

Learning Lessons Quarterly Bulletin

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Welcome

Welcome to South Staffordshire and Shropshire Healthcare NHS Foundation Trust's first Learning Lessons bulletin.

As a Trust we recognise the benefits that can be had from sharing and cascading learning from incidents and near misses, and know that if this is done effectively it can help to minimise future risk and strengthen the quality of the services we provide.

The Trust is committed to quality improvement, and will continue its strong focus on delivering high quality, safe and effective services. This new quarterly bulletin is an important component of a number of key approaches embraced by the Trust to drive forward the quality agenda.

The ultimate aim of evaluating our services and learning lessons is to improve outcomes for service users. This bulletin is intended to support this aim by communicating and strengthening local and national lessons to be learnt from both positive practice and areas for improvement.

I hope that you find this bulletin informative and useful and welcome your ideas and input into future issues.

Liz Lockett

Associate Director Quality & Risk



Quality Accounts 2009/10

In June 2010 the Trust published its first set of quality accounts. Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide.

The public, patients and others with an interest will use our Quality Account to understand:

- what the organisation is doing well;
- where improvements in service quality are required;
- what our priorities for improvement are for the coming year; and
- how we have involved service users, staff and others with an interest in the organisation in determining those priorities for improvement.

You can view a copy of the 2009/10 Quality Accounts via the Trust website at:

http://www.southstaffsandshropshealthcareft.nhs.uk/partnership/quality/docs/Quality_Accounts_2009-10.pdf



Learning Lessons Features

Medication Incidents

A review by the Chief Pharmacist of medication incidents across South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Mental Health, Learning Disabilities and Forensic wards highlighted a number of emerging themes:

- **Omitted doses with empty administration boxes**
- **Medication errors involving agency nurses (including errors of types: wrong patient, omission of dose(s), inappropriate storage, booking in expired patient's own medicines)**
- **Administration of non-daily medicines at the wrong time**
- **Medicines administration being omitted due to medicine being marked as out of stock**

The risk posed by the level of medicines errors in November 2009, was judged to warrant an overall score of at least 12 on individual Directorate Risk Registers.

“feedback from the exercise has been extremely positive, with a reduction in some of the trends”.

A memo documenting the risks, together with strategies to reduce them, was sent to all Service Managers. They were subsequently asked to conduct 'spot checks' on wards at medication round times and report back using a specifically designed checklist.

It was used as an opportunity for senior managers to discuss issues and concerns about the medication round with staff, remind staff of pertinent points in the Trust's Medicines Code, and discuss the rationale of why certain standards were important, e.g.:

- **Taking the medicines card, along with the medicines, to the patient when administering medicines**
- **Checking the expiry date prior to administration**
- **Minimising interruptions during the medicines round**

Feedback from the exercise has been extremely positive, with a reduction in some of the trends. However, the level of incidents involving omitted doses of regular medicines, with no omission code recorded, remains a concern, because of the potential for either: loss of effectiveness or the risk of doubling of doses. This needs to be a focus of attention during handover.

Positive actions resulting from the exercise, include the development of medicines management training specifically for health care support workers, in order to support understanding of their roles and responsibilities in undertaking the “second check” during medicines administration.



*Cathy Riley
Chief Pharmacist*

Learning Lessons Features

Coroners Rule 43

Having heard the evidence at an Inquest, under the Coroners (Amendment) Rules 2008, Rule 43 gives the Coroner the power to write to a person or organisation when the Coroner believes action needs to be taken to prevent future deaths. Historically, there was no obligation to act upon the Rule 43 letter received from the Coroner; nor was there any obligation to respond to the Coroner. The 2008 amended Rule however means that:

- Coroners have a wider remit than determining cause of death and also have a remit to make reports to prevent future deaths;
- A person or organisation who receives a Rule 43 report must provide the coroner with a written response to their request within 56 days;
- The Coroner must provide interested persons to the inquest, and the Lord Chancellor, with a copy of the report and the response;
- Coroners may send a copy of the report and the response to any other person or organisation with an interest;
- Additionally, the content of the Rule 43 letter and the response to it are placed in the public domain.
- The link to Rule 43 information, placed in the public domain are on the Ministry of Justice website: <http://www.justice.gov.uk/publications/summary-reports-rule-43-coroners-rules.htm> This website offers an opportunity to review lessons learned by other Trusts / organisations following Inquests.

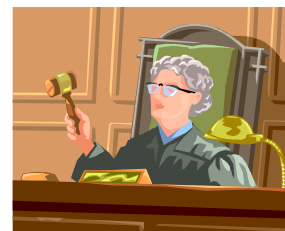
The latest Rule 43 Summary report published by the Ministry of Justice was in March 2010. It reports that between 1 April and 30 September 2009 coroners in England and Wales issued Rule 43 reports in a total of 164 inquests. These reports were most frequently issued in connection with hospital deaths, accounting for 32% of the reports issued in this period (52 reports). A further 18% of reports were issued in connection with the circumstances surrounding road deaths (29 reports). The third most frequently issued reports, accounting for 8% each, were in connection with accidents at work or health and safety issues and mental health deaths (14 reports each). Of the 14 issued reports for mental health deaths 1 was issued for our Trust and the report asked the Trust to consider the management of psychiatric services in Uttoxeter area to ensure consistency of care.

HMS Coroner - South Staffordshire District, Mr Andrew Haigh has written to our Trust recently regarding an inquest he heard in which the evidence presented indicated that more deaths may occur if a perceived shortfall in the communication with the family of the service users continues. Mr Haigh wished to be reassured that this concern has been suitably cascaded to all staff.

We were able to report progress in this area but acknowledged that there were areas that needed to be strengthened. The Trust's Lead Investigating Officer for this case stated that although the clinical team reported involvement of the family in the planning of this persons care that this was not substantially evident in the health records, so therefore she was unable to report that this had occurred when presenting evidence in Coroners Court.

This case therefore highlights the need not only to ensure that carers are involved in the care planning process but also to document this involvement clearly within clinical notes.

Kath Chambers
Senior Nurse













“Rule 43 gives the Coroner the power to write to a person or organisation when the Coroner believes action needs to be taken to prevent future deaths”



Best Practice Tips From Serious Untoward Incident Investigations

The Trust promotes an open incident and near miss reporting culture and recognises that to learn from incidents and prevent reoccurrences, it is important that lessons are shared. Each edition of the Trust's Learning Lessons Bulletin will include a series of best practice tips that have been identified through the Trust's investigation into recent serious incidents.

The best practice tips not only focus on areas identified for improvement but also incorporate elements of positive practice that have been highlighted as part of the investigation process.

-  **Changes in observation levels should be informed by an up to date risk assessment and supported by multi-disciplinary discussion**
-  **It is good practice to document the salient points of all issues discussed in the course of a clinical contact**
-  **Care plans need to clearly document supporting arrangements for service users on leave from hospital**
-  **It is important to ensure that all relevant documentation relating to MDT discussion is completed fully and reflects outcomes of the discussion held**
-  **Following a serious untoward incident, staff should consider the family and if appropriate offer support and follow up in line with the Adverse Incidents Policy**
-  **Service users should be kept informed and updated on waiting times for access to services**
-  **Care plans should be outcome focused and regularly updated to reflect changing needs**
-  **It is important to ensure that no service user sensitive information is stored outside of the record (i.e. handover books)**
-  **It is important that service users and carers have the number of someone from their local NHS Mental Health Services that they can contact in an emergency out of hours**
-  **To ensure that service users are asked if they are happy for information to be sent to their home address and if not they are offered the opportunity to provide a correspondence address.**

National Updates



Patient Safety First is a national campaign and is sponsored by the National Patient Safety Agency and the NHS Institute for Innovation & Improvement. The campaign aims to make safety of patients everyone's highest priority with no unavoidable deaths and no unavoidable harm. The Campaign website contains a range of simple, yet effective ideas for improving patient safety within organisations. The link to the Patient Safety First Campaign website is: <http://www.patientsafetyfirst.nhs.uk>

NHS National Patient Safety Agency On 23rd June 2010 the National Patient Safety Agency released a slips, trips and falls data report. The data is taken from acute and community hospitals and mental health units in England & Wales. The data has been provided to emphasise the human cost of falls in healthcare settings and is supported by good practice recommendations. The link to the report on the NPSA website is: <http://www.nrls.npsa.nhs.uk/resources/?entryid45=74567>



On June 15th 2010 Monitor released new guidance regarding the role of boards in improving patient safety. Monitor recognise that patient care inevitably raises issues of safety and that safety measures can never be failsafe, but they can always be improved. Therefore the publication offers guidance to boards on helping to bring about these improvements. Monitor identify 6 elements crucial for delivering safe patient care and describe how to take these elements forward in a trust.

The link to the publication on the Monitor website is: <http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/developing-foundation-trusts/the-role-boards-improving-patient>



On July 7th 2010 The Royal College of Psychiatrists released a new report that examines provision of care for people at risk of suicide and self-harm. The report is split into three parts: background information on self-harm; public health policy issues and practice of healthcare professionals working with those who self-harm. The link to the report on the RCP website is: <http://www.rcpsych.ac.uk/files/pdfversion/CR158.pdf>



On 7th July 2010 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness released its 2010 report. The report covers deaths by suicide for the period January 1997 to December 2007, people convicted of homicide (homicide convictions) between January 1997 and December 2006 and sudden unexplained deaths (SUD) in psychiatric in-patients for the period March 1999 to December 2007. The link to the report on the University of Manchester website is: <http://w.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiryannualreports/AnnualReportJuly2010.pdf>



This Bulletin is available on the Trust website at :

<http://www.southstaffsandshropshealthcareft.nhs.uk/Default.aspx>

Or alternatively

A hard copy can be obtained by contacting the Trust Risk Management Department on 07850 257888 ext 5953

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- We welcome your feedback on this first Learning Lessons Bulletin to help us to ensure that future editions are helpful and informative
- We would also welcome your ideas for future features or areas of learning you feel are relevant to be cascaded across the Trust

For all enquiries and comments please Contact:

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