West Hertfordshire Hospitals NHS
NHS Trust

**Agenda Item 63/12**

Public Board Meeting, 29th March 2012

***Complaints, Litigation, Incident and PALS Report Q3***

**Presented by:** Dr Colin Johnston, Medical Director

## 1. Purpose

This report provides detail of the incidents, complaints, PALS referrals and claims lodged against the Trust for the third quarter of the year 2011/2012. The scorecard draws from the figures themes and trends and identifies how the data has informed learning and influenced actions to address the issues raised through the CLIP media.

The report was reviewed at a recent meeting of the Complaints Litigation Incident and PALS Group (CLIP) where divisions are required to demonstrate how the learning from the data is used to make improvements necessary to enhance patient experience and patient safety. The CLIP report has also been presented to the Clinical Quality Advisory Committee.

## 2. Background

NHSLA Risk Management Standard 2: Learning from Experience requires all Trusts to have a coordinated approach for the management of risks identified through incidents, complaints and claims through a report including qualitative and quantitative analysis. CQC Outcome 16 requires that the Trust has systems in place to monitor the quality and safety of care.

Data from the reporting sources is entered into the Trust's Risk Management database, DATIX. This is a relational database which facilitates recording of incidents, complaints, PALS referrals and claims and enables reports to be extracted by division, department, issue and type. Incident reporting is web enabled which means that reports are made via an online report accessible on the Trust's intranet.

**Serious Incidents (SI)**
An SI is an incident which has caused serious harm or had the potential to cause serious harm and/or gives rise to lack of confidence in the Trust's ability to deliver safe and effective care. Incidents considered to be SIs (in accordance with the Trust's Serious Incident Policy) are also reportable to the main commissioning Primary Care Trust. All serious incidents including incidents drawn from the Department of Health's Extended List of Never Events are subject to rigorous internal investigation and a 45 day report is usually required which presents the findings following the investigation and includes recommendations and an action plan which is monitored both by the PCT and through the Trust's internal governance mechanisms.

**Significant Incidents**
Some incidents may not warrant reporting to the PCT but still require robust internal investigation – these are likely to be incidents in which an event was prevented but are deemed to be serious near misses and sub coded as 'significant' incidents. Such incidents also require rigorous investigation to understand how the near miss event occurred and to take steps to prevent a recurrence.

The summary findings are attached as **Appendix 1** Q3 CLIP Scorecard which represents an analysis of Complaints, Litigation, Incidents and PALS reported in Quarter 3 (1 October 2011 – 31 December 2011).

**Appendix 2** Organisational Learning (Divisional Themes and Trends) details the learning that has taken place and the actions pursued following an issue raised via a complaint, litigation, incident or PALS referral. *Please Note – unless otherwise stated, information was supplied by the Risk Lead.*

## 3. Recommendation

3.1 The Board are therefore asked to:

Approve the assurance provided by the report or identify issues for further action.

**Dr Colin Johnston**
Medical Director
29 March 2012

| Themes | Acute Medical Care Division | Surgery | Clinical Support | Maternity | Paediatrics and SCBU |
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| **<u>Communication</u>: between staff, patients and relatives**<br><br>**PALS: Communication remains a key issue, where PALS are involved in bridging the gap between patient's and clinicians throughout the Divisions. A number of cases were resolved by PALS arranging informal meetings for patient's, their relatives with Consultants, Matrons and Senior Sisters, to go through the respective treatment plans during their stay in Hospital.** | | | | | |
| Source | • Complaints<br>• PALS | | | | • Complaints |
| Current Position | • Reinforced Guidelines<br>• Training sessions for staff<br>• Sister's surgery<br>• Patients included in handovers | | | | • Investigated and responded in line with Trust Policy |
| Action (s) | • Audits<br>• Local action plans<br>• Training initiatives | | | | • Continue to communicate with parents checking their understanding of events and treatment.<br>• Increase staff awareness |
| Lessons Learnt | • Enhance communication skills<br>• Be more emphatic<br>• Involve patients & relatives | | | | • On going. Continue to monitor complaints.<br>• To prioritise work efficiently and explain to parents in a timely manner when agreed investigations are not carried out and the reasons why. |
| **<u>Discharge:</u> including discharge summaries not available for patients** | | | | | |
| Source | • Complaint<br>• PALS | | • PALS | | |

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| Current Position | • Discharge summit in place<br>• Transport & TTA delays<br>• PEG & National Patient Survey<br>• AAU Clinical Review Group | | • 3 X incidents patients who have had a long wait for medication whilst waiting in the Discharge Lounge | | |
| Action (s) | None at present | | • Wait is often caused by doctors not completing prescriptions until later in the day before sending it to pharmacy, despite repeated requests for prompt receipt to allow for early discharge. This is not a CSS issue. | | |
| Lessons Learnt | • Keep Patients/relatives informed at all times | | | | |
| **Falls**<br><br>**AMCD: the majority of falls are from AAU and the elderly care wards. In many instances falls are un-witnessed. The falls recorded also includes repeat fallers – e.g. there may be several falls recorded for the same patients in a single ward. The information recorded on Datix also includes the classification of falls where patient slide down the chair/bedside, etc – this is currently under discussion and a decision is expected soon as to what should be regarded as a fall.** | | | | | |
| Source | • Incidents | | | | |
| Current Position | • Falls Prevention Group<br>• Patient Falls Pathway<br>• Falls Cushions<br>• Hourly Rounding<br>• Closer observation for high risk<br>• Falls prevention alarm systems<br>• Falls audit | | | | |

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| Action (s) | • Pasag board indicates F as fallers<br>• Multidisciplinary board meeting discusses fallers at the ones at risk<br>• National Safety Thermometer audit | | | | |
| Lessons Learnt | • Review documentation regularly<br>• Adhere to policy<br>• Staff be more vigilant & aware | | | | |
| **<u>Medication:</u> delayed admin, wrong dose, wrong time, prescription errors, delayed TTAs, missed drugs, dispensing errors**<br><br>**Clinical Support: The Medication, dose strength and identification incidents recorded under Clinical Support do not always belong to Clinical support. The Division routinely reports incidents it identifies which are logged under the Division however these may have originated within other areas. F or Q3 of the 54 incidents reported by Clinical Support 31 originated from other Divisions** | | | | | |
| Source | • Incidents | | • Claim<br>• Incidents | | • Incidents |
| Current Position | • Control drug audits<br>• Action plans<br>• Pharmacy Summit<br>• Drug calculation test<br>• Drug round and IV training | | • Dose or strength was wrong or unclear (4)<br>• Wrong / transposed / omitted medicine label (2)<br>• Wrong medication being dispensed to the patient | | • Review admin practice<br>• Monitor errors |
| Action (s) | • Training<br>• competency assessments<br>• Safe prescribing for JNR Drs | | • Incidents dealt with in accordance with policies | | • Involve & discuss with staff |
| Lessons Learnt | • Follow drug error risk matrix<br>• Assess staff training needs | | • Incidents dealt with in accordance with | | • Continue to report, monitor & escalate |

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| | | | policies | | |
| **Nursing Care** | | | | | |
| Source | • Complaint | • Complaint | | | • Complaint |
| Current Position | • Supervision for staff<br>• Performance management<br>• Staff development courses | • The issue of extended NBM has reissued as a slight trend | | | • Investigation pending consent to investigate from parents. Complaint made by a relative. |
| Action (s) | • Recruit to reduce temp staff<br>• Monthly meetings with HR | • The NBM policy has been reviewed, and guidelines reissued to all staff.<br>• An audit is underway to determine where the problems originate | | | • Two requests for consent to investigate sent out - no response. |
| Lessons Learnt | • Assess staff training needs | • Whilst patients may self impose starving at home, we can be more proactive at enforcing the policy once they arrive in hospital.<br>• There needs to be better working relationships between the nursing staff and the anaesthetic staff to work to the policy together for the best outcomes for patients. | | | |
| **Equipment: including missing equipment and damaged equipment not fit for purpose** | | | | | |
| Source | | | | | • Incidents (4) |
| Current Position | | | | | • Securely lock away<br>• Access to identified staff only |

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| | | | | | • Check equipment & in working order |
| Action (s) | | | | | • Monitor lost equipment |
| Lessons Learnt | | | | | • Continue to monitor & escalate |
| **<u>Identification and Labelling:</u> wristbands, wrong label** | | | | | |
| Source | | • Incidents | • Incidents | | • Incidents |
| Current Position | | • Lack of clarity around the process for labelling specimens for histopathology<br>• waiting list card standards | • 3 X Diagnostic Images / specimens - mislabelled / unlabelled | | • Review suitable printers<br>• Identify funding |
| Action (s) | | • Policy has been reviewed and updated and all staff made aware<br>• An agreed set of standards has been issued to all consultants regarding minimum data required on WL cards | • dealt with in accordance with policies & procedures | | • Vigorous checks<br>• Continue to report, monitor & escalate |
| Lessons Learnt | | • Importance of revisiting policies particularly for routine every day practice.<br>• Abbreviations and unclear handwriting are not acceptable on WL cards as it leads to interpretation of clinical detail. | • Most common occurring & reported & dealt with in accordance with Trust policies and procedures. | | • Ongoing actions and monitoring |

**Additionally PALS have highlighted that for Q3:**

1. **Cancellation of appointments** - were prominent in Respiratory Medicine and Cardiology, enquiries were resolved by PALS liasing with the Assistant Divisional Manager for Medicine and sooner appointments were provided. The matter was escalated to Trust Board and Medical Director by the Assistant Divisional Manager to look for possible solutions.

2. **Cancellation of surgery -** were apparent in relation to Trauma and Orthopaedics. A number of patients were concerned about cancellation of surgery specifically relating to back surgery. The Trust have however moved forward by employing another spinal surgeon which will help in tackling the waiting list and result in less patients being cancelled for spinal surgery.