

## Trust-wide Combined Learning Report Quarter 3 and 4 2017/18

<b>Presented by:</b>	Tanya Claridge, Director of Governance and Corporate Affairs	<b>Author:</b>	Tanya Claridge, Director of Governance and Corporate Affairs on behalf of the Learning and Surveillance Hub
<b>Previously considered by:</b>	Quality Committee		

Key points	Purpose:
1. This paper provides an overview of the work of and outcomes from the Trust organisational learning response system during Quarters 3 and 4 2017/18	To note and gain assurance

Executive Summary:
<p>During the latter part of 2016/17 the Trust identified the need for a knowledge management framework to support learning from 'precursor events' (which can be complaints, incidents, claims, inquests, mortality reviews, tacit knowledge and experience of staff etc.). As a result an organisational learning response system was developed, and has been presented in a specific paper to this Committee. This paper provides an overview of the learning generated through the system, its precursor 'incident', the learning itself and the modality used to disseminate it across the Trust. This report provides a summary of the Trust wide learning during Quarters 3 and 4 2017/18. It provides an overview of the learning generated through the organisational learning response system, its precursor 'incident', the learning itself and the modality used to disseminate it across the Trust.</p> <p>The Trust, during Quarter 3, remained focused on the continued safe implementation of the Electronic Patient Record and preparation for anticipated unannounced and well led CQC inspections during Quarter 4 2017/18. Due to the volume of work required of the team and other staff involved in the learning hub during quarter 4, specifically related to winter and three consecutive CQC inspections only one learning matters was produced in that Quarter..</p> <p>There is now a standing item on the Quality Committee agenda which relates to the Quality Oversight System. This will provide a more contemporaneous summary of the work of the Learning system in addition to this quarterly report.</p>

Financial implications:
Yes – Income & Expenditure

Regulatory relevance:
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<b>Monitor:</b>	Risk Assessment Framework
	Code of Governance
	Quality Governance Framework

<b>Equality Impact / Implications:</b>	
	<p><b>Is there likely to be any impact on any of the protected characteristics?</b>  (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights)</p> <p>Yes   <input type="checkbox"/>                                      No   <input type="checkbox"/></p> <p>If yes, what is the mitigation against this?</p>

<b>Other:</b>	CQC fundamental standards
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<b>Strategic Objective:</b> <i>Reference to Strategic Objective(s) this paper relates to</i>	To be a continually learning organisation
	To provide outstanding care for patients
	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To collaborate effectively with local and regional partners

- One of the principles of the learning and response system is the absolute recognition that

1 precursor events where there was significant concern

partners, staff and patient conversations and a quarterly focus group of the learning and surveillance hub) to be used in a learning process to support

The Trust now has a dedicated

## Trust-wide Learning

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- Libraries
- Responding & Improving
- Learning matters
- Local improvement actions
- Rapid response actions
- Resources
- Corporate papers
- Latest Learning
- Drop Off Library
- Organisational Learning and Surveillance Hub
- Learning Alliance
- Model of Learning and Response
- Quality Oversight System
- Latest Learning

***'Many disasters have occurred because organizations have ignored the warning signs of precursor incidents or have failed to learn from the lessons of the past'***

We have developed and implemented a **knowledge management framework** allowing the creation, acquisition, dissemination, and implementation of this knowledge across the organisation.

This system, the **'organisational learning response system'**, enables precursor incidents (which are identified from complaints, claims, incident reporting, inquests, mortality reviews, patient experience information, ProgRESS reviews, effectiveness data information from regulators and external partners, staff and patient conversations and a quarterly focus group of the learning and surveillance hub) to be used in a learning process to support Trust-wide change and improvement and contribute to the avoidance of future incidents.

The key elements of the system are

- rapid response actions where measures are taken against immediate threats to safety
- Risk awareness publications which are safety awareness publications (we call these Learning Matters)
- Publicising actions taken which is how we widely publicise corrective actions taken to resolve safety and quality issues (we call this Responding and Improving)
- Improvement actions, which are specific actions and implementation plans for permanent improvements
- Latest Learning, supporting innovations in contemporaneous learning across our organisation

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# **1. Precursor event: Significant Concern**

Learning question	Source	Mechanism	Action	Learning outcome
How do we inform all relevant staff of the immediate action they need to take in relation to issues and concerns relating to the use of the Electronic Patient Record?	The command and control structure put in place to support the implementation of the Electronic Patient Record	SilverCommand	Issues of significant concern were escalated to Silver Command	A distinctive 'red border email' relating to the issues identified was published (see Appendix 1) and a dissemination process using face to face contact with key staff across the Trust was implemented as necessary
Are the infection prevention and control mechanisms in our theatres effective and consistent?	CQC inspection	Issues of concern were identified during the CQC unannounced inspection.	Escalated to Executive Management Team QuOC	Previous interventions in relation to the findings of a 'peer review day' had not been effective and assurance was not adequate. A review of how we place value on assurance will be undertaken during Q1 2018/19 and presented to all Sub-committees A theatre summit process was initiated. An action plan has been developed, as well as focusing on the actions needed to be taken, which focuses on the 'blocks' within the organisation to effecting change, in this case the relationship with Estates and Facilities.
Is the process by which information sharing with primary care through the Trust's EPR effective and resilient?	Serious Incident	Serious Incident	Escalated to QuOC	An unforeseen error caused a backlog in documents being transferred to primary care. An enhanced mapping and reporting assurance system was put in place. Reports from primary care of delayed documents coming into the organisation were adhoc and fragmented, making it difficult to understand the scale of the incident. As a result the system for feedback to the Trust from primary care has been strengthened.

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Learning question	Source	Mechanism	Action	Learning outcome
Do we use the outcome of national audits to effectively identify services that may be providing sub optimal care?	Sentinal Stroke National Audit Programme (SSNAP)	National audit report and evaluation	Escalated to QuOC and EMT	A review of the management of the national audit programme across the Trust will be conducted during Quarter 1 2018/19, with an additional focus on the risk assessment completed, as audits are published and the contextualisation of the outcome measures identified with other outcome measures. In addition a review of the conduct of national audits is being undertaken to ensure that data quality is good.

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## 2. Precursor event: Concern

Learning Question	Source	Mechanism	Action	Outcome
How can we ensure the quality of care of patients who are being cared for 'out of specialty'	Concerns identified by staff, incidents	IPMG L&SH Daily Huddle QuOC	Escalated to QuOC	A specific programme ('buddying') of clinical review and assessment of patients being cared for out of specialty has been implemented
How can we improve the timeliness and consistency of RIDDOR reporting?	Incidents and evidence of delays in reporting	H&S Committee Daily Huddle		Awareness campaign developed, revised flow chart consulted upon and implemented
Are we providing high quality care to young people who are cared for on adult wards?	CQC Provider Information Return	Assurance team	Escalated to QuOC	Protocol developed and risk assessment completed
How can we improve our performance specifically in relation to VTE risk assessment?	VTE Group	VTE Group	Escalated to Learning and surveillance hub	Learning matters issued (see Appendix 1)
How can we ensure the safety of patients when we are using thickening agents?	Near miss incidents	Daily Huddle	Escalated to Learning and surveillance hub	Learning matters issued (see Appendix 2) Escalated to divisions for discussion and awareness raising at safety huddles
How can we ensure the quality of care of end of life patients that require a McKinley syringe pumps.	Near miss incidents identified by palliative care team	L&SH	Learning matters developed	Learning matters issued (see Appendix 4) Initial feedback has seen a rise in staff accessing the training and contacting the Palliative Care team for advice.
How can we reduce our mislabelled blood samples within the Division of Women's and Children's?	Divisional Quality and Safety meeting	Divisional governance	Newsletter Training Awareness raising	A W&C Learning for all issued Education via supervisor support Awareness poster developed using images to attract staff was felt to be effective and approach to be considered during Q1 2018/19, needs to be consistent with the organisations approach to learning. In addition this learning should be shared

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Learning Question	Source	Mechanism	Action	Outcome
				across the Trust.
How we can ensure that oxygen is prescribed every time it is required?	CQC inspection	Executive Management team	Red border email Compliance audit	It is recognised that the prescribing of oxygen, pre the launch of EPR was sub optimal. The EPR provides an opportunity for simple contemporaneous audit and assurance and intervention in relation to prescribing
How can we ensure second order change in relation to our recording of VTE assessments on EPR?	Routine performance data	Executive Management team	Executive led change programme	The use of contemporaneous ward level data from the EPR has been the key to the improvements in recording of VTE assessments, through being able to target specific poorly performing areas in a timely way. The second order change could be replicated for other areas of patient risk assessment and care management.

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### 3. Precursor Event: Opportunities for change and improvement

Learning question	Source	Mechanism	Action	Outcome
Are our action plans that are developed after Serious Incidents and Complaints effective?	Serious Incident and Complaint Investigations	IPMG QuOC Commissioners CQC	Quarterly report to Q&S Committee and CCG Newsletter publication to describe impact of changes made trust wide	Assurance reviews of the effectiveness of action plans developed after serious incidents have occurred, are routinely undertaken and identify how effectively the organisation has responded to the recommendations made.
How can we ensure we are learning from nationally published patient experience to prevent similar incidents in our Trust?	NHS Resolution publication	L&SH	The LSH discussed the case published and its similarity to a BTHFT incident.	The Hub agreed to draft a Learning Matters for publication in Q1 2018/19



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#### 4. Precursor events: Good learning practice

Description	Mechanism	Learning and Surveillance Hub assessment
NHS Resolution is sharing the experience of patients involved in incidents or claims, to help prevent a similar occurrence happening to patients, families and staff. The case stories require the consideration of 'Could it happen here?'	NHS Resolution publication	The Learning and Surveillance Hub will routinely review the case stories and ask; <ul style="list-style-type: none"> <li>• Could this happen in my organisation?</li> <li>• Who could I share this with?</li> <li>• What can we learn from this?</li> </ul>
Are we maximising the learning from the Structured Judgement Review process?	The Learning and Surveillance hub receives regular feedback from the SJR process and contextualises, the learning in relation to our precursor events.	The Learning and Surveillance Hub suggested that a Learning Matters (See Appendix 3) and a Responding and Improving issue should focus on learning from mortality reviews and incidents involving the death of a patient. (See Appendix 5).
Have we got the process in place to enable us to learn from the investigations undertaken by the Health Care Safety Investigation Branch?	The HSIB produce interim reports with safety issues identified in the early phase of investigation and final reports with learning for all organisations.	The Learning and Surveillance Hub will receive all safety issues from interim briefings from the HSIB and all the final reports and consider their implications.

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Appendix 1 Learning Matters

## VTE. ASSESS. PREVENT.

### Venous Thromboembolism

VTE is the leading preventable cause of hospital deaths, ahead of pneumonia and infections.

Patients being cared for by us are still being harmed by, and several have died as a result of preventable blood clots.

This is because we

- Don't always complete an assessment when we should do
- Don't always act on the results of that assessment as we should.

### ASSESS. PREVENT. EVERYTIME

Every patient has a right to know if they are at risk of developing a VTE.

All patients (who are not excluded) should have an assessment of their risk completed as soon as they are admitted to hospital.

Their risk should be re-assessed after they have been an inpatient for 24 hours and if their condition changes.

All patients should have the outcome of their assessment explained to them and the preventative measures planned.

The effectiveness of the preventative measures planned should be monitored and reviewed regularly.



Documenting assessment and prevention is easy on our EPR and we should check every day that it has been done.

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## Appendix 2 Learning Matters: Thickening Agents

### Learning Matters: Thickening agents –near misses

#### Thickening agents

We have had two near miss incidents this week where thickening agents have been decanted into a non labelled pot and left within reach of patients.

In February 2015 the National Patient Safety Agency published an alert regarding '*Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder*' as a result of an incident where a care home resident died following the accidental ingestion of the thickening powder that had been left within their reach. The powder formed a solid mass and caused fatal airway obstruction.

#### What you need to know

- The qualified nurse responsible for the care of an individual patient requiring thickened fluids should risk assess each patient to decide identify storage for the agents.
- Thickening products should be stored out of reach of patients but still be visible to ensure they are used as required.
- Thickening agents **MUST NOT** be decanted into other pots i.e. cups, white medicine pots.
- Where the patient is or others in the vicinity are confused and/ or wandering alternative arrangements may need to ensure safe storage.
- On discharge, if the patient requires thickening agents safe storage and risks should be discussed with patients and/or carers.
- All near misses should be reported on Datix.

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## Appendix 3 Learning Matters Mortality

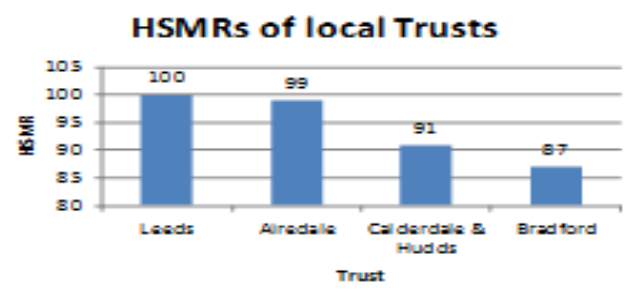
Learning Matters #12 Mortality 12/17

### Learning Matters: Mortality

#### Mortality statistics

HSMR (Hospital Standardised Mortality Ratio) is a measure of hospital inpatient mortality which shows whether the number of deaths is higher or lower than would be expected. The average score is 100, with lower scores being better than higher.

The Trust continues to have the lowest HSMR in the region, currently 86, which represents 167 less deaths than expected over the period September 2016 to August 2017. This reflects the high level of care we give.

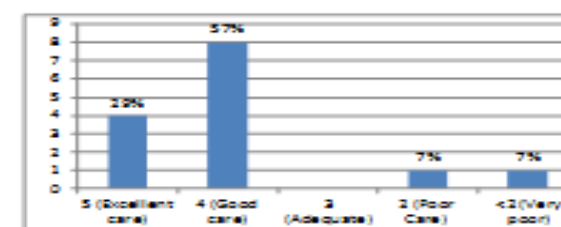


#### Findings from case notes reviews

All departments should be carrying out mortality reviews on patients using the Structured Judgement Review (SJR) method.

5% of deaths have been reviewed between July—Sept 2017 (we aim to get 25% of deaths reviewed). 86% of care reviewed was rated as good or excellent!

#### Overall Assessment of Care Scores (includes all reviews)



#### Key themes identified:

- Good recognition of the sick patient;
- Excellent communication with patients and relatives;
- Initial care within the first 24 hrs seems to be very good with good evidence of implementing relevant treatments on time;
- Good multidisciplinary cooperation;
- Good use of palliative care.
- Second review highlighted:
- Several delays led to poor care in some aspects of treatment;
- Some evidence of poor documentation—lack of times recorded by clinician and some nursing notes only written briefly and in retrospect;
- Patient with suspected infectious disease admitted to an open ICU bed. The pathology report took several hours to be seen by medical staff, hence appropriate medication was slightly delayed (it is unlikely this influenced the outcome).

The poor/very poor care scores relate to an individual case which was subjected to a second review, as per protocol.

2017-17-17-17-17

For more information or to see the full reports, please contact Caroline Hanson, Quality & Patient Safety Facilitator, or Dr Harry Ashurst.

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## Appendix 4: Learning Matters Syringe drivers

Bradford Teaching Hospitals  
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# LEARNING MATTERS

## McKinley T34 Syringe Driver incidents

### Recent incidents and themes

A palliative patient was in pain and distressed, PRN medication was given and the patient settled. A syringe driver was prescribed to optimise symptom management but was not commenced for 6 hours and so the patient was again in severe pain. This distressed both the patient and his family. The reason for delay was staff were unsure how to set up the syringe driver and were waiting for a staff member with experience to start a shift. The syringe driver should have been commenced within 2 hours of prescribing as per McKinley T34 Syringe Driver Policy.

Several patients have been discharged home with the syringe driver locked box insitu. The District Nurse (DN) is then unable to access the syringe and so cannot reprime the syringe driver. This causes a delay in patients receiving essential treatment.

A dying patient was discharged home with a syringe driver insitu but the medication was not prescribed on the community prescription chart. The DN was unable to reprime the syringe driver and the GP was then required to prescribe the medication. This caused unnecessary delay for the patient in receiving vital medication.

A patient was converted from oral to subcutaneous opioid via a syringe driver. The oral dose was not discontinued resulting in an opioid overdose.

A dying patient was discharged home with a syringe driver insitu with the incorrect dose of medication prescribed on the community prescription chart. The patient is at risk of receiving an incorrect dose of medication and the delay in repriming the syringe driver resulted in poor symptom management.

### What should we do?

All Registered General Nurses MUST:

- Complete the McKinley T34 Syringe Driver e-learning programme.
- Complete ward based competency assessment annually. Documents are available on the intranet (Palliative Care, Mckinley T34 Syringe Pump, Section 4, Education Training)
- Seek help if needed when setting up a syringe driver\*
- Remove locked box from **ALL** syringe drivers prior to discharge
- Ensure **ALL** syringe driver prescriptions & anticipatory medications are prescribed on the correct community prescription chart prior to discharge
- Check all prescriptions are for the right patient, right dose, right drug, right route and right time.

**\*How to get advice and support**

Syringe Drivers must be commenced within 2 hours of prescribing. If you need support or guidance to set up a pump please go to the [Palliative Care Webpage](#) on the intranet or call the Palliative Care team on ext 4035 (Mon – Fri, 07.00 – 17.50)

Out of hours advice can be obtained via Marie Curie Hospice on 01274 337000

For more information please contact [assuranceteam@bthft.nhs.uk](mailto:assuranceteam@bthft.nhs.uk) or on 01274 383081




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## Appendix 5 Responding and Improving: Mortality

Issue 4 February 2018

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# RESPONDING & IMPROVING

## Focus on Mortality

### Responding and Improving

When a serious incident occurs we need to make sure that it cannot happen again.

During the investigation a number of recommendations are usually identified, some are very specific to the incident, some have implications across the Trust.

We work hard to respond to recommendations. We also work hard to make sure any of the actions we take are effective and we have made sustainable improvement, meaning that we have confidence that the incident should not happen again.

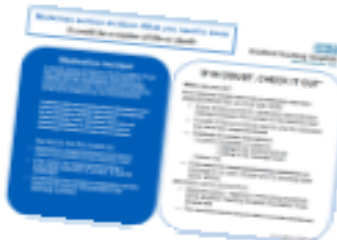
### Stopped medication

In 2016 the Trust was informed about the death of a ninety one year old lady by the Coroner. The cause of death was recorded as pulmonary thromboembolism (PE), occurring after a period of immobility due to a fractured ankle. The coroner noted this lady had been prescribed Apixaban (a drug used to reduce the risk of stroke and serious blood clots in certain patients with Atrial Fibrillation (AF)) which was stopped on admission and subsequently was not restarted at discharge.

The Trust conducted a serious incident investigation which found that the root cause of the PE still remains unknown. Apixaban, previously used as prophylaxis for AF, was not recommenced at discharge and could have been a contributing factor to the subsequent PE.

An audit of missed doses took place and a learning matters bulletin was distributed throughout the Trust to share learning from the incident. An assurance review of the action plan provided confidence that effective action has been taken to ensure an incident like this should not reoccur.

The Inquest was heard at Coroner's Court. Within the summing up, the Coroner confirmed that they were most grateful to the Trust for investigating the number of missed opportunities to re-prescribe the Apixaban and accepted the medical cause of death as proposed by the pathologist.



### Alleged inpatient illicit drug taking

In 2016 a patient death was referred to the Trust from the Coroner's office as they had been informed by the referring doctor that the death could possibly be linked to a patient having taken illicit drugs supplied to her by an external source whilst an inpatient at the Trust. The Coroner requested the Trust investigate the alleged incident and include details of the actions taken following the alleged incident.

A Serious Incident Investigation took place and although the investigation team were unable to prove or disprove whether the patient had been taking illicit drugs whilst an inpatient recommendations were made to prevent occurrence of similar incidents. The policy for the [Safe Management of Controlled Drugs: section 27: Illicit substances](#) was amended to include actions to take in the event of patients allegedly taking illicit drugs whilst in hospital, the importance of timely incident reporting was reiterated to staff and findings from this case were discussed at the Deteriorating Patient Collaborative.

An assurance review of the completion of the action plan took place which provided confidence that actions have been completed and the Policy for the Safe Management of Controlled Drugs has been amended and has clear and concise steps to take if this incident was to occur again. The [Incident Reporting and Investigation Policy](#) has also been reviewed and includes the process and responsibilities for incident reporting.

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## Head injury sustained by an Inpatient

In December 2015, a patient left the Acute Medical Unit, whilst in an altered state of mind, and sustained a life changing head injury which later contributed to their death. This was investigated as a serious incident.

The investigation concluded that the patients head injury might have been prevented if staff had had clearer guidance and training on the application of the Mental Capacity Act and Deprivation of Liberty Standards. An action plan was developed and implemented.

In September 2016 a [ProgRESS review](#) was undertaken into the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS). This gave the Trust confidence that recommendations in the Serious Incident Investigation had been completed and staff awareness of MCA and DoLS has improved.

At a glance guidance for staff who are dealing with a patient who lacks capacity, including guidance on preventing a patient leaving a ward area has been developed and implemented and can be found [here](#). Advice can also be sought from the Safeguarding Team on 01274 364345 and out of hours by contacting the Clinical Site Matrons/ On Call Manager.

## Spot light on Mortality Reviews

It is expected that when an inpatient dies, their care will be reviewed in compliance with our mortality review processes. A standardised case note review approach is used called the Structured Judgement Review (SJR) method. SJR is nationally recognised and is also recommended by the national mortality programme. The review method combines structured reviewer comments with quality of care scores to assess the care of people who die in hospital. The SJR method also encourages reviewers to identify and celebrate good care as well as poor care and facilitates the identification of actions for improvement, suggesting lessons that may be learned and cascaded widely. All staff involved in mortality reviews are expected to use this method.

The Trust aim is that 25% of patients who die in hospital will receive a review. From 2017 to date, this figure stands at 13%. For more information contact Chioma.Obasi@bthft.nhs.uk

## Support to the 'second victims' of patient safety incidents

The Yorkshire Quality and Safety Group undertook a review into support to 'second victims' of patient safety incidents (PSI). A staff survey was sent to all healthcare professionals working in BTHFT, to gather information on personal experiences of being involved in patient safety incidents.

The aim of the survey was to understand what support they received or would have liked to have received during the time that followed the incident. The results from this survey will be used to help inform the research teams at BIHR in developing resources to improve the support systems available to healthcare professionals both locally and nationally.

The results found that :

- respondents generally agreed that their organisation understands that staff can suffer after being involved in a PSI and need help to deal with it. Despite this, not many respondents felt that their organisation provides a variety of resources to help in the aftermath of a PSI, or that their wellbeing is a priority for the organisation.
- Most respondents did not take time off work after the PSI, despite many wishing for a break from work.
- The PSI knocked respondents' confidence in their abilities.
- A key theme was that respondents wished to be kept involved in the investigation process and updated on the patient's health.



The full report can be viewed [here](#).

Responding and Improving is developed by the Learning and Surveillance hub. For more information please contact Saba Chaudhary on extension 3081 or by email [Saba.Chaudhary@BTHFT.NHS.uk](mailto:Saba.Chaudhary@BTHFT.NHS.uk)