Sharing how we care

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience.

***Sharing* how we care** is about how we make our Trust values the golden thread of everything we do, how we share where we have gone wrong and when care has been excellent so we can make improvements together and learn how to minimise harm for the next patient.

Insight:

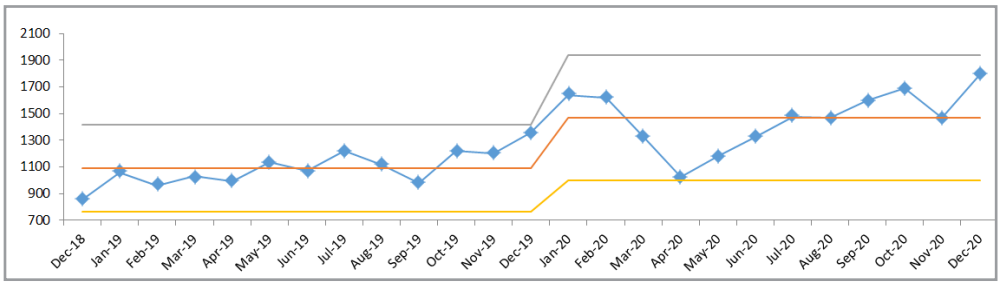
Measurement, incident response, medical examiners, alerts, litigation

Improve our understanding of safety by drawing insight from multiple sources of patient safety information

What are we reporting?

Incidents you report on datix are also sent to the National Reporting and Learning System (NRLS), which is voluntary and for the purposes of learning. The number reported by each organisation therefore reflects reporting culture, and is not necessarily the actual number of incidents occurring. A 'low' reporting rate for an organisation should not necessarily be interpreted as a 'safe' environment; it may represent under-reporting. Conversely a 'high' reporting rate should not be interpreted as 'unsafe'; it may represent a more open culture.

Year on year reporting rate at DBTH (31 December 2020)



The chart (above) demonstrates the last 24 months of data. December 2020 demonstrates an increase in reporting (+328 from November) signifying the highest number of incidents ever reported within the Trust (1793 in total). The data remains within expected control limits.

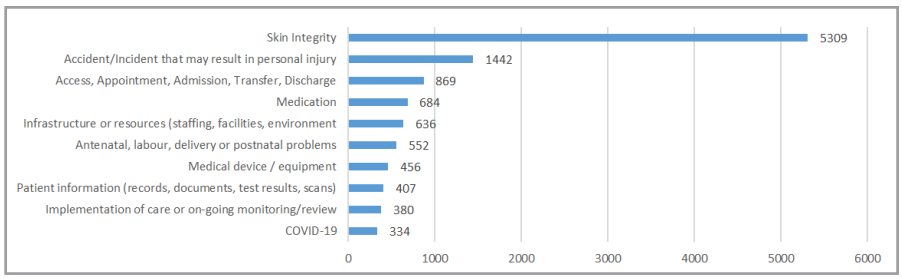
This month has seen more skin integrity incidents (+61) reported and more general incidents (+163). In January 2020 all skin integrity incidents were reported through the Datix system, therefore the control limits have been re-evaluated from this point in time, accounting for the step increase in the chart above.

Top catergories of incidents

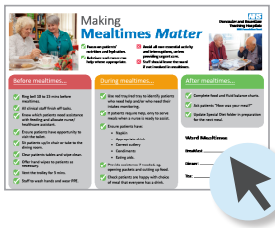
The top categories are skin integrity, which includes pressure ulcers present when patients are admitted to our care, as well as pressure ulcers that are hospital acquired.

Falls are the next most reported incident, followed by issues relating to appointments, admission and discharge.

Medication is the 4th most reported incident, followed by staffing, facilities and the environment.



What Serious Incidents have been reported?



Nutrition and Hydration are integral to the health and recovery of our patients. Several initiatives have tried to address how this can be improved for patients, such as Making Mealtimes Matter.

When our patients are unable to swallow, referral to Speech and Language Therapy (SLT) is crucial for us to understand the physiology and prognosis of the patients' swallowing problems and establish the safest method of feeding for them. Swallowing problems (dysphagia) pose risks of choking, malnutrition, dehydration and recurring aspiration episodes which can lead to pneumonia.

Patients' diet texture can be modified and fluids can be thickened in order that the patient can still take some oral diet and fluids safely within the capability of their oropharyngeal muscular strength, aiming to minimise aspiration and choking risks. Our Trust fully adheres to the International Dysphagia Diet Standardisation Initiative (IDDSI) which standardises levels of diet and fluids and our Trust was an early implementer of IDDSI as well as ICS Regional Quality Improvement Winner 2019 for the Trustwide and Doncaster Place-wide roll out.

It is important to follow the SLT recommendations exactly as specified because bolus size, patient posture, speed of bolus delivery, whether the patient has an open cup/teaspoon etc can all significantly impact on the aspiration or choking risk posed to our patient. Often, SLT will also recommend that patients have non-tablet form medications in order that medication can be effectively administered for patients.

On discharge home, if thickener is on JACS, it is essential that the thickener prescription is documented on the discharge letter to the GP as thickener becomes a prescription item in community. A tub of thickener must also be sent home with the patient, this is obtained from the kitchens. If a patient is on thickened fluids, please link with the dietitians as supplements have differing levels of thickness.

Unfortunately, in the past two months, two patients who were on modified diet and thickened fluids were given ice cream. After aspirating, one patient subsequently died and this is now being investigated as a Serious Incident.

What is the immediate learning?

If a patient is on modified diet or fluids, it's important they are not given soup or ice cream. There are specific special diet menus – Levels 4-6. Soup and ice cream are not available on these menus. Please only order from these menus for patients on Levels 4-6. If a patient is on Level 7 diet (regular) but on thickened fluids, they still must NOT be given soup or ice cream due to the aspiration risks these present.

A patient was witnessed eating from a tin of thickener which had been left at their bedside. Later, the patient's medical condition deteriorated. He was transferred to ICU and had a bronchoscopy to ascertain if he had aspirated any of the thickener. This is now being investigated as a Serious Incident.

What is the immediate learning?

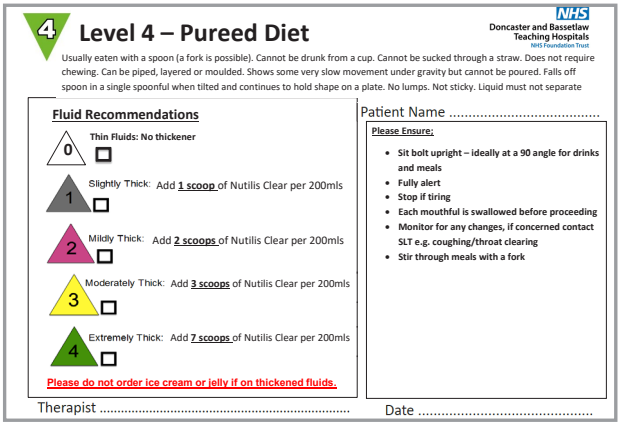
It's crucial that thickener is never left within reach of any patient and locked away after use as it is harmful if eaten directly. In 2015, a patient safety alert was raised nationally (access the alert here) after a patient directly ate thickener and died after the substance thickened and asphyxiated them. This alert has been sent out a number of times across our Trust since 2015 and is registered on our Trust Risk Register.

What else has happened to make sure patients get the diet they should?

- The Nursing Assessment Bundle has been edited to indicate modified diet, modified fluids and any other type of special diet.
- Alerts have gone out in the Buzz on 8th, 15th and 22nd December
- SLT have now started documenting in the Nutrition and Care Conditions sections of Nerve Centre.
- The Speech and Language Therapy team continue to put the Swallowing Recommendations Pink Sheet in the nursing notes, write an entry in the doctor's notes, input thickener needs on JACS and place a sign behind the patient's bed for every patient they have assessed for swallowing problems.
- We have an ongoing development being worked through with an aim for Nerve Centre to communicate with the Sodexo Saffron ordering system if IT governance can allow. In the meantime, wards are to continue to log all their patients with special diet needs on the Special Diet This is to log which patients are on modified diet and fluids.
- Online training has been developed to go out live via Education for x4 sessions commencing 8th January 2021 throughout January. This will then go onto on HIVE to watch and complete the quiz on staff demand. There is also targetted training for specific areas.
- Editorial access to the Dr Toolbox app has been secured so we can add swallowing/SLT information on there too.

Thank you all for everything you're doing to keep our patients safe and well.

The behind the bed signs are helpful for all staff interacting with the patients to know at a glance how to provide care. Ward staff don't need to write SLT recommendations on behind the bed board and are encouraged to use the SLT SIGN (see below)



4 Level 4 – Pureed Diet

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Usually eaten with a spoon (a fork is possible). Cannot be drunk from a cup. Cannot be sucked through a straw. Does not require chewing. Can be piped, layered or moulded. Shows some very slow movement under gravity but cannot be poured. Falls off spoon in a single spoonful when tilted and continues to hold shape on a plate. No lumps. Not sticky. Liquid must not separate

Fluid Recommendations

0 Thin Fluids: No thickener

1 Slightly Thick: Add 1 scoop of Nutilis Clear per 200mls

2 Mildly Thick: Add 2 scoops of Nutilis Clear per 200mls

3 Moderately Thick: Add 3 scoops of Nutilis Clear per 200mls

4 Extremely Thick: Add 7 scoops of Nutilis Clear per 200mls

Please do not order ice cream or jelly if on thickened fluids.

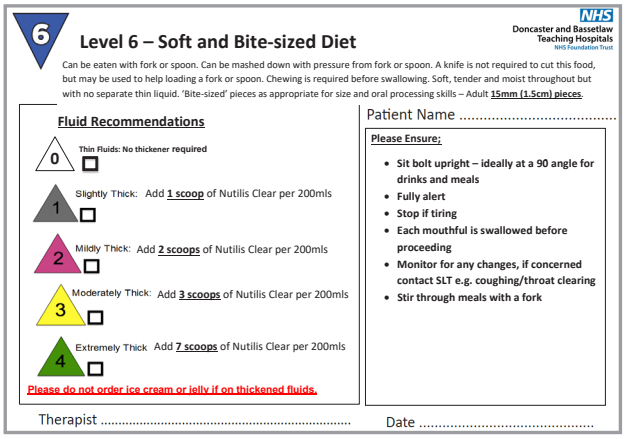
Patient Name .....

Please Ensure;

- Sit bolt upright – ideally at a 90 angle for drinks and meals
- Fully alert
- Stop if tiring
- Each mouthful is swallowed before proceeding
- Monitor for any changes, if concerned contact SLT e.g. coughing/throat clearing
- Stir through meals with a fork

Therapist .....

Date .....



6 Level 6 – Soft and Bite-sized Diet

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Can be eaten with fork or spoon. Can be mashed down with pressure from fork or spoon. A knife is not required to cut this food, but may be used to help loading a fork or spoon. Chewing is required before swallowing. Soft, tender and moist throughout but with no separate thin liquid. 'Bite-sized' pieces as appropriate for size and oral processing skills – Adult 15mm (1.5cm) pieces.

Fluid Recommendations

0 Thin Fluids: No thickener required

1 Slightly Thick: Add 1 scoop of Nutilis Clear per 200mls

2 Mildly Thick: Add 2 scoops of Nutilis Clear per 200mls

3 Moderately Thick: Add 3 scoops of Nutilis Clear per 200mls

4 Extremely Thick Add 7 scoops of Nutilis Clear per 200mls

Please do not order ice cream or jelly if on thickened fluids.

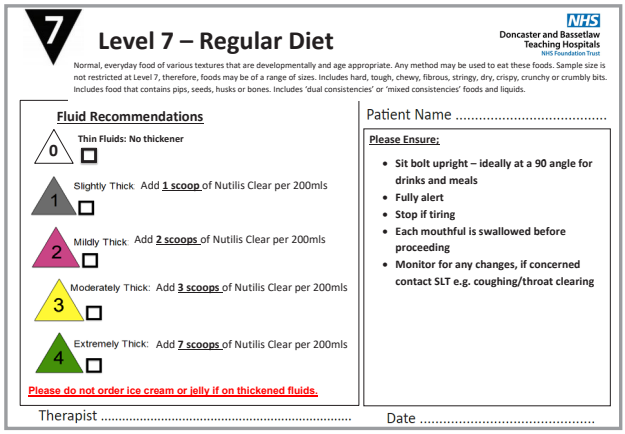
Patient Name .....

Please Ensure;

- Sit bolt upright – ideally at a 90 angle for drinks and meals
- Fully alert
- Stop if tiring
- Each mouthful is swallowed before proceeding
- Monitor for any changes, if concerned contact SLT e.g. coughing/throat clearing
- Stir through meals with a fork

Therapist .....

Date .....



7 Level 7 – Regular Diet

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Normal, everyday food of various textures that are developmentally and age appropriate. Any method may be used to eat these foods. Sample size is not restricted at Level 7, therefore, foods may be of a range of sizes. Includes hard, tough, chewy, fibrous, stringy, dry, crispy, crunchy or crumbly bits. Includes food that contains pips, seeds, husks or bones. Includes 'dual consistencies' or 'mixed consistencies' foods and liquids.

Fluid Recommendations

0 Thin Fluids: No thickener

1 Slightly Thick Add 1 scoop of Nutilis Clear per 200mls

2 Mildly Thick Add 2 scoops of Nutilis Clear per 200mls

3 Moderately Thick: Add 3 scoops of Nutilis Clear per 200mls

4 Extremely Thick: Add 7 scoops of Nutilis Clear per 200mls

Please do not order ice cream or jelly if on thickened fluids.

Patient Name .....

Please Ensure;

- Sit bolt upright – ideally at a 90 angle for drinks and meals
- Fully alert
- Stop if tiring
- Each mouthful is swallowed before proceeding
- Monitor for any changes, if concerned contact SLT e.g. coughing/throat clearing

Therapist .....

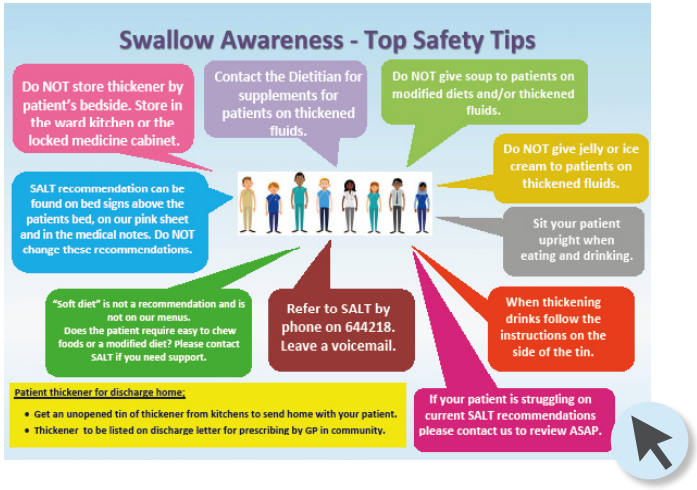
Date .....

Swallow Awareness training – top safety tips

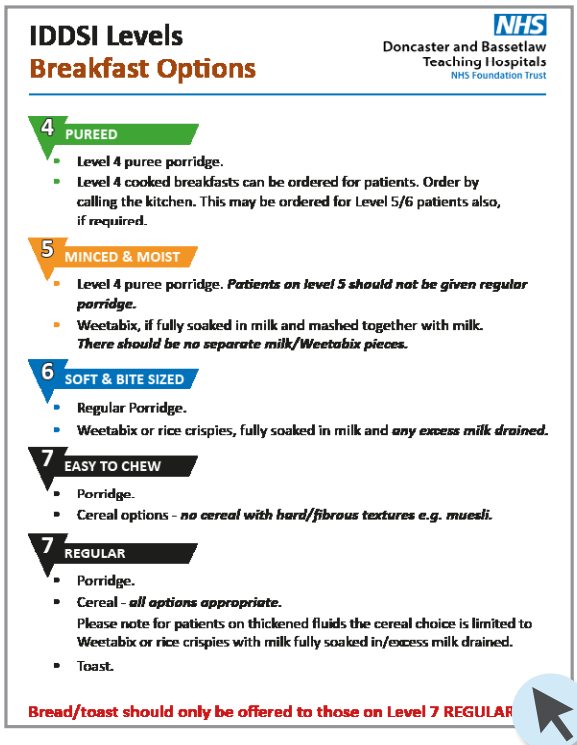
New 30 minutes virtual training from Speech & Language Therapy! Open to ALL staff. Dates are:

- Friday 8th January 2021 at 13:30
- Wednesday 20th January 2021 at 15:00
- Thursday 21st January 2021 at 10:00
- Monday 25th January 2021 at 13:30
- Wednesday 27th January 2021 at 16:00

All the top tips, tricks and essential safety advice to help you manage patients with swallowing problems on your ward. To book please contact the Education Department.



Please print off for use in your area



IDDSI Levels

Breakfast Options

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

4 PUREED

- Level 4 puree porridge.
- Level 4 cooked breakfasts can be ordered for patients. Order by calling the kitchen. This may be ordered for Level 5/6 patients also, if required.

5 MINCED & MOIST

- Level 4 puree porridge. ***Patients on level 5 should not be given regular porridge.***
- Weetabix, if fully soaked in milk and mashed together with milk. ***There should be no separate milk/Weetabix pieces.***

6 SOFT & BITE SIZED

- Regular Porridge.
- Weetabix or rice crispies, fully soaked in milk and ***any excess milk drained.***

7 EASY TO CHEW

- Porridge.
- Cereal options - ***no cereal with hard/fibrous textures e.g. muesli.***

7 REGULAR

- Porridge.
- Cereal - ***all options appropriate.***
  Please note for patients on thickened fluids the cereal choice is limited to Weetabix or rice crispies with milk fully soaked in/excess milk drained.
- Toast.

Bread/toast should only be offered to those on Level 7 REGULAR

Please print off for use in your area

Update from the Medical Examiner

The medical examiner system is a point of contact for bereaved families to raise concerns about the care provided to the death of a loved one.

The purpose of the medical examiner is to provide greater scrutiny of non-coronial deaths, ensure the appropriate direction of deaths to the coroner, improve the quality of death certification and improve the quality of mortality data and ensure these are discussed with the next of kin/informant, establishing if they have any concerns about the care that could have led to the patient's death.

During December 2020 there were 306 hospital deaths across the Trust. The ME team have scrutinised 86% (264) of these. Almost a quarter of all deaths are referred to the Coroner and it is the responsibility of a **senior Doctor** to report the death as soon as possible after death.

It has become more and more apparent over the last month that many referrals are completed by junior Doctors and the quality of the referral is often lacking in detail. The ME team have raised this with individual specialties and will continue to monitor this over the next few months and report into the Mortality Governance Group.

One of the most demanding roles of the ME team is to speak to bereaved relatives. These very emotive conversations, vary in length, complexity and sensitivity, ranging from a 5 minute conversation to a 45 minute detailed explanation of care, medical conditions and management.

During December, of the 264 phone calls made to bereaved families, 254 were generally happy with the care their loved one had received and the ME team provided feedback to wards and individual staff when asked to do so. This is hugely satisfying for the clinicians involved in the care of the patients and the ME team making the call. Considering the challenges we are all facing, this is a credit to the teams caring for our patients. Thank you.

In December 2020, four families raised concerns and were unhappy that their loved one had apparently acquired Covid-19 whilst in hospital and six families raised issues with either a lack of communication or not understanding what had happened to their relative whilst in hospital. When concerns can't be resolved with the families, these are then passed onto PALS and enter the complaints process.

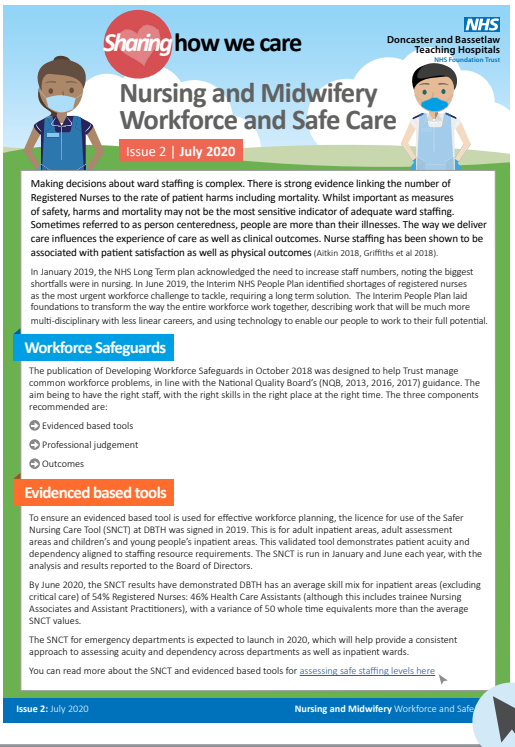
What are we doing about Safe Staffing?

The challenges to achieve safe staffing are significant and our 5th most reported incident. Clinical and managerial colleagues continue to work tirelessly to ensure that they do the right thing for their service to try and keep you and our patients as safe as possible.

For nurse staffing, we are always looking at ways to innovate and improve our staffing levels. Currently establishments are set by using the Safer Nursing Care Tool, and we are now looking at ways to improve the daily deployment of staff with the Safe Care system on Allocate.

To help communicate the ongoing work to keep our clinical areas safe, we have developed a twice yearly Safe Staffing newsletter for nursing colleagues. The last one was published in summer 2020 but the January edition was also picked up by NHSi as a recognition of good practice for sharing.

https://improvement.nhs.uk/resources/dbth-safe-staffing-newsletter/



Sharing how we care

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Nursing and Midwifery Workforce and Safe Care

Issue 2 | July 2020

Making decisions about ward staffing is complex. There is strong evidence linking the number of Registered Nurses to the rate of patient harms including mortality. Whilst important as measures of safety, harms and mortality may not be the most sensitive indicator of adequate ward staffing. Sometimes referred to as person centeredness, people are more than their illnesses. The way we deliver care influences the experience of care as well as clinical outcomes. Nurse staffing has been shown to be associated with patient satisfaction as well as physical outcomes (Aitkin 2018, Griffiths et al 2018).

In January 2019, the NHS Long Term plan acknowledged the need to increase staff numbers, noting the biggest shortfalls were in nursing. In June 2019, the Interim NHS People Plan identified shortages of registered nurses as the most urgent workforce challenge to tackle, requiring a long term solution. The Interim People Plan laid foundations to transform the way the entire workforce work together, describing work that will be much more multi-disciplinary with less linear careers, and using technology to enable our people to work to their full potential.

Workforce Safeguards

The publication of Developing Workforce Safeguards in October 2018 was designed to help Trust manage common workforce problems, in line with the National Quality Board's (NQB, 2013, 2016, 2017) guidance. The aim being to have the right staff, with the right skills in the right place at the right time. The three components recommended are:

- Evidenced based tools
- Professional judgement
- Outcomes

Evidenced based tools

To ensure an evidenced based tool is used for effective workforce planning, the licence for use of the Safer Nursing Care Tool (SNCT) at DBTH was signed in 2019. This is for adult inpatient areas, adult assessment areas and children's and young people's inpatient areas. This validated tool demonstrates patient acuity and dependency aligned to staffing resource requirements. The SNCT is run in January and June each year, with the analysis and results reported to the Board of Directors.

By June 2020, the SNCT results have demonstrated DBTH has an average skill mix for inpatient areas (excluding critical care) of 54% Registered Nurses: 46% Health Care Assistants (although this includes trainee Nursing Associates and Assistant Practitioners), with a variance of 50 whole time equivalents more than the average SNCT values.

The SNCT for emergency departments is expected to launch in 2020, which will help provide a consistent approach to assessing acuity and dependency across departments as well as inpatient wards.

You can read more about the SNCT and evidenced based tools for assessing safe staffing levels here

Issue 2: July 2020 Nursing and Midwifery Workforce and Safe

Involvement :

Patient safety partners, curriculum and training, specialists, Safety II

People have the skill and opportunities to improve the patient safety, throughout the whole system.

What's next?- Learning from Excellence and Safety II

We are starting work on a new Quality Strategy at DBTH, with the aim of being the safest Trust in England.

The pursuit of patient safety is a key component of the wider endeavour to improve quality of healthcare delivery. Our efforts to improve safety are therefore almost entirely focused on identifying adverse incidents and errors, and implementing adaptations to avoid their recurrence.

This reactive approach to safety ('Safety-I') advocates incident reporting and root-cause analysis in order to identify adverse incidents and their causes. You can read more about this here.

Following major reports emphasising the significant role of human error and the need for organisational learning from adverse incidents, incident reporting has become well established in the National Health Service (NHS). Trends of monitoring and reporting of adverse events are increasing.

While this approach may achieve good results, with higher levels of adverse incident reporting correlating with a more positive safety culture, some studies of healthcare safety interventions suggest that the benefits of this approach are limited.

Adverse incident reporting is widely encouraged in the NHS, but reporting rates and methods for investigating incidents vary widely between organisations. Staff and patients may not always receive feedback about incidents in which they have been involved, and there is often inadequate evidence of lessons learned or effective change implemented following incidents.

Second victims

An important consideration of Safety-I practice is the potential negative impact on healthcare workers. Staff involved in incidents may often experience the second-victim phenomenon. Effects on second victims may include detachment, anxiety and depression, as well as reduced clinical confidence and cognitive functioning, potentially impairing that individual's clinical performance. You can read more about support for second victims here.

What is Safety II?

In general, Safety-II is about learning from things that go right and improving resilience, where Safety-I is about learning from things that go wrong and improving compliance. Read more about it here.

The five core concepts of Safety-II are:

Definition of safety: 'Safety' is not defined as the absence of failures or adverse outcomes, which is considered 'Safety-I thinking', but as the ability to make things go right.

Safety management: Safety management is focused on maintaining adaptive capacity to respond effectively to inevitable surprises.

Role of humans: Humans are not seen as a risk, but as a resource necessary for system flexibility and resilience.

Accident investigation: The purpose of accident investigations is to understand how things usually go right, since that is the basis for explaining how things occasionally go wrong.

Risk assessment: Risk assessment is focused on understanding 'conditions where performance variability can become difficult or impossible to monitor and control'.

In summary, Safety-II is about learning from things that go right, with a focus on 'Work As Done' (WAD) instead of 'Work As Imagined' (WAI), meaning the paper-based reality of rules and guidelines. Safety-II is not intended as a replacement, but as a complement to Safety-I. The originators of the theory state that the two perspectives on safety must co-exist, at least for the foreseeable future

You can watch this simple video on Safety II by Professor Suzette Woodward here.

Improvement :

Deterioration, spread, maternity, medication, mental health, older people, learning disability, antimicrobial resistance, research

Improvement programmes enable effective and sustainable change in the most important areas.

Patient safety improvement programmes (SIPs) are led by the national patient safety team. SIPs include:

- the National Patient Safety Improvement Programme
- the Maternity and Neonatal Safety Improvement Programme
- the Medicines Safety Improvement Programme

1.1. National Patient Safety Improvement programme

The National Patient Safety Improvement Programme (NatPatSIP) is led by the national patient safety team. The programme is delivered by 15 regionally-based Patient Safety Collaboratives (PSCs). The PSCs are each commissioned through one of 15 Academic Health Science Networks (AHSNs).

NatPatSIP supports two areas of work:

a. Preventing deterioration and sepsis:

This helps the avoidance of harm or death caused by failure to recognise or respond to physical deterioration in a patient's condition, wherever they are being cared for.

The NEWS, a structured observation to recognise deterioration has been in use at DBTH for several years. To continue to improve further, eObservations, provided by Nervecentre was introduced to the Trust in early 2019, and helps in the recording and distribution of tasks within wards and departments between health professionals.

During 2020- eObservations were successfully rolled out on the adult wards at BH and medicine and frailty wards at DRI.

Continuing in January 2021, Nerve centre will be upgraded to 6.1 which will enable us to deploy clinical assessments and care plans. This will enable improvement in documentation for handovers and communication with families.

b. Adoption and spread of effective, evidence-based practice:

This helps accelerate the adoption and spread of evidence-based practice across the NHS in England.

There are currently four adoption and spread priorities across England:

- emergency laparotomy care bundle
- prevention of cerebral palsy in preterm labour (PReCept)
- emergency department safety checklist
- chronic obstructive pulmonary disease discharge care bundle.

The programme also works with national, regional and local partners to develop a "pipeline" of future improvements.

1.2. Maternity and Neonatal Safety Improvement Programme

The Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) is led and co-delivered by the national patient safety team, who work with the 15 regionally-based Patient Safety Collaboratives (PSCs) and with maternity teams from 132 NHS trusts. The aim being:

- improve the safety and outcomes of maternity and neonatal care of all women, babies and families in England, reducing unwarranted variations in care and experience of care
- help reduce maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025 – a national target set out in Better Births.

Shared Learning in Maternity

Colleagues in Maternity have developed a What's Hot newsletter to share clinical governance issues with all colleagues in maternity and gynaecology. You can see the link to all the newsletters here.

1.3. Medicines Safety Improvement Programmes

The Medicines Safety Improvement Programme (MedSIP) is led nationally and commissioned by the national patient safety team. It supports an initial set of projects linked to the evidence base on medication errors, and the NHS Long Term Plan. Medicines SIP @DBTH include:

- The current JAC EPMA system is planned for an upgrade before June 2021. This will have the existing functionality for medicines administration recording, but it is moving to being web based so will have a different look and feel. The project team will continue the work before training is planned for February 2021. This will enable colleagues prescribing in ED to have a joined system.
- Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults – see link here. Work will be commencing to implement the recommendations
- Medical Gases committee, chaired by the MSO will recommence with refreshed ToR which will help focus on managing issues with the current oxygen supply.

Thanks this month go to: Cindy Storer, Dr Tim Noble, Kerry Turner, Tracy Evans Phillips, Bonny Stevenson