Patient Safety Webinar

Quarter 3, 2024

Welcome. Thank you for joining us today.

We are just setting up. Please do mute yourselves while joining or during presentations. (We may mute you on entry – this is not an audio fault, and you can of course unmute yourself any time).

Please introduce yourself in the Chat Box by full name and organisation and please make use of it throughout for Q&A.

Pressure ulcers: how to safeguard adults - GOV.UK (www.gov.uk)

Guidance released 16 Jan 2024 (England)

These documents help practitioners and managers across health and care organisations to provide caring and quick responses to people at risk of developing pressure ulcers.
The guidance offers a process for the clinical management of harm removal and reduction where ulcers occur, considering if an adult safeguarding response is necessary. The guidance also outlines how the appendices should be used if a concern is raised:
appendix 1: adult safeguarding decision guide
appendix 2: body map
appendix 3: concern proforma

POLL

How many of you are now using Purpose T?

Time	Item	Presenter(s)
13:00	Welcome and Introductions	Julia Russell, Senior Clinical and Quality Improvement Manager, Hospice UK
13.05	Medication Safety followed by Q + A *Deferred to a future webinar*	Angela Carrington Lead Pharmacist for Medication Safety, HSC Northern Ireland
13.30	Medication Discrepancies; 'Stand Up and Be Counted' followed by Q + A	Vicky Hill Quality Assurance Lead St Columba's Hospice
13:45	Booklet for managing meds at home	Dr Sarah Mollart Consultant in Palliative Medicine St Nicholas Hospice Care
14:00	Our PSIRF Journey! Followed by Q + A	Lesley Munro Director of Patient Care and Communities Princess Alice Hospice
14:15	Patient Safety Data	Julia Russell
14.20	Update on Short Life Working Group	Julia Russell
14:30	Summary & Close	Julia Russell

Vicky Hill

Quality Assurance Lead
St Columba's Hospice

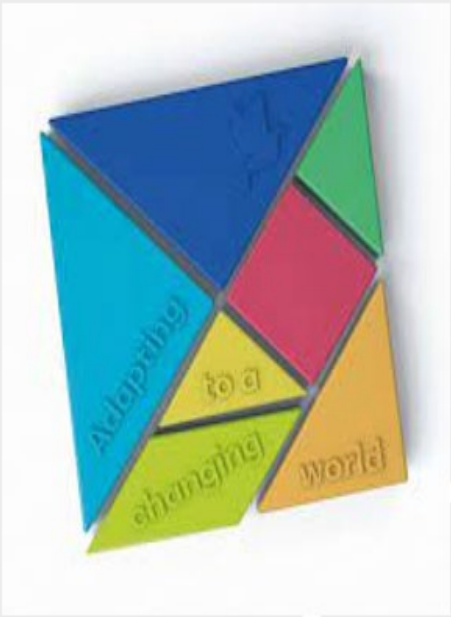
St Columba's Hospice Care

Stand Up and Be Counted

Working together to improve safety

Vicky Hill, Quality Lead

www.stcolumbashospice.org.uk



St Columba's
exists to give everyone
who needs it the very best
Hospice Care

Background

Working together to improve systems following medicine discrepancies

Routine Inpatient medicines audit over December 2022 identified medication issues and complicated medicine management with an increase in reported medicine incidents.

A similar situation occurred in 2017 resulted in increased staff anxiety.

Outcome was improved governance for zopiclone (log balance and stock register).

We set out to-
Create
Empower
Sustain

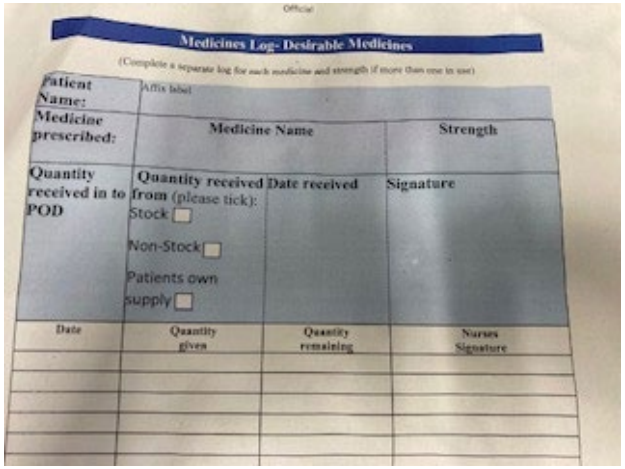
- **Create** systems to support staff in delivering safe and effective care
  - Joint working RNs, Pharmacy, QA and Managers
  - Forums for discussion and decisions rther development of established log system
  - Increased support

- **Empower** staff to learn from incidents and to be an active part of developing a positive safety culture with an open and honest reporting system so that trends and improvements can be implemented

- **Sustain** safety and improvements in day-to-day practice

What we did

Nov-Dec 2022	Meetings identified 3 workflows -Schedule 3-5 governance arrangements -Patients own medicine processes -Improved staff induction
Jan-Mar 2023	Sub-group proposals planning
Mar 2023	**Implementation of the only staff suggestion** -enhanced governance for schedule 3-5 medicines (log and register- extending existing system for zopiclone)
July 2023	Feedback requested
October 2023	Author reflections
December 2023	Feedback requested



Results

Month	Nos reported	Details
Mar 23	1	Stock entered incorrectly
April 23	0	-
May 23	4	Not identifying medicine for log Lorazepam 1 tab discrepancy Diazepam 1 tab discrepancy Pregabalin 1 tab discrepancy
Jun 23	1	Pregabalin 1 tab discrepancy
July 23	2	Gabapentin appeared to be full box but not Diazepam 1 tab discrepancy
Aug 23	0	-
Sept 23	1	Pregabalin 1 tab discrepancy
Oct 23	1	Pregabalin 1 tab discrepancy
Nov 23	3	Pregabalin 1 tab (2 occasions) discrepancy Pregabalin strength recording error
Dec 23	0	-
Jan 23	0	-
Total	13	

Key Questions:

Increased incidents- are we more or less safe?

How does this relate to audits prior to 2023?

Reason?

Empower

Feedback at RN Meeting 2022-23 | **Feedback August 2023** | **Feedback December 2023**

We don't feel trusted

Good attendance at meeting 1 and 2 but decreased significantly Jan-Mar with one RN attending

No response to email asking for feedback

Poster in team room- anon feedback

5

Do you think the new systems are safer?
"I don't think they were ever unsafe"

Did you feel that you were heard?
"heard but not listened to."

Is there anything you think we could change?
"Listen to nursing staff", "Less bureaucracy"
"Actively encourage no interruptions."

How did it feel to be part of the group?
NOT ANSWERED

Proposal: Remove logs, move to registers and dispense from drug room

"Logs are confusing- especially if multiple doses of pregabalin or gabapentin"

"move to the drug room- Concern re nurses waiting to dispense adding delays and make the drug room busier.

"return to the drug room would allow greater concentration. It can be distracting when dispensing any drugs in a busy bay/room even when wearing aprons"

I would support the move to the drug room for administration from register

9 staff

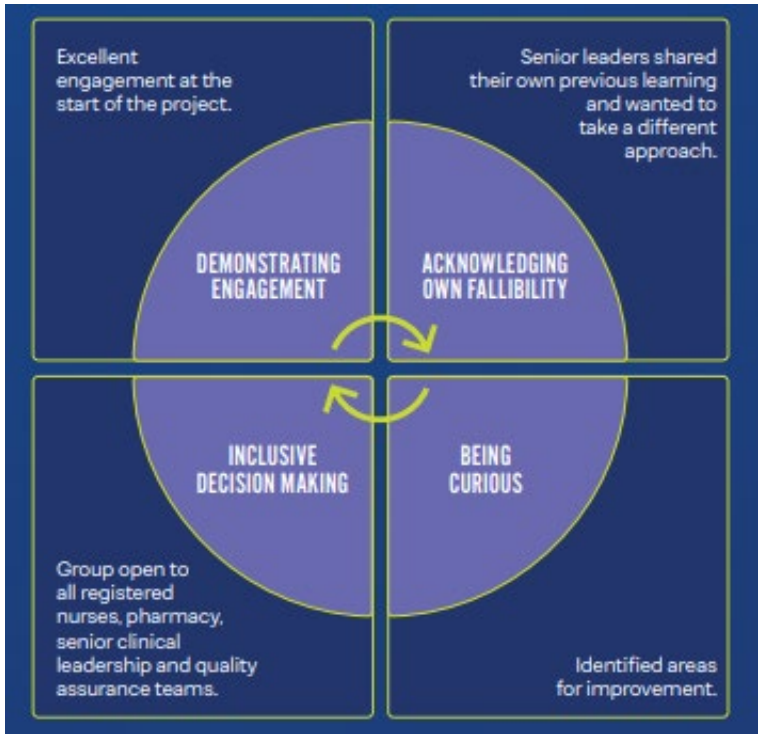
More positive feedback and engagement

Empower


Patient Safety Facilitator
"Working with the team, their knowledge and expertise meant the driving force of improvement and patient safety was always centre stage."
Pharmacy Team:
"It's great that the pharmacy team are more involved in the admission process."
IPU Nurse
"I would like to participate in other projects for change and improve safety."
Charge Nurse:
"I enjoyed being part of a group that came up with a 'collaborative' solution. It was a positive experience having our concerns listened to and considered."
Quality Lead:
"There have been some difficult and emotional discussions, these have been helpful in leading to change in practice."

Psychological Safety

Creating a Culture for Openness, Transparency and Improvement



Success?

- Did we increase engagement?
- Did we work together?
- Did we improve safety?
- ***"Success is a product of trying"***

Thank you

Vicky Hill (Quality Lead)
Orlagh Sheils (Quality Facilitator)
Gail Riding (Charge Nurse IPU)
Fiona Milne (Pharmacist)
Dot Partington (Deputy CEO)

Contact details
For more information contact: qualityassuranceteam@stcolumbashospice.org.uk

Dr Sarah Mollart

Consultant in Palliative Medicine

St Nicholas Hospice Care

Family-administered ‘Just in Case’ medications – the Suffolk process

Dr Sarah Mollart

Palliative Medicine Consultant, St Nicholas Hospice Care and West Suffolk Hospital

Background

- Throughout the UK, and other countries (e.g. Australia), it is common practice for family members (lay carers) to be trained to administer subcut end of life injections as needed, for people in their own homes
- Usually, the injections are given via a SC cannula/port (though injections via SC needle are also possible)
- This can provide more rapid symptom control, compared to when this task is solely delegated to community nursing teams
- This is not suitable for every patient/family situation
- But when chosen appropriately, family carers value the role and can feel empowerment, pride, achievement – rather than helplessness
- The Suffolk policy and practice documents to support this were ratified and launched in May 2020
- Easy-to-use paperwork prompted collaboration with the other hospice-region in our ICB (Suffolk and North East Essex) in 2023

Families Administering Medications at EOL at home:

The use of a single card booklet to house every necessary document. Simplifying and streamlining care through sensible stationery.

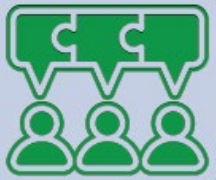
Mollart S 1 , Keighley A 2 , Jacobs D 1
1 St Nicholas Hospice Care, Bury St Edmunds Suffolk, England, 2 West Suffolk NHS Foundation Trust, Bury St Edmunds Suffolk, England

In many areas of the UK, family and other lay carers are being offered training to give subcutaneous medications at the end of life, to support good symptom control for adult patients dying at home. There is growing evidence that this is safe and effective, that it provides good symptom control for those who die at home, and equips family carers to feel more empowered.

There is no single UK programme – a variety of different programmes are used, in different geographical regions. Most programmes comprise multiple documents: policies, checklists, flow charts, risk assessments, consent forms, information leaflets, instructions/training competencies, and medication administration charts.

For the Suffolk FAM programme (Families Administering Medications), apart from a single underpinning policy document (for use by healthcare professionals), everything else is in a single booklet, containing all the paperwork both staff and families will need. The writing of the original version of this was supported by an MDT and lay volunteers. Everything is written in a user-friendly style, and is all held together in one place: a card, A4 booklet. This ensures no part of the process gets missed or lost, and all key documentation remains accessible to family carers and professionals, at all times. Families have their competencies documented in the booklet, for ease of repeated review of the administration process. They then use this same booklet to document their administration of each medication.

All booklets contain family and staff feedback forms, which come with prepaid envelopes. Evaluation of feedback received so far has been very positive about the booklet, which is described as being very clear. Evaluation also allowed real-time feedback about useful edits for needed for version 2, which were able to be rapidly incorporated.



The FAM programme was initially agreed for the county of Suffolk, but presentation of the process to the newly-formed Suffolk and NE Essex ICB in 2022 was very positively received, with North East Essex staff preferring the streamlined Suffolk booklet to their own documentation. This led to the appetite for vital collaboration, with the combination of the processes across the two areas, as a new ICB-wide process is agreed (this version is currently in progress, and expected to be finalised in late 2023). The wider reach of the process will benefit patients and families (particularly those in border areas within the ICB), and enable the pooling of resources for implementation of the process, to maximise those to whom it is made available. The authors are also exploring collaboration with another neighbouring ICB.

"Overall, the experience was wonderful. It gave us some kind of control over what we were going through, and what mum was going through. And, a certain amount of control over the pain. We felt we were active in trying to help her. It took away the panic, and the stress, of calling out a nurse, and not knowing when they could come. We could give morphine before the carers visited so it had time to work. It really, really helped us, I can't even say how much it helped us."

All families and staff returning feedback forms expressed that the training and booklet were clear.

Two families expressed a request for the "volume to be drawn up" was included on the MAR chart (as well as the dose in mg). This was incorporated into version 2 (the next print run).

Staff felt that the paperwork was very clear and comprehensive, and that the training session they'd attended left them feeling well-equipped.

because you matter

St Nicholas Hospice Care

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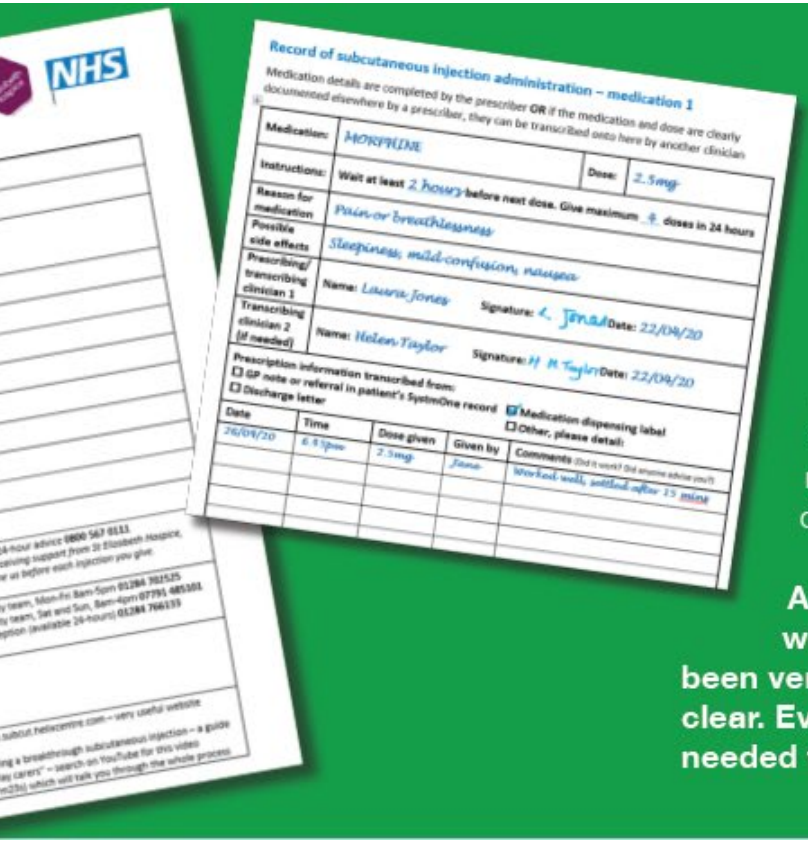

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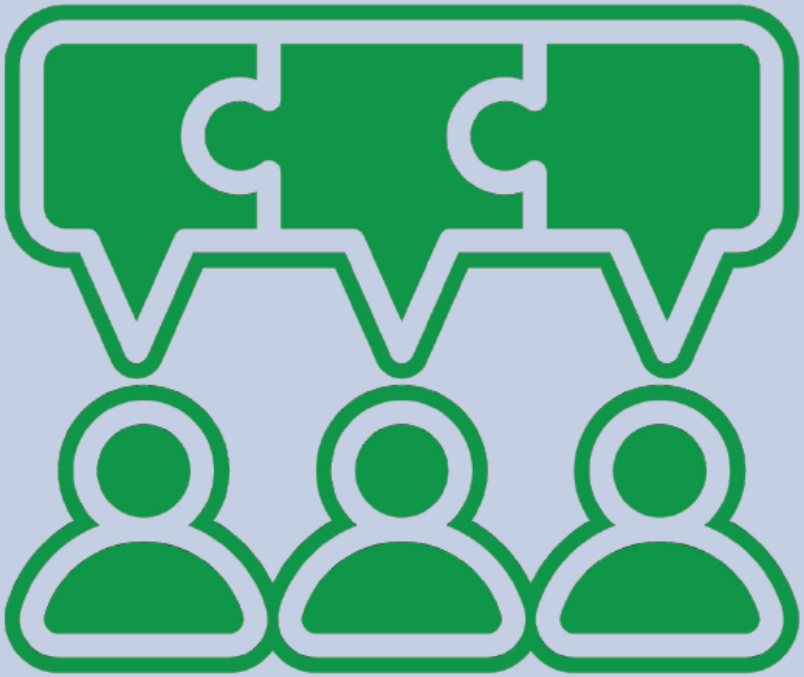

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Progress elsewhere in UK - Wales

because you matter

The CARiAD package

CARer-ADministration of as-needed subcutaneous medication for common breakthrough symptoms in home-based dying people in Wales

The CARiAD package supports willing and able lay carers to administer needle-less as-needed subcutaneous medication for common breakthrough symptoms in the last days of life in people who wish to be at home when they die.

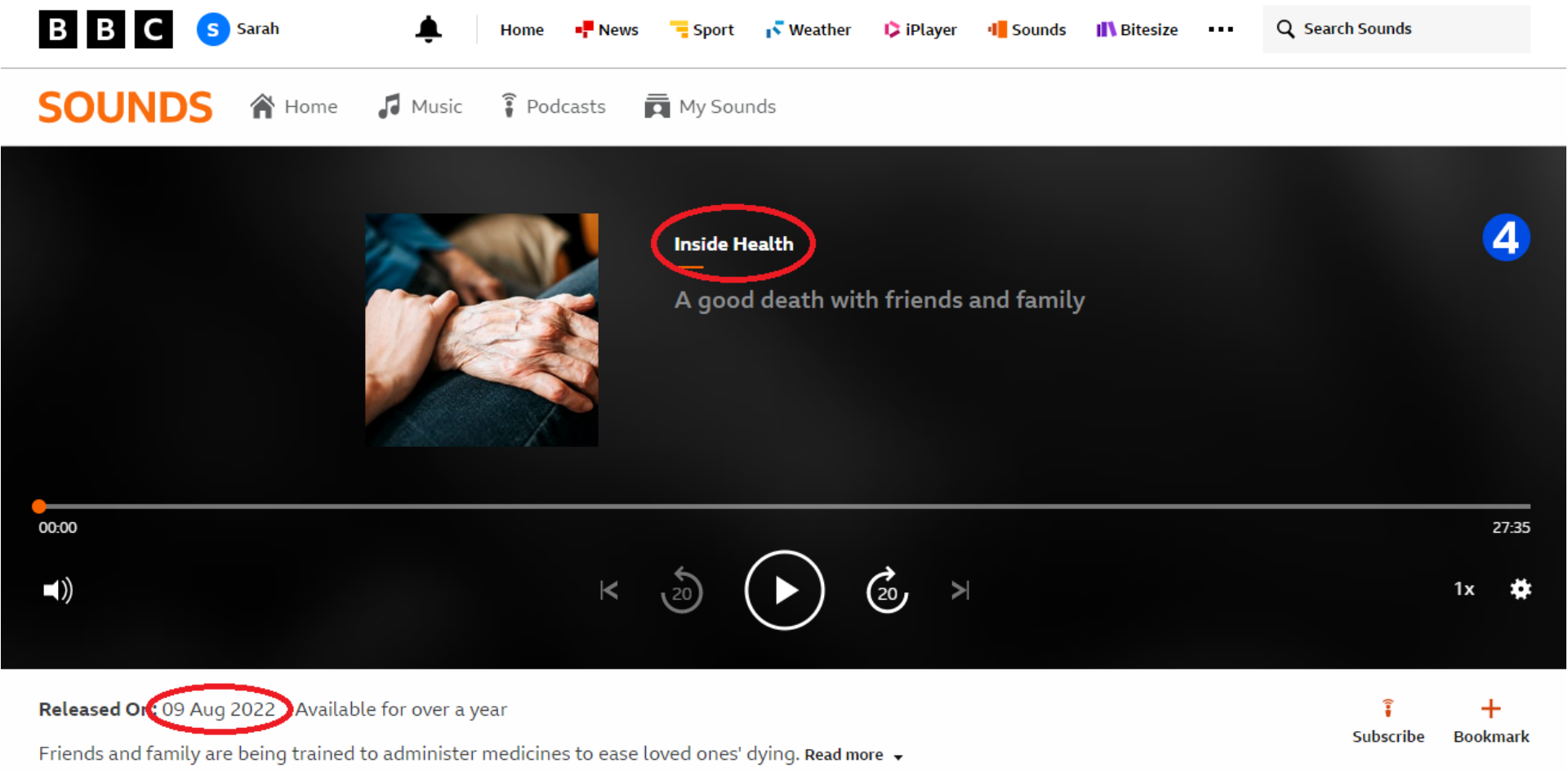
These symptoms are pain, nausea/vomiting, restlessness/agitation, noisy breathing/rattle and breathlessness.

For the purposes of this package, the term 'lay carers' refers to family members or friends or other lay carers looking after their loved one at home, and who are not paid to do this work. It includes healthcare professionals acting in the lay carer role for a loved one.

- **CARiAD Patient and carer information sheet (*PDF, 808Kb*)**
- **CARiAD A guide for carers - insert (*PDF, 215Kb*)**
- **CARiAD Process Flowchart May 2020 (*PDF, 339Kb*)**
- **CARiAD Instruction Sheets (Ampoule) (*PDF, 1.2Mb*)**
- **CARiAD Instruction Sheets (No Needle) (*PDF, 1.4Mb*)**
- **CARiAD Competency Checklist (*PDF, 308Kb*)**
- **CARiAD Information for prescribers (*PDF, 372Kb*)**
- **CARiAD Risk Assessment (*PDF, 739Kb*)**
- **CARiAD Structured debrief for carers (*PDF, 300Kb*)**
- **CARiAD A guide for carers (*PDF, 2.2Mb*)**
- **CARiAD for Covid-19 policy v1.0 20 March 2020 (*PDF, 939Kb*)**
- **CARiAD Injection training pack (*PDF, 391Kb*)**
- **CARiAD Instruction Sheets (Blunt Needle) (*PDF, 1.5Mb*)**
- **CARiAD Case Review Sheet May 2020 (*PDF, 225Kb*)**
- **CARiAD Carer Diary Intervention (*PDF, 1.5Mb*)**
- **CARiAD Process Checklist May 2020 (*PDF, 329Kb*)**
- **CARiAD Regular Clinical Review Guidance May 2020 (*PDF, 376Kb*)**

Radio recommendation:

because you matter



Survey of the meeting:

because you matter

In your personal lives:

1. If you were very closely involved in the care of a friend or family member in their last days at home, would you want to be ***offered*** training to administer injections (via a port)? (Raise your hand for **yes.**)

2. Would you consider having the training and sign off, to allow you to give injections if needed? (Raise your hand for **yes.**)

In your professional lives:

3. Has anyone here ever been involved in offering this training to families? (Raise your hand for **yes.**)

Conclusions

- Family-administered SC injections can make a huge positive impact on the care of patients dying in their own homes – for both the patients and families
- However, despite over three years since the launch in Suffolk, numbers of cases where this is used are still small
- Improving familiarity with the process in primary care and hospice is the key to widening access

Questions

sarah.mollart@stnh.org.uk

Lesley Munro, Jo Reynolds

Princess Alice Hospice

Patient Safety Incident Response Framework - Princess Alice Hospice

Jo Reynolds
Practice & Quality Lead
Lesley Munro
Director of Patient Care & Communities

Who are we?

Princess Alice Hospice

For Compassion. For People.

- Princess Alice Hospice
- Esher, Surrey

- Inpatient Unit
- Hospice at Home
- Wellbeing Service
- Bereavement Services

- Provide services across 2 ICBs: South West London and Surrey Heartlands

Our timeline: August 2022

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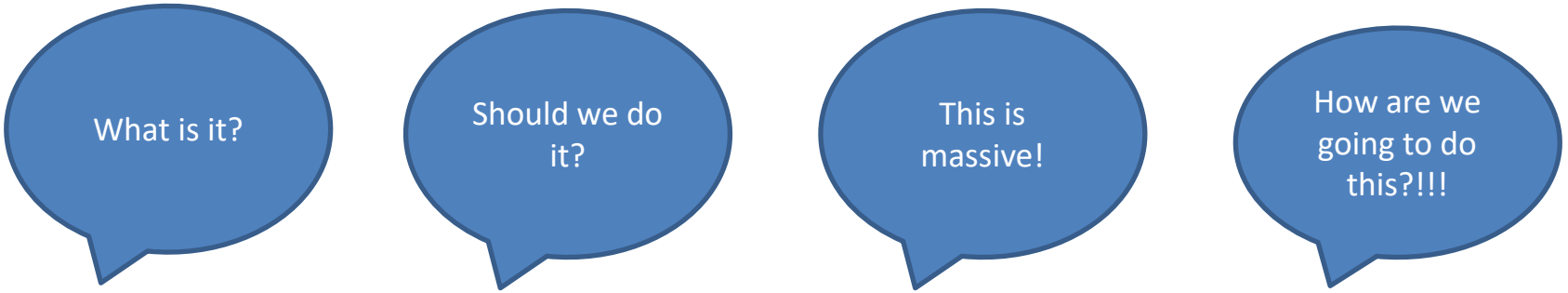
- PSIRF launches
- Initial thoughts:



- 2 month reading and trying to understand what it actually was! Also, speaking to our ICBs and reading supporting documents
- Deciding to take it to our board subcommittee as:
  - We have an NHS contract
  - It was the right thing to do! Potential for brilliant learning and changing how we do things

Our timeline: October 2022

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- Take PSIRF to our board subcommittee (CCQA)
- Overwhelming support to adopt, acknowledging
  - This will change how we review incidents
  - This will change how we provide oversight
  - The Quality and Assurance team will lead on the development of the plan
  - There needs to be executive support
  - There needs to be buy in from all the clinical leads
  - The approach around Just Culture is of real value
- Rejig of staffing in the Quality Team (no extra time, but moved some other roles and responsibilities to allow for some dedicated time).

Scoping and training:

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- 2 Year Data Review: Looking an incident reports, Safeguarding submissions, Complaints.
  - No real surprises – Pressure Ulcers, Falls and Medication Incidents
- Scoping meetings: IPU team, H@H team, Clinical Leads
  - Learning not necessarily related to harm
  - Incident review process is laborious and sometimes slow
  - Need more work to embed ‘Just Culture’
- Roles identified: Executive lead, investigation leads, family liason.
- Identified training for these individuals
  - ICB: Systems approach to learning from patient incidents (trainer led on Teams from external provide and self led on HSIB)
  - ICB: Patient and family involvement training.
  - Arranged our own Oversight training for us and other hospice leads.
  - Training budget identified from Education

Lightbulb moments!

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- Benefits of Swarm Huddles: In our case post falls to help investigate and mitigate
- SEIPS approach when reviewing incidents
- Moving away from rating of harm. Instead consider potential for learning and likelihood for reoccurrence
- Patient Safety Partners – thinking about they can be incorporated into our approach to add value

Development of our draft plan

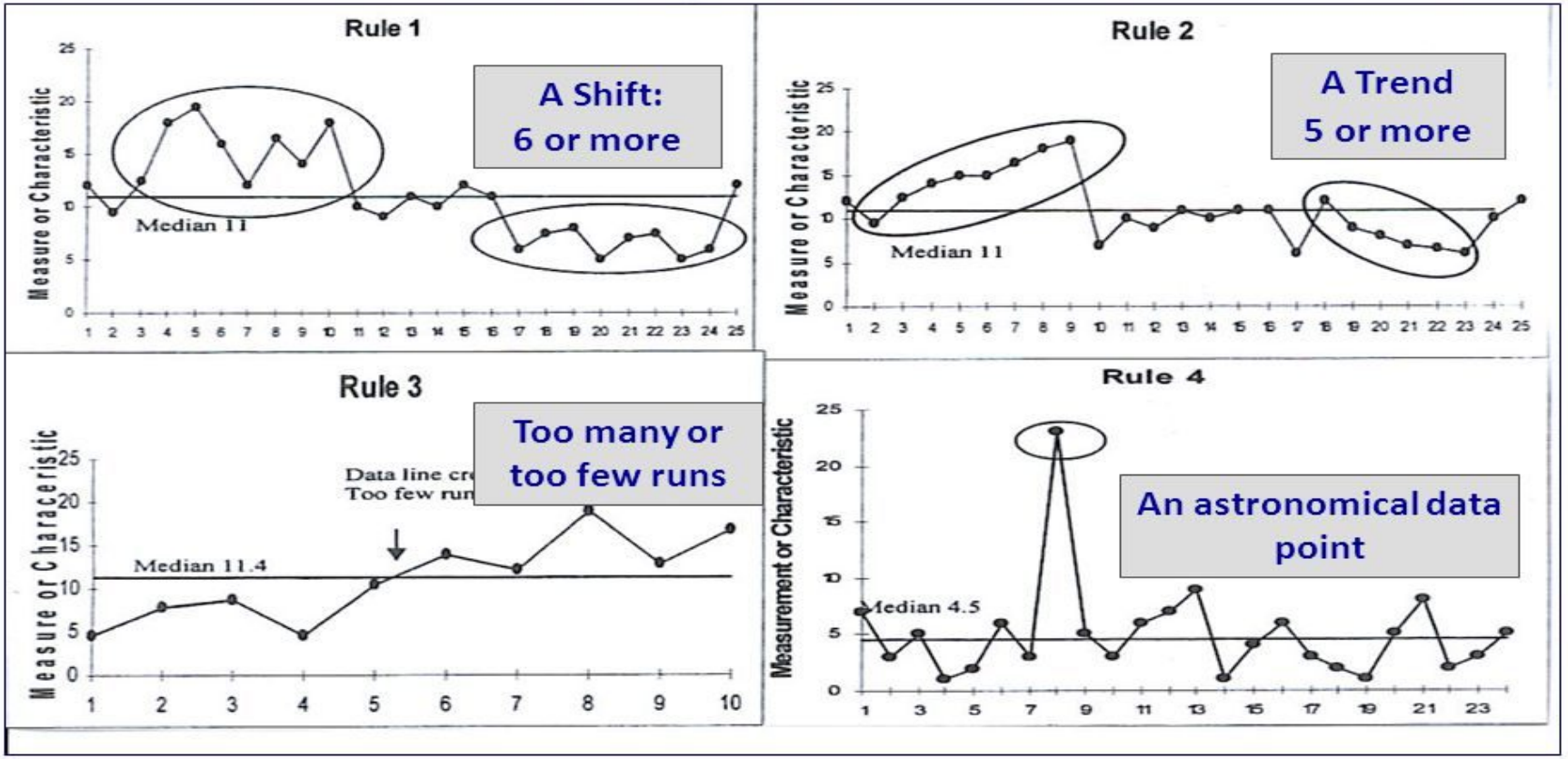
Princess Alice Hospice

For Compassion. For People.

- Falls: Swarm huddles after each event to mitigate risk. Pull themes of falls for thematic analysis
- All incidents will continue to have a baseline assessment. Streamlined templates on Vantage to reduce reporter and investigation burden.
- Where incidents (pressure ulcers and medication incidents) are identified as having the potential for further learning or risk of a high risk of re-occurrence, to complete a PSII / MDT review / after action review
  - Choice will be made by 3 leads who have had learning response training
- Recruit a patient safety partner. They will review draft incident responses before being finalized to add another public perspective
  - Keeping an open mind about how patient safety partners can support as a new and evolving role for many organisations
- Some Patient Safety Syllabus modules on e-learning for health will become part of mandatory training.
- Adding patient safety into the new staff inductions to help embed just culture
- More open sharing post incidents – reports available to read. Video summaries for staff who cannot attend post incident sharing meetings.

Patient Safety Incident Data self-reported by Adult Hospices

Non-Random Signals on Run Charts

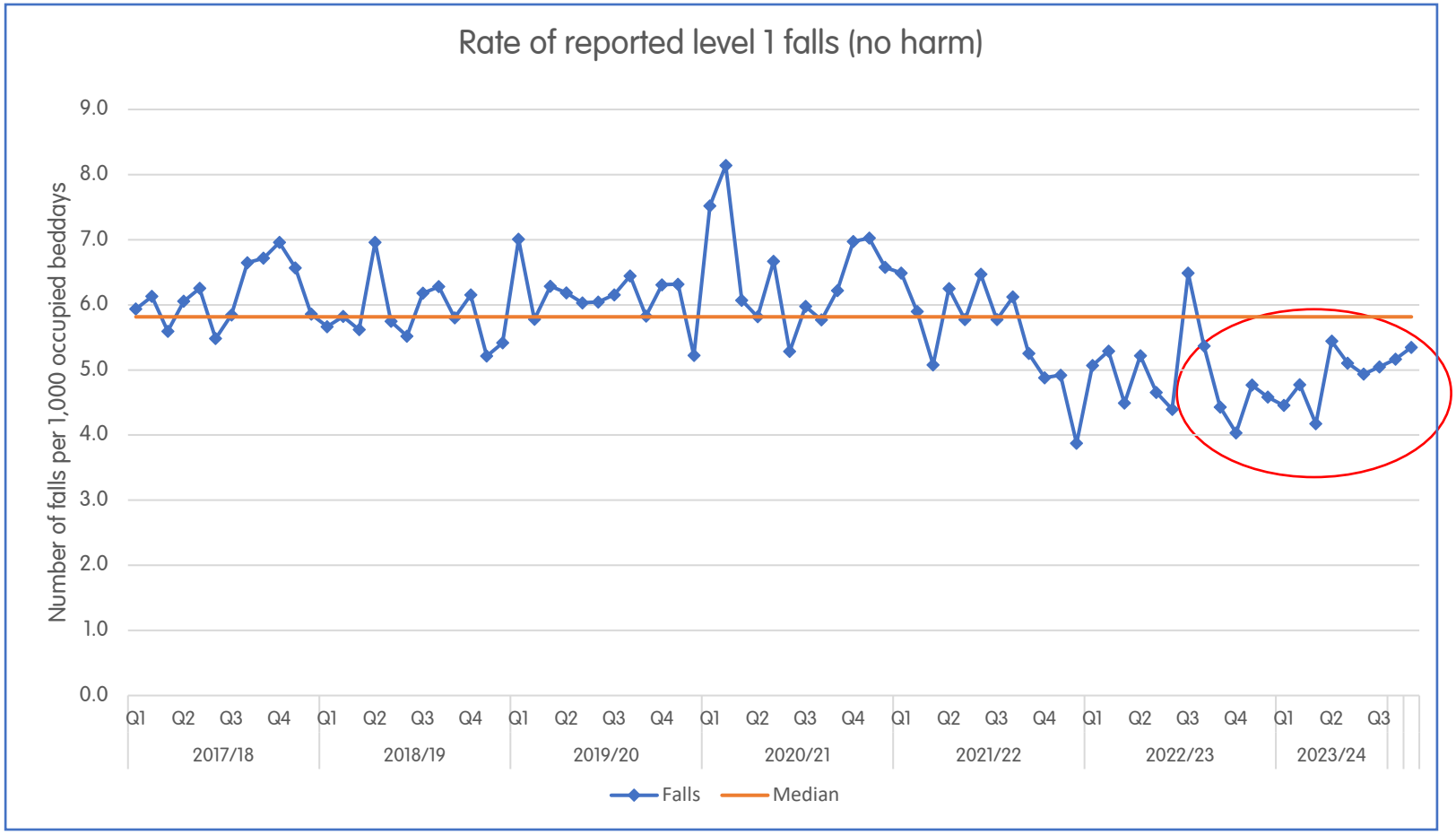


Evidence of a non-random signal if one or more of the circumstances depicted by these four rules are on the run chart. The first three rules are violations of random patterns and are based on a probability of less than 5% chance of occurring just by chance with no change.

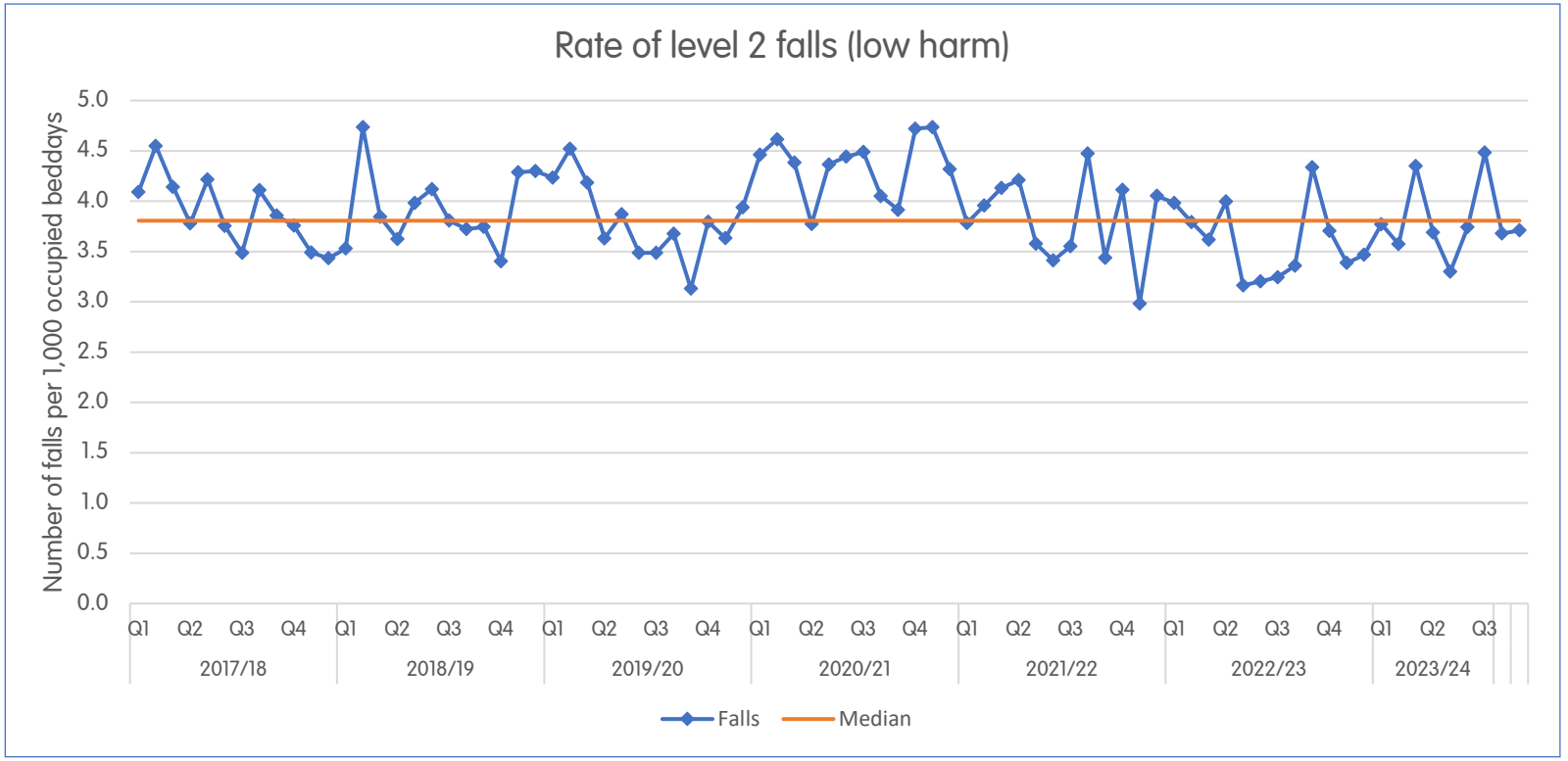
The Data Guide, p 3-11

FALLS

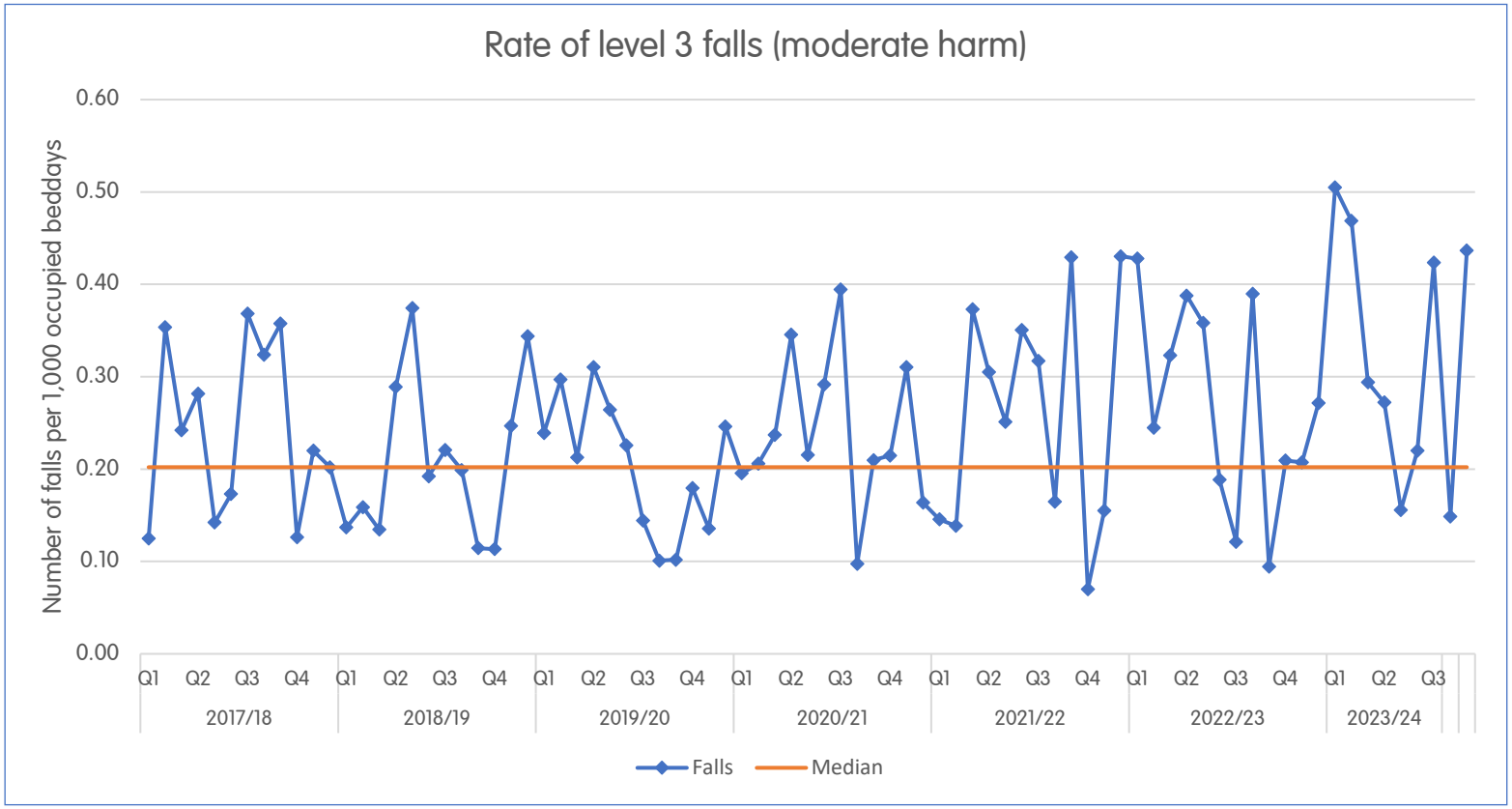
Level 1 falls over time



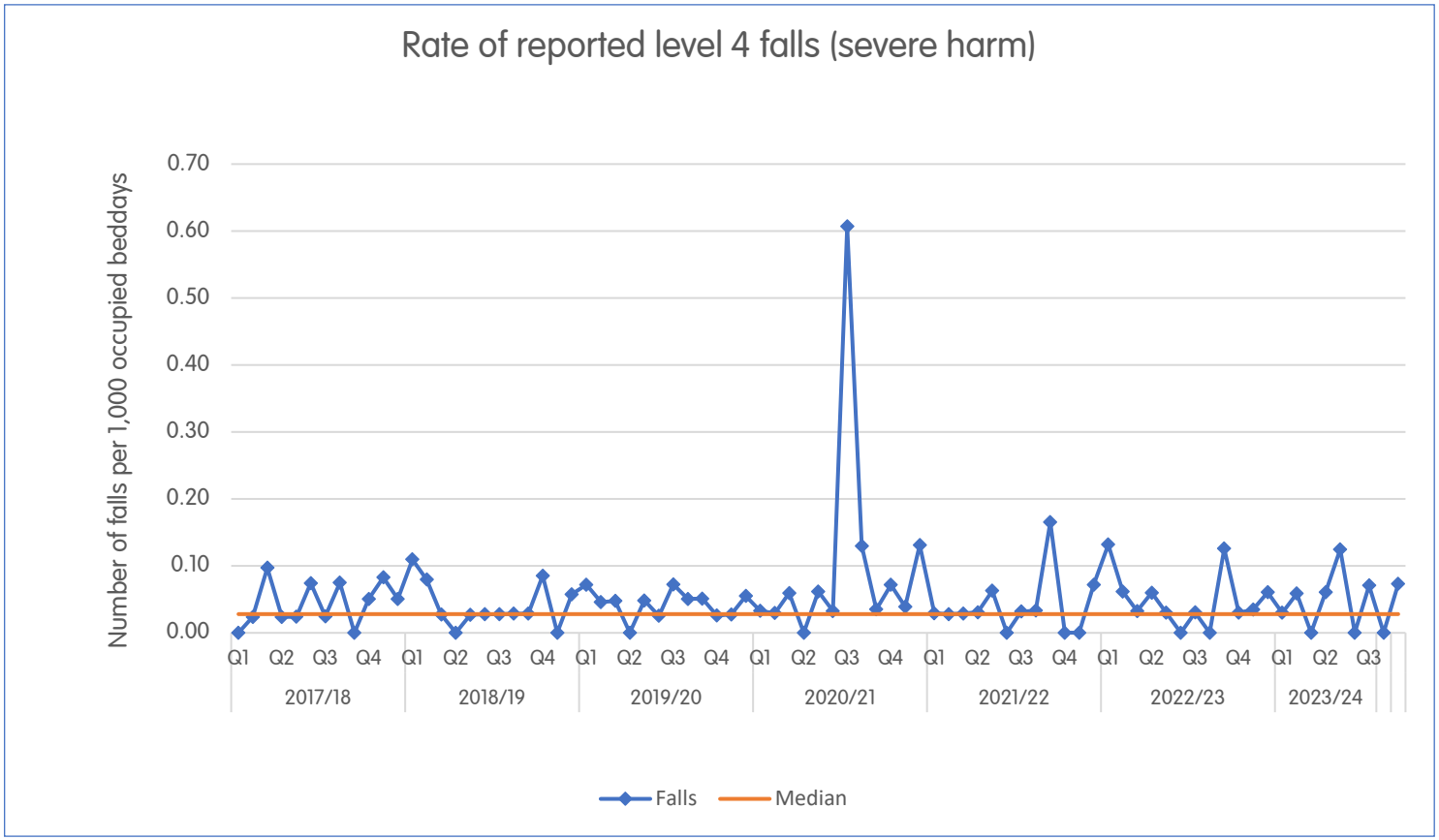
Level 2 falls (low harm) over time



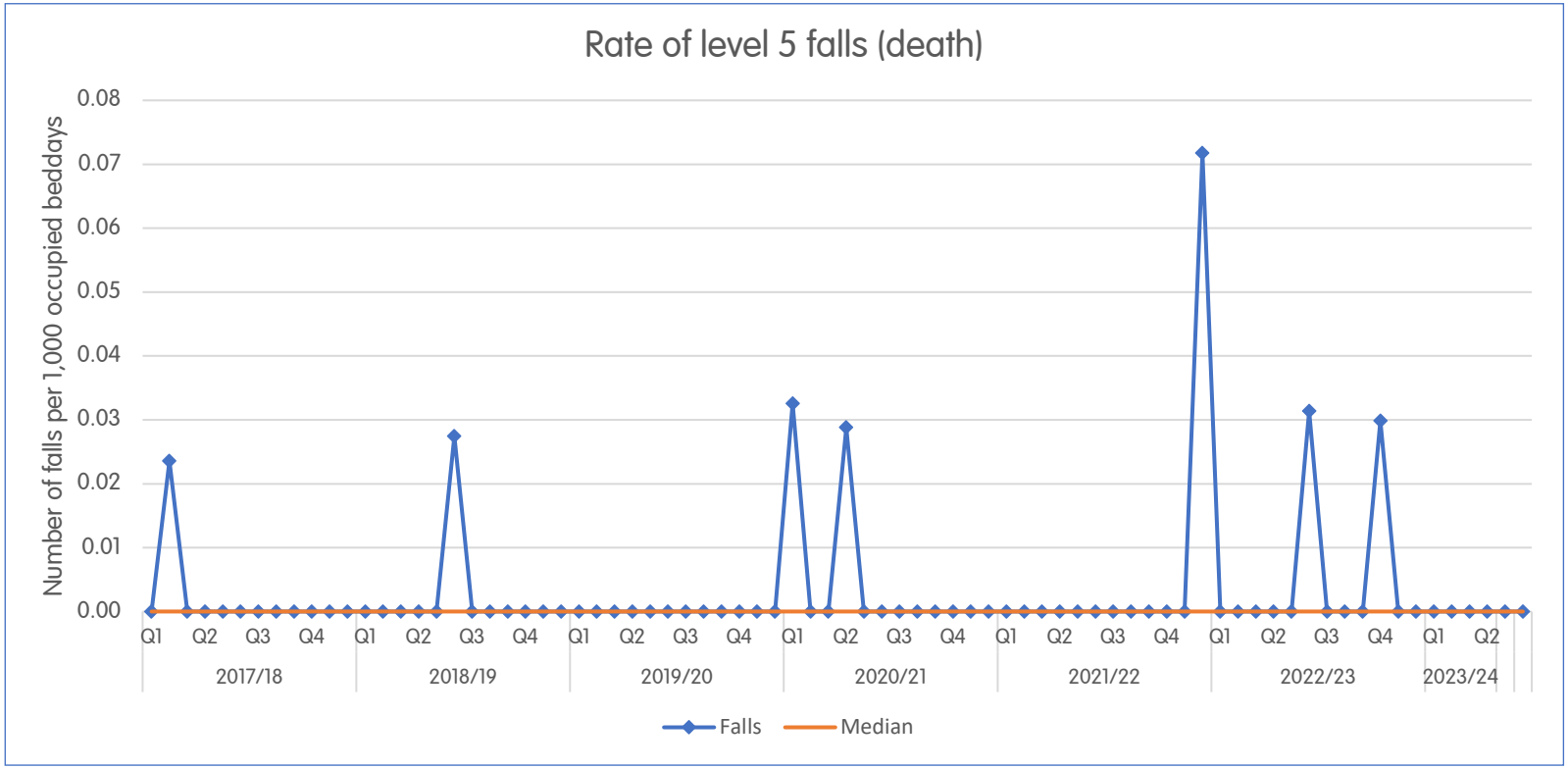
Level 3 falls (moderate harm) over time



Level 4 (severe harm) falls over time

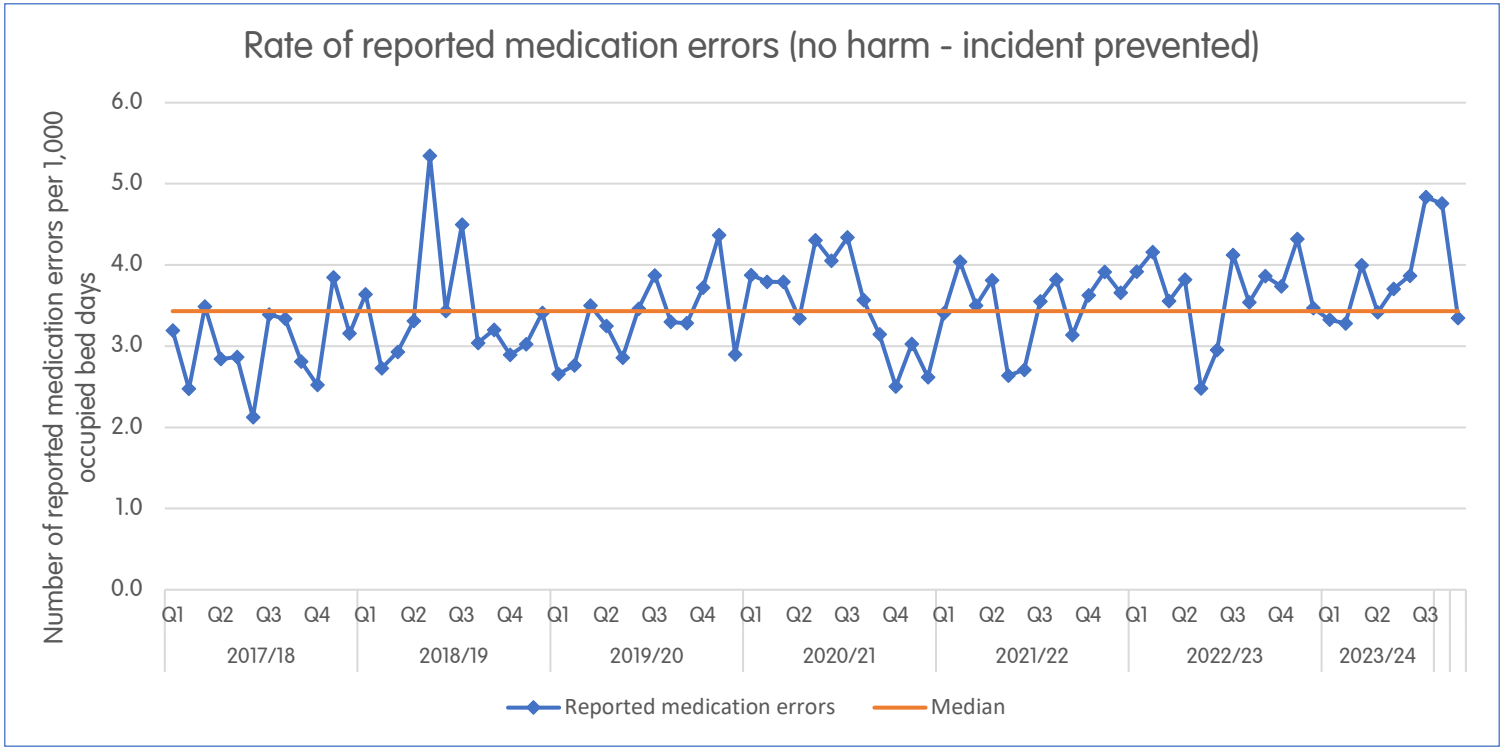


Level 5 (death) falls over falls over time

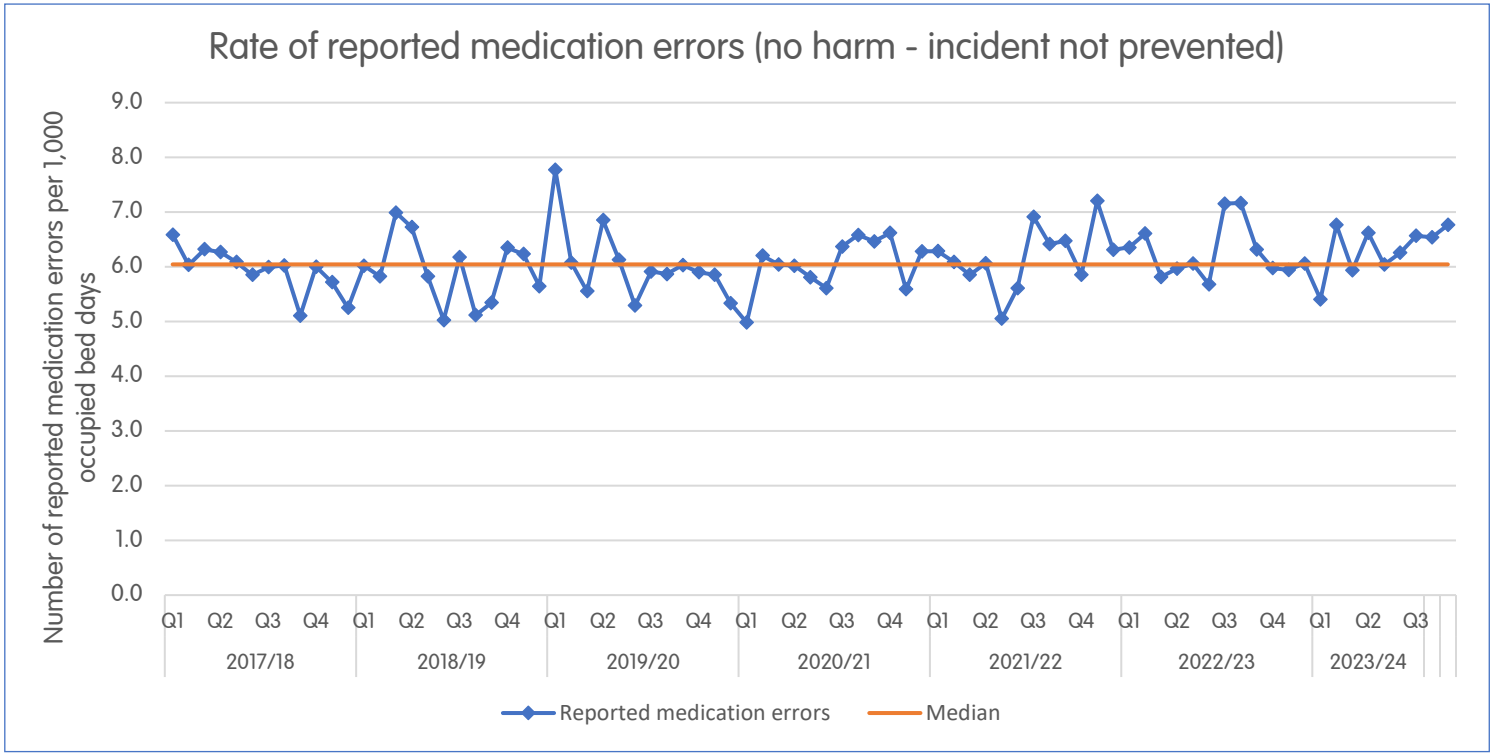


MEDICATION

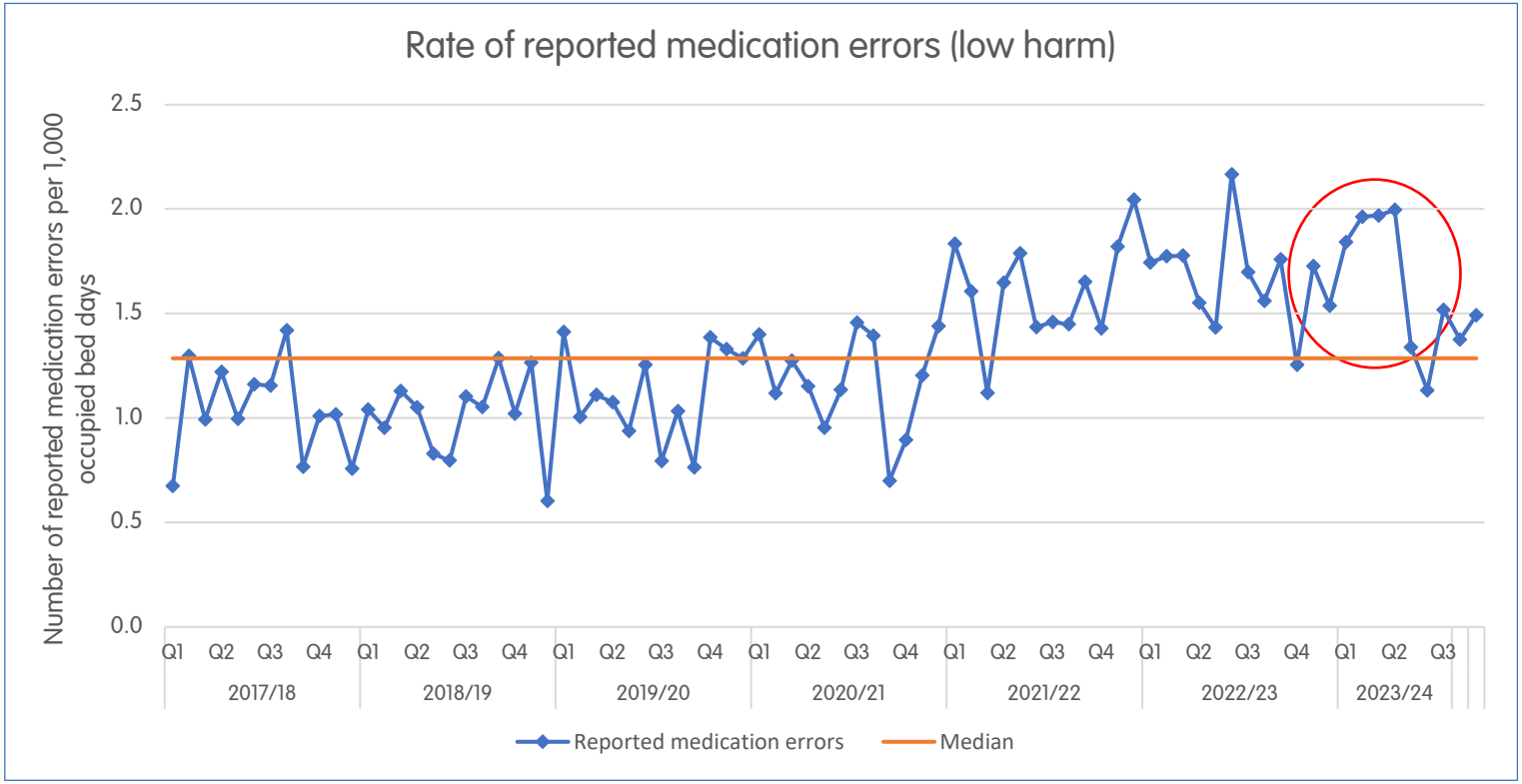
Rate of medication incidents; no harm – incident prevented (adults)



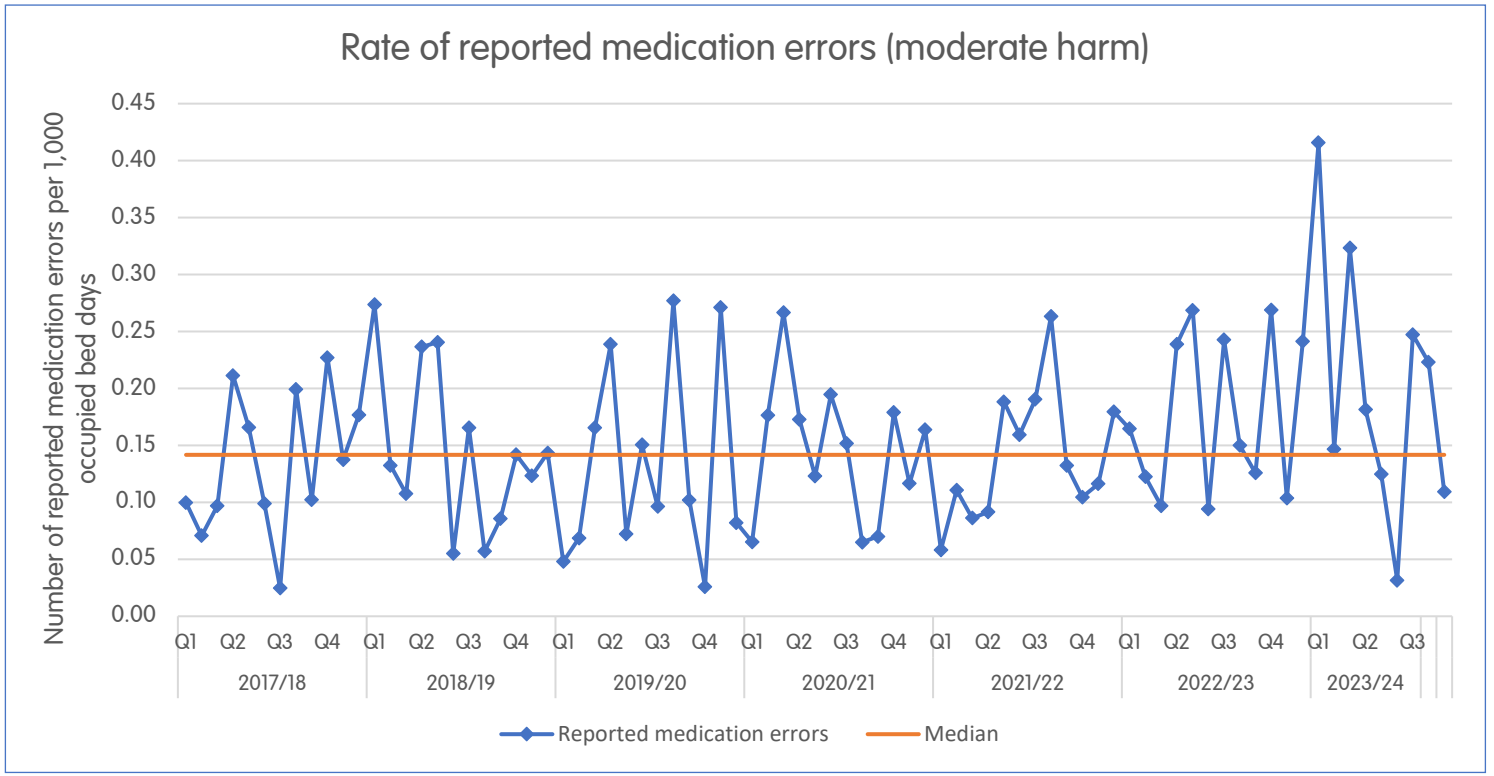
Rate of medication incidents; no harm (incident not prevented)



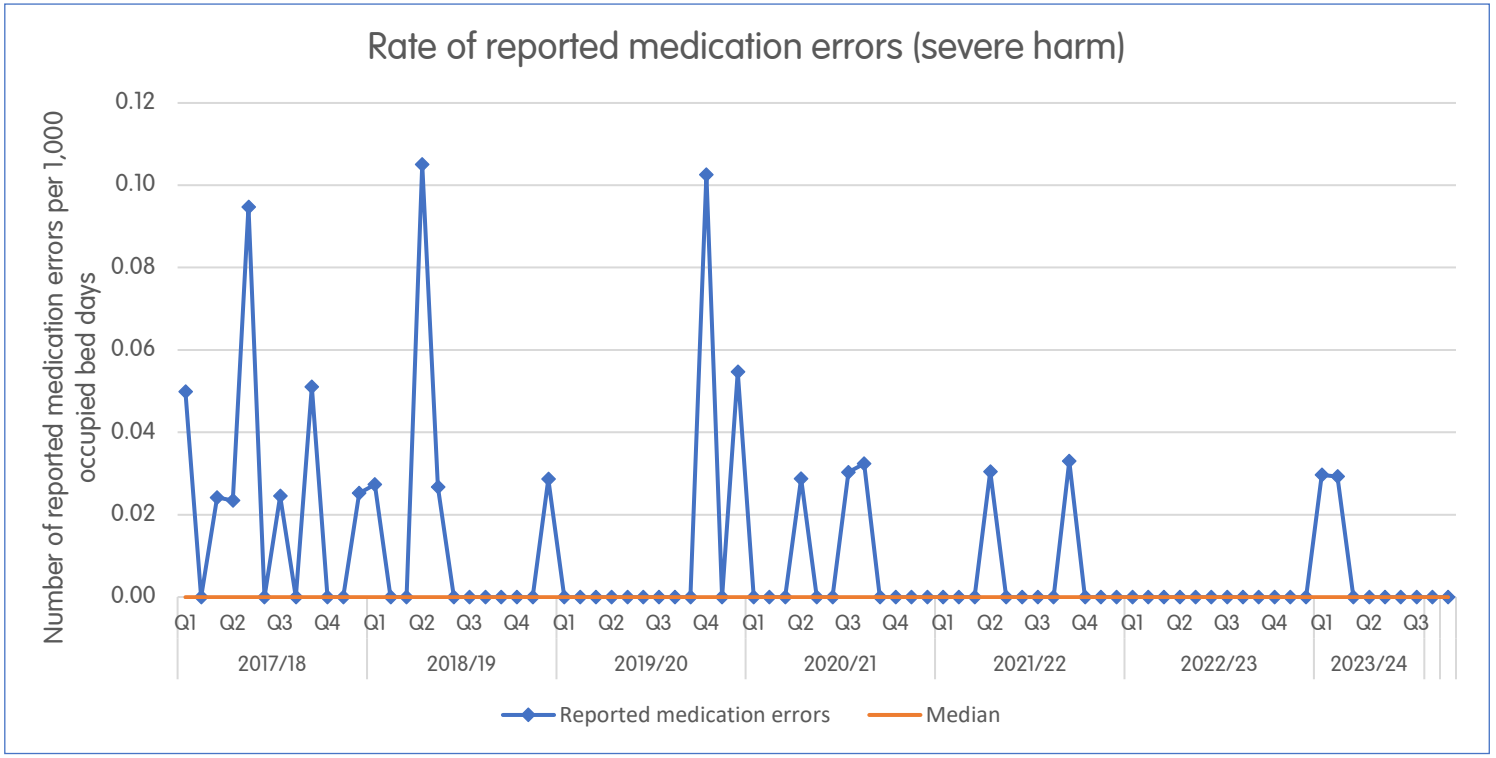
Rate of medication incidents; low harm



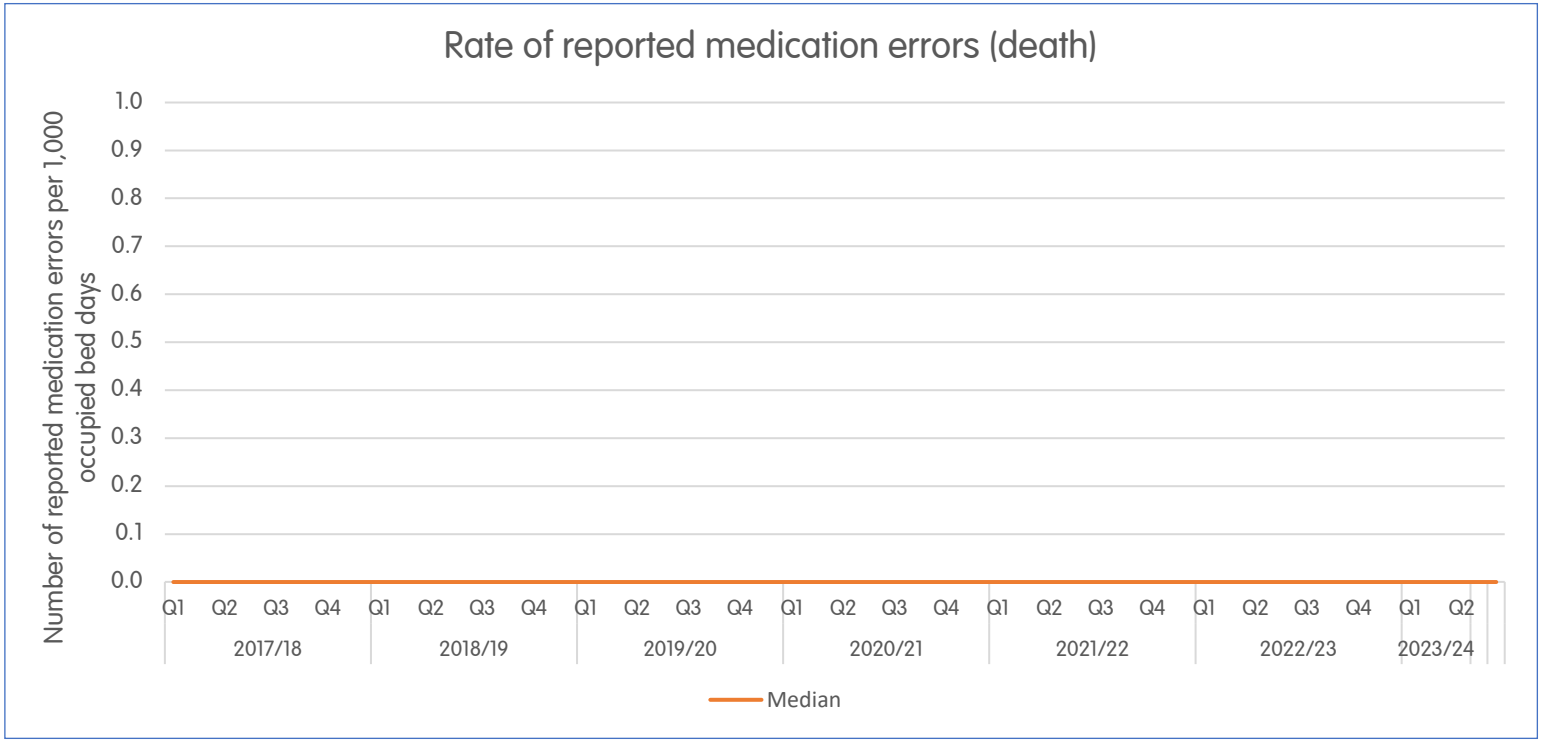
Rate of medication incidents; moderate harm



Rate of medication incidents; severe harm



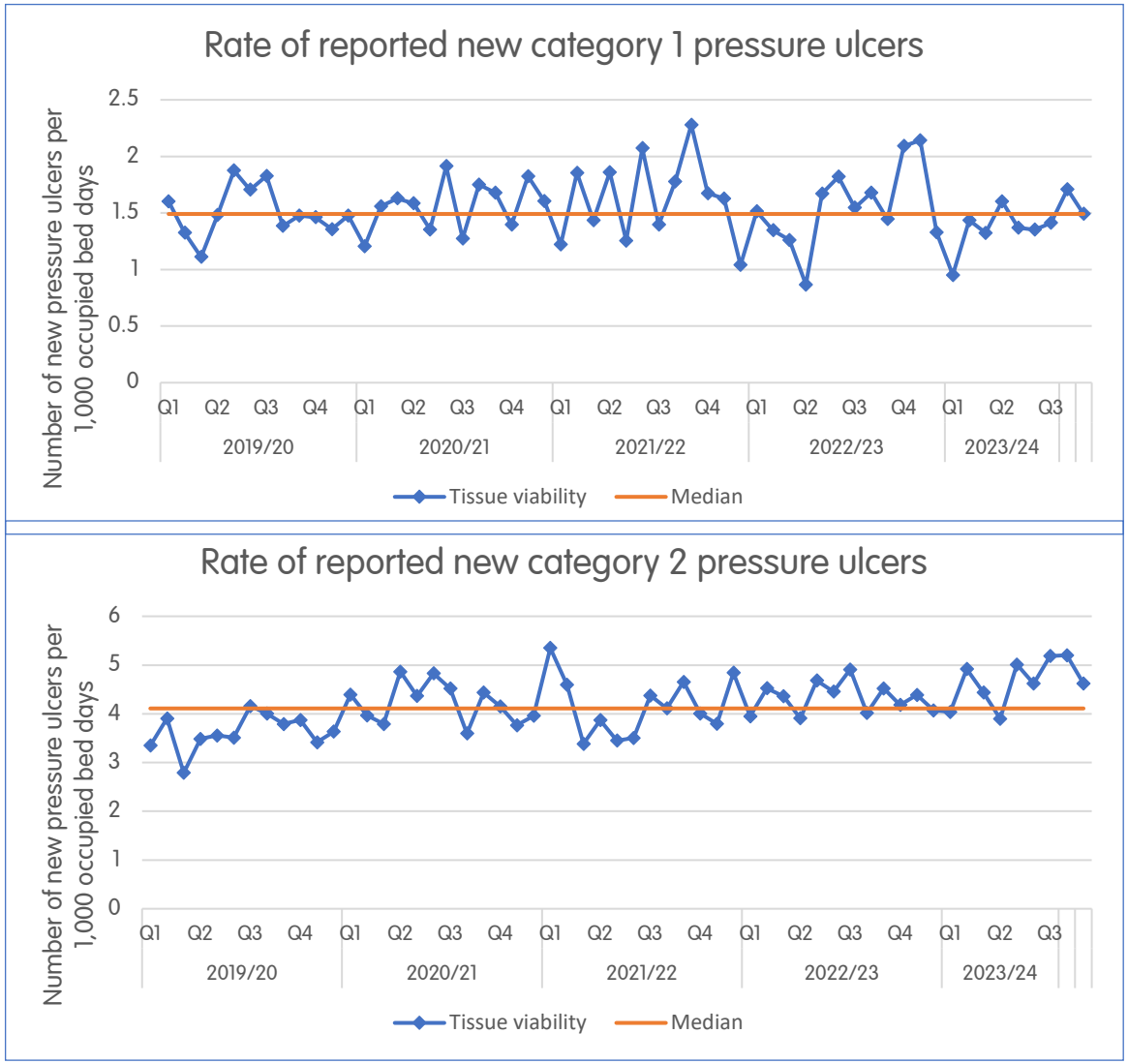
Rate of medication incidents; death



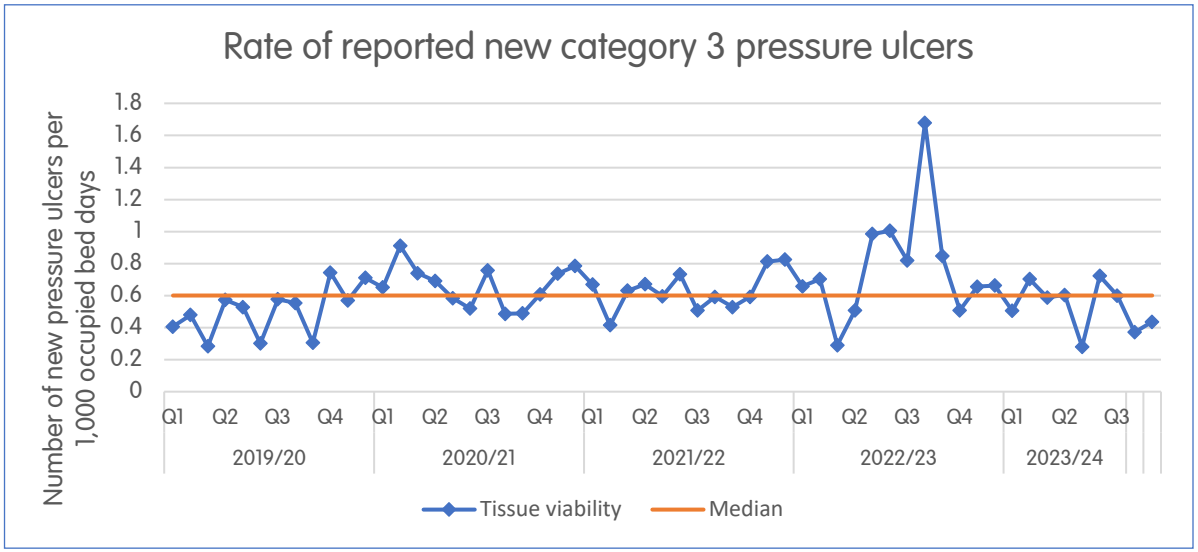
TISSUE VIABILITY

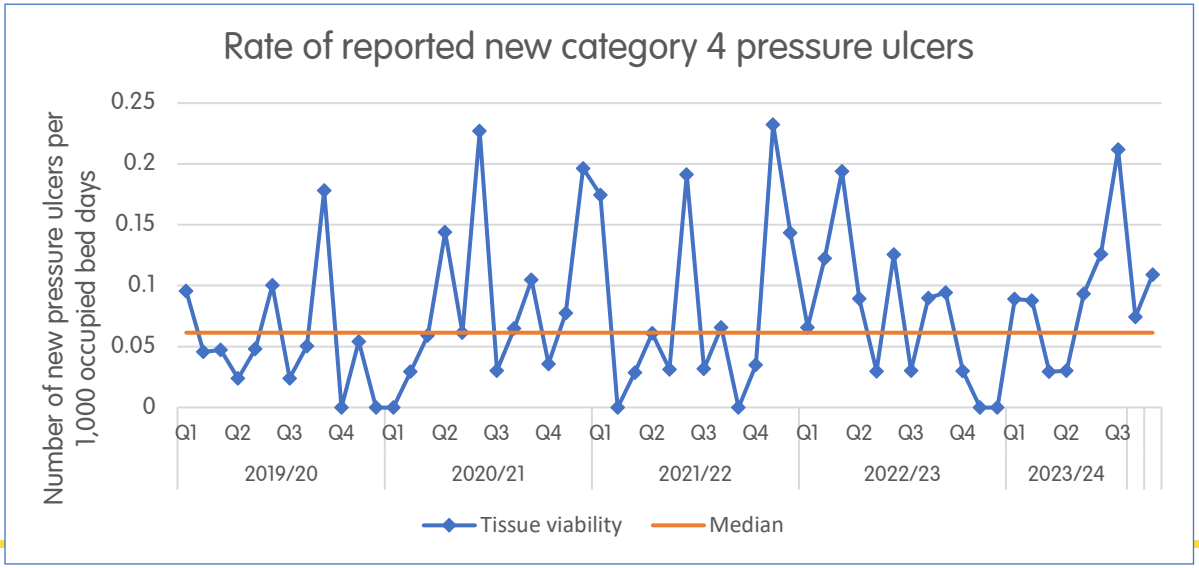
New Pressure Ulcers

Rate of new Cat 1 & Cat 2 Pressure ulcers



Rate of new Cat 3 & Cat 4 Pressure ulcers





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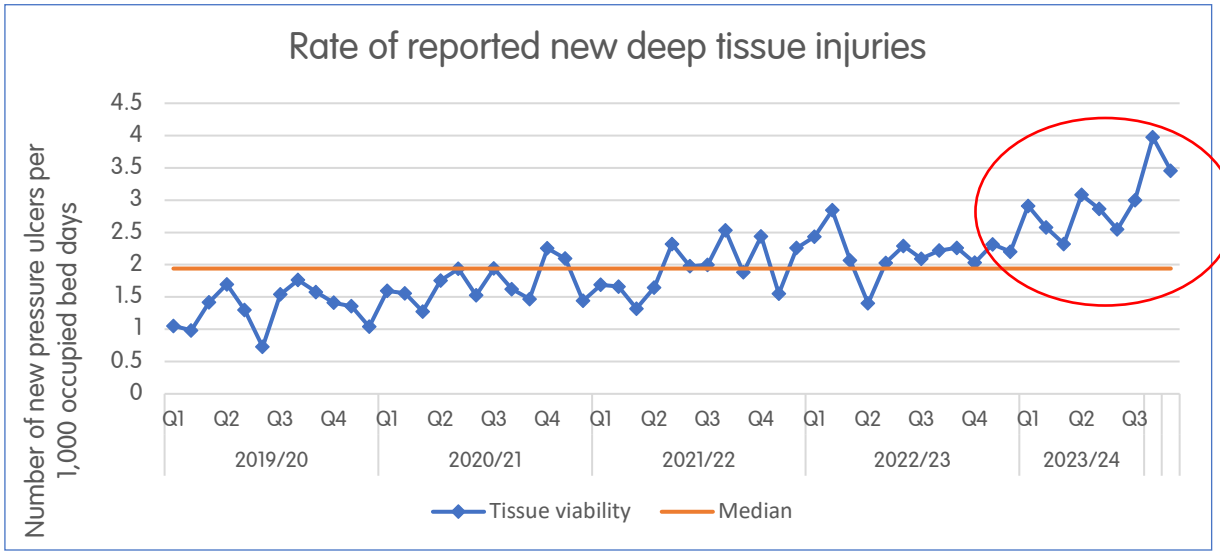
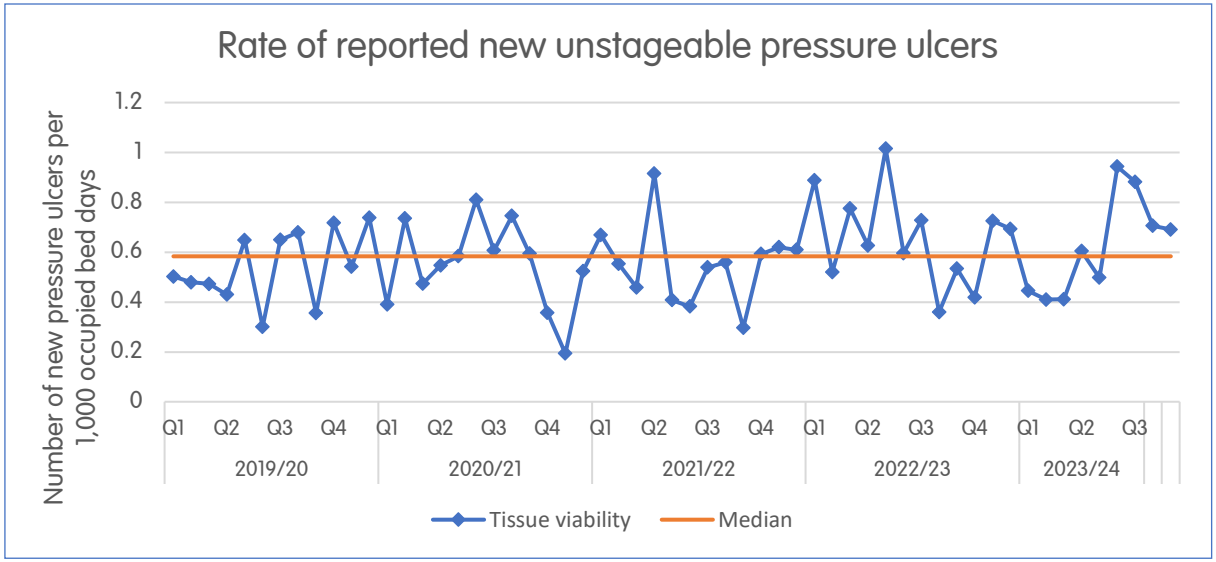
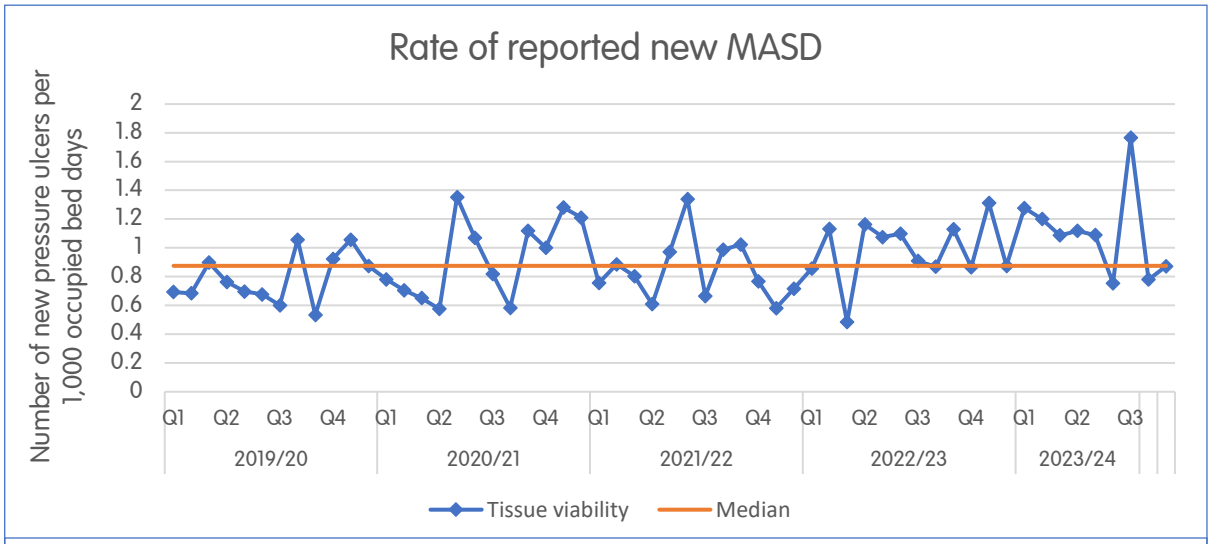
Rate of new DTI's & US Pressure ulcers

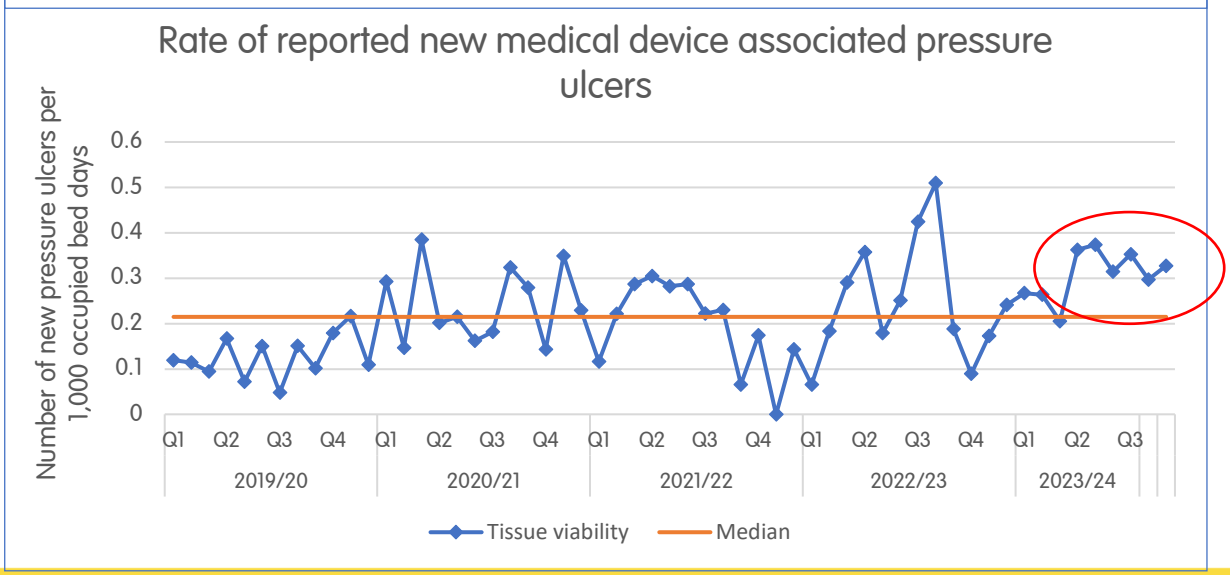


SHIFT



Rate of new MASD & MDA Pressure ulcers

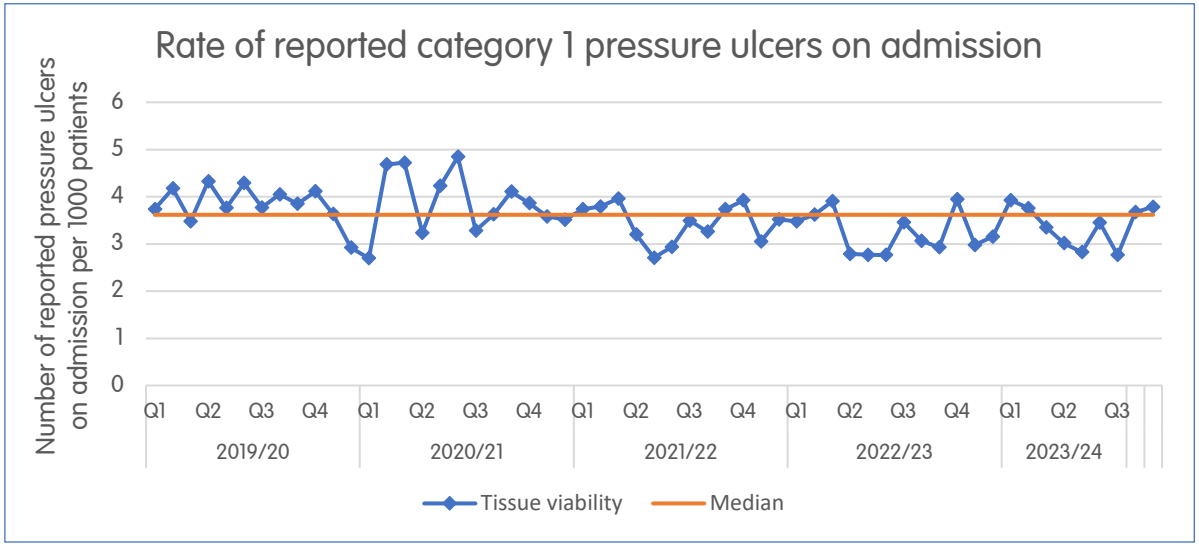


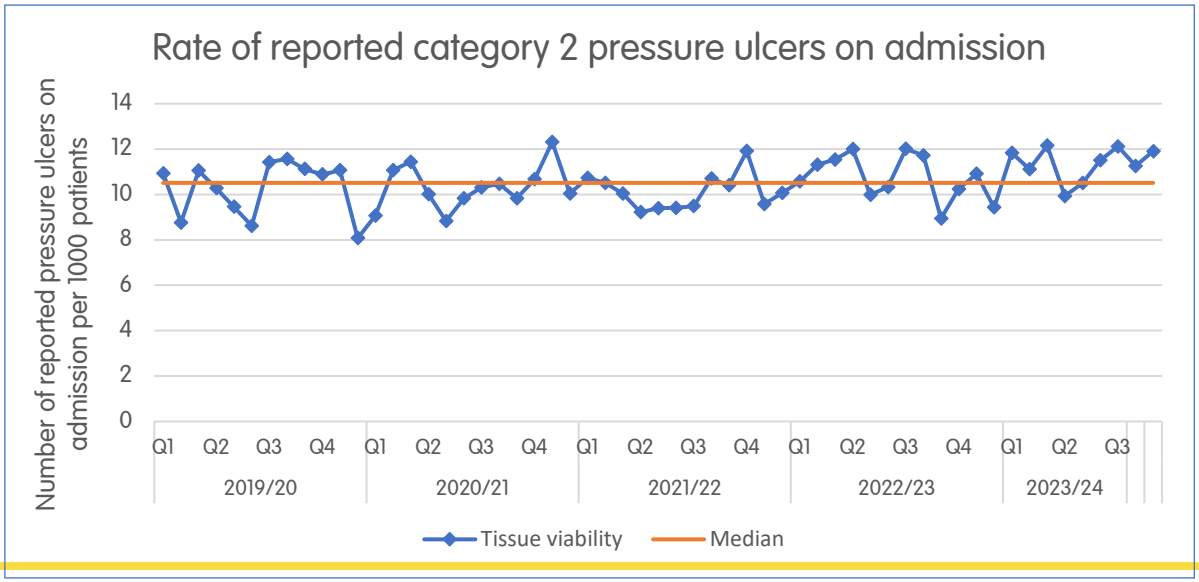


SHIFT

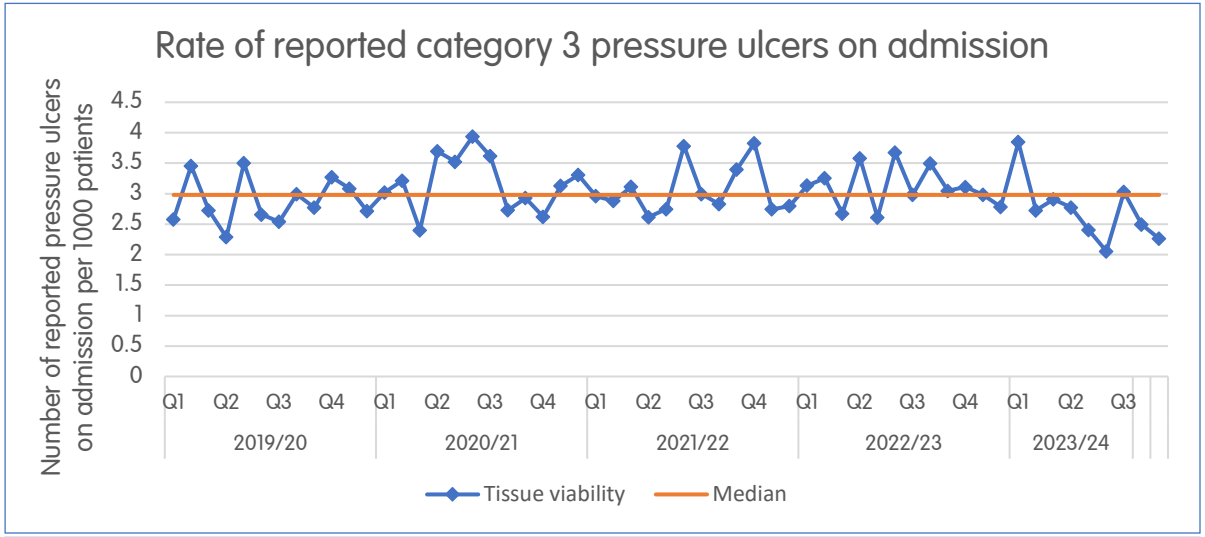
Pressure Ulcers on Admission

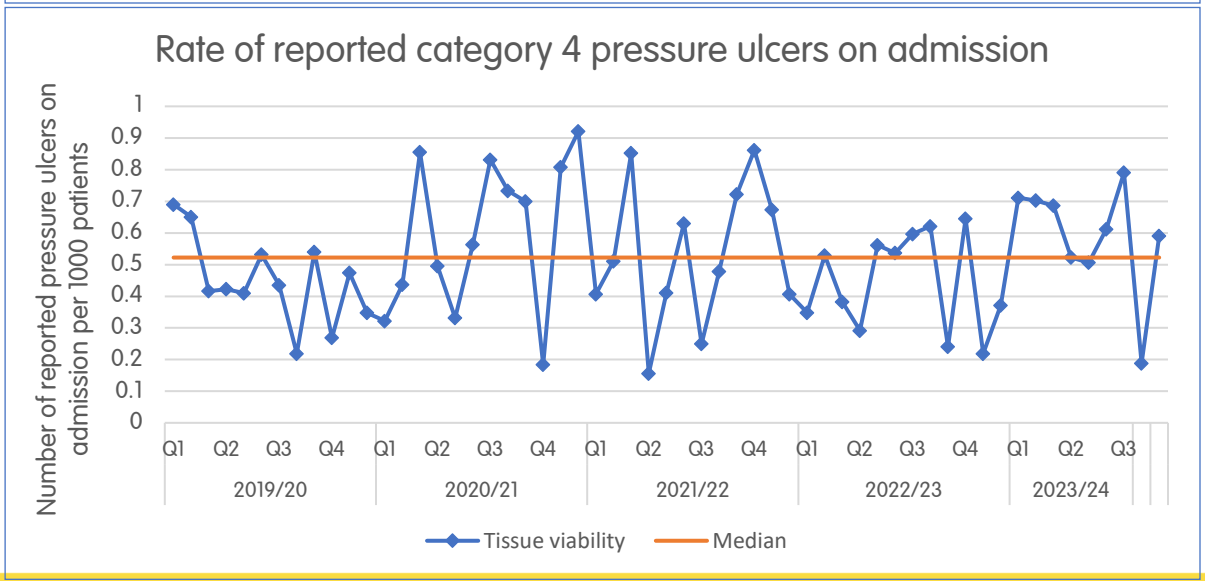
Rate of Cat 1 & Cat 2 Pressure ulcers



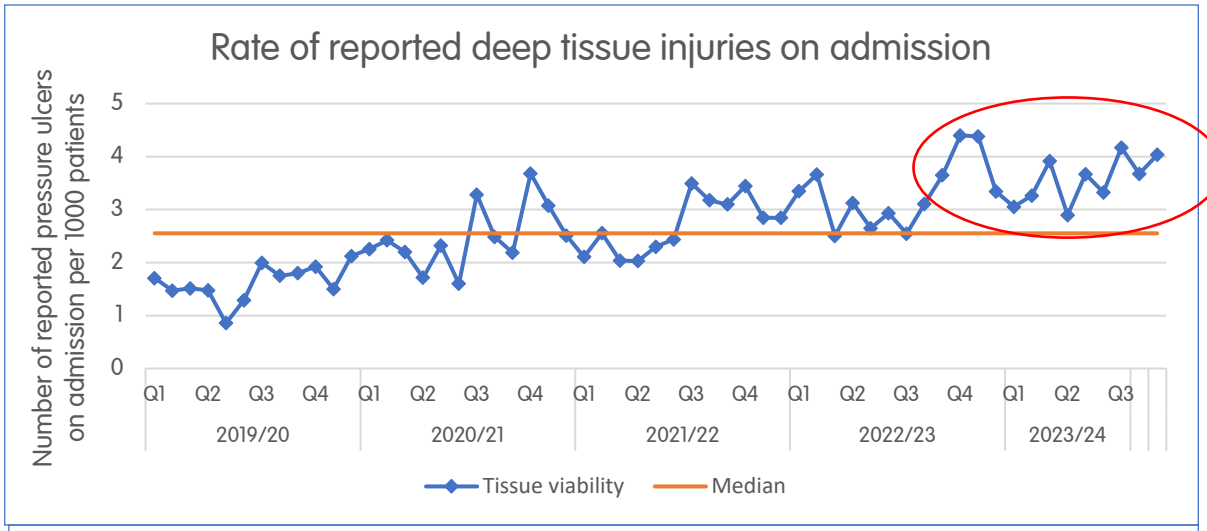


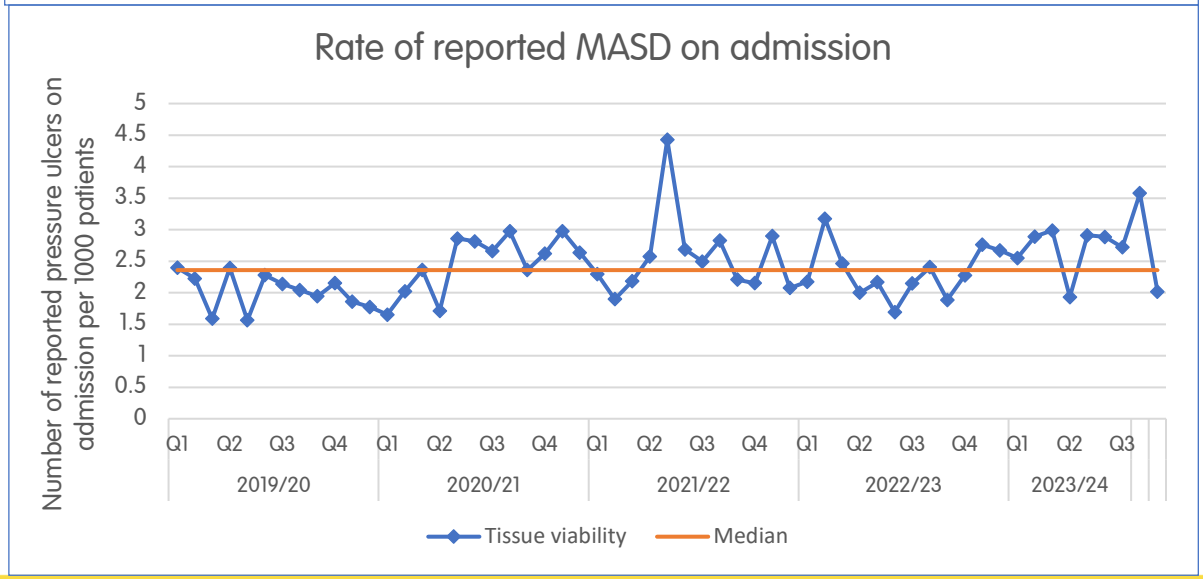
Rate of Cat 3 & Cat 4 Pressure ulcers



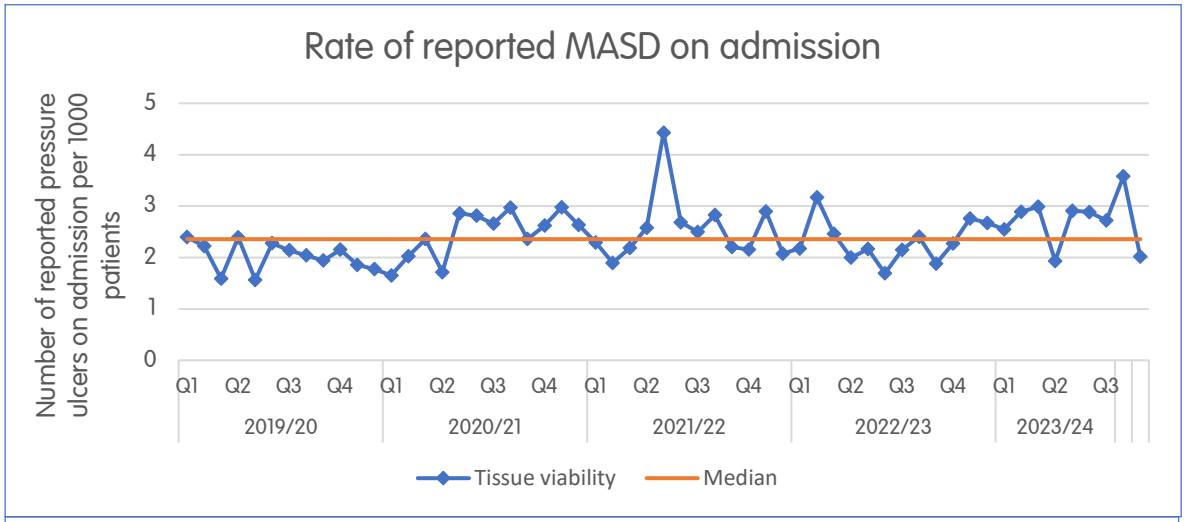


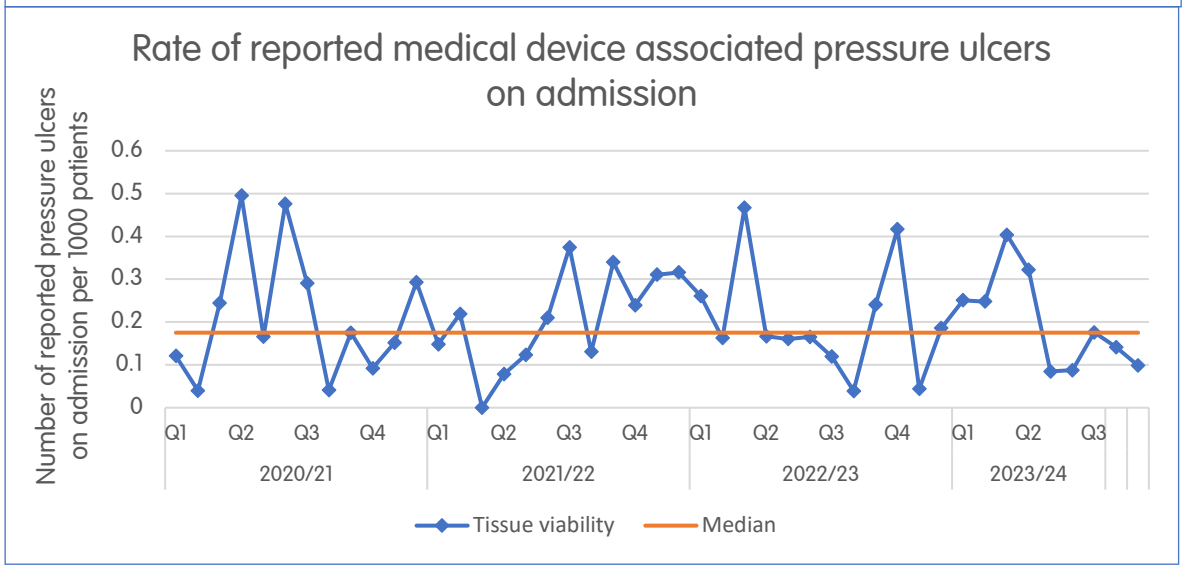
Rate of DTI & US Pressure ulcers





Rate of MASD & MDA Pressure ulcers





PSIRF TEAMS CHANNEL

Please contact Julia if you'd like to join.

RESOLVE training resources Outcome Measures

Hull and York Medical School Access RESOLVE training resources | Hull York Medical School (hyms.ac.uk)

Are you a hospice based in London working towards adopting PSIRF?

https://www.eventbrite.co.uk/e/819925147187?aff=oddtdtcreator

Join Health Innovation Network South London (HIN), Imperial College Health Partners & UCLPartners for an online Pan-London event dedicated to hospices transitioning to and embedding the Patient Safety Incident Response Framework (PSIRF).

This event aims to provide valuable insights and guidance on implementing the principles of PSIRF to enhance patient safety in hospice settings. Learn from experts in the field, share experiences, and connect with fellow professionals passionate about patient safety in hospices

Please find the link to the report here which was published on the 15th November for your information. Including Safety Observation O/2023/005:

Palliative care providers can improve patient safety by reviewing their ambulatory infusion pumps checks to determine whether they are in line with the Palliative Care Formulary guidance and the minimum expectations of NHS England

https://www.hssib.org.uk/patient-safety-investigations/risks-to-medication-delivery-using-ambulatory-infusion-pumps/investigation-report/

Raising the Bar: Leading in Quality and Safety

A one-day conference looking at the hospice workforce, with a focus on delivering the best possible, high-quality care for patients and their families whilst recognising the wellbeing of all staff.

Thursday 18 April 2024, The Grand Hotel, Leicester

Clinical and HR Leaders Conference | Hospice UK

Patient Safety in Hospices (healthcareconferencesuk.co.uk)

Friday 7th June 2024

This conference focuses on improving safety for hospice patients.

The day will highlight best practice in improving safety in hospices, highlight new developments such as the implications of the new Patient Safety Incident Response Framework (PSIRF), and the new CQC Inspection Framework, and will focus on key clinical safety areas such as falls prevention, medication safety, reduction and management of pressure ulcers, nutrition and hydration, improving the response and investigation of incidents, preparing for onsite inspections and developing a compassionate culture in hospices

Managing and Reducing Medication Errors – online conference, 24 April 2024

Find out more and register

Next Meeting:

16 May

Please get in touch if you would like the opportunity to present or would like to suggest guests to join us.

FEEDBACK!

Please take our 3-minute survey to help us make our webinars deliver for you:

https://www.surveymonkey.com/r/PS_20_Feb_2024

Submit

https://www.hospiceuk.org/innovation-hub/clinical-care-support/quality-improvement/patient-safety

Quarter	Months	Submission deadline	Final reports circulated
Q1	Apr, May, Jun	14 July 2023	28 July 2023
Q2	Jul, Aug, Sep	13 Oct 2023	27 Oct 2023
Q3	Oct, Nov, Dec	12 Jan 2024	26 Jan 2024
Q4	Jan, Feb, Mar	12 Apr 2024	26 April 2024

request a copy of the submission links:

https://www.hospiceuk.org/professionals/clinical-and-care-support/quality-improvement/patient-safety-project/request-submission-links

Thank you