Oxleas NHS
NHS Foundation Trust

Trust Patient Safety Group Meeting

In attendance:

Jane Wells (Chair)	JW	Director of Nursing
Comfort Adeyeye	CA	PDN Adult Mental Health and Learning Disabilities
Naidoo Armoordon	NA	Head of Nursing (HoN) Acute Adult & Crisis Mental Health Services
Tom Clark	TC	Joint interim Medical Director
Shereen Cottle	SC	Serious Incident Investigator and Inquest Manager
Rachel Evans	RE	Director of Estates and Facilities
Abi Fadipe	AF	Medical Director
Maggie Grainger	MG	Trust Head of Nursing Ed Development and Practice Improvement
Steve Hardy	SH	PDN ALD
George Harvey	GH	Medical Device Officer
Fananidzai Hove	FH	HoN Forensic and Prisons
Christine Kapopo	CK	Associate Director of Nursing
Lynda Longhurst	LL	Head of Patient Experience and Patient Safety
Katherine Maciver	KM	Modern Matron Oxleas House
Ellen McGowen	EM	Head of Quality Assurance
Aydin Misiri	AM	Serious Incident Investigator
Rebecca Mortimer	RM	HoN CYP
Julian Moss	JM	Head of Health and Safety and Compliance
Chris Naiken	CN	HoN Forensic and Prisons
Aminat Oladipo	AO	Business Analyst / Project Manager
Sue Owen	SO	Risk and Governance Manager
Kerri Rivers-Simpson	KRS	Lead Nurse for Practice Improvement
Aamer Sarfraz	AF	Consultant Psychiatrist P/T Patient Safety Specialist Visiting Professor
Caroline Stroud	CS	Serious Incident Investigator and Inquest Assistant
Mary Titchener	MT	HoN Adult Community Services
Claire Tobias	CT	PDN
Nyree Traynor	NT	Patient Safety / SI Officer
Stacey Washington	SW	Trust Lead Safeguarding Adults and Prevent
Emma Woods	EW	Trust Patient Safety Lead
Vicky Woods	VW	Associate Director of Quality
James Woollard	JWo	Chief Clinical Information Officer and Caldicott Guardian
Nicky Wright	NW	Datix Administration Manager

Apologies:

Caroline Le Miliiere	Serious Incident Lead
Laura Oyewole	Community Physical Health Lead Nurse
Victoria Rawlins	Tissue Viability Nurse Specialist
Nicola Stacey	Resuscitation Officer

Item		Actions
1	**Welcome and Apologies**	
2	**Minutes**	
	All agreed as correct	
3	**Action Tracker**	
	Action tracker updated.	
4	**Learning and Systems Improvements of all SI complete in previous months**	
	• **LL** presented the SI Monthly report for June to the group. This paper was shared via the bundled papers sent out to the group. • **CS** presented the SB – IHTT SI report to the group. This paper was shared via the bundle sent out to the group. • **LL** presented the Serious Incident Newsletter to the group. **I.** **JW** feels that this newsletter should contain information regarding Prisons and Forensics advising that they have their own dedicated incident lead with contact details added, as this Newsletter is sent out Trust wide. **JW** feels that the time has come to amalgamated the Prison and Forensic SI team with the central team, saying that "this is not a separate entity; we are one organisation." This is to be reviewed in a few months with **LM** Director of Prisons and Forensics. **II.** **JW** says that where there's terminology such as "RCA" there will be people who are not aware of what an RCA is, so it might be worth saying that the methodology is changing and putting Route Cause Analysis there. **III.** **AF** feels that the SI team need to think of "a catchy name" for themselves, that captures peoples attention when they see the "Serious Incident" **AF** says that she will let the team know if she thinks of a name. **IV.** **VW** said that she thought the newsletter did not say very much or tell anybody anything. **VW** suggests that there should be some graphics on the first page that give the key metrics in the key areas in a pictorial form. **VW** says that there is work that needs to be done on this and is quite happy to support on it, as there is a comms lead starting in the team soon. **VW** also suggests that the Serious Incident alerts are included in the newsletter. **AS** says that he agrees with **VW** and the SI team will incorporate all of that going forward. **Questions on SB - IHTT** **AF** asks – Does the complete report have the "why" **CS** replies that the team were unable to get to the "why" which is often the case with these sorts of SI's. There were no issues around the levels of staffing that may account for why it wasn't done. **AF** asks if there has been any feed back given to the teams as it will be important to bring up the "why" in the feedback to the teams. The report can pick up the "why" if there is something in the teams when feed back is given. **CS** replies feed back is to be given on the 05/08/2022. **JW** says that this was discussed and minuted at the last meeting, maybe when the feed back is given, some additional open questions should be asked. Engaging staff in a conversation about what could be done differently, so that this doesn't	

	happen again, regardless of recommendations that have been made to see what comes out. **CS** replies that when she met with the team to try to gain more understanding, they really could not say why it didn't happen. More reflection around the "whys" will be done when the feed back is given to the team. There is however a lot of reflection that has already gone into this. **JW** says that it would be really helpful to use this as a case study and an action for feed back at the next meeting on how the discussions went and whether their reflections did enable staff to think about the "whys" without being blaming and genuinely learning. **AF** says that a lot of SI action plans and recommendations that follow them say the same thing. There are no "whys" so it is not known whether embedded learning is or has helped or not. So one of the first questions maybe should be "How many people at the session know about the zoning policy." Or about the policies that were reviewed during the SI. This may be the starting point. We really need to get to know the "why," so that learning can be assured. **AS** said maybe it should be taken to different forums so that they can be cascaded with teams. **Action:** **CS** to give a verbal update the group in August, on the feed-back which was given to the team and what was received regarding the "whys."	**CS**
5	**<u>Patient Safety Priorities 2022</u>**	
	• **EW** presented the Patient Safety Priorities Report for QTR 1. The report was shared with the group via the bundled papers sent out. • **JW** reminded the group that from August we should be using the Dashboard. This will mean that everyone will be logging onto the Dashboard and where there are exceptions, this will be reported back at the meeting. This is in addition to the Patient Safety Priorities. There will be some things that overlap, but a lot of things will be additional contents. It is expected that there will be 13 metrics that will be on the Dashboard. **<u>Questions:</u>** **VW** asks for more clarity around the physical health monitoring after rapid tranq. There is concern around the compliance level for this, as this is a must do for the CQC and something that should be achieved unless in exceptional circumstances. Is it the compliance rate for meeting the policy or the compliance rate for having it done, as previously there used to be two scores? **EW** says that this was agreed when KPMG that there were certain parameter's that had to be met, with 4 being recorded in the first hour and they had to be recorded at the time of the event, not 2 hours later onto NEWS2. This information is collected manually on a spreadsheet and if they are not recorded correctly then they don't pass. **VW** says that this is great and is the right thing to do but doesn't feel that there is any assurance about what has been done about it from the services. **EW** says that it is passed to Ward managers and Heads of Nursing on a weekly basis. Should they be reporting back to this meeting? **JW** says that this would be part of the exception reporting that needs to be done. **CK** says that work is needed with the older peoples services especially when there is a change in leadership. It is known where the gaps are and this will be followed up on and ensure that the exception reports will be brought to the Trust PSG. **NA** says that the issue with WIFI connectivity on the unit has been put onto the risk register. This needs to be taken into consideration as staff are having to wait until they can get WIFI connectivity before the NEWS2 can be completed directly onto the iPad. A lot of efforts have gone into inducting and staff training making sure that they are aware of what is required. **JW** says that that is a good point and that we might need to modify the audit so that there are 4 recorded within the hour.	

	VW asks whether there is anyway that we can just say that the checks have been done on the time that the checks should be done over the hour and then be added, because if it is a recording error there should be a way to fix that, we shouldn't have to rely on connectivity. **EW** says that this is a massive issue across the Trust, but the whole idea of putting it on to the NEWS 2 forms on RiO was so that a score can be recorded and then up escalate, if need be, so it does need to be put onto the system at the time of the process being carried out. **VW** asks if there are paper forms that can be used for NEWS 2. **EW** says that a lot of time has spent trying for years to get staff off of the paper forms, so this is not encouraged at all and will not be reintroduced. **KRS** agrees with this and asks for paper forms not to be re-introduced. **JW** says that this will need some thought, but if at the moment when exceptions are reported that staff have not done this within the hour, it needs to be quantified as to whether this is due to connectivity issues. This would be helpful to set the context.	
6	**<u>Incidents Of Short Staffing</u>**	
	• **CK** presented a report to the group. This report was shared separately from the bundled papers.	
7	**<u>Clinical Digital Safety</u>**	
	• **JWo** gave an update to the group. No paper was shared. • **JWo** said that the training session that was held went well and gave colleagues a good understanding of issues. **Action:** **JWo** to organise a follow up meeting for the attendees of the training session to reflect and to think how support can be given to staff, going forward and bring it back to the group in September.	**JWo**
8	**<u>Assurance</u>**	
	• **CN** gave a short verbal update on the QI focus for Prisons. No paper was shared. • **CN** informed the group that the current QI in Belmarsh is for reducing patient dependency on sleep medication by 25%. • The project for HMP Thameside reducing medication queues by August 2022 is currently on hold due to the lack of a project lead. **Question:** **VW** asks **CN** to confirm whether the suspension of the QI in HMP Thameside is due to the lack of a lead. **CN** said that he will find this out for sure and get back to the group. **Actions:** **CN** to confirm with the group a reason for the suspension on the QI at HMP Thameside.	**CN**
9	**<u>Enablers</u>**	
	• **CK** presented the updated Clinical Risk Assessment Policy to the group. This policy was shared via the bundle sent out. Policy Ratified. • **JW** thanked **CK** and said well done as a lot of hard work has gone into this piece of work.	
10	**<u>Compliance</u>**	
	• CAS Alert – EW presented a paper to the group. This was shared via the bundle sent out. I. **VW** asks if a CAS audit is going a head this year as it is part of the CQC requirements. **EW** replied that it is on her list of audits to do but is not sure when this will be achieved as **EW** has no capacity at the moment.	

	• Duty of Candour – **EW** presented a paper to the group. This was shared via the bundle sent out. This paper should be presented monthly. • Ligature Management Report – **JM** presented a paper to the group. This paper was shared with in the bundle sent out. • Medical Device – **GH** gave an update to the group on medical devices. A paper was shared via the bundle sent out. I. **GH** informed the group that the suppliers of the electric profiling beds that are used in the wards, have stopped making them now, so a new supplier will have to be located. There are some community ones that can be used in the meantime, until this issue is sorted out. • Pressure Ulcer Update – **MT** presented a paper to the group. This paper was shared within the bundle sent out. I. **VW** says that the report on page 5 of the pressure ulcer report is not easy to understand. **MT** agrees with this and will speak to **VR** in regard to tidying it up. II. **MT** added that they are aware that they are under reporting as there is never a report received from Bromley. This is a concern and it is hoped that additional training will result in more reporting. Reports from Prisons are not included either and reports from children's services are occasionally received. **Questions on Pressure Ulcers:** **TC** asks if teams are supposed to be reporting category 1 pressure ulcers and is the breakdown able to be done per team instead of per borough, as it would be interesting to find out where the hotspots are. **MT** says that category 1 pressure ulcers are not expected to be reported, but some staff do which is why it is included in a category. **MT** says that yes, the report is broken down into teams and in particular where avoidable pressure ulcers are looked at. This is to understand what teams are doing differently. This information is shared within the Directorate and used for learning. **JWo** asks why are people not taking photos, is it a lack of consent issues or lack of cameras. **MT** replies, it is neither of those things, some people don't think to do it and others do it a lot. It is in the policy and in the processes and it is definitely in the training so it's something that is being worked on with teams. ICB introduced some good practice of taking pictures of the ulcer on admission and on discharge. This is being encouraged in other teams. **Action:** **JW** asks that the amount of ligature incidents is look into on Goddington ward. **CK** says that she will ask **LY** to look into this.	**CK LY**
11	**AOB**	
	• Patient Safety Update – **LL** presented a paper to the group. The paper was shared within the bundle sent out. • Medication Incident grading on Datix – **EW** spoke to the group about this item. No paper was shared. The group agreed to this being carried out. **I.** **EW** informs the group that the Datix handler needs to be able to amend the level of the Datix when they review, so that the true harm is correctly recorded. • Expectations of Patient Safety Reporting – **EW** presented a paper to the group. The paper was shared within the bundle sent out. • **JW** wished **TC** well and thanked him for everything that he has done within Oxleas. **Question on Expectations of Patient Safety Reporting:** **EW** asks **VW** for clarification and to confirm that all of the priorities that RL comes	

	across on the dashboard do not have to be manually collected as they will be coming across from reports that have already been done. **VW** says this can't be guaranteed yet as a conversation is needed about how the metrics will be developed, as some of the new metrics will have to be developed over time.	
12	**Next meeting:**	
	• **15/08/2022 @ 14.00**	