Introduction

In this edition of Nevermore for the Community, we focus on incident reporting and a claim made against the Trust.

It is important that when something untoward happens, action is taken as soon as possible to rectify the situation and that it is reported on the Trust’s incident reporting system (Datix). If incidents are not reported then potentially harmful practices or system errors may continue.

We have had a number of Serious Incidents and Never Events, which have not been reported on Datix, and which we only became aware of via different means. This resulted in delays in the investigation and more importantly in ensuring that patients are safe.

Whenever an incident occurs we should offer a verbal apology to the patient or their relative and in the case of incidents resulting in moderate or severe harm, this should be followed up with a written apology.

A link to the template for the written apology is included in this issue.

Recently we launched the Trust Whistleblowing Helpline. If something at work is troubling you and you can’t get a resolution with your manager, then you can raise your concern via the Whistleblowing Helpline at 01904 724488 or 7724488

Regards

Lisa Pinkney
Patient Safety Manager
Incident reporting.

Reporting of incidents is important to ensure that we learn from errors, including near miss incidents. By reporting incidents patients can be reassured that we are an open and honest organisation. Importantly, from a management perspective it helps us to focus our resources towards those frequently occurring incidents.

Chart 1 indicates the top ten incidents reported from Community Hospitals and Community Care and compares figures from January to June 2016 with the same time period in 2015.


Slips, trips and falls were the highest reported incident and have increased in number when compared with the same period in 2015. These reporting figures contrast with 2015, where pressure ulcers were the highest reported incident. This could be suggestive of a better reporting culture around falls, but also reflects the fact that the number of pressure ulcers reported has reduced substantially over the last year from 393 between January and June 2015 to 266 in the same period in 2016.

The number of clinical incidents has reduced significantly. Incidents categorised as clinical include:
- Admission/transfers
- Clinical assessment
- Communication problems
- Dietetics/nutrition
- Infection control
- Patient complications
- Radiation issues
Medication errors have reduced slightly since last year, as have staff incidents, staffing issues, and patient issues. Equipment issues are now in the top ten community incidents in contrast to last year’s figures.

**Datix update.**

In order to obtain a greater understanding of the issues facing Community Services, Datix now enables incidents to be reported by each locality as follows:

- East and West York
- North York
- Scarborough and Ryedale
- Selby and South York
- Whitby

The complaints module went live on Datix at the end of last year allowing Senior Managers to directly access and manage complaint information. This provides us with an electronic management system and will support the development of reports and analysis of trends, enabling staff to understand where improvements are necessary and where they have been achieved. This will ultimately help towards improving the quality of the patient experience.

Step-by-step guides are available for staff investigating complaints using the new module. These can be accessed when logging onto the complaints module. Following the successful roll out of this module, the PALS module will soon be launched to enable cross-referencing with the complaints module, providing a comprehensive database for Directorates to access.

**Never Events**

The list of Never Events was revised in March 2015 and has remained the same for 2016.

The amended list is available via the following link. It is vitally important that we report Never Events as soon as they are recognised. [Q:\York Hospitals Trust\Never Events and Learning\Nevermore 3\Never Events 2015.doc.doc](Q:\York Hospitals Trust\Never Events and Learning\Nevermore 3\Never Events 2015.doc.doc)


**Duty of candour**
It is very important that when things do go wrong, an apology and a full and prompt explanation are given to the patient and their relatives. In cases of moderate or severe harm, we have a statutory obligation to write to those involved advising them of the process of investigation and giving them a timescale in which we will contact them with details of the outcome of the investigation. A template has been developed for those staff who will be sending these letters and this is available using the following link; Q:\York Hospitals Trust\Never Events and Learning\NM 3 Community\Duty of Candour letter.doc

Litigation update

Clinical negligence claims brought against the Trust are managed within the civil litigation process. A claim is made against the Trust, not an individual. Clinicians are indemnified for their NHS work by the Trust’s membership with the NHS Litigation Authority (NHSLA).

A claim will succeed if it is accepted that there has been a breach of duty (care fell below an acceptable standard) and that this caused an injury or damage to the patient.

Table 1 indicates the claims received in Community Care and Community Hospital settings over the last four years.

Table 1. Claims received in Community Care and Community Hospital settings:

<table>
<thead>
<tr>
<th>Location (type)</th>
<th>Incident Year</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME</td>
<td>2013</td>
<td>Records disclosed</td>
</tr>
<tr>
<td>HOME</td>
<td>2013</td>
<td>Partial admission</td>
</tr>
<tr>
<td>SWMH</td>
<td>2014</td>
<td>Settled (£7,250) awaits costs</td>
</tr>
<tr>
<td>WHITBY MIU</td>
<td>2014</td>
<td>Records disclosed</td>
</tr>
<tr>
<td>WXCC</td>
<td>2013</td>
<td>Admission awaits settlement</td>
</tr>
<tr>
<td>HOME</td>
<td>2012</td>
<td>Settled (£10,000) awaits costs</td>
</tr>
<tr>
<td>WHITBY MIU</td>
<td>2011</td>
<td>Settled (£185,000) awaits costs</td>
</tr>
<tr>
<td>MALTON MIU</td>
<td>2010</td>
<td>Admission awaits settlement</td>
</tr>
</tbody>
</table>

Common themes from claims submitted are the failure to correctly interpret radiology and pressure ulcer recognition/care.
We feature here a claim against the Trust which has only recently been settled, but which dates back to 2012. It involves acute and community settings. There is significant learning from this case and key learning points are noted at the end of this article.

A patient was admitted to Scarborough Hospital A&E on 29th February 2012 following a fall at home on the previous day. Upon further assessment they were diagnosed with an oblique distal femoral fracture. On admission it was recorded that the patient had a Category 2 pressure ulcer on their right hip and a pressure risk management plan was commenced on 1st March 2012. On 9th March 2012 the patient underwent surgery for their fractured femur, and in theatre it was noted that the patient had a number of pressure ulcers. On 11th March these were graded as Category 3 pressure ulcers. The patient received treatment from the Tissue Viability Nurse and ward staff until discharged on 29th March 2012. The patient’s care was taken over by the District Nurses; however, the patient was readmitted to Scarborough hospital on 4th May 2012 because pressure ulcers on a heel, buttock, upper thigh, and inner aspect of their left knee had been identified whilst receiving day care at a hospice. One wound was exuding excessively. The patient subsequently remained in the hospital until 6th August 2012, at which point the ulcers were clean and healing.

The patient made a claim against the Trust. It was alleged that the care provided at Scarborough General Hospital, and by the District Nurses, fell below the standard of care the patient was entitled to expect, by failing to adequately assess the patient’s pressure damage, and put in place steps to avoid/relieve it. As a result the patient developed pressure damage that was avoidable. It was difficult to establish from the contemporaneous records the exact sequence of events with regard to risk assessment and care provided. However, on the basis of in-house and independent expert opinion, it was accepted that the pressure ulcers were avoidable.

The claim settled for £50,000 plus costs.

Whilst the patient had their treatment in 2012 the claim was not settled until 2016. The time taken to settle claims can vary, and is dependent on a number of factors. For example, in this case, it was difficult to establish from the records the exact events and therefore independent expert opinion was required. This evidence takes time to collate and assess.

**Key Learning points**

- Patients who are admitted to hospital are often at high risk of pressure ulcers in conjunction with their other illnesses. It is important to be vigilant in reporting all pressure ulcers and assessing them accurately.
• It is also important to provide a seamless transition through services by accurate communication between staff members with well-documented records. If it is not recorded, the legal system will consider that it did not happen.
• The Trust has recently introduced new methods of reporting, classifying and assessing pressure ulcers to simplify this process. The wound care passport has also been re-launched to help provide a more seamless transition through services. The new pressure ulcer policy and associated tools can be accessed at http://staffroom.ydh.yha.com/policies-and-procedures/clinical/a-z-list-of-clinical-policies/a-z-integrated-documents/pressure-ulcer-prevention-and-management/view.

Nevermore is produced by the Patient Safety Team and we welcome contributions. Please contact Lisa Pinkney on ext. 771 2860 or at lisa.pinkney@york.nhs.uk