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Tees, Esk and Wear Valleys NHS Foundation Trust

Care Quality Commission inspection update for Darlington Health & Housing Scrutiny Committee

25th August 2021

Recent CQC inspections of our Adult Mental Health (AMH) wards and Psychiatric Intensive Care Units (PICU)

- During 2021 the Trust has been subject to two CQC inspections of its AMH & PICU wards. The first was undertaken 20th -22nd January and the second 25th – 27th May

- From a West Park Hospital Darlington perspective Elm Ward (female AMH) was inspected in the first visit and then Elm Ward and Cedar (PICU) in the second visit

- The key message from the January inspection was that the inspectors were not assured that we had systems and processes in place, across the Trust, to safely assess and mitigate patient risk

Immediate actions undertaken

- Quality improvement work to rapidly redesign the templates for patient safety summaries and safety plans (previously known as risk assessments)
- All key risk information about a patient is now contained in one place and updated at least daily (in-patients)
- This work has also been extended to community patients
- A robust Quality Assurance schedule has been designed to replace previous audit activity. This allows early escalation of any key issues to managers and clinical leads for rapid resolution (see next slide)

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Quality Assurance Schedule

The following timetable was scheduled during the reporting Quarter:

KEY	
	Assurance Self-declaration (QA2)
	Modern Matron Quality Review (QA3)
	Practice Development Review Tool (QA4)
	Peer Review (QA6)
	MDT Walkabouts/ Visit (QA7)
	Director's Visits (QA12)

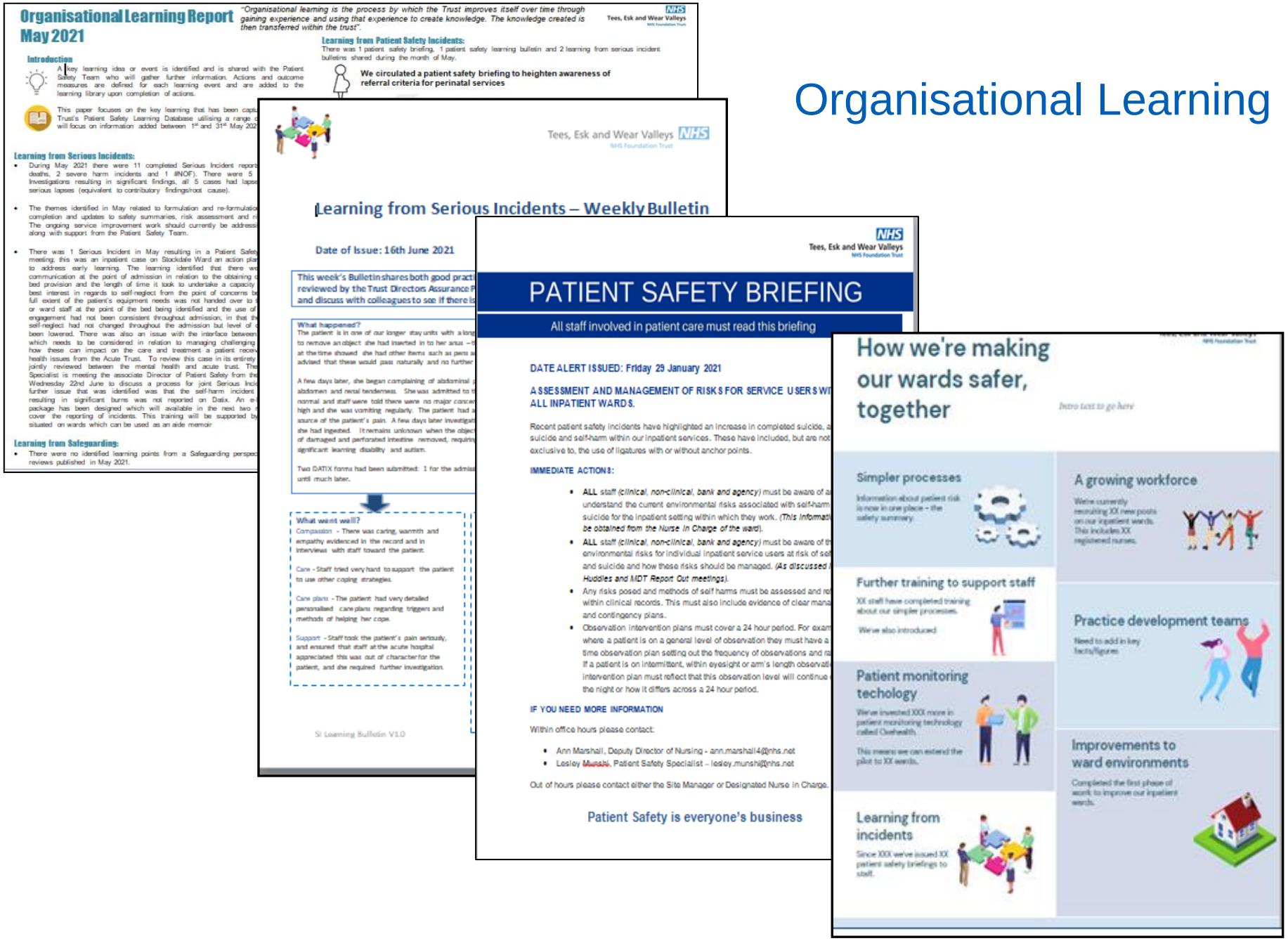
*In addition to this, a Community Caseload Management Review was implemented from the 1st June 2021

Quarter 1 2021/22 (Apr-21 – Jun-21)							
Week commencing	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
05/04/21							
12/04/21							
19/04/21							
26/04/21							
03/05/21							
10/05/21							
17/05/21							
24/05/21							
31/05/21		 *					
07/06/21							
14/06/21							
21/06/21							
28/06/21							

Further actions undertaken

- Rollout of Safe Care system
- Improved processes for escalation of staffing concerns
- Environmental safety – anti-ligature work including £3.8m of capital investment
- Sexual safety initiatives – working as part of a national collaborative to ensure we keep patients safe from these types of incidents
- To ensure we have systems in place to allow organisation - wide learning we have created a new Organisational Learning Group. The group will have oversight of learning themes, actions and gain assurance on impact of any changes

Organisational Learning



Organisational Learning Report May 2021

"Organisational learning is the process by which the Trust improves itself over time through gaining experience and using that experience to create knowledge. The knowledge created is then transferred within the trust".

Tees, Esk and Wear Valleys NHS

Introduction

A key learning idea or event is identified and is shared with the Patient Safety Team who will gather further information. Actions and outcome measures are defined for each learning event and are added to the learning library upon completion of actions.

This paper focuses on the key learning that has been capt... Trust's Patient Safety Learning Database utilising a range ... will focus on information added between 1st and 31st May 202...

Learning from Patient Safety Incidents:

There was 1 patient safety briefing, 1 patient safety learning bulletin and 2 learning from serious incident bulletins shared during the month of May.

We circulated a patient safety briefing to heighten awareness of referral criteria for perinatal services

Learning from Serious Incidents:

- During May 2021 there were 11 completed Serious Incident report... deaths, 2 severe harm incidents and 1 #NOF). There were 5 ... Investigations resulting in significant findings, all 5 cases had lapse... serious lapses (equivalent to contributory findings/root cause).
- The themes identified in May related to formulation and re-formulatio... completion and updates to safety summaries, risk assessment and ri... The ongoing service improvement work should currently be address... along with support from the Patient Safety Team.
- There was 1 Serious Incident in May resulting in a Patient Safety ... meeting; this was an inpatient case on Stockdale Ward an action pla... to address early learning. The learning identified that there wa... communication at the point of admission in relation to the obtaining ... bed provision and the length of time it took to undertake a capacity ... best interest in regards to self-neglect from the point of concerns b... full extent of the patient's equipment needs was not handed over to ... or ward staff at the point of the bed being identified and the use of ... engagement had not been consistent throughout admission, in that th... self-neglect had not changed throughout the admission but level of ... been lowered. There was also an issue with the interface between ... which needs to be considered in relation to managing challenging ... how these can impact on the care and treatment a patient receiv... health issues from the Acute Trust. To review this case in its entirety ... jointly reviewed between the mental health and acute trust. The ... Specialist is meeting the associate Director of Patient Safety from the ... Wednesday 22nd June to discuss a process for joint Serious Inci... further issue that was identified was that the self-harm incident ... resulting in significant burns was not reported on Datix. An e... package has been designed which will available in the next two ... cover the reporting of incidents. This training will be supported b... situated on wards which can be used as an aide memoir

Learning from Safeguarding:

- There were no identified learning points from a Safeguarding perspe... reviews published in May 2021.

Learning from Serious Incidents – Weekly Bulletin

Tees, Esk and Wear Valleys NHS

Date of Issue: 16th June 2021

This week's Bulletin shares both good practi... reviewed by the Trust Directors Assurance P... and discuss with colleagues to see if there is...

What happened?

The patient is in one of our longer stay units with a long... to remove an object she had inserted in to her anus – t... at the time showed she had other items such as pens a... advised that these would pass naturally and no further...

A few days later, she began complaining of abdominal ... abdomen and rectal tenderness. She was admitted to t... normal and staff were told there were no major concer... high and she was vomiting regularly. The patient had a... source of the patient's pain. A few days later investigat... she had ingested. It remains unknown when the objec... of damaged and perforated intestine removed, requiri... significant learning disability and autism.

Two DATIX forms had been submitted: 1 for the admis... until much later.

What went well?

Compassion - There was caring, warmth and empathy evidenced in the record and in interviews with staff toward the patient.

Care - Staff tried very hard to support the patient to use other coping strategies.

Care plans - The patient had very detailed personalised care plans regarding triggers and methods of helping her cope.

Support - Staff took the patient's pain seriously, and ensured that staff at the acute hospital appreciated this was out of character for the patient, and she required further investigation.

SI Learning Bulletin V1.0

PATIENT SAFETY BRIEFING

Tees, Esk and Wear Valleys NHS

All staff involved in patient care must read this briefing

DATE ALERT ISSUED: Friday 29 January 2021

ASSESSMENT AND MANAGEMENT OF RISKS FOR SERVICE USERS WI... ALL INPATIENT WARDS.

Recent patient safety incidents have highlighted an increase in completed suicide, a... suicide and self-harm within our inpatient services. These have included, but are not ... exclusive to, the use of ligatures with or without anchor points.

IMMEDIATE ACTIONS:

- **ALL** *staff (clinical, non-clinical, bank and agency)* must be aware of a... understand the current environmental risks associated with self-harm ... suicide for the inpatient setting within which they work. *(This informat... be obtained from the Nurse In Charge of the ward).*
- **ALL** *staff (clinical, non-clinical, bank and agency)* must be aware of t... environmental risks for individual inpatient service users at risk of sel... and suicide and how these risks should be managed. *(As discussed ... Huddles and MDT Report Out meetings).*
- Any risks posed and methods of self harms must be assessed and re... within clinical records. This must also include evidence of clear mana... and contingency plans..
- Observation intervention plans must cover a 24 hour period. For exam... where a patient is on a general level of observation they must have a ... time observation plan setting out the frequency of observations and re... If a patient is on intermittent, within eyesight or arm's length observati... intervention plan must reflect that this observation level will continue ... the night or how it differs across a 24 hour period.

IF YOU NEED MORE INFORMATION

Within office hours please contact:

- Ann Marshall, Deputy Director of Nursing - ann.marshall4@nhs.net
- Lesley ~~Munshi~~, Patient Safety Specialist – lesley.munshi@nhs.net

Out of hours please contact either the Site Manager or Designated Nurse In Charge.

Patient Safety is everyone's business

How we're making our wards safer, together

Intro text to go here

Simpler processes

Information about patient risk is now in one place – the safety summary.

A growing workforce

We've currently recruiting XX new posts on our inpatient wards. This includes XX registered nurses.

Further training to support staff

XX staff have completed training about our simpler processes.

We've also introduced

Practice development teams

Need to add in key facts/figures

Patient monitoring techology

We've invested XXX more in patient monitoring technology called Oxehealth.

This means we can extend the pilot to XX wards.

Improvements to ward environments

Completed the first phase of work to improve our inpatient wards.

Learning from incidents

Since XXX we've issued XX patient safety briefings to staff.

Current position

- AMH and PICU report from second inspection (25-27th May 2021) has recently been received for factual accuracy comments by the Trust
- Too early to give accurate feedback but it would appear that CQC feel our systems and processes in relation to risk management have been improved
- We know we still have work to do to continue to improve the safety and quality of services we deliver but we are committed to doing this and will keep the Committee updated of our progress