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Leicestershire Partnership NHS Trust

Trust Board Patient Safety Incident and Incident Learning Assurance Report July 2024

Purpose of the report

This report for May and June 2024 provides assurance on LPTs incident management and 'Duty of Candour' compliance processes. The process reviews systems of control which continue to be robust, effective, and reliable underlining our commitment to the continuous improvement of keeping patients and staff safe by incident and harm reduction. The report also provides assurance on 'Being Open', numbers of incident investigations, themes emerging from recently completed investigation action plans, a review of recent Ulysses incident and associated learning.

Analysis of the issue

Teams are working collaboratively to continuously improve our ability to review and triangulate incidents with other sources of quality data with the incident data we have available.
The quality of our data and ability to triangulate this information is essential to the culture of continuous improvement. We are exploring opportunities both internally and externally to develop safety dashboards and ways to improve this data and provide more meaningful data that is available closer to clinical teams.

The NHS continues to be challenged with resources and priorities and to offer assurance we are working to improve the safety data and intelligence within the organisation, along with the Patient Safety Improvement Group (PSIG) we are ensuring that we are also reviewing learning identified nationally across the NHS and implementing learning in LPT.

Rapid Improvement Programme

We have received three preventing future deaths reports from HM Coroner (Regulation 28). Following a thematic review of the learning from these, a series of improvement actions are being implemented via a rapid improvement programme.

The preventing future deaths reports have highlighted there are some potential gaps in processes and assurance oversight. The risk profile for the organisation has subsequently increased and a rapid plan is required to ensure appropriate actions are taken to share and embed learning from incidents along with plans for improving visibility and oversight of risk.

We are responding by connecting our learning and a thematic analysis of these has identified the below themes:

- MDT function
- Embedding learning identified through our patient safety reviews.
- Robust discharge process
- Evidence of risk assessment
- Communication
- Family involvement
- Continuity of care

To address the key elements of work required to make the necessary improvements the following workstreams are now in place:

- Directorate Governance
- Accountability

- Serious Incident and Investigation
- Safety Oversight
- Inquest Preparation
- Regulation 28 Process
- Risk Assessment, Control and Management Plans
- Safeguarding
- Crisis Pathway

As part of the learning and rapid improvement programme, safety huddles are being implemented across the organisation. Many studies across healthcare literature suggest that introducing safety check-ins enable and enhance teamwork through improved communication and problem-solving and a shared understanding of focus and priorities. They also enable clinicians to have a greater insight and awareness of any safety concerns, thus improving a safety culture and ultimately enhancing patient safety. This provides an opportunity for teams to come together daily and assess any risks and problem solve together risks to safety for the shift ahead, this ensures a view through a clinical lens, and that actions are taken to maintain safety and assurance gained that 'we are safe today'. The impact of these interventions will be evaluated across all three directorates.

Patient Safety Incident Response Framework (PSIRF)

We transitioned to PSIRF 1st November 2023. We continue to build on our processes as we learn and develop these collaboratively. PSIRF allows organisations to design and learn from their incidents in line with their local context for patients, families and staff whilst considering local and national safety learning requirements. This is the largest scale national and organisational change in patient safety in the last twenty years and therefore there is not an expectation that these changes will happen rapidly. This change in 'thinking' requires a level of safety maturity, both in culture and expertise; we are continuing to build capability by providing awareness of the human factors models used to consider complex situations and identify wider system changes to support our staff to do their best work. The aim is that these reviews will really identify the system issues and associated actions.

Feedback from staff has been positive and they appreciate the collaborative nature of the new investigation style and shared that they feel part of the process rather than being investigated (as per previous serious incident framework); we are starting to gather formal feedback from our staff involved through electronic anonymised feedback.

Investigation compliance with timescales set out in the previous serious incident framework.

This is an improving picture (see graphs in slides) as we complete the backlog of incidents and transition to our new processes. A trajectory of six months has been agreed to complete this and a trajectory line will be added to the slides to track this.

Analysis of Patient Safety Incidents reported.

Appendix 1 contains Statistical Process Control (SPC) charts utilising the NHSI Toolkit to support the narrative and analysis and local speciality incident information. The overall position is also included for all investigations and action plans.

All incidents reported across LPT.

Incident reporting should not be seen as a good single indicator of safety in the clinical environments; however, these can provide an early indication of incident change in specialities or even across the Trust or a wider healthcare system. Our numbers reported remain around 2000 per month. The 'Reporting and Managing incidents; leading safely', training that is led by CPST is very well attended, popular and oversubscribed; we have responded to the

demand by providing additional sessions on Ulearn.

Review of Patient Safety Related Incidents.

The overall numbers of all reported incidents continue to be just above or on the mean and can be seen in our accompanying appendices.

Pressure Ulcers - Patients affected by pressure ulcers developed whilst in LPT care.

LPT continue to see 'normal' variation in the number of Category 2 and 4 pressure ulcers developed or deteriorated in our care, with a reduction of category 3 pressure ulcers developed or deteriorated in our care noted since March 2024. Oversight of pressure ulcer prevention work and revised action plans are now being monitored via a weekly CHS improvement meeting.

Key actions and quality improvement areas of focus include early implementation of equipment and information for patients around effective pressure ulcer prevention so that they can participate in their plan of care. Wound photography also supports staff to gain specialist advice and monitor progress, this includes RN oversight of category 2 pressure ulcers to implement additional preventative interventions to prevent further deterioration; this continues to be a theme.

A thematic review was undertaken of four 'in-patient' Category 4 pressure ulcers to consider the themes from the four investigation reviews and assess the actions to ensure that the appropriate improvements are in place. A refreshed improvement plan is in place and the associated presentation from the review used in training.

The majority of category 4 pressure ulcers are attributed to patients in the community. The learning from these incidents is different and the increase has in part attributed to the increased complexity of patients in the community. The learning actions are focussed on the possible interventions to reduce risk.

The clinical community nursing service continues to prioritise 'Pressure Ulcer Prevention' training and a new tiered Trust wide pressure ulcer prevention training framework based on NICE Guidance is in development incorporating also the findings from the inpatient thematic review the Tissue Viability Lead is also supported by Learning and Development.

Falls Incidents.

The total number of falls across the trust remains static. A deep dive on falls in the Bradgate unit this month focussed on falls risks associated with the environment. Several recent incidents have occurred in bathrooms and showers and the team are looking at options to reduce risk of slipping.

Further focus has been the falls risks associated with poor nutrition and hydration and the refusal of food and drink and a new pathway is being developed which will support staff in addressing this risk. Environmental risks were also considered in the review of CHS falls identifying trip risks and layout of toilets and bathrooms on some wards presenting potential risk. Flat lifting continues to be utilised appropriately and effectively with no incidences of hoists being used to lift patients off the floor in June.

Both CHS and DMH have relaunched their staff falls champion programme to work locally with their teams on raising falls awareness, prevention and supporting patients; this has been supported by the Patient Safety Lead Nurse and senior nurses/DMH physical health nursing team to include learning from incidents.

Deteriorating Patients.

The Deteriorating Patient and Resuscitation Group (DPRG) are actively working towards the objectives outlined in the workplan provided by PSIG, and progress is being made in these areas. Our focus has been on establishing a DPRG policy that can serve as a foundation for our other initiatives. This policy has been approved by PSIG and is currently moving through the Trust's governance structures. DPRG discussed a communications strategy to ensure that this policy is effectively communicated throughout the organisation.

We acknowledge that there have been changes in leadership for certain aspects of the workplan, such as non-contact observations and the NEWS2 escalation process. Moving forward, we will prioritise creating clear strategies for these areas. Additionally, we have been sighted on the plans for the Trust to participate in the second phase of a pilot program for the national 'Martha's Rule' Call for Concern initiative. This is an initiative that provides a way for families to request a review if they think their loved one is deteriorating, and it has not been recognised.

Efforts to standardise cardiac arrest trolleys have begun, with an options appraisal underway to ensure that we are aligned with resus council care standards and meeting our service level agreement with UHL for cardiac arrest support. The options appraisal will be presented to EMB for final approval later this month.

Groups related to self-harm and suicide prevention.

Trust self-harm and suicide prevention group

The group are continuing to recruit and engage appropriate membership. They have considered the key priorities and developed a matrix to assess areas of work by self-assessing our current position against the recently published NHSE Suicide Prevention Strategy and NCISH self-harm toolkit. The Trust suicide and self-harm prevention lead has made good progress with this assessment. Staff training in suicide prevention has been assessed as a gap and is being added to the Training Needs Analysis. A case of need has been developed to re-introduce the nationally recognised STORM training, which, is the preferred model of training designed to improve knowledge, skills, and confidence of our staff in considering patients at risk of suicide. The options appraisal includes a model to train an initial cohort of staff in additional to training a further group to continue in a 'train the trainer model'.

There is a workshop planned to invite the input of our clinical teams to co-produce the actions against our Suicide Prevention Plan.

The group are also working to develop LPT's postvention support for our staff in line with recognised in the national suicide prevention strategy and will be creating our local pathway.

MH Safe and Therapeutic Observations Task and finish group

The group has completed the following areas of work identified:

- Reviewed and updated the safe and therapeutic observation handover guidance for staff.
- Completed a baseline survey of patient, staff and families' views and experiences around observations.
- Explored improvements in electronic observation recording.
- Updated the Trust policy with local improvements.

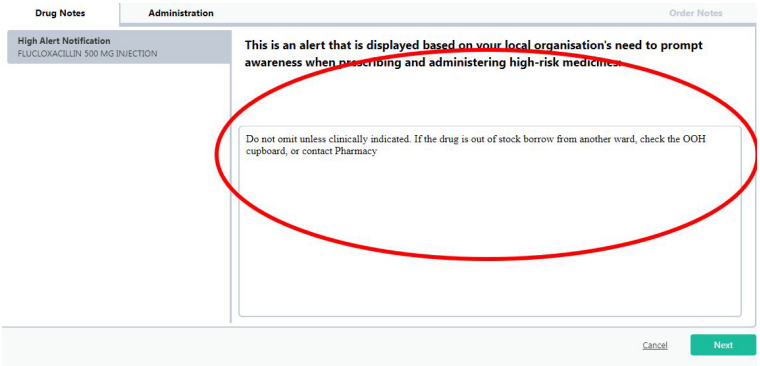
LPT and NHFT have formed an Improvement Collaborative, and 3 areas have been identified for quality improvement projects:

- Inpatient pathway review – acute care - This has now moved to the MH Inpatient transformation project.
- Nighttime observation – safety vs therapeutic relationship and sleep hygiene
- Training and competences/use of technology

The groups are commencing baselines and change ideas from Quarter 2.

Medication incidents and Medication Safety

Work is ongoing to align the model with the NHS England patient safety strategy and to ensure there is appropriate oversight of data and reporting in from Directorates. Electronic prescribing system is currently being updated to identify drugs that meet the 'critical drug' criteria and to highlight to nursing staff the importance of avoiding delays and omissions in administering these drugs and is almost ready to launch. This improvement has also included a review of the medication error configuration on Ulysses related to 'critical drugs' that we have made mandatory for this to be answered as part of the medication error incident reporting along with a link into the instruction to report omitted drugs. Additional staff messages have been applied the electronic prescribing system to limit the omissions or delays as review identified that staff were not always seeking 'unavailable' medication from other wards where it ok to do so and recording as not available (example below):



This work also continues to explore the system issues that may be contributing, i.e., by reviewing stock drugs in relation to the current context and common unavailable drugs for patients transferred from acute providers, i.e., eye drops for treating glaucoma. Additional training and policy review is also being undertaken to support staff to engage and deliver the changes required for sustained improvement along with shared learning from UHL of family feedback via a video involving delay in Parkinson's drugs and the impact it had on their family member.

The current process of reviewing and investigating medication errors is being reviewed to bring this into line with modern system safety thinking rather than focussing on individual actions. The role of Medicines Safety Officer (MSO) continues to be progressed which is essential to build on medicines safety improvement work.

The increased reporting is across the organisation and is not currently highlighting any particular areas as outliers. The medicines safety groups are requesting directorates report in on their themes and actions taken in relation to medication safety.

Integrated Care Boards/Collaboratives/Commissioners/Coroner/CQC

We continue to update Commissioners and CQC with any significant incidents that have occurred even though they will not be formally reported as an SI and ongoing work with all commissioners to appropriately update on our transition to PSIRF. This includes understanding how trust will align assurances, as we move away from relying on the review of Serious Incidents.

Learning from Deaths (LfD)

The group are continuing to review the learning from the review of the Norfolk and Suffolk learning from deaths process and strengthening our processes.

The Medical Examiner process is now being extended to Primary Care, this extension of the process will both provide improved access to the data for our patients cause of death and therefore greater opportunity for learning. As well as greater opportunities to work with ICB colleagues where potential learning across and between the ICS is identified.

Patient Stories/Sharing Learning

Patient stories are used to share learning from patient safety reviews. It is important that we learn from both when things go well and not so well Trust-wide to ensure focused learning is part of our culture and new way of thinking. Evidence suggests that staff learn better from patient stories, and we are working to ensure our stories are based on system thinking and human factors. The appendices illustrate stories provided by directorates which have been shared within Improvement Groups for cross trust learning, based on human factors and therefore transferrable.

Decision required.

- Review and confirm that the content and presentation of the report provides assurance around all levels and categories of incidents and proportionality of response.
- Be assured systems and processes are in place to ensure effective investigations are undertaken that identify appropriate learning.
- To enable sighting of the Senior Trust team of emerging themes, concerns through incident reporting and management and patient safety improvements.

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	James Mullins, Interim Chief Nurse	
Paper authored by:	Tracy Ward, Head of Patient Safety	
Date submitted:	July 2024	
State which Board Committee or other forum within the Trust's governance structure.	PSIG-Learning from Deaths-Incident oversight	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	Assurance of the individual work streams are monitored through the governance structure	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning		
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	1. Trust's systems and processes and management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient. 2. Trust may not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

Patient safety – learning from incidents

Introducing Pete (not his real name).

Pete is a 77-year-old man who was admitted informally to an MHSOP ward for treatment resistant depression, however, was not making any improvements with the agreed treatment plan. He had persistent thoughts of physical health ailments, which had been ruled out and his consultant felt he needed ECT (Electro-convulsive therapy) to lift his mood. Pete was not in agreement with this, therefore he was assessed and placed on Section 3 of the Mental Health Act for treatment, so that this could occur in his best interests. Pete had not been eating or drinking well on the ward as he felt like he had bacteria in his throat, and therefore needed lots of prompting with this. He was physically well and mobilised independently. Following Pete's first treatment of ECT, he sustained a fall and fractured his right neck of femur.

What happened.

The night before his first treatment, Pete was placed on level 3 (constant) observations, so he could not stop the treatment from going ahead by eating or drinking after midnight, as due to the general anaesthetic patients must be nil by mouth from midnight prior to treatment. On the morning of the treatment, Pete had an episode of loose stools. This was handed over and he went to have his treatment and he was given 500mls fluids whilst under anaesthetic via IV to help with the poor fluid intake. During his treatment, Pete experienced a further episode of loose stools, other than this, the ECT went well, and he recovered well from anaesthetic, with the anaesthetist advising that he was for routine recovery. His vital signs returned to baseline, and he refused food and fluids after the treatment. He was transferred back to the ward once recovered.

Pete returned to the ward in a wheelchair, due to the distance from the ECT department to the ward and having had general anaesthetic. He returned to being on level 1 (hourly) observations, as he was on prior to the level 3 being put on for a specific period. He ate lunch and drank whilst on the ward. The ward doctor saw him and advised that the ECT went better than expected and prescribed the next session of ECT. Pete had his routine observations taken at 14.10 and scored 2 on NEWS for low Blood pressure (BP)104/53 and a Heart rate of 100. A faecal sample was sent off, which had been requested that morning and he was encouraged to take more fluids to increase his low BP.

The staff on the ward checked Pete every 15 minutes during the hour prior to his fall (believing he was on level 2 observations). It was noted that Pete was asleep at 17.08, 17.21, 17.26. At 17.35, he was found by staff having fallen in his room. Pete had been incontinent of urine and was attempting to change his trousers. He reported he felt lightheaded and collapsed to the floor. The doctor was called who reviewed him at 17.40. During the assessment, the patient reported experiencing a headache. Additionally, he complained of pain in his right hip, which he rated as 8 out of 10 in terms of severity. Following the assessment, the on-call doctor arrived and evaluated the patient. The doctor recommended moving the patient from the floor with a hoist and transferring the patient to LRI for further investigation.
The ambulance was rang, and Pete was transferred from the floor using the flat lift equipment. The ambulance attended within 4 hours.

Learning from the Incident.

Following review of the incident we have identified the following factors which may have impacted on Pete falling and the subsequent fracture he sustained

- Pete underwent a procedure with general anesthetic, which can cause dizziness and can increase the risk of falls.
- Pete had low fluid intake, which can cause blood pressure to drop and increase the risk of falls.
- Pete had experienced diarrhea, which could reduce hydrations levels and increase risk of falls.

- To ensure staff are aware to accompany patients needing the toilet quickly, where possible, when patients are receiving fluids to improve hydration or feeling dizzy following an anaesthetic.
- Pete had reduced BP after ECT, which was not unusual due to low fluid intake, but other factors had not been considered.
- Staff had not recognized the need for a further falls risk of due to combination of general anaesthetic, poor fluid intake and diarrhea and had not considered any further interventions that may be required.

How we improved.

The following action have been undertaken as a result of learning from the incident:

- A learning board has been created for wider learning across DMH

- The Associate Medical Director has contacted all medical staff to remind them that we have flat lifting equipment, and we are not to hoist patients from the floor.

- A meeting was held with ward staff and ECT staff to look at how we can improve communication on return from ECT to understand patients' presentation and any interventions required.

- A handover document is being created for the escorting staff to update the ward nurse in charge on return from ECT about any specific treatment and recommendations for follow up on the ward, including review of observations levels and consideration of reviewing falls risk assessments to consider and change in treatment plans that may impact on patients falls risk

Leicestershire Partnership NHS Trust

Patient Story – learning from incident 306447 Anna

About Anna:

Anna is a 16 year old who was under the care of CAMHS due to low mood, anxiety and panic for 2 years. During this time Anna had been seen by multiple professionals, either on her own or sometimes with one of her parents.

In August 2022, Anna's mother made a complaint via the LPT PALS Service where she reported her daughter had made disclosures of sexual abuse to professionals which had not been appropriately acted on. Mum believed it represented a failure to safeguard her daughter.

Anna, herself, shared her parents view and believed CAMHS clinicians did not take her disclosures seriously which contributed to her anxiety.

What Happened:

In March 2020, Anna disclosed a historic incident during a telephone appointment with the CAMHS Access Team. The clinician advised Anna she should share this information with her mum, and also contacted the LPT Safeguarding Advice Line.

Anna was allocated a Lead Professional and the safeguarding concern was handed over verbally from the CAMHS Access Clinician. Telephone reviews were held in May and June with less contact during July and August due to some Was Not Brought and cancellations by the family. In October 2020 Anna attended her first face to face appointment.

In January 2021 Anna disclosed suicidal intent to drink bleach, naming previous sexual assault as a trigger. She was assessed by a CAMHS On-Call Psychiatrist and commenced on medication. The historic assault was not mentioned by Anna again. She was seen several times between January 2021 and April 2022. During the review session in April, Anna again made reference to a previous experience of sexual assault and more recent experience of being sexually propositioned by a peer.

In June 2022, Anna disclosed to the Psychiatrist that she had been sexually propositioned by a friend and her friend's boyfriend, and that these unwanted advances had been distressing and had resulted in an increase in anxiety symptoms and self-harming behaviours.

August 2022 – concerns raised with LPT PALS.

Good Practice:

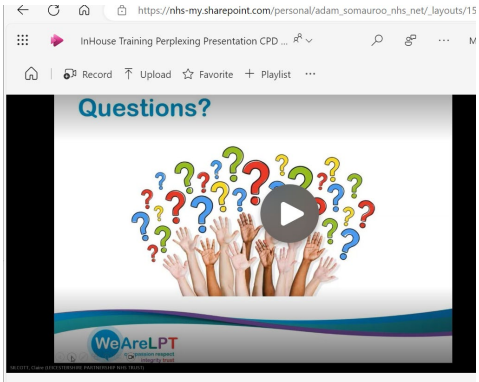
The Lead Professional / Community Psychiatric Nurse had initially demonstrated commitment to supporting Anna with engagement. Following multiple Was Not Brought/Did Not Attends and appointment cancellations, he continued to reach out to the family and schedule alternative appointments rather than discharging in accordance with the Was Not Brought Policy.

Learning:

The local CAMHS induction checklist has been updated to ensure Safeguarding is covered in the first week. Safeguarding is also now a standing agenda item for each team meetings which includes expectation and recording of safeguarding information due to staff highlighting there was a variation of the understanding of how to escalate safeguarding concerns and the process.

The report was shared at the Trust Clinical Effectiveness Group for consideration of reviewing the medication review process to ensure there is a robust process in place for monitoring of prescribed medication. Feedback from the Group was that this should be embedded into any service guidance around medication prescribing; if we are consistently not following NICE guidance this should be logged as a local risk.

In-House Training on Perplexing Presentation CPD and Safeguarding Documentation in SystmOne was delivered November 2023 - a recording of the training is available for staff to access on Staffnet.



In-House Training Perplexing Presentation CPD & Safeguarding Documer
SystmOne

Safeguarding Children Level 3 training to include awareness of sexual safety for children and young people. To use the Safeguarding templates on S1 to record details of safeguarding conversations

To ensure accuracy of record-keeping in relation to safeguarding or disclosures, including appropriate detail and paying particular attention to reporting language used by young person.

Learning contd:

For staff from all clinical specialities to have access to Safeguarding supervision.

For clinicians to regularly review care plans for young people who have been open to services for a long time, particularly if clinical presentation has changed or not improved, or if the young person has had multiple change of Lead Professional.

Patient Safety - Learning from incidents
CHS Community Nursing

Jill's Story

Jill was a 77-year-old lady who had been diagnosed with lung cancer. She had been receiving palliative treatment for this since September 2021. Jill's other medical conditions were Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension and Atrial Fibrillation. Jill was on the caseload for palliative care and was receiving support visits for her and her husband who lived with her. Her wishes were to remain at home with her husband.

Jill was known to the City East community nursing team where she was visited twice weekly for wound care and had a monthly care plan for palliative care support which included a medication stock check. The medications were last counted and documented as correct on the 27th April 2023. Her last visit before the incident was on 25th May 2023 for wound care.

What happened to Jill?

On 27th May 2023 at 17:56hrs Jill's husband called Single Point of Access (SPA) to request a home visit for symptom control. He reported that Jill was becoming extremely agitated, restless and her breathing was irregular.

The call was triaged by a Band 5 Registered Nurse (RN), who was triaging referrals for the community nursing hub. It was identified that the authorisation on SystmOne was dated 22nd September 2022 and so the nurse believed it was out of date and therefore it was not

valid. The authorisation states "If not immediately used and patient's condition remains the same this authorisation remains valid for 3 months from date of 16/09/2022".

Patient Safety - Learning from incidents
CHS Community Nursing

The nurse triaging the referral contacted Jill's husband and requested that he call NHS 111 himself to request that the Out of Hours (OOH) GP provide a new authorisation.

Gill's husband reports, in his concern, that he did call NHS 111, and they called him back at around 20:30hrs, he was advised by the NHS 111 service that it would take a maximum of 10 minutes for the authorisation to be on his wife's record.

Jill's husband called SPA again to ask if the authorisation had been received. He was told by the SPA call handler the authorisation had not yet been received. At 20:46hrs the nurse triaging called him back to advise the authorisation had still not been received, however, she could see that the OOH service had accessed the electronic record therefore it would likely be received soon. Jill's husband was advised that as soon as it was on the electronic record a visit by the community nurses would be arranged.

Due to the distress his wife was in, Jills husband called 999 for an ambulance but following the call with SPA he cancelled this ambulance because he was assured the nurses would be out to visit shortly.

Jill's husband received a call from a doctor at 22:45hrs to say that she had been asked to support, as there was a problem with the download onto the electronic patient record, Jill's husband explained that his wife had died at 22:30hrs.

Patient Safety - Learning from incidents
CHS Community Nursing

Effect on Jill's family

Jill's husband told the doctor that called him at 22.45hrs that his wife was pulling and pushing her nightie and covers and was in a lot of distress and the medication would have put her at peace. He felt he could not get anyone to listen to him or provide his wife some help and support in her final hours.

Our Learning Focus

- A nurse could have attended and supported Jills husband and the update of the authorisation
- Not all nursing staff were aware of the expiry date on EOL authorisations if not immediately used, the authorisation may not be valid and staff were not aware of the requirement to check authorisation forms on every visit.
- The Triage nurse asked the family to call 111 to renew the authorisation, the review identified that there was no administrative support at the time of the calls and the staffing was below the planned staffing levels for the service.
- The OOH service had documented a new authorisation was on the system but the investigation found that this was never added.

Changes made following this incident.

- EOL task and finish group are nearing the end of developing a new community authorisation where an expiry date is not stated. The form better supports staff in giving symptom control medication when needed without asking for new forms from GPs.

Patient Safety - Learning from incidents
CHS Community Nursing

In the meantime;

- Nursing staff to be aware of EOL authorisations and this to be added into formal training.
- Checking authorisations to be added to care plan to prompt staff to check at each visit. List of palliative patients on teams board with expiry dates/best practice review dates for the authorisations, these have also been added to care plan.
- Nursing staff to inform patients and their relative and care home staff about the need to review regularly with a suggested date for review.
- SOP has been updated and the expiry date is in fact a best practice review date and is only a recommendation and not legally binding.
- Medication can be given past the 'expiry date' however always good practice to keep authorisations up to date and current.

Leicestershire Partnership NHS Trust

341233 Jane (December 2023 – January 2024)

Learning from incident

About Jane:

Jane is a 25yr old female with a diagnosis of a mild learning disability, autism and emotionally unstable personality disorder.

Jane was admitted to the Agnes Unit in October 2021. Prior to this she had been living in supported accommodation. When she was admitted, Jane was presenting with suicidal ideation, self-harm, intense agitation; with verbal and physical aggression towards others.

Jane has a positive behaviours support (PBS) plan in place. The PBS plan details strategies (pro-active, active, reactive and post incident) to follow to support her

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What Happened:

Between 29.12.2023 and 09.01.2024 Jane had 9 reported incidents of ingesting objects such as pieces of an electric toothbrush, parts of a wooden photo frame and parts of make-up brushes among other objects. Some incidents were observed via CCTV and on other occasions Jane disclosed to staff that she had swallowed an object.

Immediate Actions & Good Practice:

Jane has a PBS plan in place which details how to support her if she swallows items. The PBS plan has 2 scenarios - one for high-risk objects such as batteries, coins, magnets items larger than 6cm; and one for non-high risk objects.

The PBS plan details sign of symptoms of obstruction, perforation, and dysphagia. Post incident /tension reduction techniques and information about how to observe Jane and when to follow seclusion guidelines.

In all incidents, staff offered Jane reassurance and used de-escalation techniques documented in her PBS plan to reduce her risk to self.

Learning:

The Agnes Unit now has a process for co-ordinating urgent MDT meetings for when they recognise a change in a patient's presentation. This has enabled faster more responsive collaborative multi-disciplinary decision making.

The Unit has now introduced a traffic light system which is a quick easy read document that identifies Jane's likes, dislikes, triggers and de-escalation techniques that Jane finds supportive when she is struggling to maintain her safety. This is to aid staff due to the large amounts of information contained within Jane's 11 care plans.

The Unit has person centred development days where as a team staff spend the day learning about Jane, her PBS plan, physical health needs and care plans.

The Agnes Unit has ABC and PBS training delivered by the Practice Development Nurse (PDN) and ward matron. PBS training is 3 days initial face to face training followed by an annual in-house update.