Introduction

In this edition of Nevermore for the Community we focus on patient falls and pressure ulcers.

We also look at feedback from the inaugural Patient Safety Conference.

Reporting of incidents is important to the Trust to help us to identify themes and trends and to know where additional work is needed to reduce the incidence.

This issue also focuses on the Mental Capacity Act and Deprivation of Liberty. This can be a complicated issue to understand so the Safeguarding Team have provided a case study highlighting the pitfalls and some useful guidance links.

Recently we have launched the Trust Whistleblowing Helpline. The Trust’s Whistleblowing Helpline: 01904 724488 or internally 772 4488. A copy of the policy is available on Staffroom.

We hope you find the content of this issue useful, any suggestions for future issues should be sent to Diane Palmer, Deputy Director of Patient Safety.

Regards,

Patient Safety Team
Never Events

Please remain vigilant and aware of what constitutes a Never Event. In the Acute sector we recently had an incident of methotrexate being prescribed (but not administered) daily for an inpatient. **Methotrexate should not, unless specifically authorised by a Consultant, be prescribed to any inpatients and it should NEVER be prescribed daily.**

Although this was an acute incident we have previously had a similar incident in a community hospital so staff need to be aware of the guidance and be ready to challenge any attempts to work around it by professionals who may not be directly employed by the Trust.

Falls and Pressure Ulcers

Falls

A reduction in the number of patient falls incidents and specifically serious injury from falls remains a priority for the Trust. A target of reducing falls resulting in moderate or severe injury by 30% was an agreed target for 2014 – 2015 and the Trust achieved a 55% reduction by March 2015. We are aiming to achieve a further 20% reduction in falls resulting in moderate or severe harm by March 2016.

**Table 1.** Total number of fall incidents reported 2014 - 2015. Data source: Datix

<table>
<thead>
<tr>
<th></th>
<th>York Acute</th>
<th>Scarborough (including Bridlington)</th>
<th>Community Hospitals</th>
<th>Community Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td><strong>No harm</strong></td>
<td>247</td>
<td>283</td>
<td>325</td>
<td>392</td>
</tr>
<tr>
<td><strong>Low harm</strong></td>
<td>151</td>
<td>122</td>
<td>107</td>
<td>133</td>
</tr>
<tr>
<td><strong>Moderate harm</strong></td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td><strong>Severe / Death</strong></td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td><strong>Pending</strong></td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>409</td>
<td>411</td>
<td>445</td>
<td>534</td>
</tr>
</tbody>
</table>

Although the overall number of patient falls incidents remains high, there has been a significant reduction in the number which resulted in moderate or severe harm or death.

The Trust is seeing a decrease in falls in Q1 in the community compared with the same period last year and also the number of falls that result in moderate and severe harm. Whereas at the York Acute site there has been an
increased number of falls compared to Q1 last year, however, the number resulting in severe harm has reduced.

Community Hospitals implemented a revised risk assessment and intervention process during 2014-2015 with focused training sessions around falls prevention delivered to Nurses and Health Care Assistants which may account for some of this improved position.

A continued focus on falls prevention and implementation of revised policies and processes is necessary.

Analysis of the patient falls Serious Incident (SI) investigations has identified that there has been sustained improvement in the timing for the initial risk assessment however; there remains a lack of understanding with the process of assessment of patients at risk of falls and the associated interventions.

The following actions have been recommended;

- Move to electronic process of risk assessment in acute hospitals during August 2015.
- Development of a training package for undertaking lying and standing blood pressure.
- Reminder of the requirement for falls risk assessments to be reviewed every seven days as a minimum and when patient’s condition changes or deteriorates.
- Reminder to provide patient information leaflets to patients or relatives where risks are identified and discuss the outcomes of falls assessments.
- Reminder of the correct use of bed rails.

**Pressure Ulcers**

Reduction in the development of pressure ulcers remains a priority for the Trust. We aim to reduce the incidence of Category 3 and 4 pressure ulcers, which are developed or deteriorated in our care by 20%.

**Table 1. Total number of pressure ulcers reported by site each Quarter 2014 - 2015.**

*Data source: Datix*

<table>
<thead>
<tr>
<th></th>
<th>York Acute</th>
<th>Scarborough Acute</th>
<th>Community Hospitals</th>
<th>Community Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1  Q2  Q3 Q4</td>
<td>Q1  Q2  Q3 Q4</td>
<td>Q1  Q2  Q3 Q4</td>
<td>Q1  Q2  Q3 Q4</td>
</tr>
<tr>
<td>Cat 2</td>
<td>32  21  36 36</td>
<td>28  16  32 42</td>
<td>41  18  9 17</td>
<td>51  35  47 40</td>
</tr>
<tr>
<td>Cat 3</td>
<td>8  5   9 4</td>
<td>10  2   9 3</td>
<td>5  0  0 1</td>
<td>22  11  7 5</td>
</tr>
<tr>
<td>Cat 4</td>
<td>1  0   0 2</td>
<td>0  0   0 0</td>
<td>0  0  0 0</td>
<td>1  0  2 0</td>
</tr>
<tr>
<td>Unstageable</td>
<td>11  7  18 16</td>
<td>7  6  19 11</td>
<td>2  5  4 7</td>
<td>13  13  25 17</td>
</tr>
<tr>
<td>Total</td>
<td>52  33  63 58</td>
<td>45  24  60 56</td>
<td>48  23  13 25</td>
<td>87  59  81 62</td>
</tr>
</tbody>
</table>
The number of unstageable pressure ulcers was higher than expected, particularly in community care. The reason these ulcers remained as unstageable related mainly to how they are reported on Datix and that the reports are not updated once the ulcers can be categorised or in some instances the patient has died before the ulcer can be categorised. This failure to categorise a large number of pressure ulcers may result in failure to recognise serious deterioration and whilst the patients may have received appropriate treatment the opportunity for learning and trend analysis is missed.

One of the reasons for a higher number of unstageable pressure ulcers in community care may be that it is more difficult to manage patients in their own homes where there may be less compliance with the plan of care, and patients are not monitored as closely as they would be in a Community Hospital setting.

Comparing the same reporting period in 2014-15, the Community Hospitals are reporting a significantly lower number of incidents overall in Q1 2015/16. In considering Category 3 and 4 pressure ulcers there is a reduction on all sites when compared with the same reporting period in 2014-15 and a significant reduction in Community Care.

Following analysis of Serious Incident reports a number of recommendations have been made as follows;

- The overall incidence of unstageable pressure ulcers should be an area of focus, particularly in regard to reporting via Datix.
- Training in pressure ulcer prevention and in particular earlier detection of high risk patients through accurate use of tools, including the Waterlow assessment and the COMFE tool.
- Management plans specifically targeting spinal and neurologically injured patients.
- More effective use and documentation of Duty of Candour.

**Mental Capacity Act/Deprivation of Liberty**

**Case Study**

A patient was admitted to Care of the Elderly via the ED. The patient was referred by their GP for an x-ray as, although no trauma, they had been unable to weight bear for several days. X-ray indicated fracture left neck of femur.

They were then admitted for surgical repair and supported on the fractured neck of femur care pathway.
Review

There was evidence from the onset of admission that the patient’s capacity should have been assessed. Cognitive difficulties had been cited on assessment and there had been a previous capacity assessment.

It appears that the patient had fluctuating capacity which then gave rise to uncertainty about the Mental Capacity Act framework. There was also the difference of opinion by professionals regarding the patient’s capacity.

Matters were further complicated by the patient consenting to treatment then “changing their mind”.

Best interests were discussed despite the anomalies over capacity.

Best Practice within Mental Capacity Act Framework

A patient's capacity should be assessed based on the specific decision and in a timely manner by the medical team proposing treatment. If, at the point of medical treatment proposal the patient lacked capacity then best interests consultation and actions should follow.

There was no reason to suggest the patient’s partner was not acting in the partner’s best interest. Their involvement supported the patient’s previous views within best interest discussions and the option of “No surgery” (least restrictive) would have been included in this.

There was no requirement for an Independent Mental Capacity Advocate (IMCA) unless it was believed that the patient’s partner was not acting in the patient’s best interest.

If the patient was assessed as having capacity and refused surgery then appropriate measures should have been instigated to proceed with discharge and aftercare.

Any capacity assessment should include whether the patient was likely to regain capacity. The question would have been “Would the patient be able to regain sufficient capacity to understand the proposed treatment?”

It was documented that the patient suffered multiple anxiety issues and physical bouts of confusion. This could have indicated that regaining sufficient capacity to understand the impact of the patient’s decision may not be possible. An early assessment of capacity could have established this.

Summary

There was confusion regarding:

1) Who should perform an assessment of capacity.
2) When this should be done.
The patient’s fluctuating capacity also contributed to staff confusion.

There appeared to be a lack of confidence in taking ownership of the decision to either state that the patient lacked capacity and therefore proceed to best interests or acceptance that the patient’s decision to not have surgery was capacitious and to discharge the patient with the appropriate aftercare.

There was no application for a deprivation of liberty authorisation – this may have been necessary if the patient had lacked capacity to consent to the treatment.

**Outcome for patient**

The patient’s partner disputed the fact that the patient had capacity. This was taken to the Court of Protection and the Trust incurred the costs. The court order agreed that the patient lacked capacity and that surgery should only take place in the patient’s best interests.

The court order also stated that a Deprivation of Liberty authorisation should be sought.

**Learning**

Assessment of capacity should be embedded within the admission process for patients. Support mechanisms for managing Mental Capacity and Deprivation of Liberty matters are available though clearly not widely known.

The Trust Statutory and Mandatory Training programme includes Mental Capacity Act and Deprivation of Liberty Training. An intranet resource page has been made available which includes the guidance and paperwork necessary together with contact information.

The Trust Safeguarding Adults team have begun a regular ward contact programme to reinforce the support available and capture any immediate issues.

A pocket guide for all potential decision makers is also being distributed. Decision makers should also be aware of their own responsibilities under the Mental Capacity Act and Deprivation of Liberty codes of practice.

In mitigation there has been a change to the criteria in which Deprivation of Liberty (Cheshire West Supreme Judgment) may apply which has a huge impact on patients in our care who are viewed to lack capacity. There has been limited guidance on how to implement this judgement in acute settings. However an implementation plan has been submitted to the Board of Directors and the Safeguarding Adults Team continue to target specific high risk areas with support.
Useful links;


http://staffroom.ydh.yha.com/Learning-Development-and-Professional-Registration/safeguarding-adults

Follow the link to Q:\York Hospitals Trust\Never Events and Learning\Nevermore 3\Mental Capacity Act 2005 (A7).pdf

Saying sorry

Saying sorry when things go wrong is vital for the patient, their family and carers, as well as to support learning and improve safety. Of those that have suffered harm as a result of their healthcare, fifty percent wanted an apology and explanation. Patients, their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has occurred.

Follow the link to read the full guidance. Q:\York Hospitals Trust\Never Events and Learning\Nevermore 3\Saying Sorry - Leaflet.pdf

Patient Safety Conference

General feedback on the day very positive with delegates saying there was a “buzz” about it but also that it felt relaxed. They also said they thought the quality of the agenda and speakers was good. Feedback from the opinion survey has ratified these comments some two weeks later.

In terms of organisation delegates felt they had had enough information up front to make decisions about attending and which sessions they would choose and they had in the main found the registration process simple. We need to understand why a number of people turned up without registering as this caused problems with the bus from Scarborough (with which we had our own logistical problems with the company cancelling the day before) and, in terms of getting their feedback as some also did not come to the registration desk at the conference venue so we do not know who to contact.

The morning session started with an entertaining speaker who some said set the tone for the day. Positive feedback has been received about all the keynote speakers.
Feedback from the Poster competition was excellent with 43 entries being received and the final 3 making an excellent presentation at the end of the day to the delegates.

One of the finalists was Lyeanda Berry, whose poster “Implementation of NEWS and Deteriorating Patient Escalation Policy at Community Hospitals” and explanation of the process, was very well received.

A link to Lyeanda’s poster can be found at: Q:\York Hospitals Trust\Never Events and Learning\Nevermore for the Community 2\Lyeanda & Cat.ppt

Content of the breakout sessions has been confirmed as excellent in some areas to not quite delivering expectations in others. Attendance at the sessions was variable with most being full to standing room only at some sessions. The feedback from the survey has been useful in identifying what delegates might want to see more of next year.

Trust staff provided us with some information stands which proved very popular and these were interspersed with commercial exhibitors who not only contributed but also helped from a financial perspective.

A planning committee is being set up for next year’s conference and requests for expressions of interest to join the committee have been made.

**Policies Update**