# Board of Directors' Meeting
# 12 May 2022

The Shrewsbury and Telford Hospital NHS Trust

| | | | | |
|---|---|---|---|---|
| **Agenda item** | 087/22 | | | |
| **Report** | Incident Overview Report | | | |
| **Executive Lead** | Director of Nursing<br>Medical Director | | | |
| | **Link to strategic pillar:** | | **Link to CQC domain:** | |
| | Our patients and community | √ | Safe | √ |
| | Our people | | Effective | |
| | Our service delivery | | Caring | |
| | Our partners | | Responsive | √ |
| | Our governance | √ | Well Led | |
| | **Report recommendations:** | | **Link to BAF / risk:** | |
| | For assurance | √ | BAF 1, BAF 2, BAF 4, BAF7, BAF 8, BAF 9 | |
| | For decision / approval | | **Link to risk register:** | |
| | For review / discussion | √ | | |
| | For noting | | | |
| | For information | | | |
| | For consent | | | |
| **Presented to:** | | | | |
| **Dependent upon** (if applicable)**:** | | | | |
| **Executive summary:** | This paper is presented to the Board of Directors monthly to provide assurance of the efficacy of the incident management and Duty of Candour compliance processes.<br><br>Incident reporting supporting this paper has been reviewed to assure that systems of control are robust, effective and reliable thus underlining the Trust's commitment to the continuous improvement of incident and harm minimisation.<br><br>The report will also provide assurances around Being Open, number of investigations and themes emerging from recently completed investigation action plans, a review of datix incidents and associated lessons learned. | | | |
| **Appendices:** | Appendix One – Serious Incidents – March 2022<br>Appendix Two – Learning and Actions – March 2022 | | | |
| **Lead Executive:** | John Jones H O'Neill | | | |

## 1. Introduction

This report highlights the patient safety development and forthcoming actions for May/June 2022 for oversight. It will then give an overview of the top 5 reported incidents during March 2022. Serious Incident reporting for March 2022 and also rates year to date are highlighted. Further detail of the number and themes of newly reported Serious Incidents and those closed during March 2022 are included in Appendix 1. Detail relating to completed actions and lessons learned are included in Appendix 2.

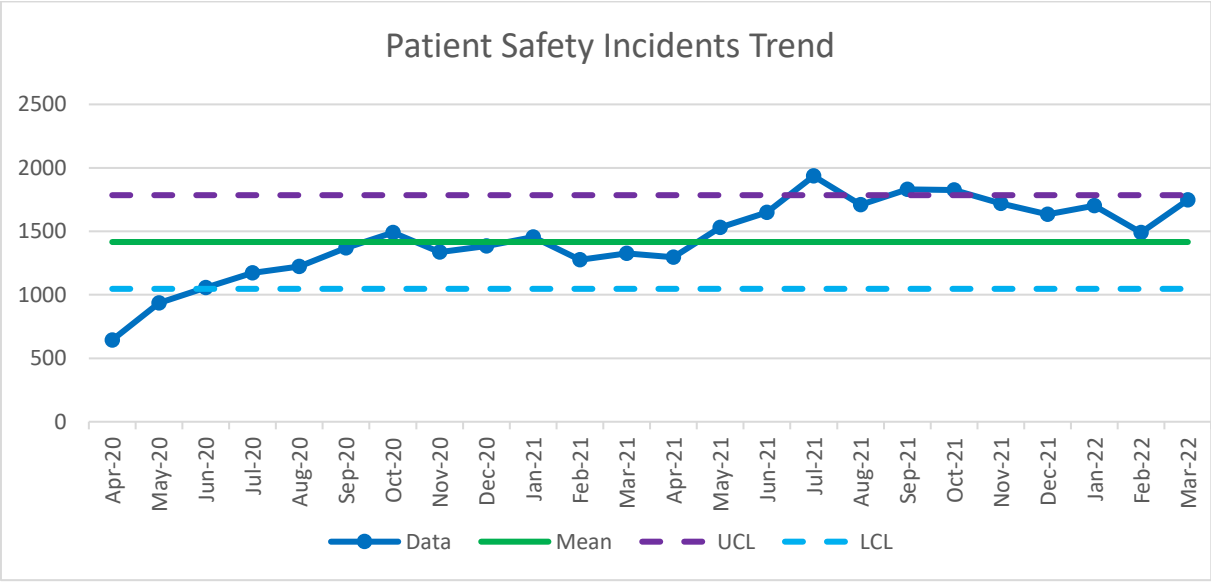
## 2. Patient Safety Development and Actions planned for May/June 2022/23

- Work with the National and Regional Patient Safety Network to develop a clear plan for progress to the new National Patient Safety Incident Response Framework, which will require significant changes to the way in which the Trust approaches patient safety investigations – due to be rolled out Nationally during 2022.
- Develop Safety links/champions in all ward areas to support learning and sharing.
- Embed the new Divisional Quality Governance Teams and Quality Governance Framework
- COVID19 communication/second stage duty of candour for hospital acquired harm

## 3. Analysis of March 2022 Patient Safety Incident Reporting

The top 5 patient safety concerns reported via Datix are reviewed using Statistical Process Charts (SPC). Any deviation in reporting, outside of what should reasonably be expected, is analysed to provide early identification of a potential issue or assurance that any risks are appropriately mitigated. SPC Chart 1 demonstrates Patient Safety Incident reporting over time, which shows an upward trend in reporting this may relate to a more open reporting culture, during July 2022 it is planned to undertake a pulse survey of staff to test this assumption.

**SPC Chart 1**




## 3.1 Review of Top 5 Patient Safety Incidents

During March there were 1,748 Patient Safety Incidents reported which were classified as incidents attributable to Shrewsbury and Telford Hospitals. The top 5 reported incidents account for 33% of the reported incidents during March 2022 – see Table 1. The top 5 reported incidents are explored in more details below.

**Table 1**

| Top 5 Patient Safety Incidents | Totals |
|---|---|
| Admission of patient | 166 |
| Falls | 126 |
| Bed shortage | 108 |
| Staffing Problems | 89 |
| Care / Monitoring / Review Delays | 85 |
| Total | 574 |

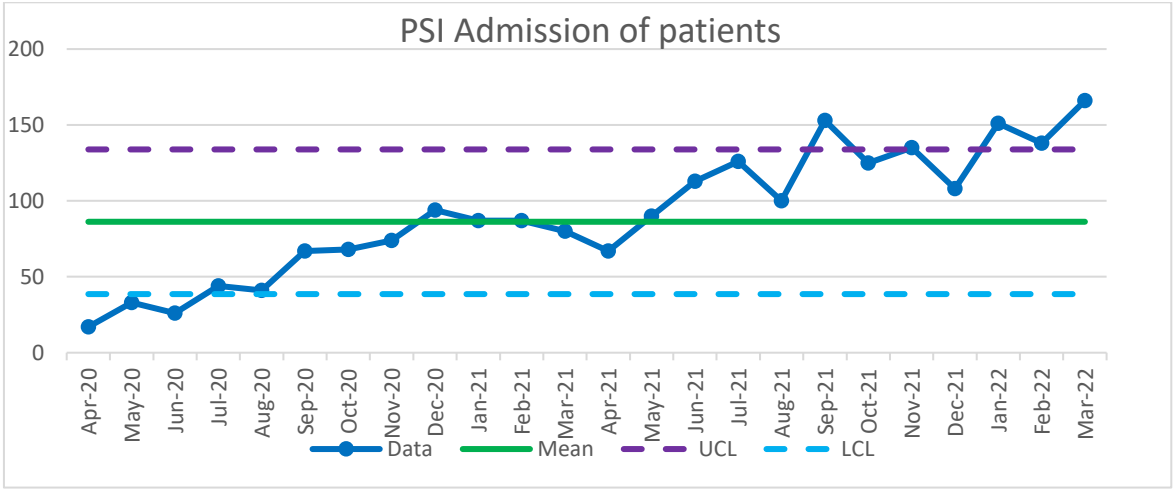
### 3.2 Admission of patients

9.5% of all reported incidents during March (166) were categorised as incidents related to the admission of patients. This category covers a wide range of concerns relating to the admission of patients, such as ambulance offload delays and delay with allocation of beds out of the Emergency Department. The number of incidents and % of incidents has increased during January, February and 2022.

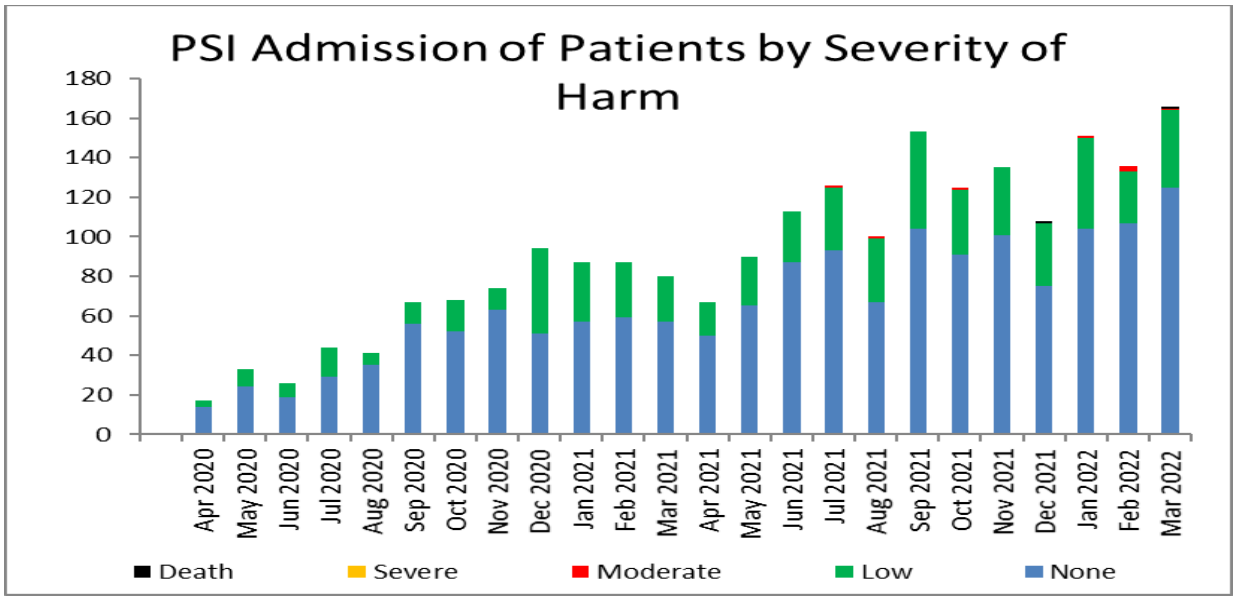
Analysis of ambulance offload delay and long waits in the Emergency Department in demonstrates increased harm caused to patients. It is also important to note that each incident report for ambulance offload delay may have multiple patients attached to it – each patient is reviewed to assess any harm caused due to delay in admission.

SPC chart 4 shows that during September, October and November incidents exceeded the upper control limit it is noted the during December there was a small reduction in incidents however January, February and March has once again exceeded the upper control limit and demonstrates significant pressure with the Emergency Department and capacity concerns with the Trust.

**SPC Chart 2**




**Graph 1 – Severity of Harm Admission of Patients**



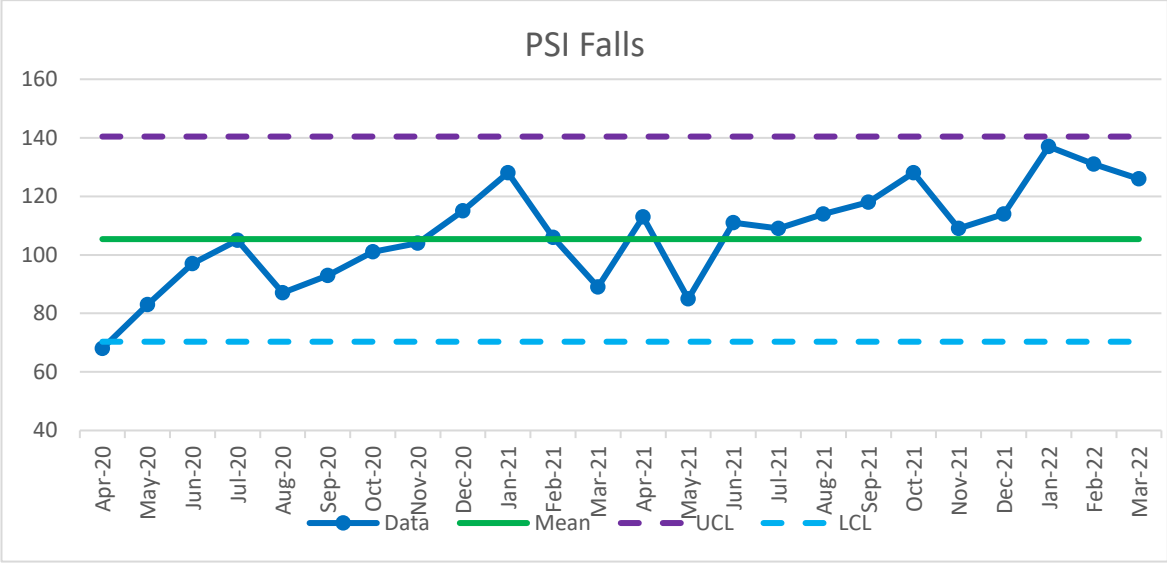

### 3.3 Falls

7,2% of all reported incidents during March (126) were categorised as a Fall. Of these, 1 was reported as severe harm and has been reported as a Serious Incident and are under investigation. Completed investigation reports are presented to the Nursing Incidents Quality Review Meeting (NIQAM) which is Chaired by the Deputy Director of Nursing where learning is identified and shared.

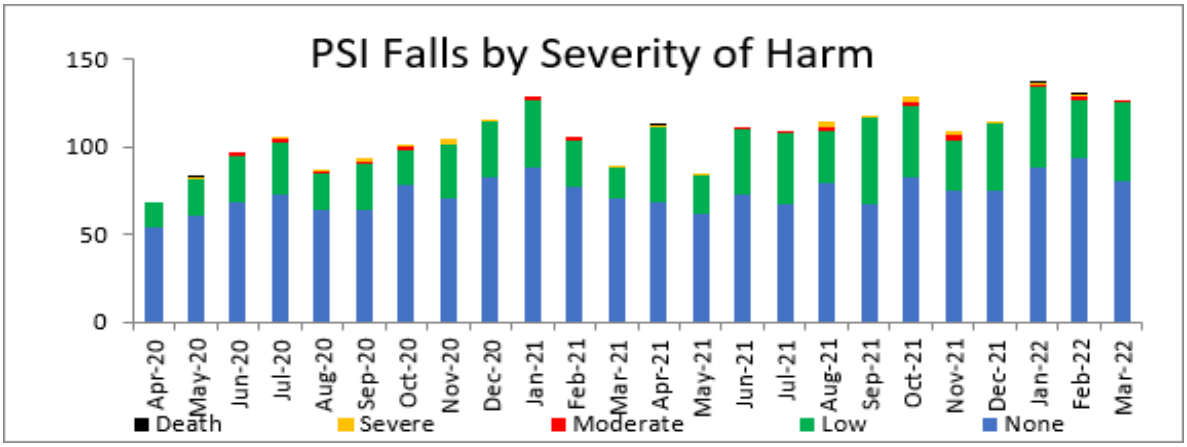
All inpatient falls are reviewed daily by the Quality Matrons and the Falls Lead Practitioner, identifying areas for improvement and shared learning.

SPC Chart 3 identifies an increasing trend in inpatient Falls reported, although there had been a reduction seen in November and December 2021, January 2022 saw an increase in falls reported, however February and March have seen a reduction. The Trust is part of the Regional Falls Group working to share learning and falls prevention strategies. The Group have noted an increase in falls Nationally, which may be linked to the COVID 19 pandemic.

**SPC Chart 3**



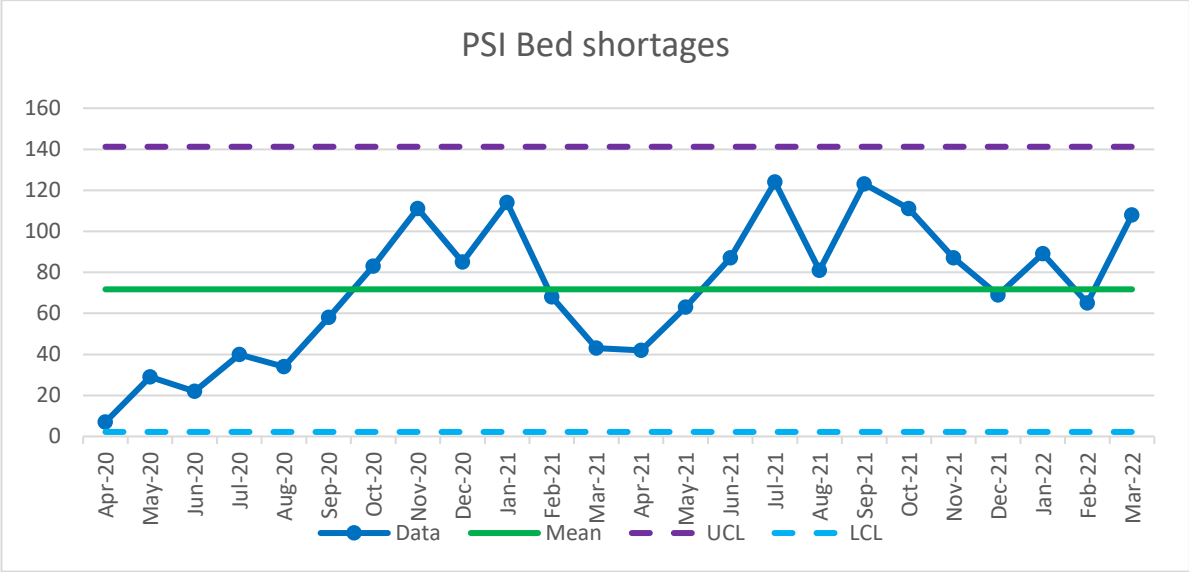

**Graph 2 – Severity of Harm Falls**



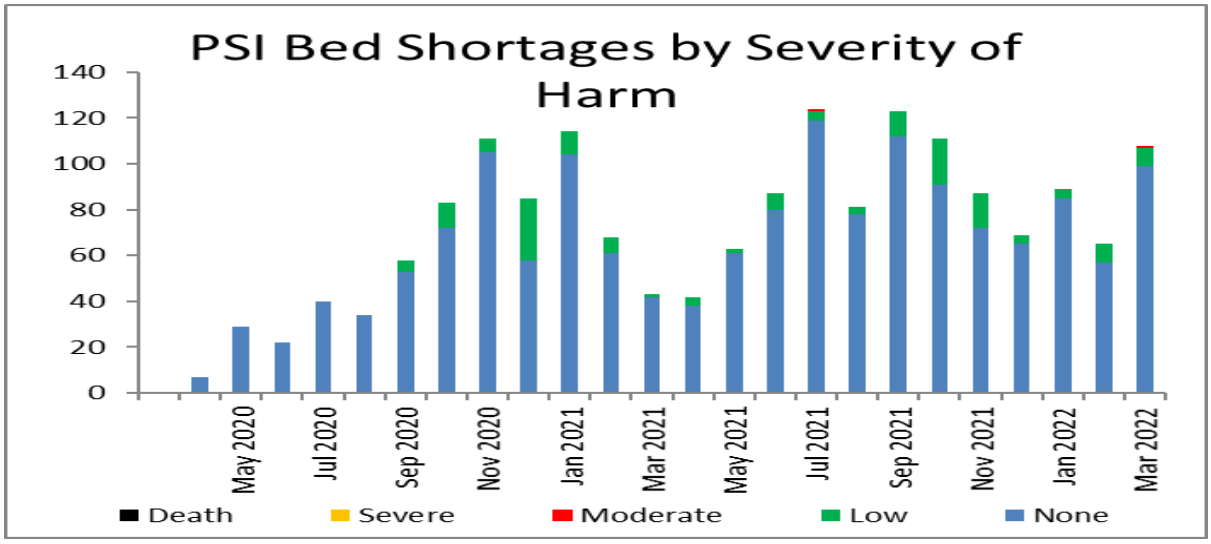

### 3.4 Bed Shortage

6,2% of all reported incidents during March (108) were categorised as bed shortages. These incidents include 12 hour breaches for patient admission from ED, it is important to note that 1 incident report for 12 hour breaches may contain multiple patient detail and delay in discharge from Intensive Care Unit to a ward bed.

**SPC Chart 4**




**Graph 3 Severity of Harm Bed Shortages**



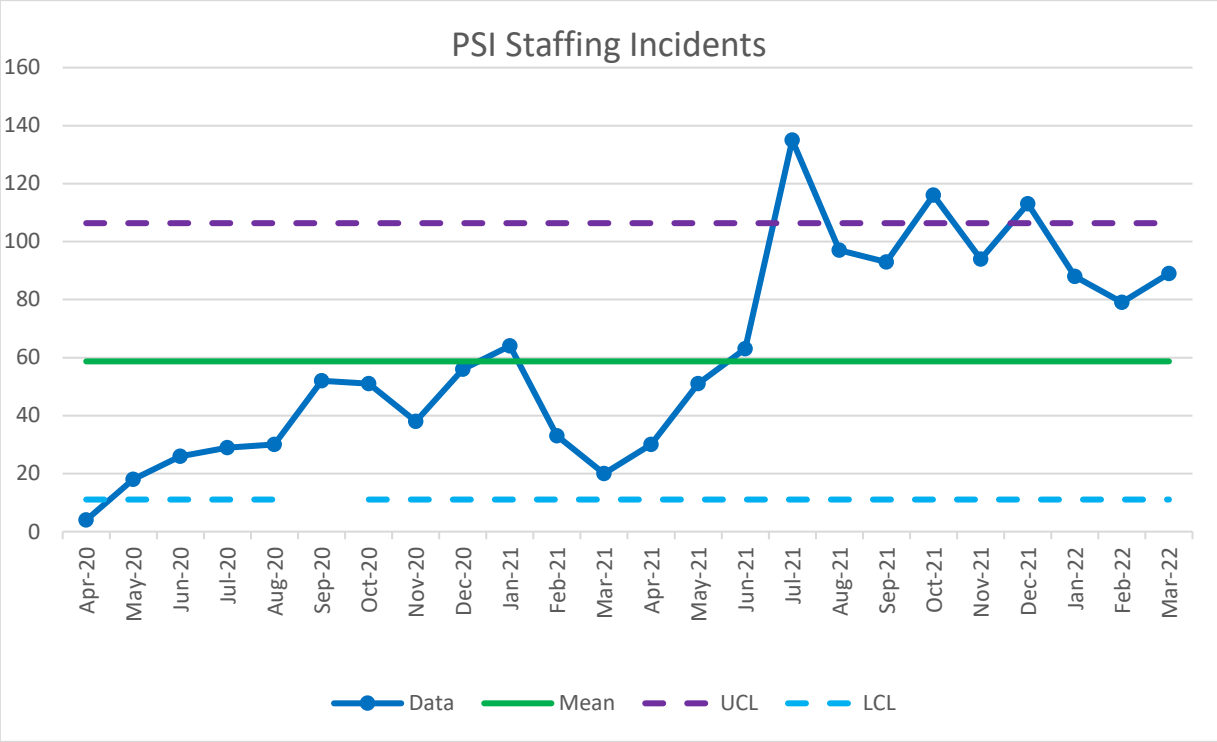

### 3.5 Staffing Problems

5% of all reported incidents during March (89) were categorised as Staffing Problems.

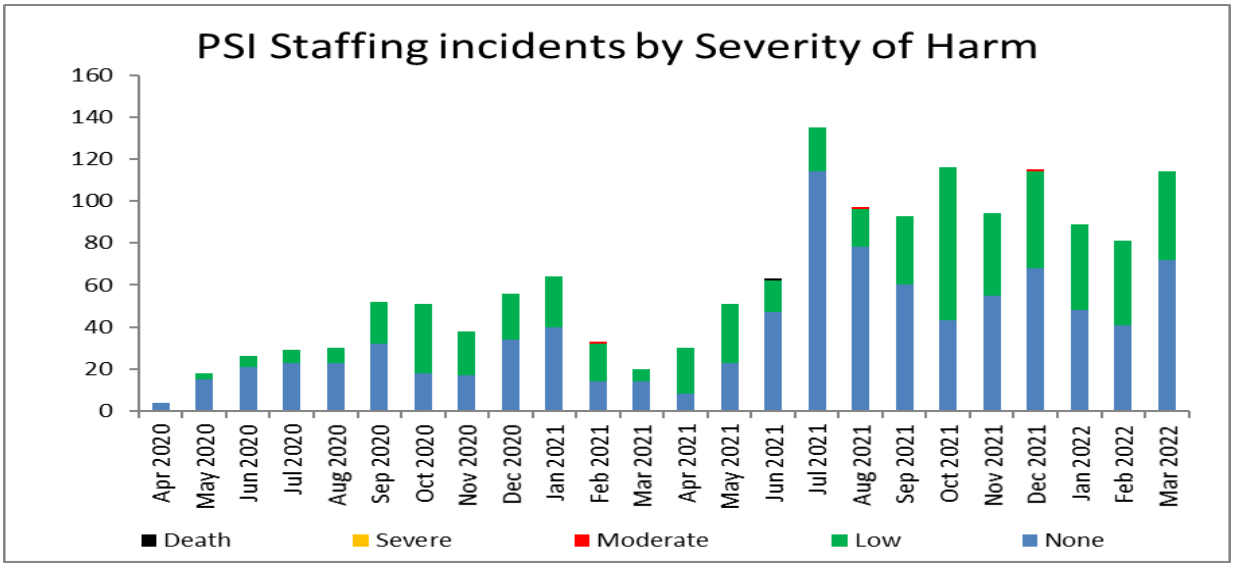
Data relating to staffing incidents is triangulated with quality metrics and reported through the Divisional Directors and the Director of Nursing through to Quality and Safety Assurance Committee.

SPC Chart 5 demonstrates that staffing incident reports have increased since June 2021 and have remained on or above the upper control limit, many of which related to COVID related/isolation absence.

**SPC Chart 5**



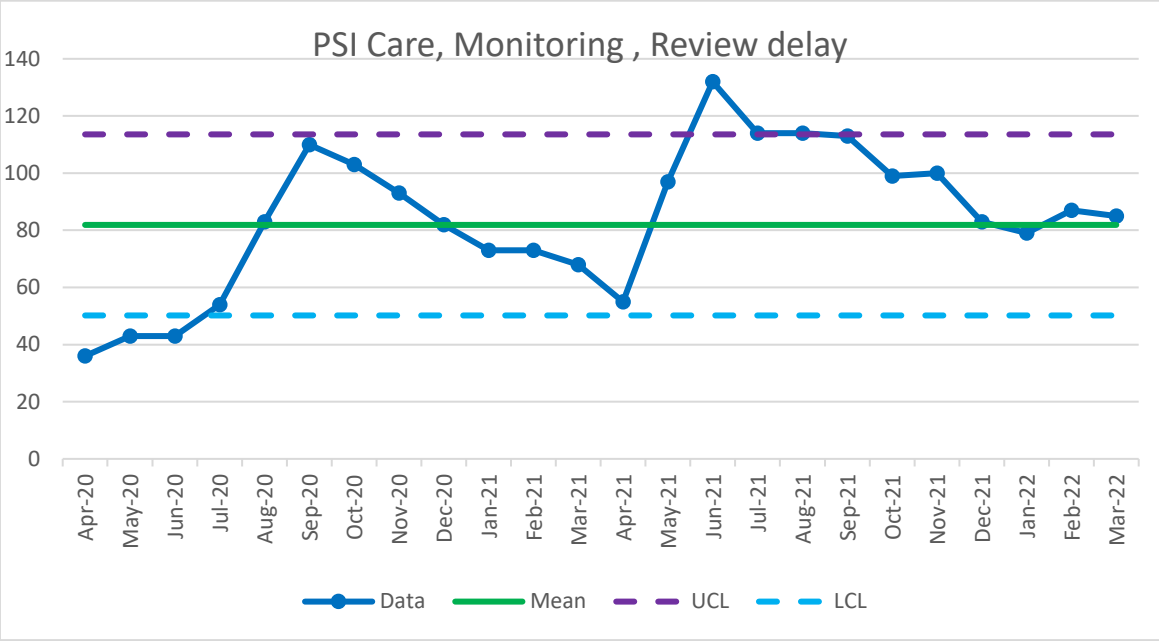

**Graph 4 Severity of Harm Staffing**



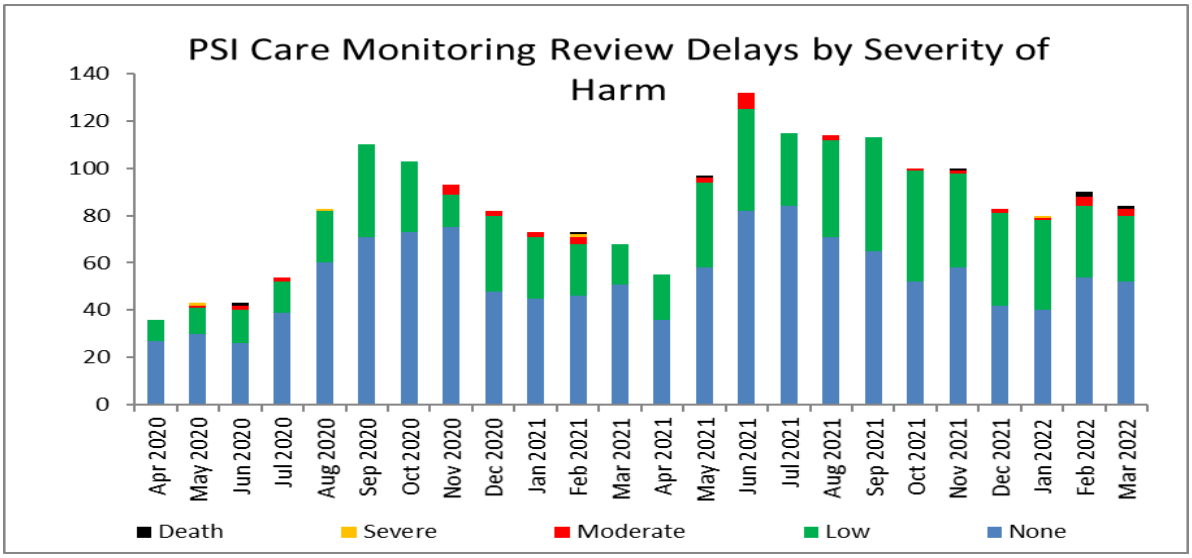

### 3.6 Care Monitoring Delay

4.9% of all reported incidents in March (85) were categorised as Care Monitoring Delays. Analysis of this group of datix is complex and identifies a wide range of issues, which relate to delays due to staffing, delays due to lack of beds, delays in escalation, delays in observations. Ongoing work in relation capacity, flow and staffing should help to mitigate harm. SPC Chart 6 demonstrates a rise in incidents between April 2021 and June 2021 which correlates to pressures seen within the Trust, particularly attendances to the Emergency Department. It is noted that during August through to January that the trend is now on a downward trajectory.

**SPC Chart 6**




**Graph 5 Severity of Harm Care Monitoring Delays**




## 4. Incident Management including Serious Incident Management

### 4.1 Review, Action and Learning from Incident Group (RALIG)

8 New case assessments were reviewed by RALIG during March, Chaired by the Co-Medical Director, resulting in 4 Serious Incident Investigations being commissioned and 4 Internal Investigations.

### 4.2 Nursing Incident Quality Review Meeting (NIQAM)

1 Serious Incident Investigations were commissioned during March relating to a fall with severe harm. (See appendix 1 for detail).

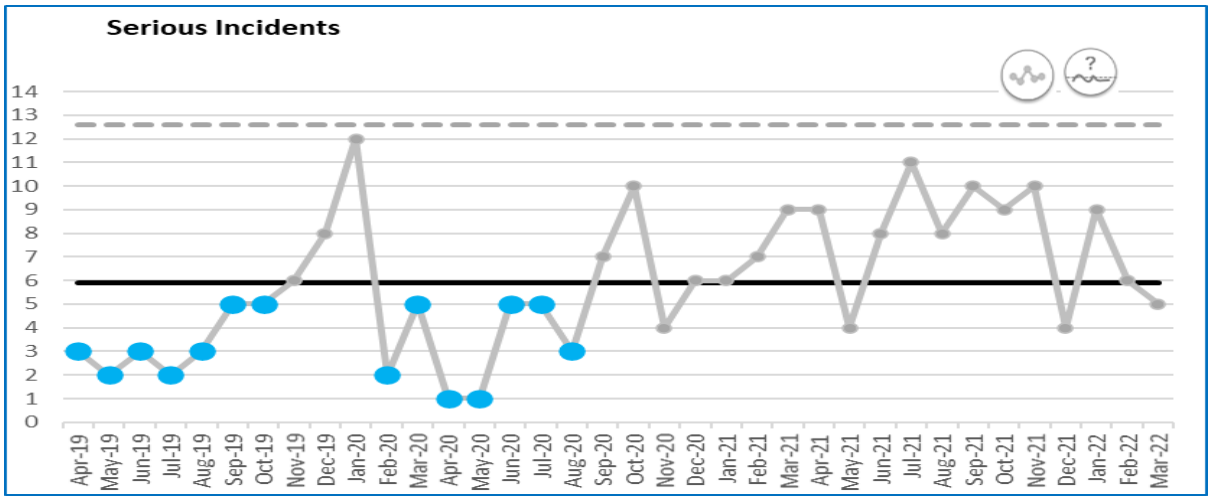
### 4.3 Maternity

There was 1 serious incident reported for Maternity during March (See Appendix 1 for detail).

### 4.4 Serious Incident Reporting Year to Date

At the end of March 2021/22 the Trust had reported 93 serious incidents. An increase in serious incident reporting is noted from 64 in 2020/21, which may reflect a more open reporting culture.

### SPC Chart 7




### 5. Never Events

There have been no Never Events reported in March 2022, with only 1 reported during the year 2021/2022, which is a reduction from 3 reported in year 2020/2021.

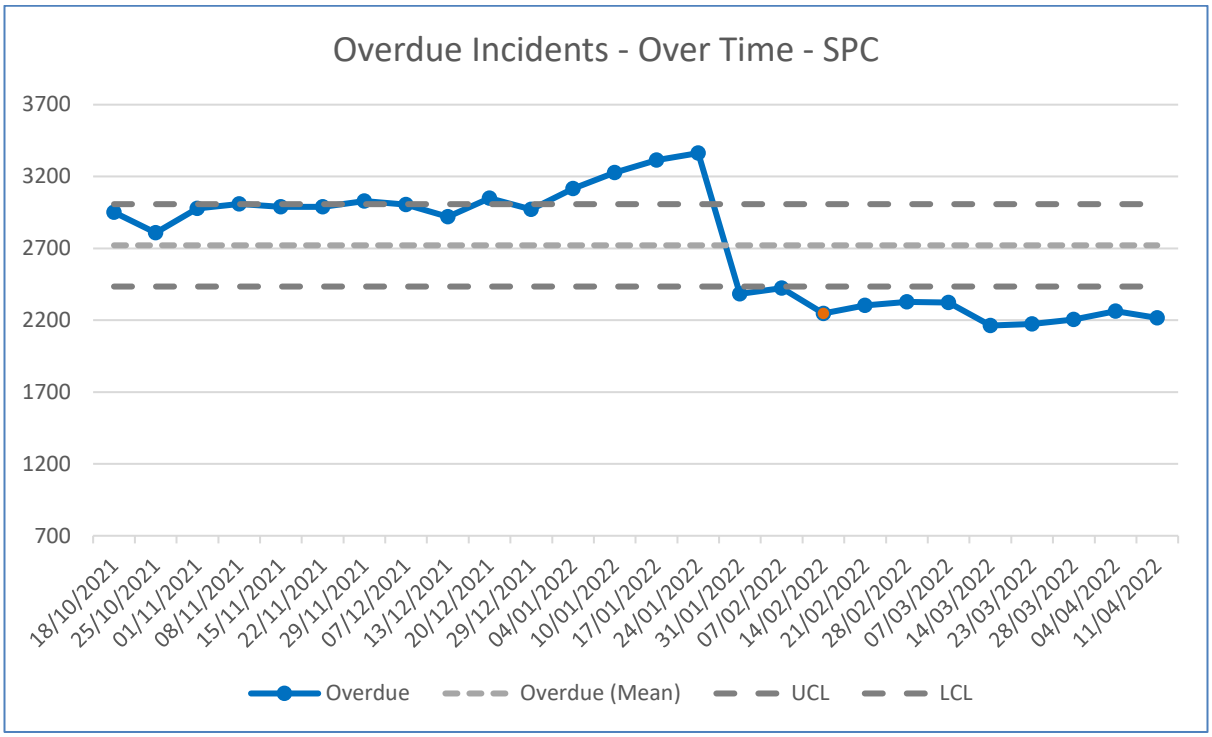
### 7. Overdue datix overtime

SPC 8 shows that between October 2021 and January 2022 the number of overdue Datix incidents remained on or above the control limits. On review of the increase this coincided with a significant surge in emergency activity within the Trust which resulted a reduction of capacity within the clinical teams to review datix. The creation of the new Quality Governance teams has supported a reduction in overdue datix during January, February and has been sustained during March 2022 with 9 data points now demonstrating sustained improvement. Work continues within all divisions to further improve the number of overdue datix.

### Mitigation and trajectory for improvement

All datix are reviewed daily by the Quality Governance/Safety teams who filter out those datix that require immediate actions. Moderate harm or above incidents are reviewed at the weekly Review of Incident Chaired by the Assistant Director of Nursing. All Divisions have a weekly incident review meeting to prioritise and escalate incidents, such as Neonatal and Obstetric risk meeting, Medicine incident review group, ED weekly incident review.

**SPC Chart 8**




## 8. Lessons Learned and Action Plan Themes

There were 7 Serious Incidents closed in March. A sample of the learning identified can be found in Appendix 2 and 3.

## 9. Duty of Candour

There have been no reported breaches in Duty of Candour during March. An internal audit of duty of candour is due in July 2022, the results will be reported in September 2022.

## 10. Quality Governance Framework

The new Quality Governance Framework and structure is now in place to support Divisional Quality Governance teams to create a robust resource to enable a standardised approach to Quality Governance across the Divisions.

## Appendix One

### New Serious Incident Investigations - March 2022

A summary of the serious incidents reported in March 2022 is contained Table 1.

There were 5 serious incidents reported in March 2022.

**Table 1**

| SI | Number Reported |
|---|---|
| 2022/5108 Delay in referral and treatment – RSH Outpatients | **1** |
| 2022/5233 Suboptimal care – Ward 17/ITU | **1** |
| 2022/6195 Fall - subdural haematoma – Ward 22T/0 | **1** |
| 2022/6195 Embedded pessary – Gynaecology Outpatients | **1** |
| 2022/6202 Obstetric - affecting baby – Delivery Suite | **1** |
| **Total** | **5** |

### Closed Serious Incident Investigations – March 2022

| SI – Closed March 2022 |
|---|
| 2021/24326 Fall resulting in fracture neck of femur |
| 2021/23692 Fall resulting in fracture neck of femur |
| 2021/22662 Fall resulting in fracture neck of femur |
| 2021/15019 Maternity Obstetric affecting baby |
| 2021/14486 Maternity Obstetric Post Natal Care - Downgraded |
| 2021/11460 Maternity Obstetric affecting mother and baby |

## Appendix Two

### Learning identified from closed incidents in March

### Key themes:

| |
|---|
| • Post falls bundle, options should be explored to make the initial required medical assessment a more focussed check list/procedure which can guide medical staff to ensure all assessments are completed thoroughly to reduce risk and support nursing staff in ensuring the correct level of assessment is undertaken. |
| • Nurses on the ward should be reminded of their professional accountability to ensure the correct procedure for retrieving patients from the floor is followed. Where they are specifically instructed to deviate from this process, they should ensure that these alternative instructions are clearly documented in the notes by the requester, so they assume responsibly for the decision. |
| • Falls Prevention Management Plans both on admission to the ward and post fall, should have the appropriate falls prevention measures in place, updating assessments when there are changes in a patient's mobility or cognition, completing neurological observations accurately. |
| • Staff should be reminded of the importance of using physiotherapy recommendations to inform their updating of patients moving and handling plan |
| • Staff should have additional training with the Trust Falls Prevention Lead on the correct procedures to follow when working in a TAG bay |
| • Physiotherapy staff to be reminded of the importance of explicitly documenting their mobility recommendations in their plans. In addition, they will now be asked to document in their notes how their mobility recommendations have been communicated, who they have been communicated to and if their assessments and recommendations have been discussed with the patient where they have capacity. |
| • Documentation needs to be reviewed to enable fuller care evaluations on interactions with mothers and newborns in first 24 hours, specifically regarding assisted feeding |
| • To review the locum doctor induction program and audit compliance |
| • An audit of practice with regard to the measurement of symphysiofundal height be undertaken for the antenatal area in order to ensure that practice is within guidance |
| • There is continued training in human factors in order to recognise situations in which there may be a reduction in the awareness of risk and confirmation bias as well as promoting staff to speak up when they become aware of something unusual. Human factors training should also ensure that communication channels must be maintained when an individual or team become task focussed. |