was found to have a large Stage 2 pressure ulcer to her left heel.

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Patient Safety - Learning from incidents 1

On 06/11/2023, Sylvia was reallocated to a bed close to the nurse's station for closer observation for Sylvia's safety, due to Sylvia attempting to stand alone.

Sylvia developed periods of confusion from 07/11/2023 which continue for several day. Numerous tests were performed which identified that Sylvia's new confusion was due to a Urinary Tract Infection and commenced on oral antibiotics.

Sylvia experienced episodes of dizziness and it was identified that Sylvia was having a sudden drop in her blood pressure when she stood up from sitting. This was reviewed by a Consultant, who thought this was due to Sylvia's diagnosis of Parkinson's.

On 12/11/2023 the bed rails assessment was reviewed due to Sylvia becoming restless. It was reasoned that bed rails were not suitable to be used for Sylvia and the care plan was updated to highlight this. Alternatively, for Sylvia's safety, a decision was made to utilise the low bed, without bedrails. Under supervision, Sylvia was independently mobile with a frame, and Sylvia would use her call bell to request supervision when mobilising, as she had been advised to.

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Patient Safety - Learning from incidents 1

The morning of 13/11/2023 Sylvia was found on the floor at 1100hrs on her right side, this fall had not been witnessed, however no injuries were sustained. Nurses recognised that Sylvia required closer observation due to attempting to mobilise without asking for assistance. Approximately 1500hrs a Mental Capacity assessment was completed which regarded Sylvia did have capacity, even though she appeared confused at times. There was no indication for one-to-one observation for Sylvia.

At approximately 1650hrs on 13/11/2023, Sylvia was witnessed getting up from her chair unaided and attempted to walk. Staff did not reach Sylvia in time and unfortunately Sylvia fell hitting the left side of her head. On full examination, Sylvia was found to have shortened rotated left leg, which is common indicator of a fracture hip. A Flo Jack hoist was used to lift Sylvia safely back to her bed. An ambulance was called but it was 12 hours before the ambulance arrived, and Sylvia was then transferred to University Hospital of Leicester. It was confirmed that Sylvia had a left hip fracture, however, no other injuries found, therefore, Sylvia underwent a total hip. Following surgery, Sylvia was discharged to a replacement Care Home and have input from the Leicester Partnership NHS Trust Community Nursing Team for pressure ulcer and medication management.

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Patient Safety - Learning from incidents 1

Effect on Sylvia's family

Sylvia's husband remained at home. Family were upset that their mum had fractured her hip but understood that this was a high risk of happening. Unfortunately, Sylvia was unable to return home with her husband and she was placed in a care home where she eventually passed away.

Our Learning Focus

- Staff identified Sylvia's risk of falling was increased by her new confusion and trying to mobilise alone. specific care interventions.
- Staff acted as soon as Sylvia's increased falls risk was identified by moving her to a bed closer to the nurse's station.
- Falls and bed rails assessment were reviewed as well as assessing Sylvia's Mental Capacity. And Sylvia's capacity was re-assessed again following the fall at 1100hrs on 13/11/2023, and although Sylvia was presenting with episodes of mild confusion, it was deemed that Sylvia did in fact have capacity.
- Sylvia's blood pressure had not been checked or repeated on several occasions when Sylvia had reported feeling dizzy.
- A mild postural drop on 30/10/2023 had not been repeated.

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Patient Safety - Learning from incidents 1

- Sylvia's observations had not been taken at least twice daily.
- Sylvia's behavioural charts had not always been fully completed, which was difficult to ascertain how often Sylvia was taking risks.
- Sylvia's fluid intake between 11/11/2023 and 13/11/2023 was recorded as 2,685ml in total. which was well below her expected intake.
- All post falls assessments and paperwork were completed in a timely manner and post fall actions to the policy were adhered to.
- Staff monitored Sylvia's wellbeing during the 12 hour wait for the ambulance and managed Sylvia's pain. Anticoagulant medications were not administered accordingly, and neurological as well as physical observations were monitored.
- Sylvia's daughter was informed of the fall.

Changes made following this incident.

- ✓ Observations should be completed a minimum of twice daily, or otherwise indicated.
- ✓ The associated risks of low beds should be considered for patients attempting to stand without assistance or observation.
- ✓ The Learning Board will be shared at MDT meetings and the ward meeting to be read by all staff via supervision.