Patient Safety Webinar Quarter 3 2022/23

16 February 2023

16 February 2023 Patient Safety Webinar 13.00 – 14.30hrs

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).

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

Any issues please message ‘Stuart Duncan’ in the Chat Box and we will try to assist.

Time	Item	Presenter(s)
13:00	Welcome and Introductions	**Julia Russell,** Senior Clinical and Quality Improvement Manager, Hospice UK
13.05	PSIRF Implementation	**Mark Heath,** Clinical Quality and Safety Manager, Sue Ryder
Colleagues from Scotland, Wales and Northern Ireland to join		
13.40	Tissue Viability	**John Sharman,** Data + Quality Senior Assistant, Mountbatten Isle of white Hospice
14:10	Quarter 3 Data	**Julia Russell,** Senior Clinical and Quality Improvement Manager, Hospice UK
14:30	Summary & Close	**Julia Russell,** Senior Clinical and Quality Improvement Manager, Hospice UK

Patient Safety Incident Response Framework (PSIRF)

Welcome

Mark Heath
Clinical Quality and Safety Manager
Quality and Governance Team

Sue Ryder

We are Sue Ryder

Introducing PSRIF to Sue Ryder

Mark Heath, Clinical Quality and
Safety Manager/ Patient Safety Lead.
February 2023

palliative, neurological and bereavement support

PSIRF

- August 2022 NHS England published its Patient Safety Incident Response Framework (PSIRF), which replaces the Serious Incidents Framework (SIF). Early adopters from 2020.
- The Patient Safety Incident Response Framework (PSIRF) – a core element of the NHS Patient Safety Strategy – establishes the NHS's approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement.
- The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care.

Sue Ryder palliative, neurological and bereavement support

PSIRF

- Additionally, unlike the SIF, the PSIRF requires a degree of training to ensure that those conducting investigations – as well as those providing oversight of the process – have an adequate level of knowledge and experience to ensure that investigations lead to learning and improvement.
- The PSIRF has four key aims with regards to patient safety incidents: compassionate engagement and involvement of those affected; a system-based approach to learning; considered and proportionate responses; supportive oversight focused on strengthening response systems and improvement.

PSIRF and Sue Ryder

- Early scoping in 2022. Formation of a work plan (!) and designated leads.
- Leads for patient safety profiles, engagement, education etc.
- Set up a working group and steering group
- Recognition this is a large piece of work which requires cultural change
- This work will underpin our PSIRP and policy.

Sue Ryder palliative, neurological and bereavement support

What's next….

- Have commenced engagement with our services so they can lead and shape their safety profiles.
- Roles and responsibilities – who does what?
- We will determine our patient safety priorities through workshops with our services.
- Map out our learning methods against incidents (AAR/ swarms/ thematic reviews etc) and what method will best support our learning.
- Will formulate our PSIRP and policy in the coming months to support our learning as well as supporting governance.

Sue Ryder palliative, neurological and bereavement support

What's next….

- Transition into PSIRF later this year. Not underestimating the scale of the challenge but will remain proportionate to our organisation.
- Engaging with ICB's. Understanding expectations.
- We are actively exploring Patient Safety Partners and how they will support our learning and safety culture.
- Will be a moving picture over coming weeks, months and years.

Sue Ryder
palliative, neurological and bereavement support

Mark.heath@sueryder.org

palliative,
neurological
and bereavement
support

Questions…..

1. Have other hospices identified leads for learning, response and oversight?
2. How are other hospices adapting the PSIRF plan?
3. How are other hospices working alongside their local NHS trusts?
4. Have hospice's identified a lead?
5. How are hospices undertaking the patient safety training (or plan to?)
6. How have others adapted the plan for a small independent organisation?
7. Does any one have any advice on implementing PSIRF?

DATE FOR YOUR DIARY

PSIRF for Hospices
9th March 10 – 11am

A chance to hear from early adopters and ask some questions.

https://supporter.hospiceuk.org/public/event/eventBooking.aspx?id=EVT01768

Welcome

John Sharman

Data and Quality Senior Assistant
Mountbatten Isle of White

Living, dying, remembering

Under pressure: an in-depth approach to tissue viability data

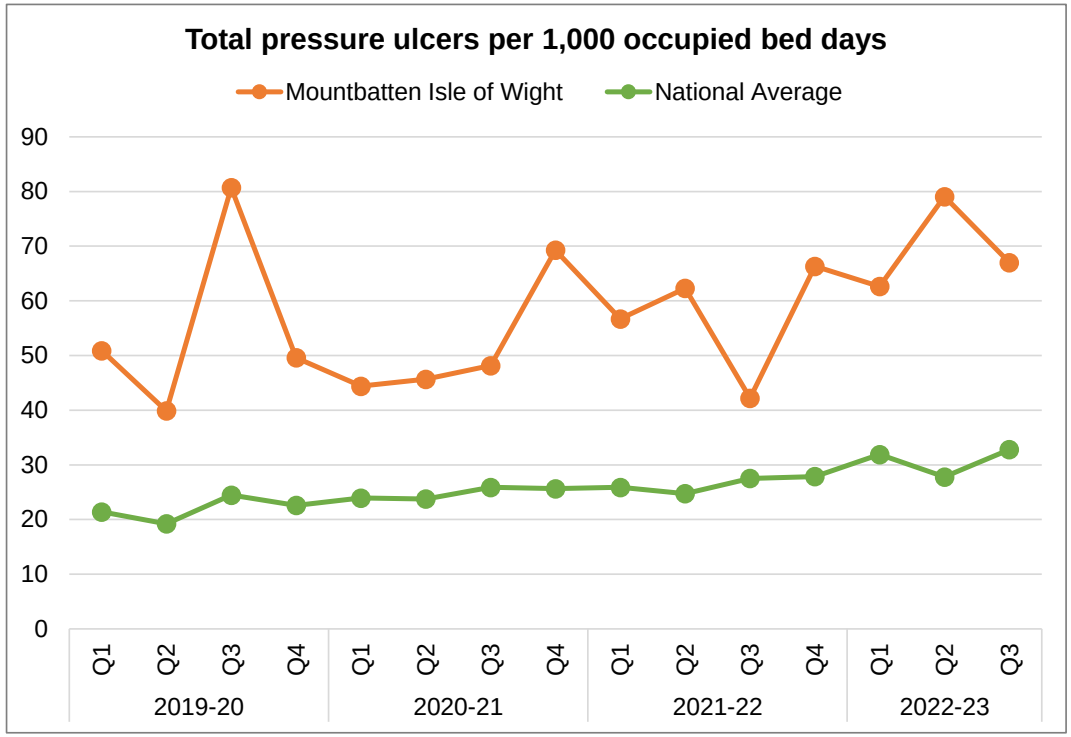
John Sharman – Quality & Data

Mountbatten

Living, dying, remembering

Our approach

- Good culture of reporting
- Low reporting threshold
- Training



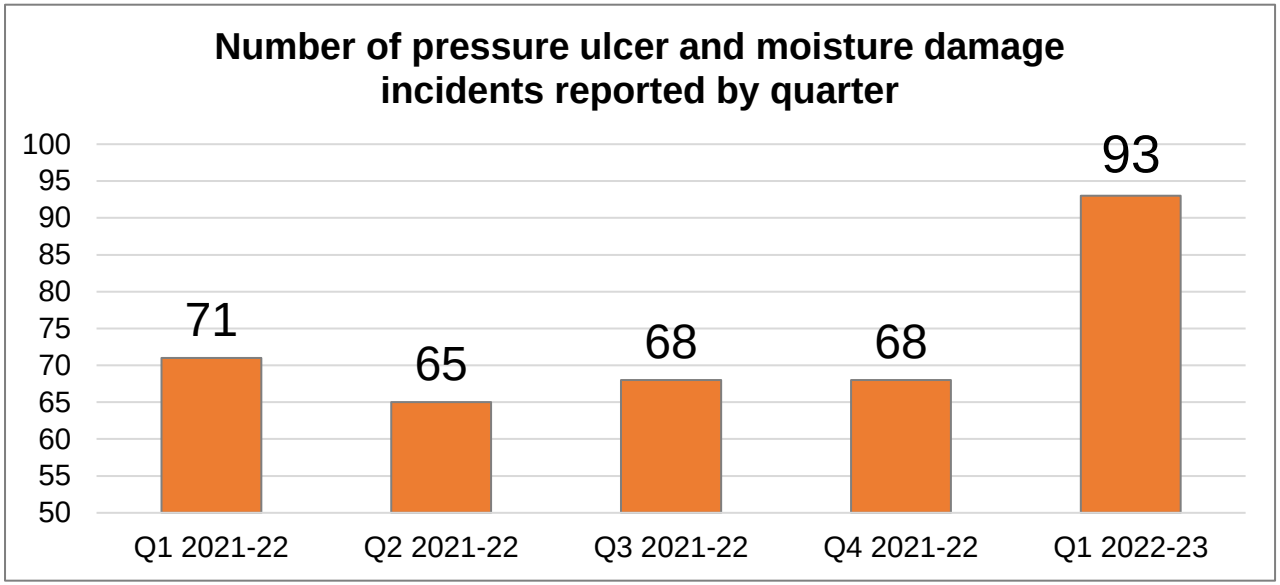
- DATIX form designed around the standards
- Monthly reviews / quarterly reporting

Mountbatten

Living, dying, remembering

Why did we review?

- IPU team initiative
- Outlier on quarterly reporting
- Discussed at Clinical Services



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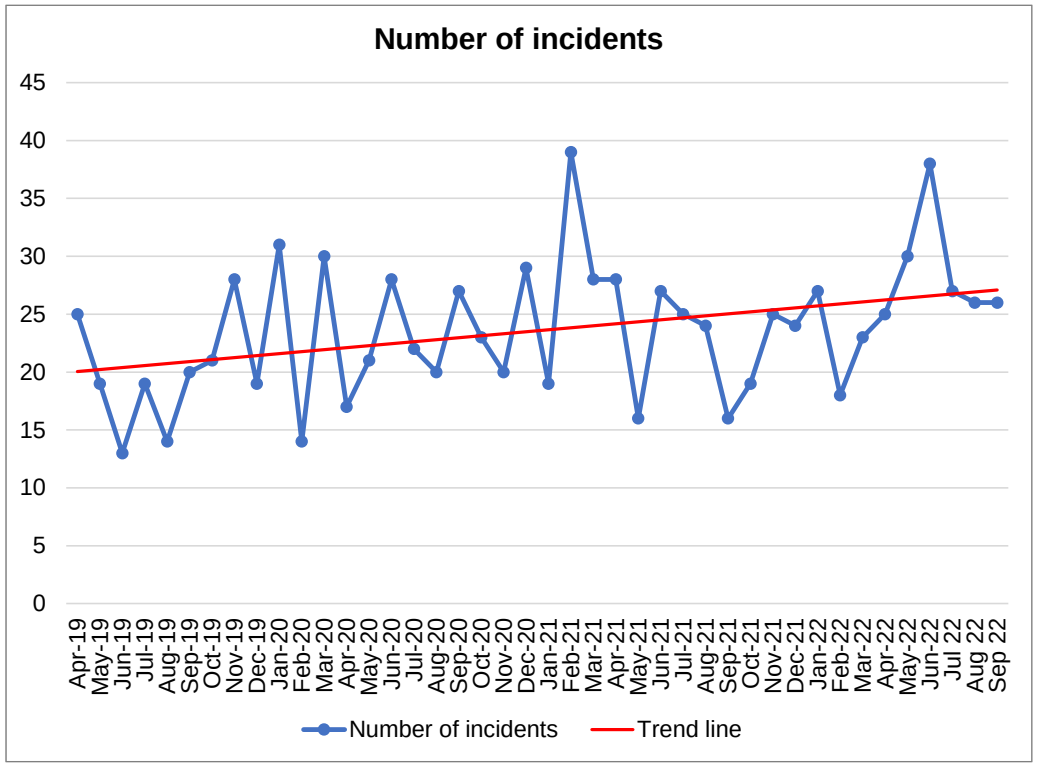
Living, dying, remembering

Review process

- Trustee led + Director of Nursing, IPU Lead, Tissue Viability Lead

- Four main themes:
  - Data
  - Staffing
  - Equipment
  - External trends



Mountbatten

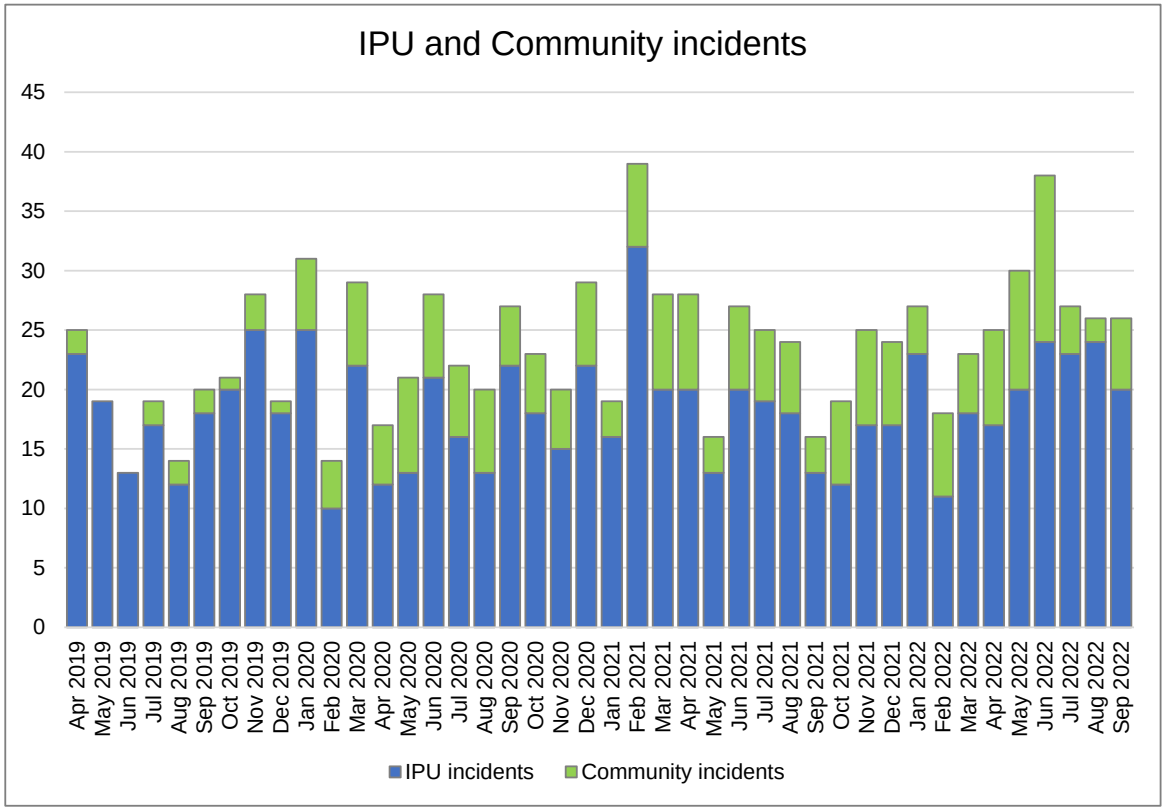
The data approach

- Review of how and when we record
- Long term picture
- Comparison with wider data
- Run charts and statistical process control (making data count)
- Patient level audit (small sample)

Improving the data

- Reporting process

- Community incidents – possible double reporting



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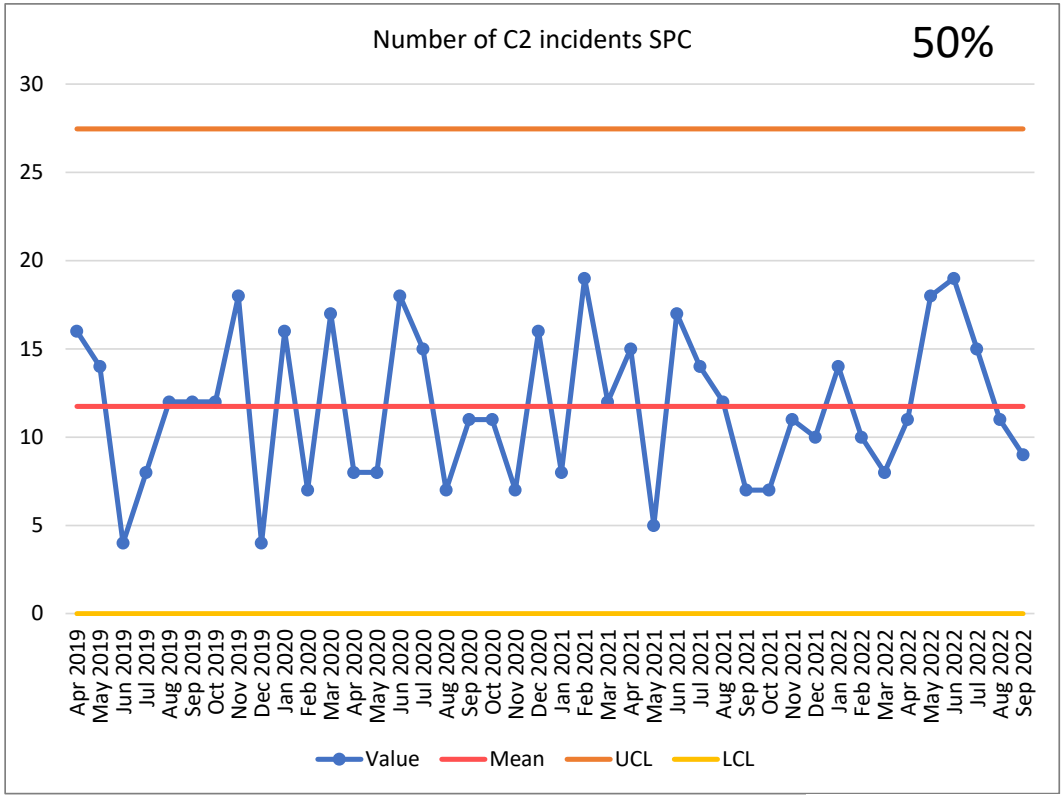
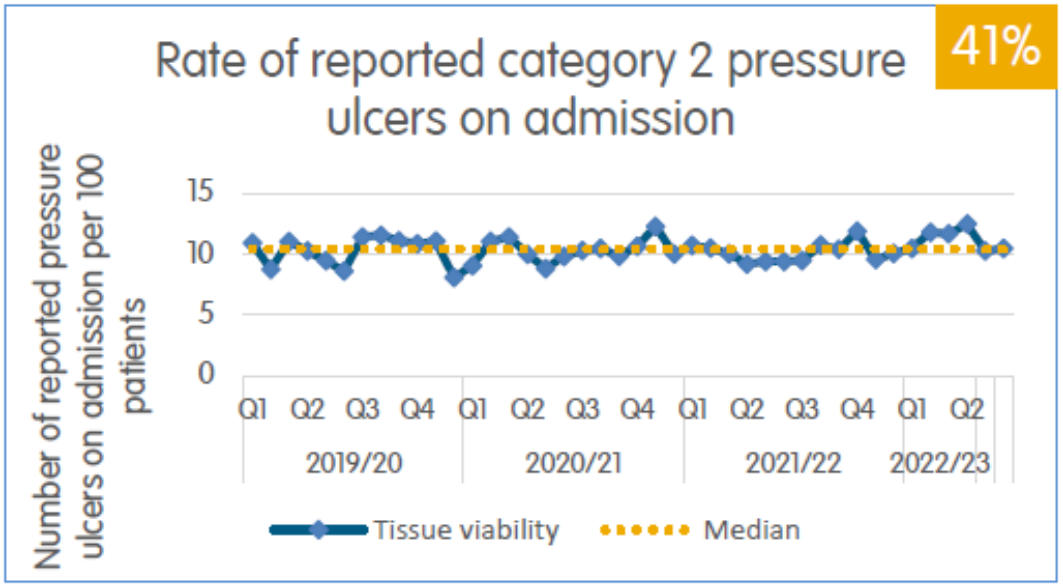
Living, dying, remembering



Category 2



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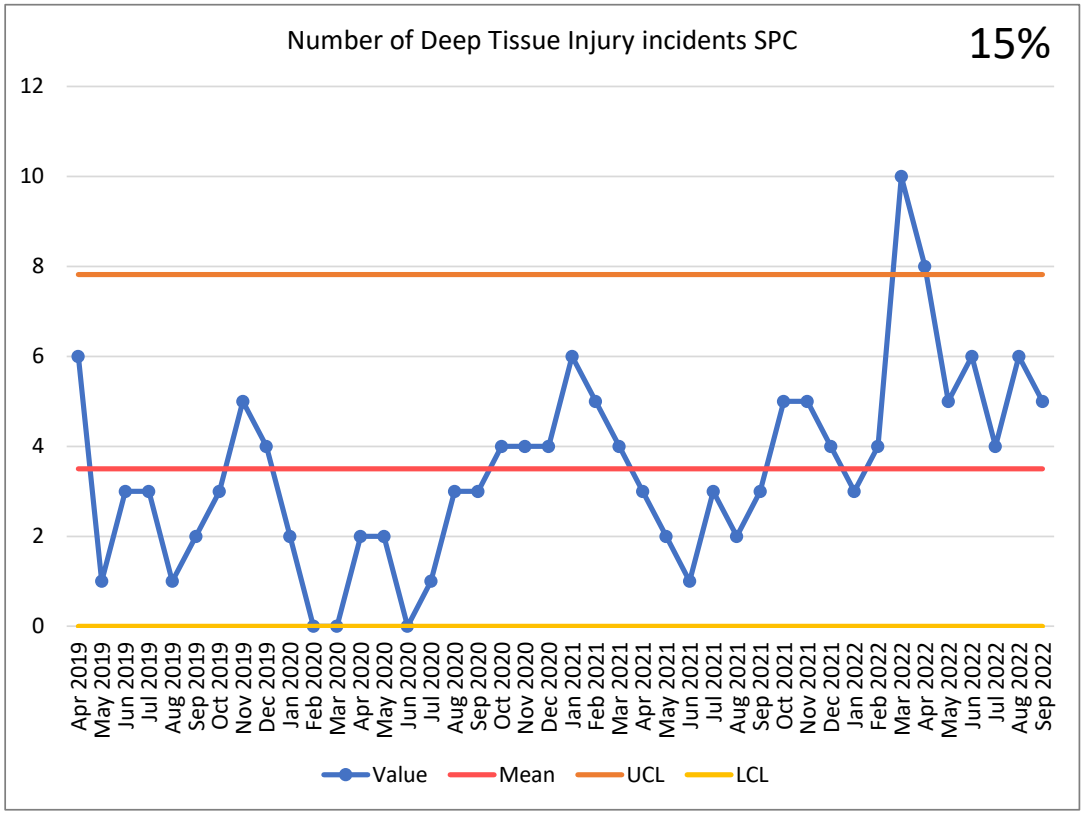
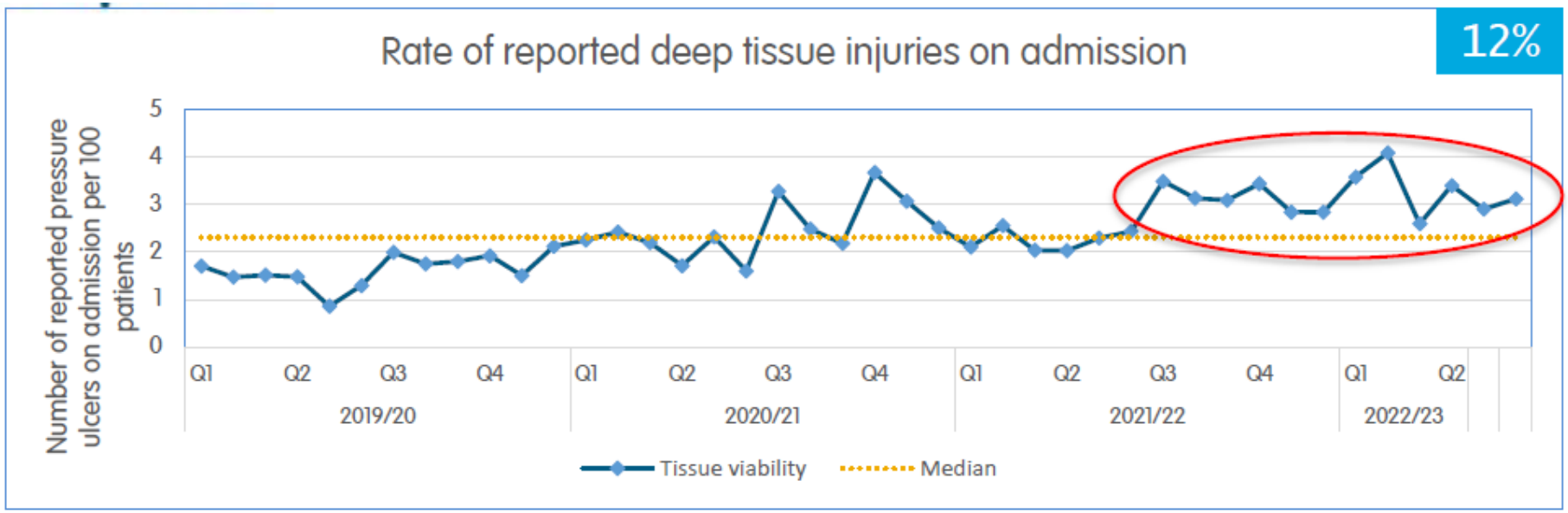
Deep tissue Injuries





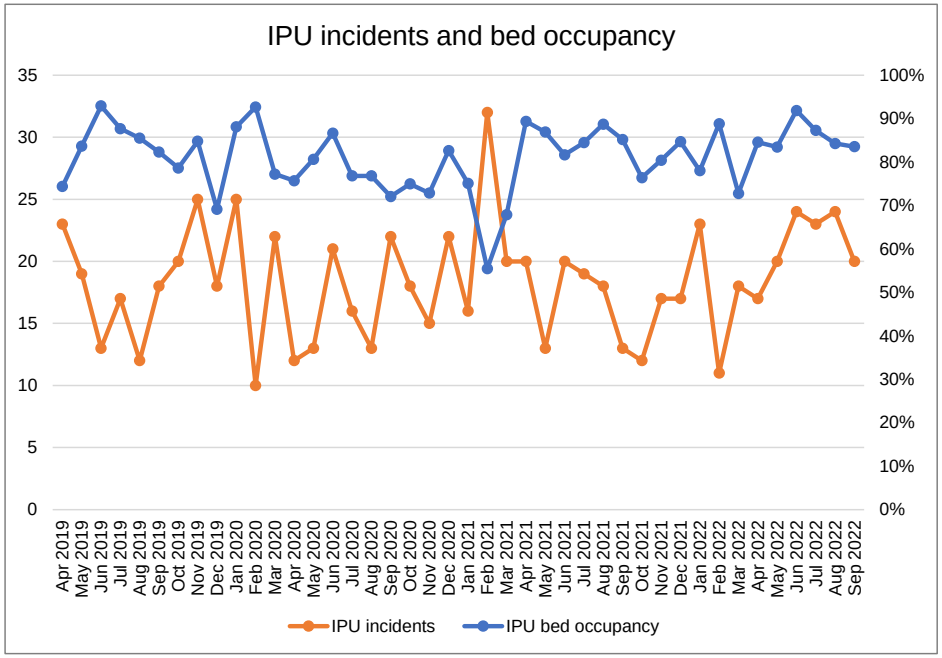
Breakout sessions

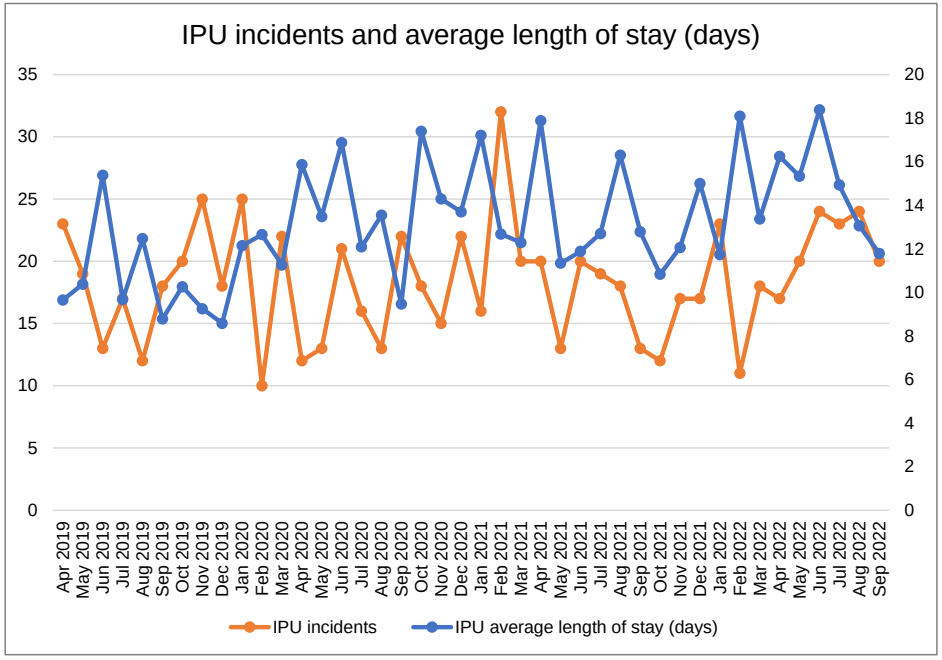
Group A - longer term data

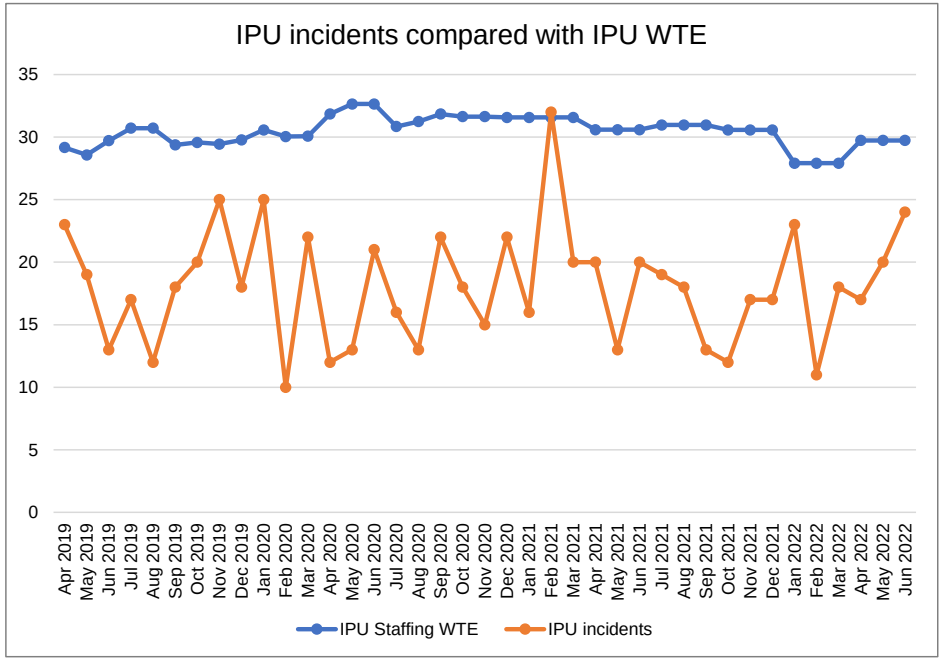
Group B – COVID-19 impact / winter pressures

Group C – mattress and cushion integrity

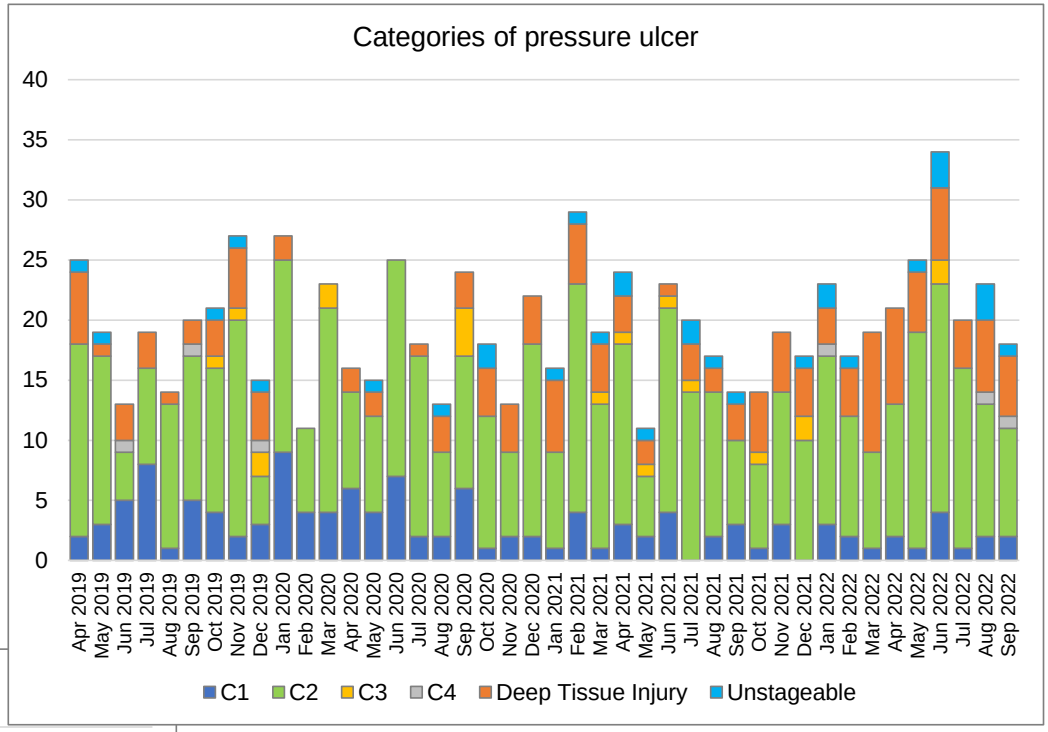
Staffing and IPU activity

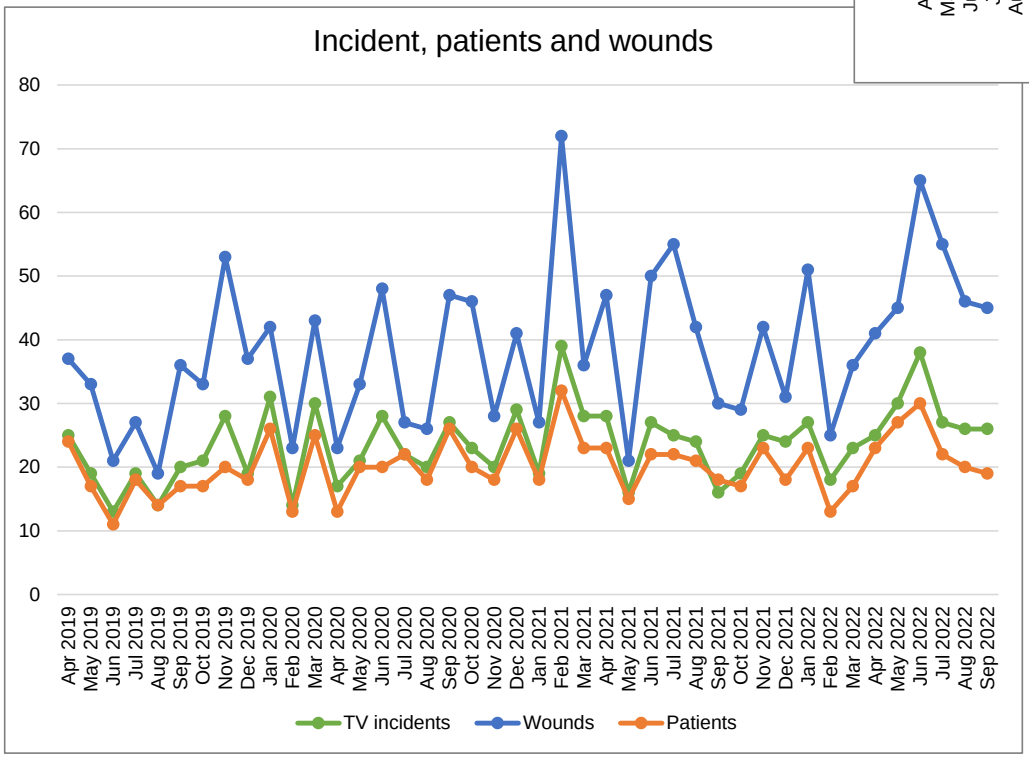






Patients, incidents and wounds





Living, dying, remembering

Findings and action plan

- Some duplicate reporting – locations
- Positive reporting culture
- Training – new starters – external training
- Process for mattress / cushion checks
- Chair cushions
- Equipment settings + oxygen tubing
- Making documentation easier
- Clinical helpers, review guidance

Questions

Living, dying, remembering

Breakout sessions

Group A - longer term data

- How useful do you think looking at several years data would be?
- Have you tried that approach in your hospice and what have you found?

Breakout sessions

Group B – effects of COVID-19 / winter pressures

- How far do you think the COVID-19 pandemic has affected patients coming to end of life (in your experience) especially with regard to pressure ulcers?
- Do winter pressures have an effect?

Breakout sessions

Group C – mattress and cushion integrity

- What is your process for checking pressure relieving mattresses or chair cushions?
- Where are they in use?
- How old are they and when will they be replaced?

CQC Notifications

(To discuss if time or defer to a future meeting)

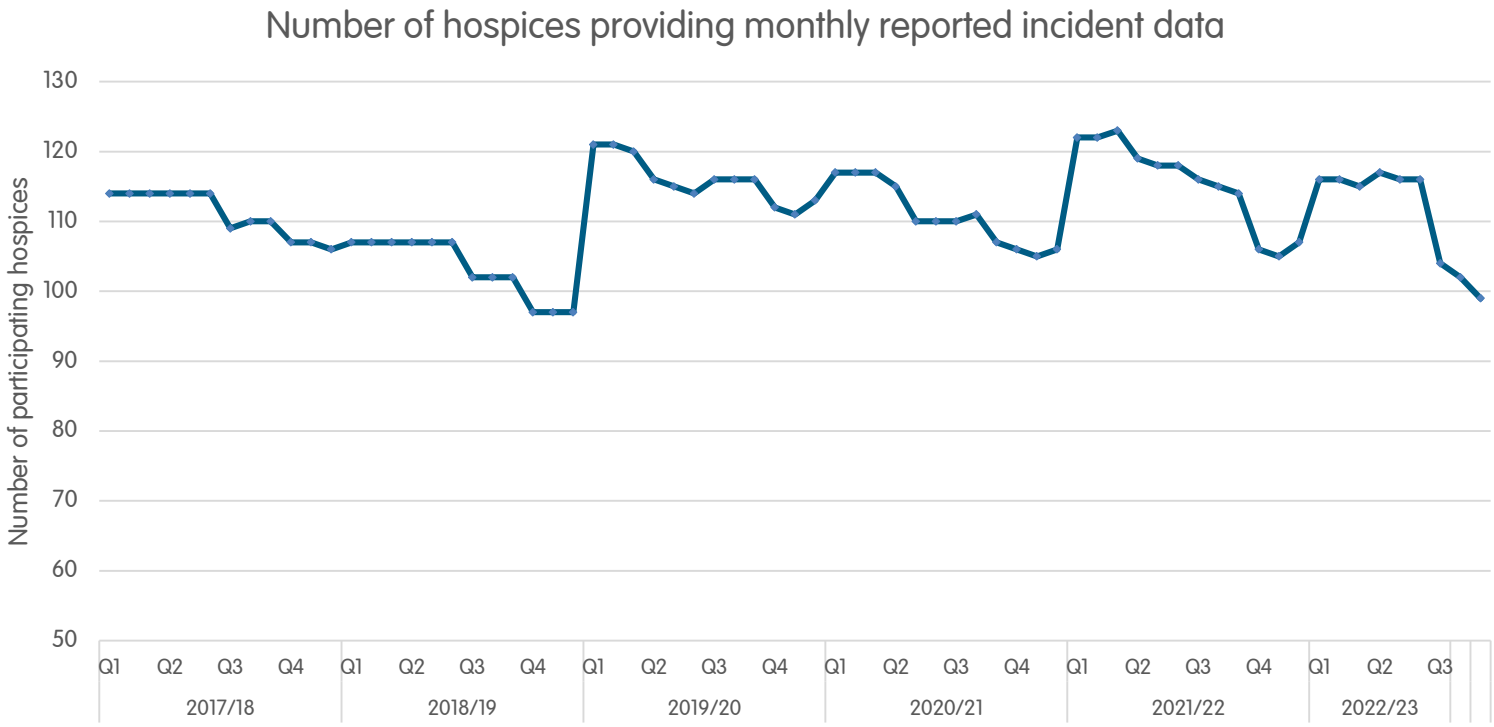
Regulation 18: Notification of other incidents

"Injuries include those that lead to, or that if untreated are likely to lead to, permanent damage – or damage that lasts or is likely to last more than 28 days, including:

- the development after admission of a pressure sore of grade 3 or above that develops after the person has started to use the service"

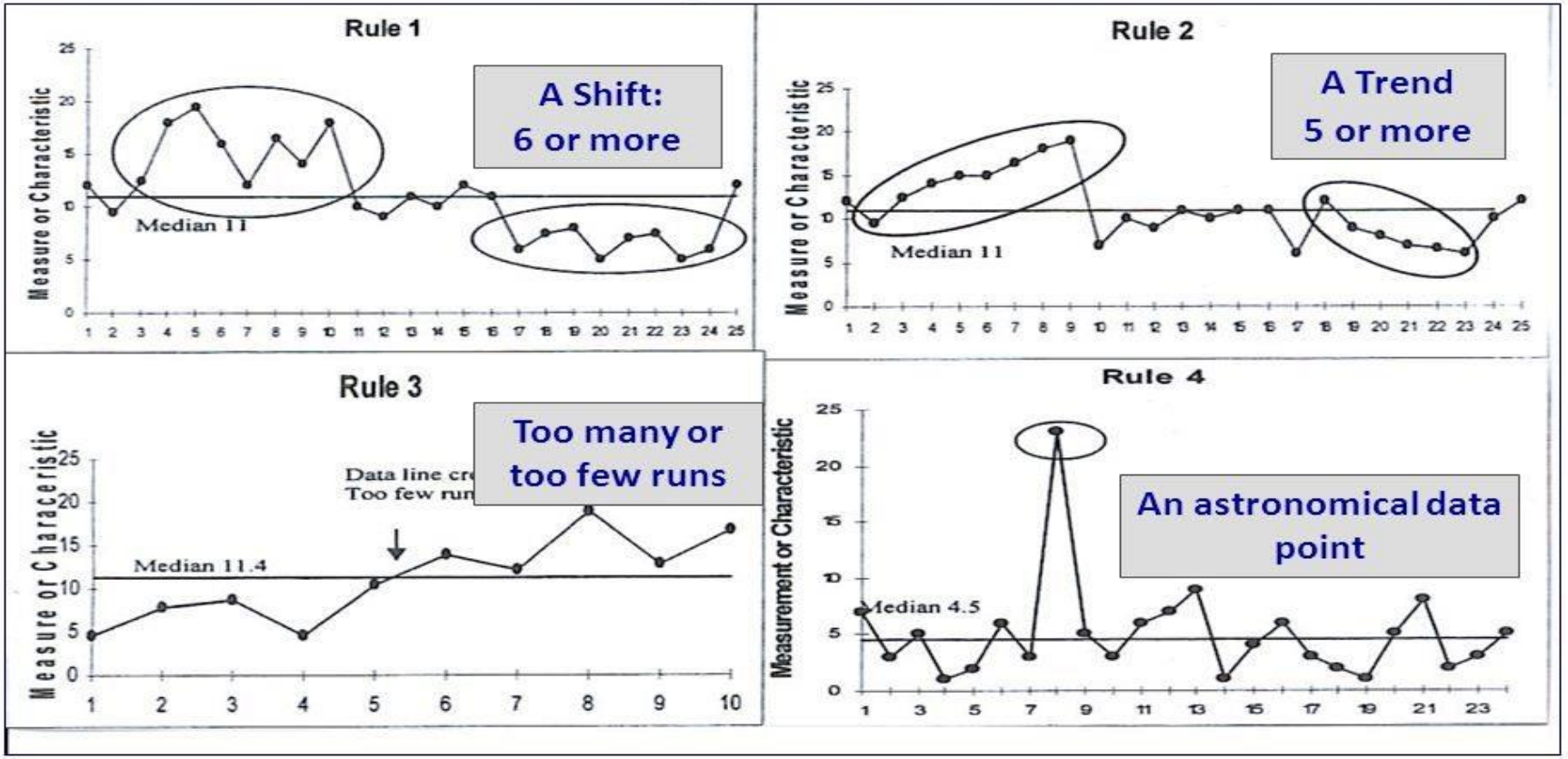
Patient Safety Incident Data self reported by Hospices.

Data Submissions: Years and Quarters



From the beginning!

Non-Random Signals on Run Charts

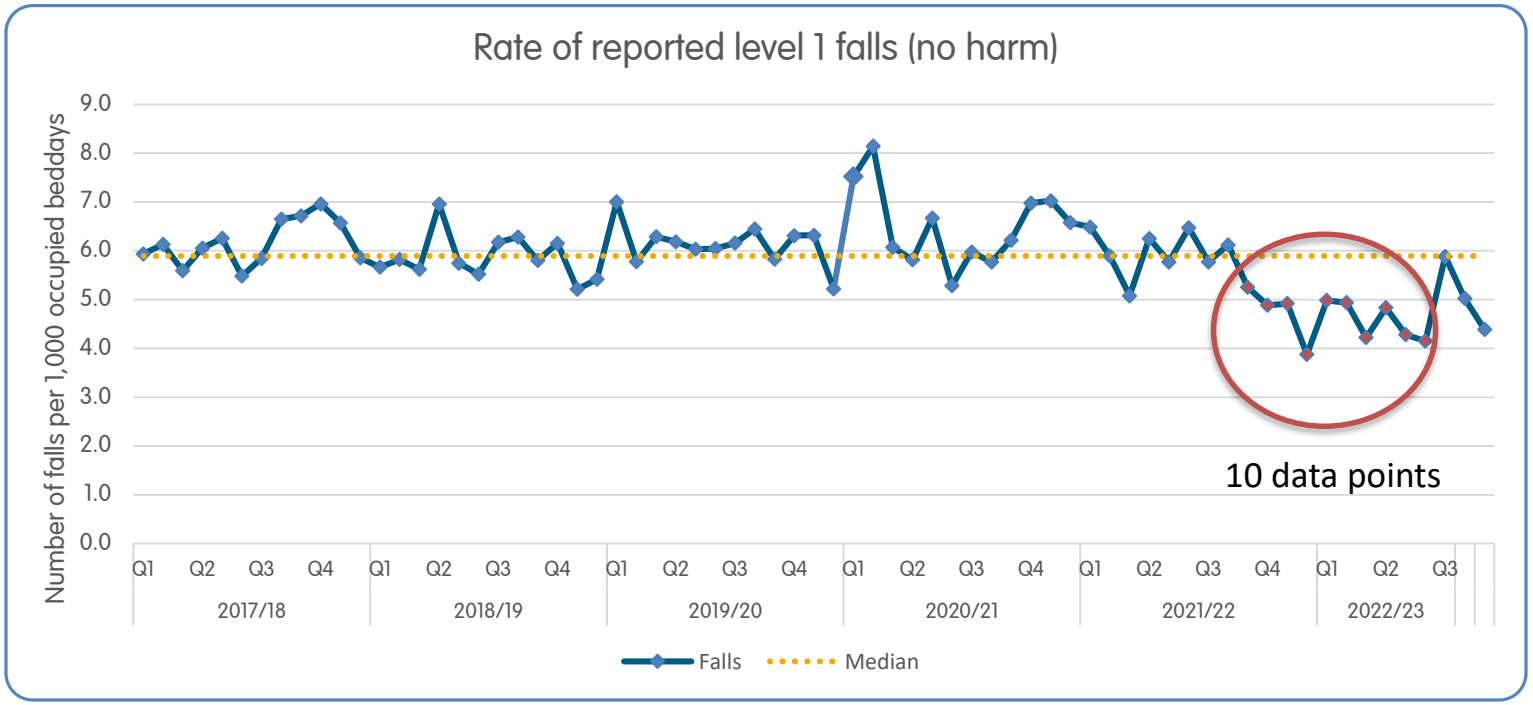


Evidence of a non-random signal if one or more of the circumstances depicted by these four rules are on the run chart. The first three rules are violations of random patterns and are based on a probability of less than 5% chance of occurring just by chance with no change.

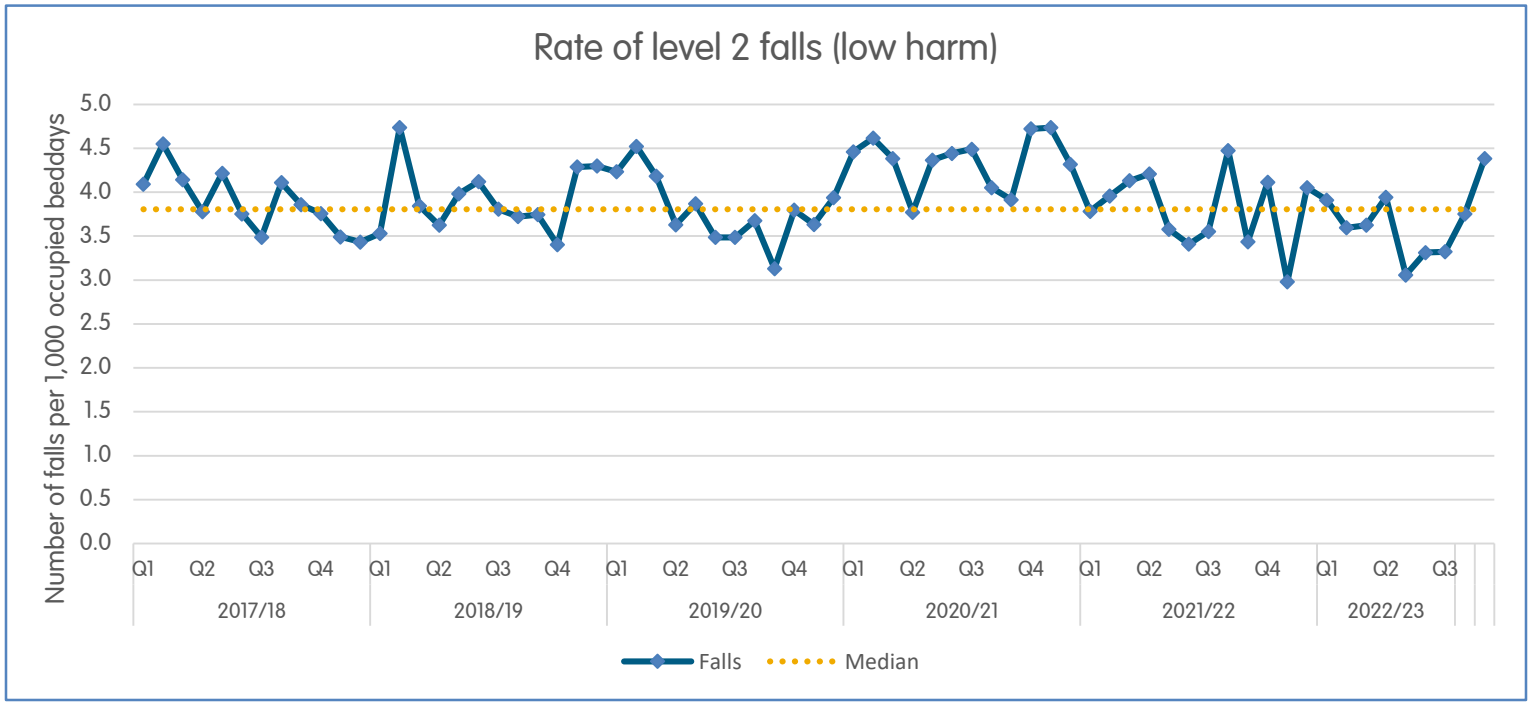
The Data Guide, p 3-11


hospiceUK
Falls

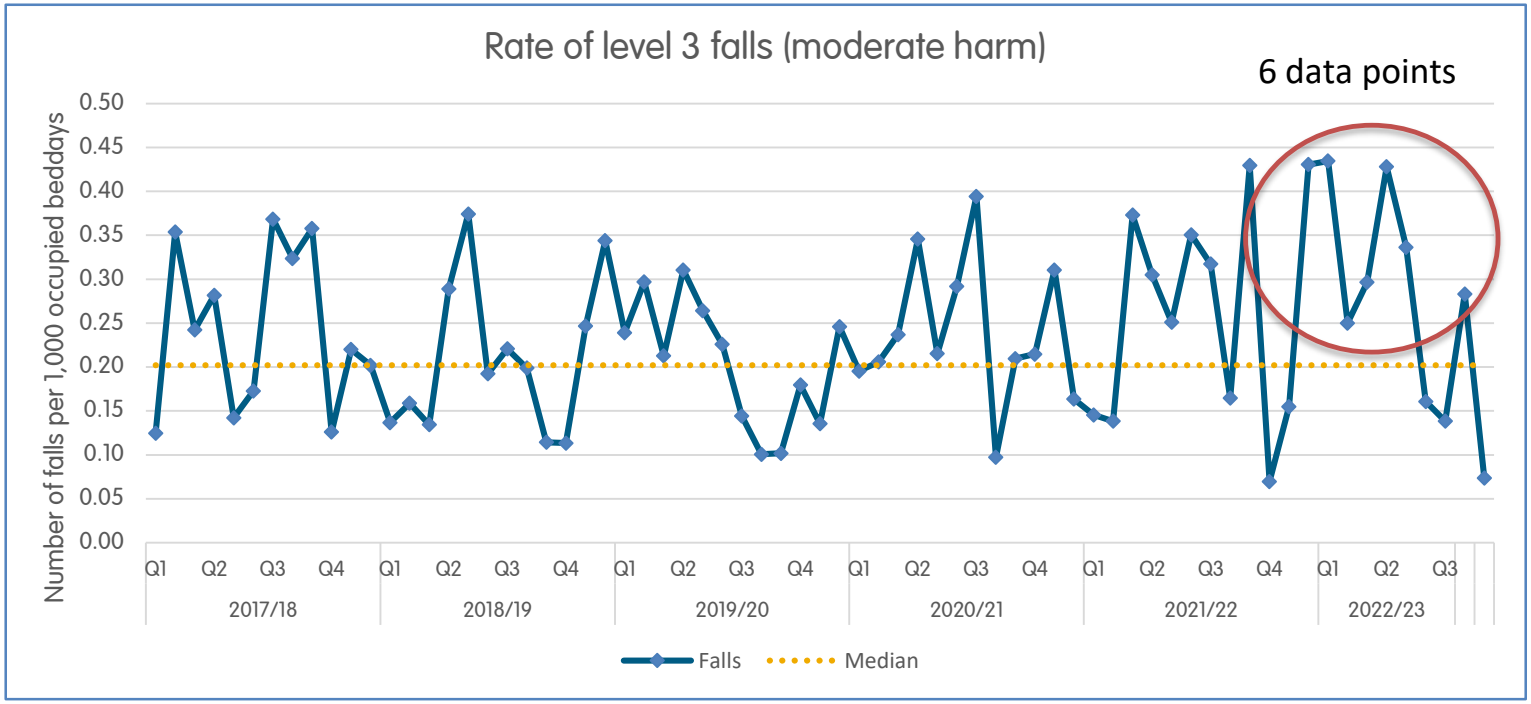
Level 1 falls over time: adult inpatient hospice



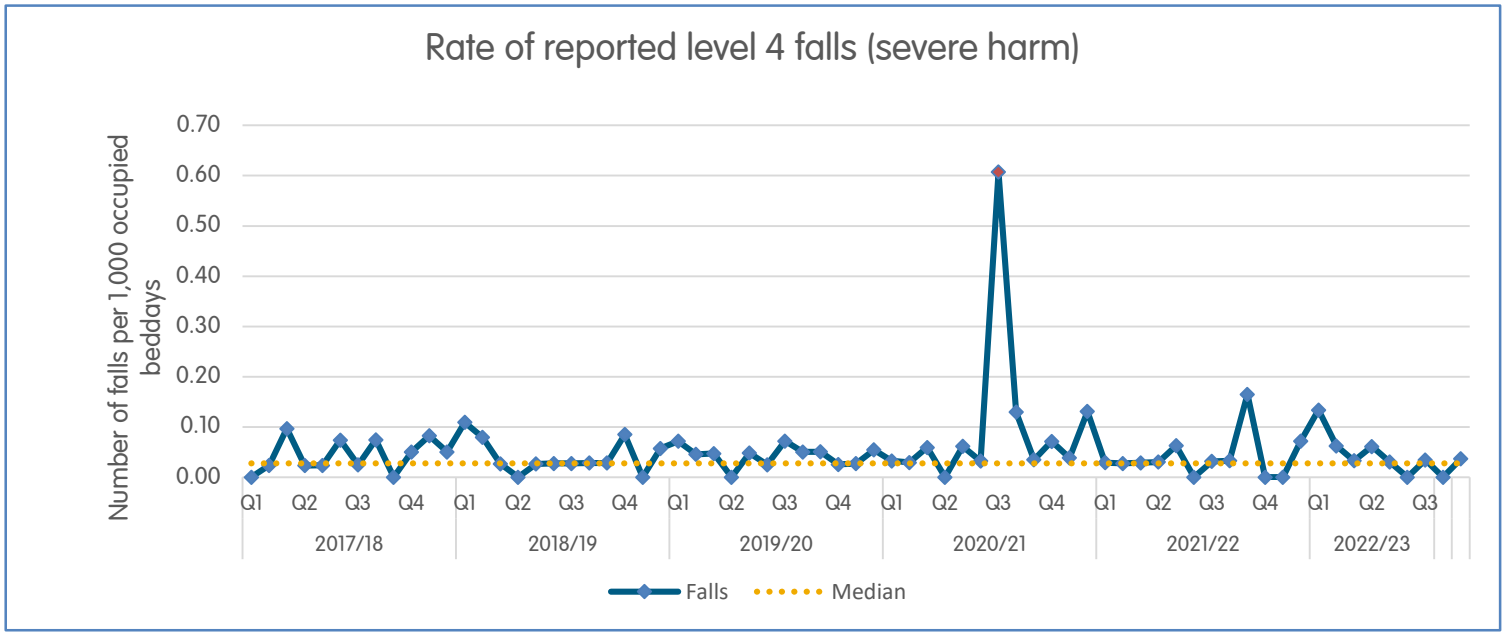
Level 2 falls (low harm) over time: adult inpatient hospices



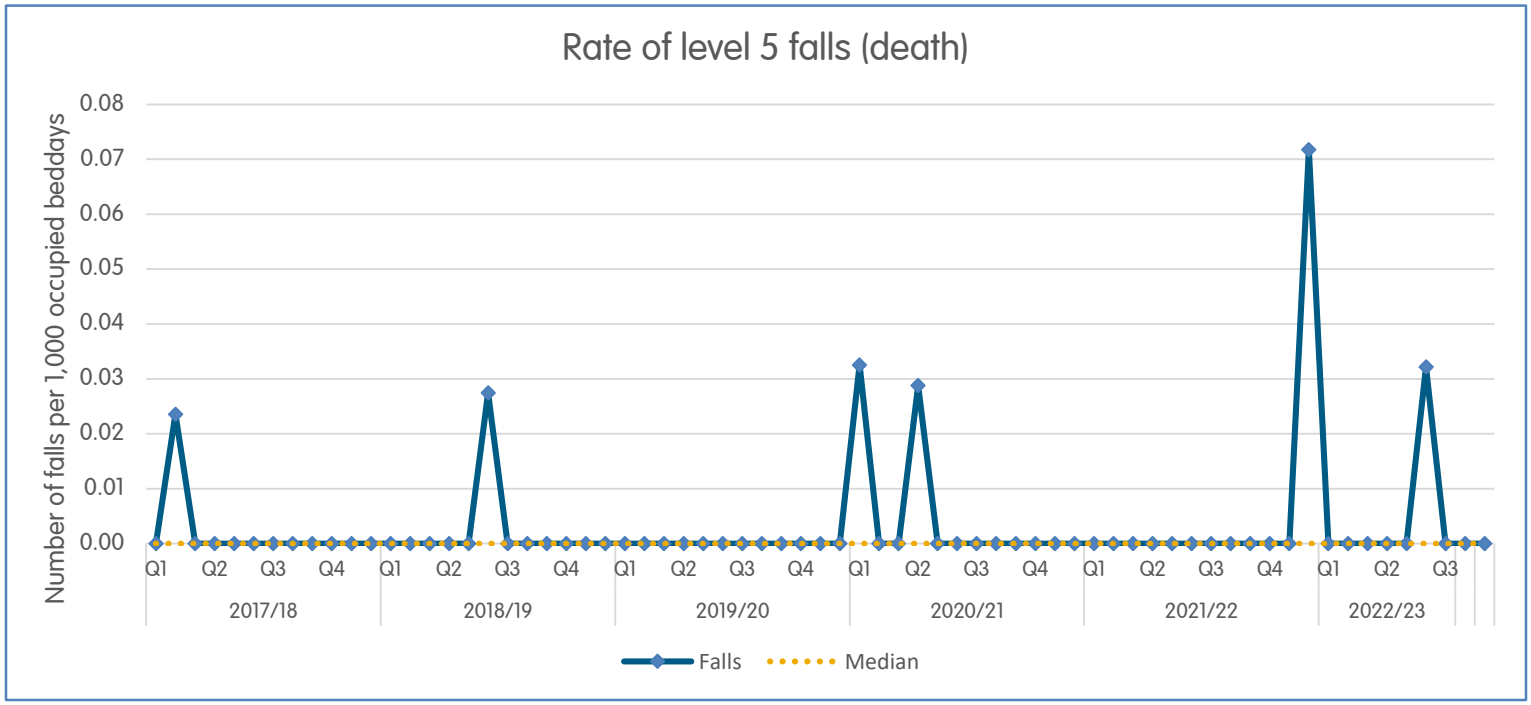
Rate of level 3 falls (moderate harm)



Rate of level 4 falls over time, adult hospices

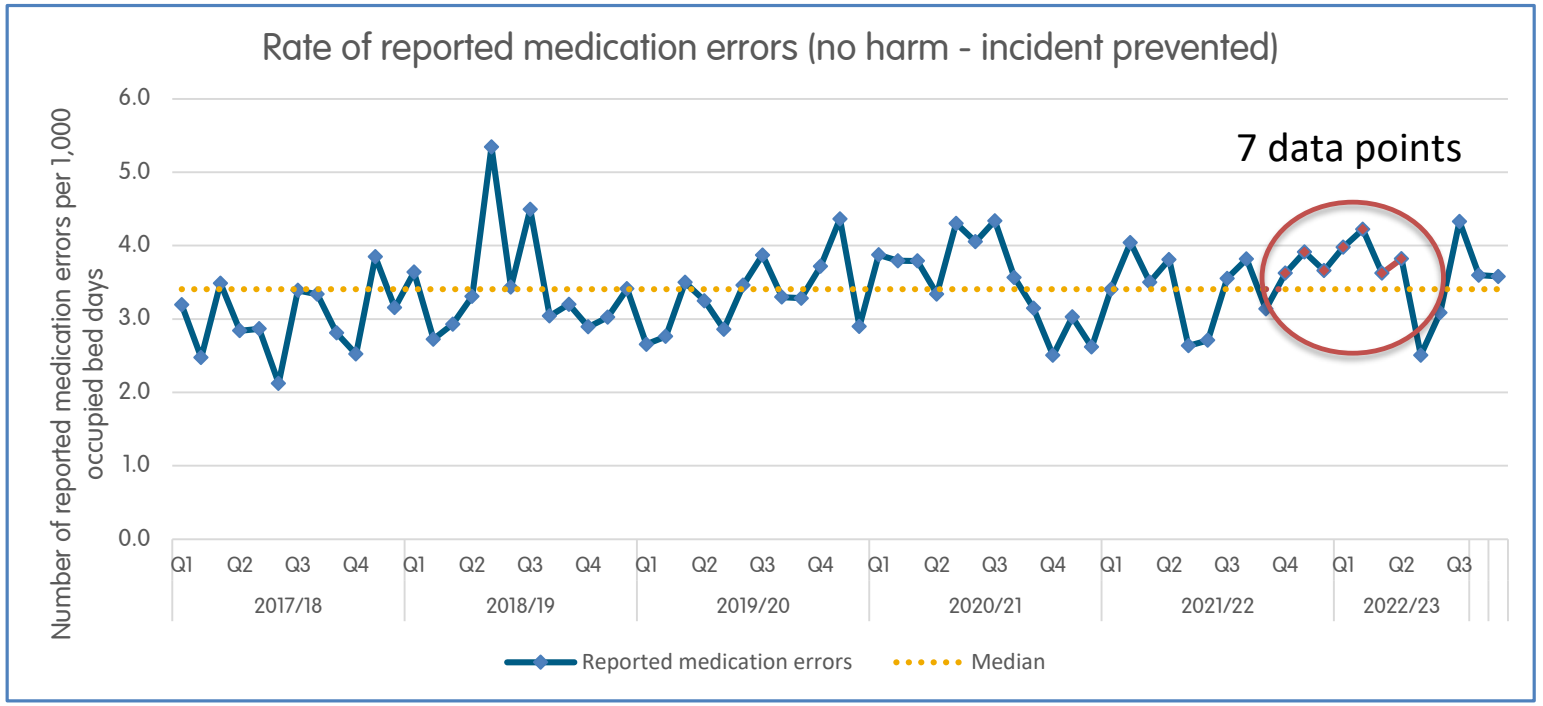


Rate of level 5 falls (death) over time: adult hospices

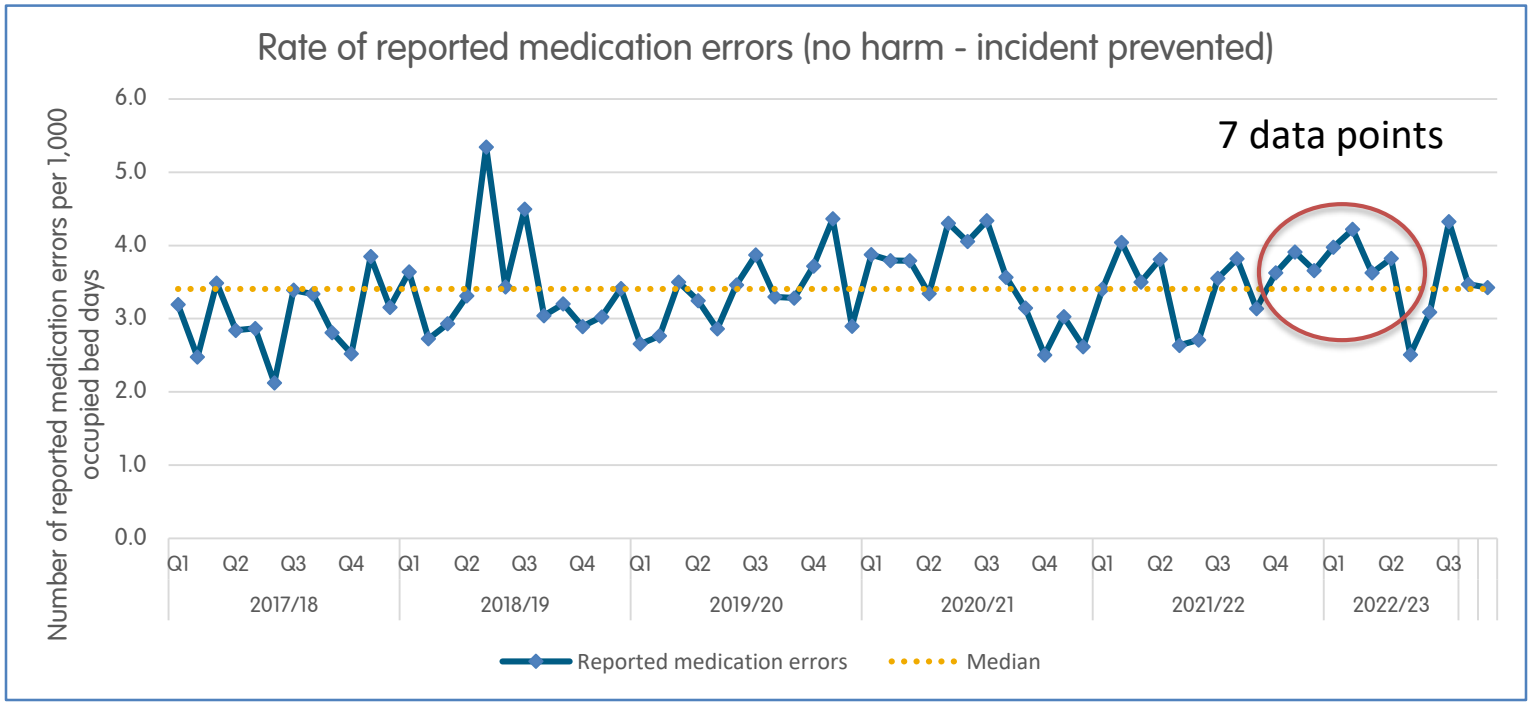



hospiceUK
Medication

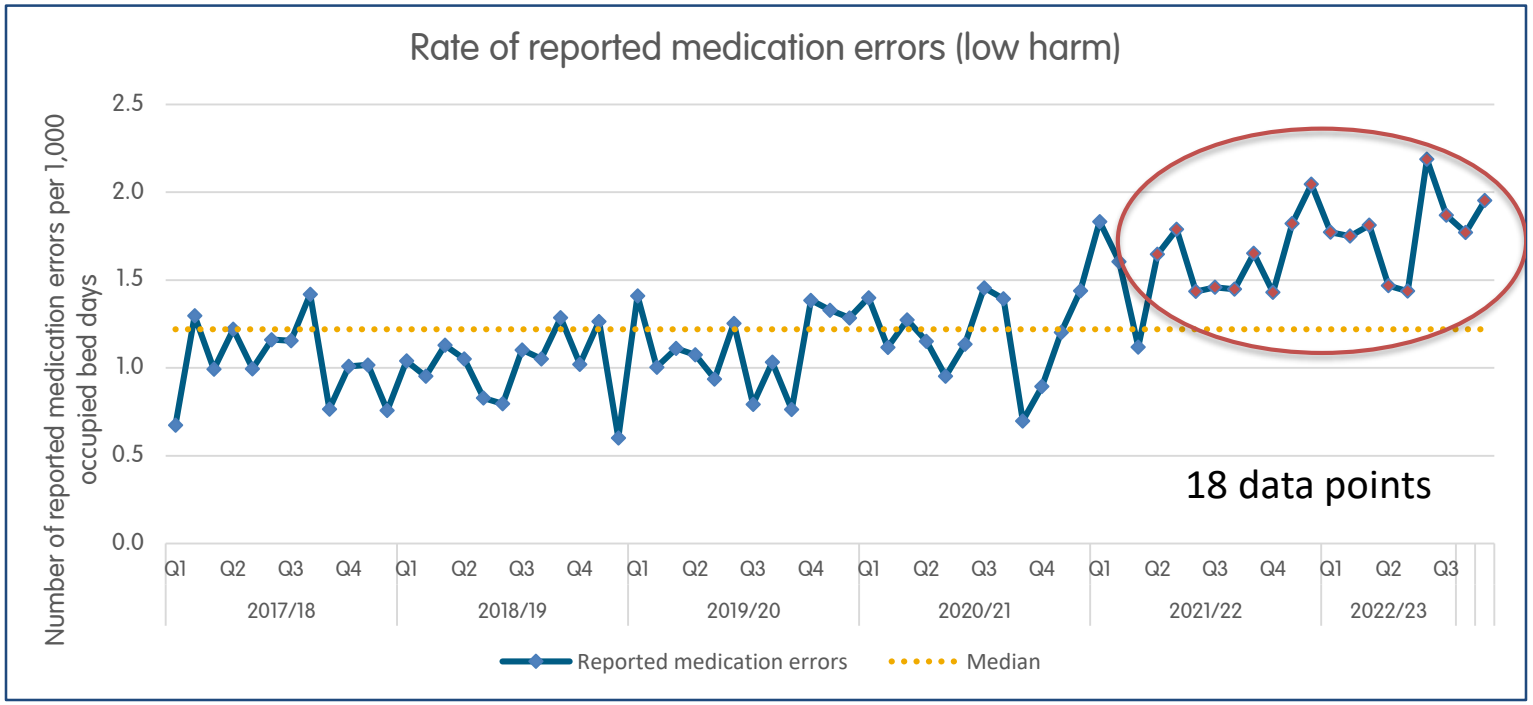
Rate of medication incidents – no harm – incident prevented (adults)



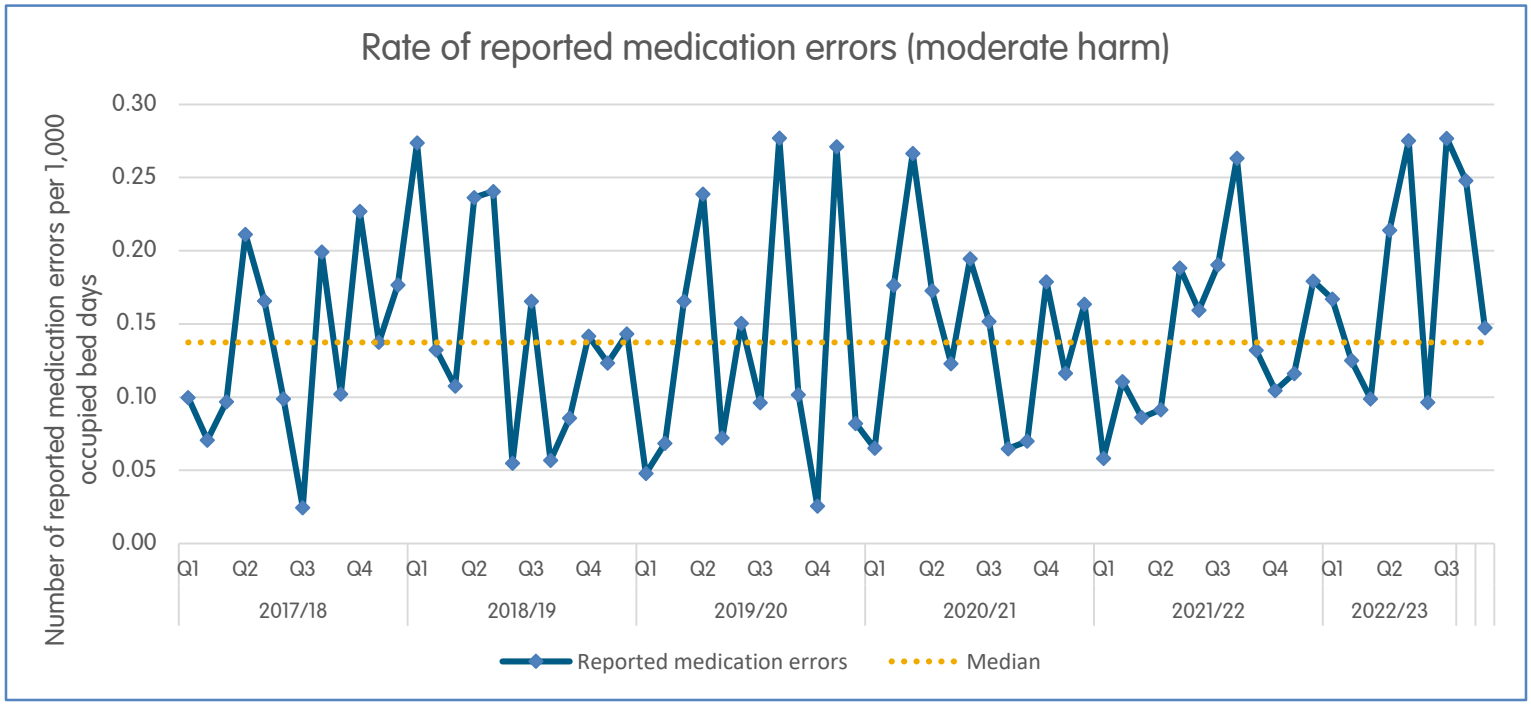
Rate of medication incidents – no harm –incident not prevented



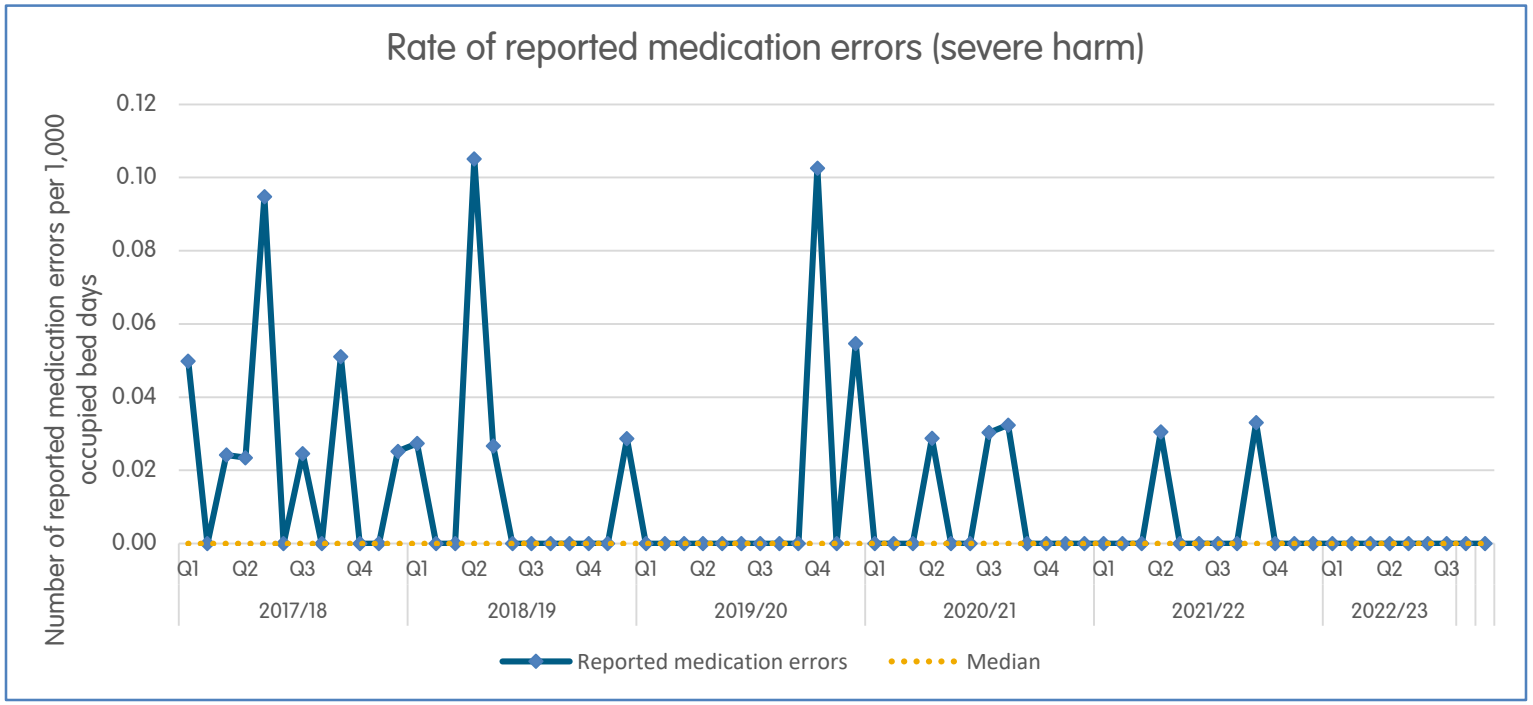
Rate of medication incidents – low harm



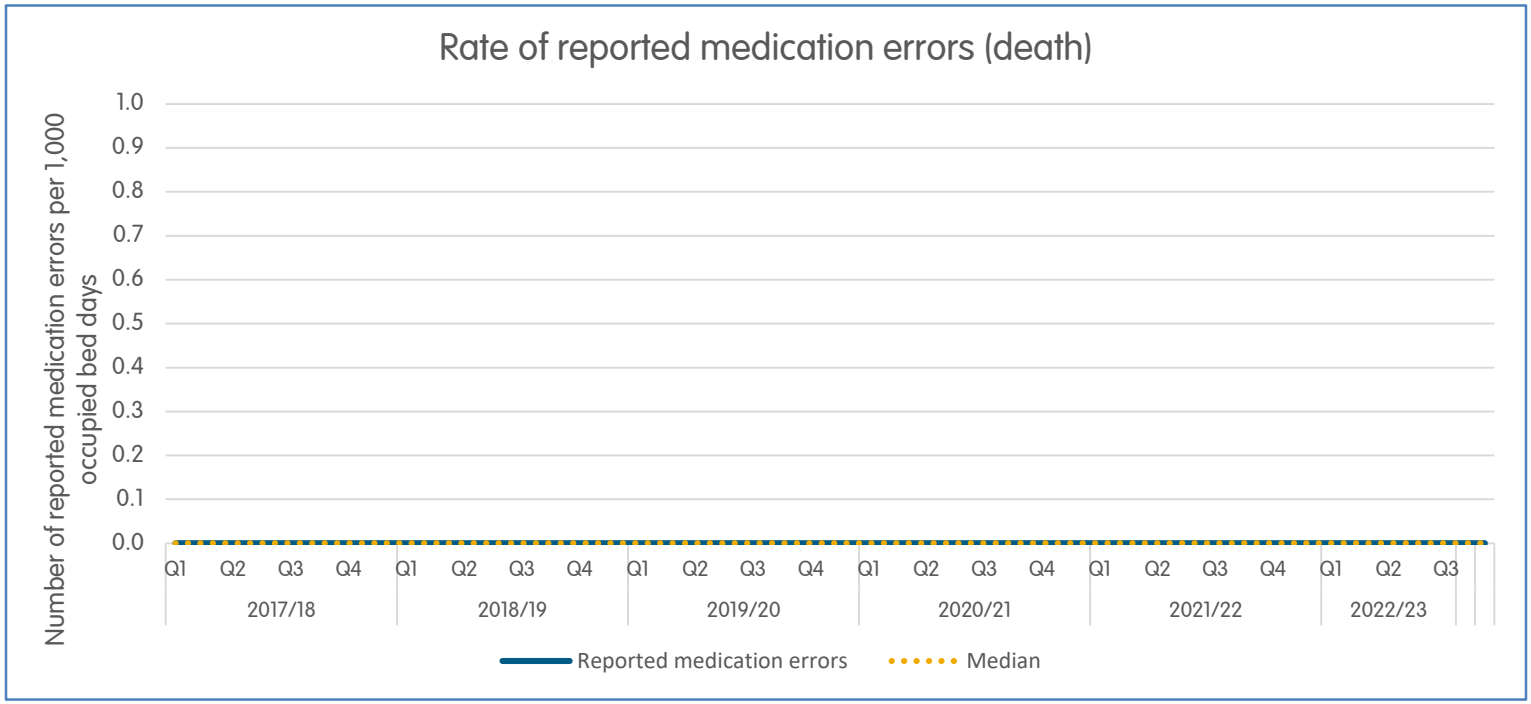
Rate of medication incidents – moderate harm



Rate of medication incidents, severe harm

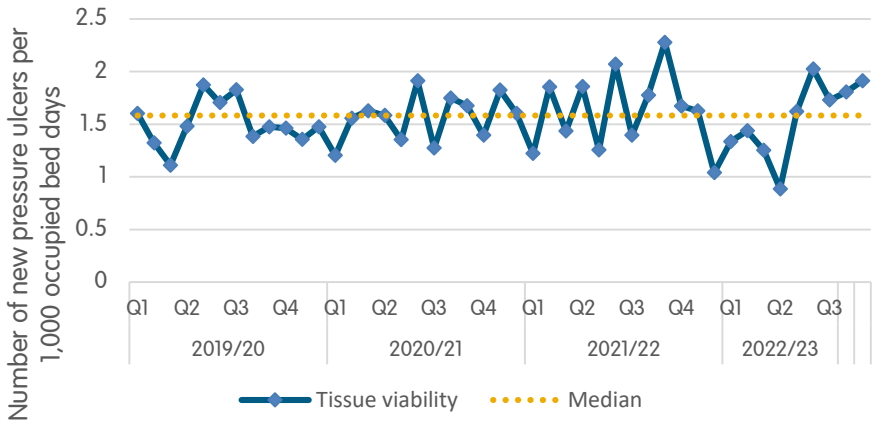


Rate of medication incidents, death

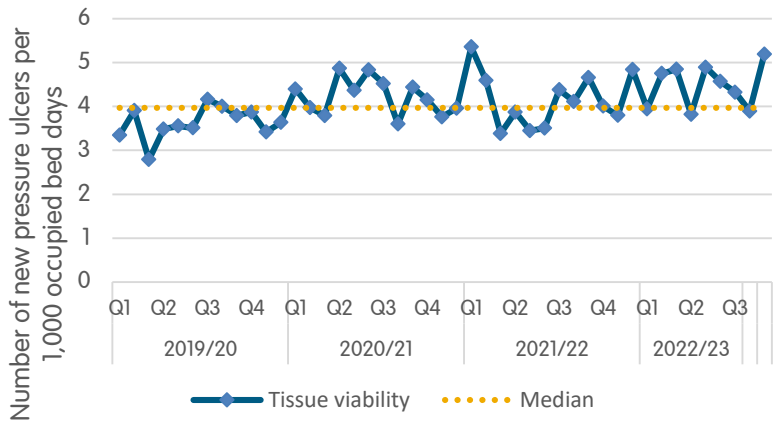



hospice UK
Tissue Viability

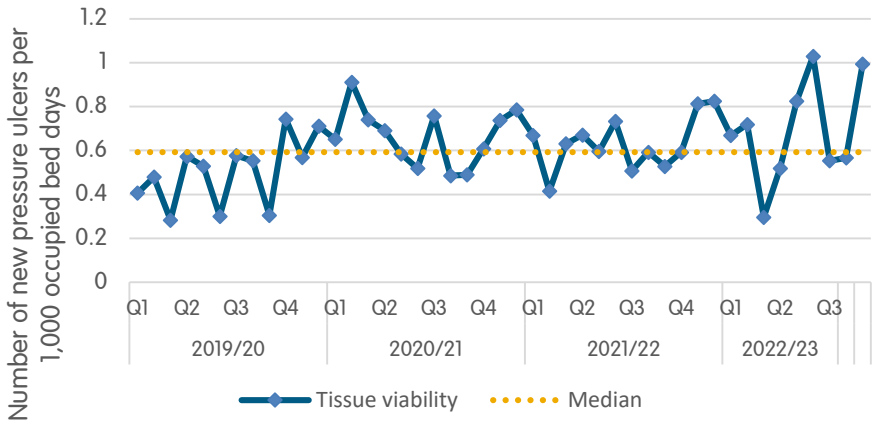
Rate of reported new category 1 pressure ulcers



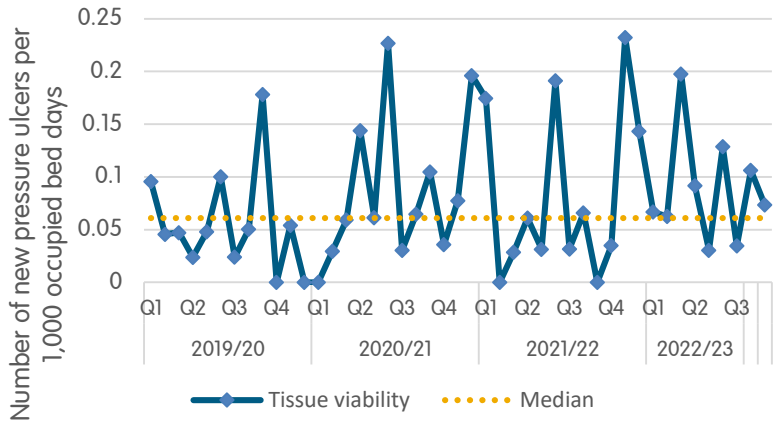
Rate of reported new category 2 pressure ulcers

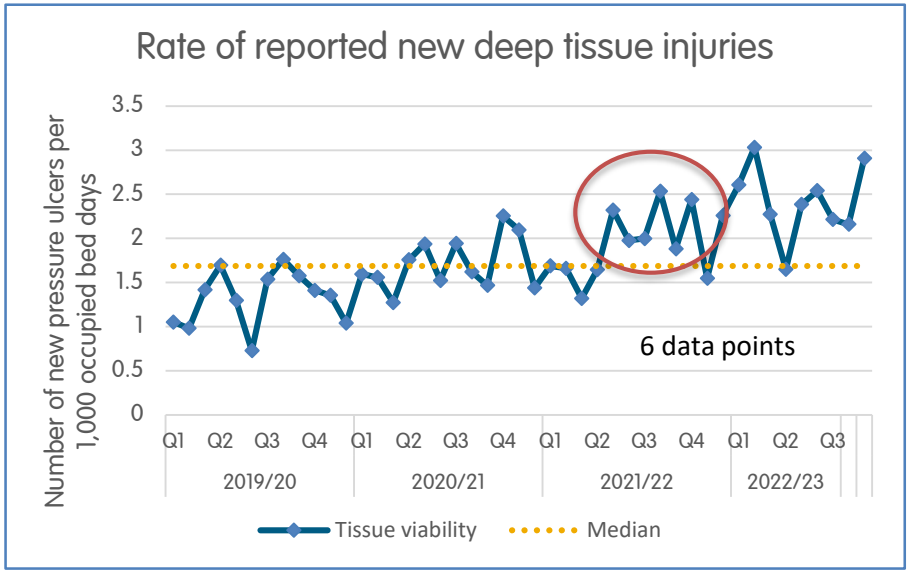


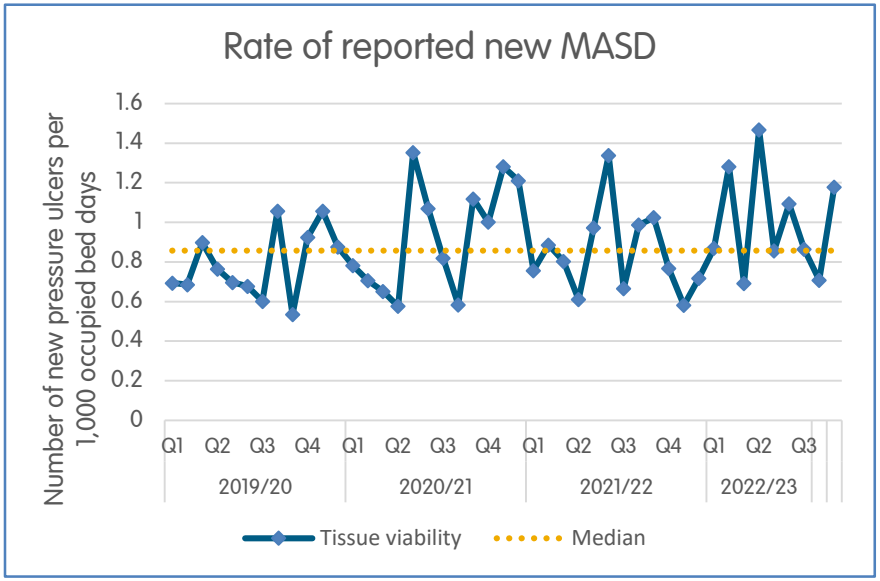
Rate of reported new category 3 pressure ulcers

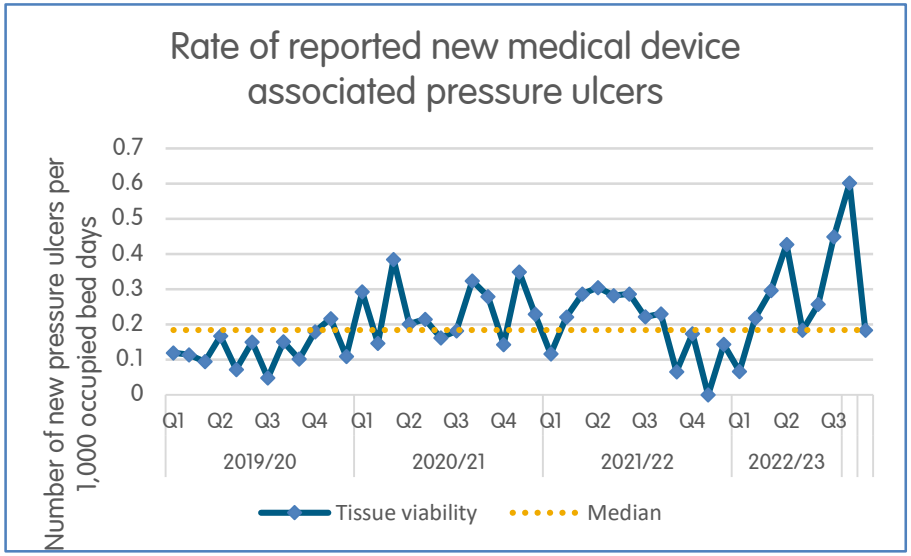


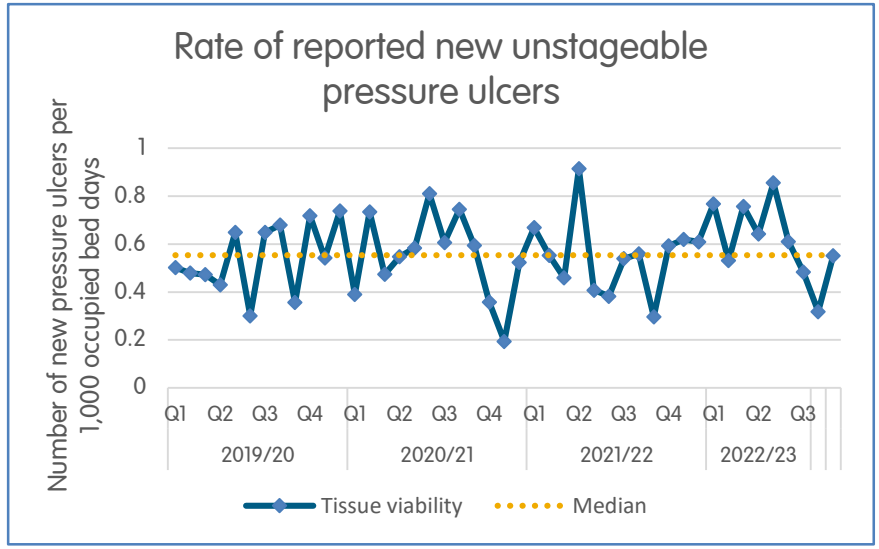
Rate of reported new category 4 pressure ulcers

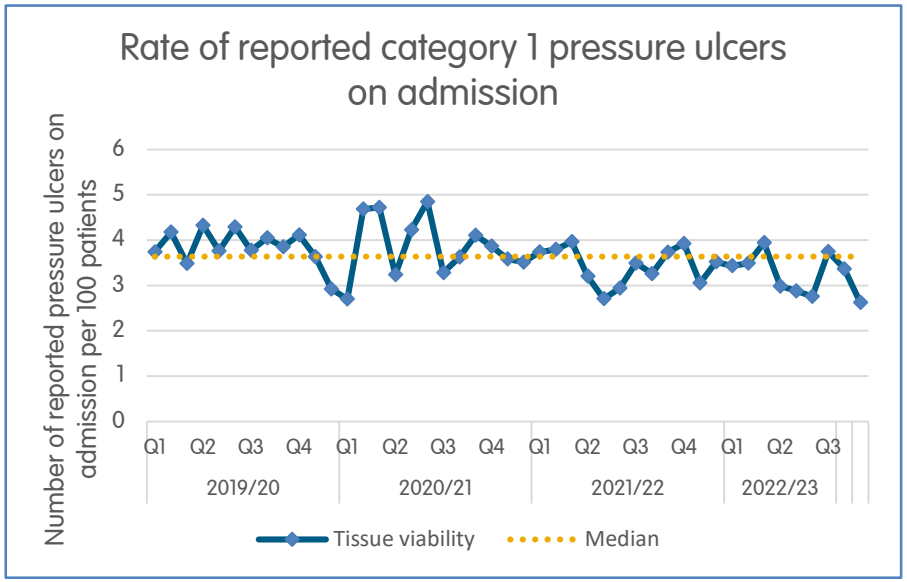


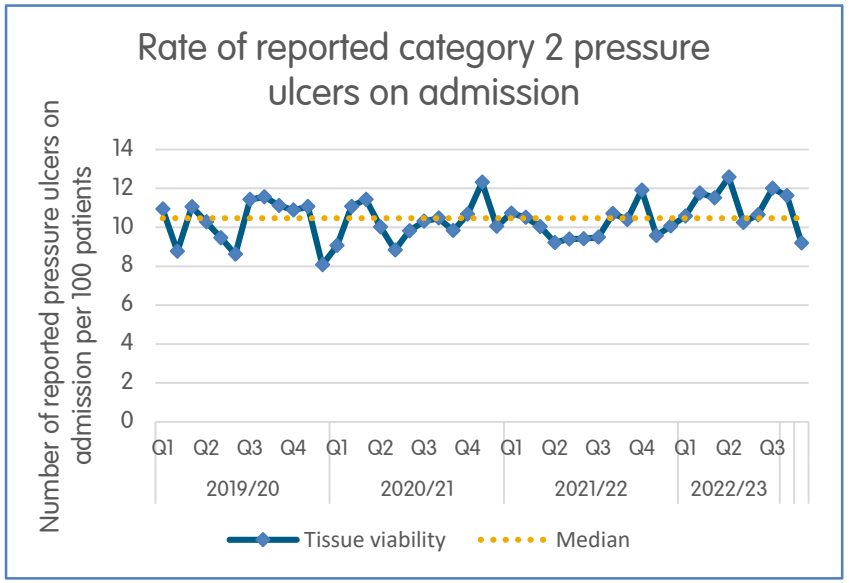

Rate of reported new deep tissue injuries
Number of new pressure ulcers per 1,000 occupied bed days
3.5
3
2.5
2
1.5
1
0.5
0
6 data points
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

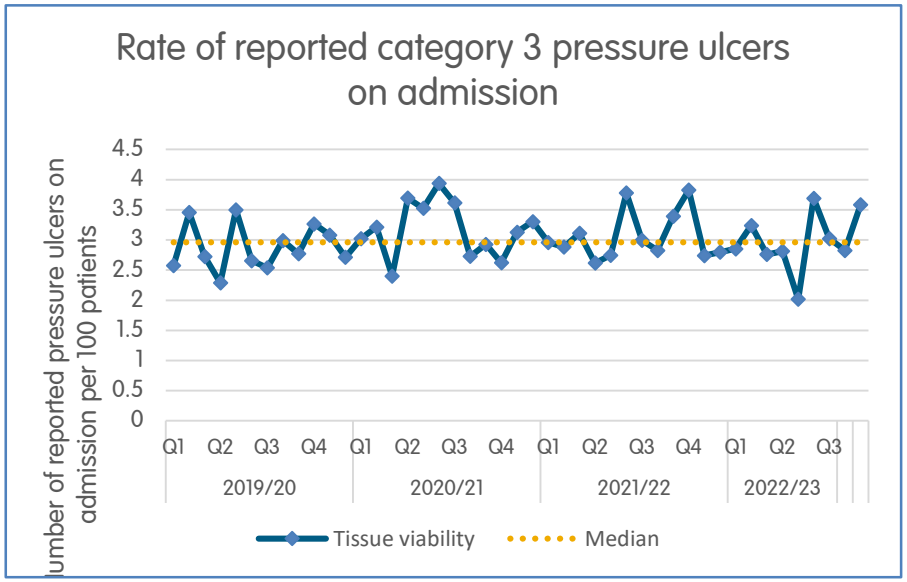

Rate of reported new MASD
Number of new pressure ulcers per 1,000 occupied bed days
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

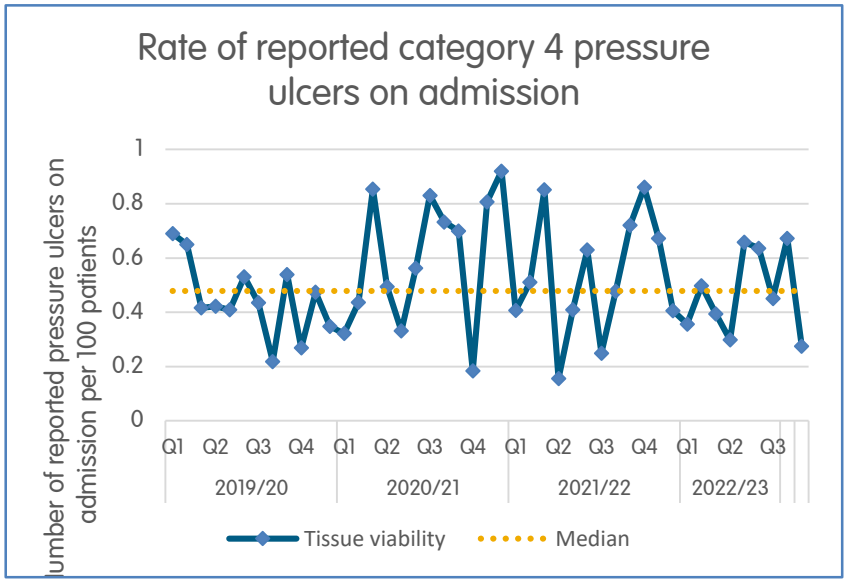

Rate of reported new medical device associated pressure ulcers
Number of new pressure ulcers per 1,000 occupied bed days
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

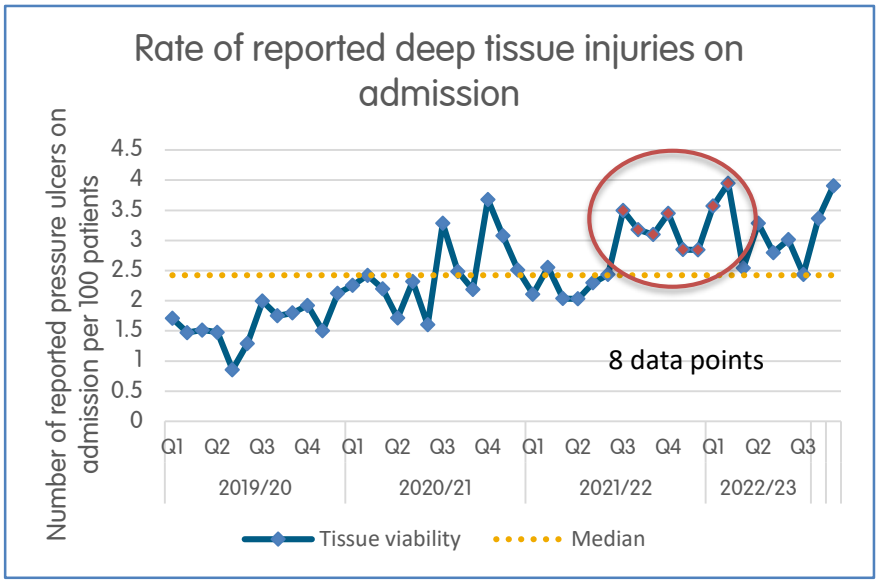

Rate of reported new unstageable pressure ulcers
Number of new pressure ulcers per 1,000 occupied bed days
1
0.8
0.6
0.4
0.2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

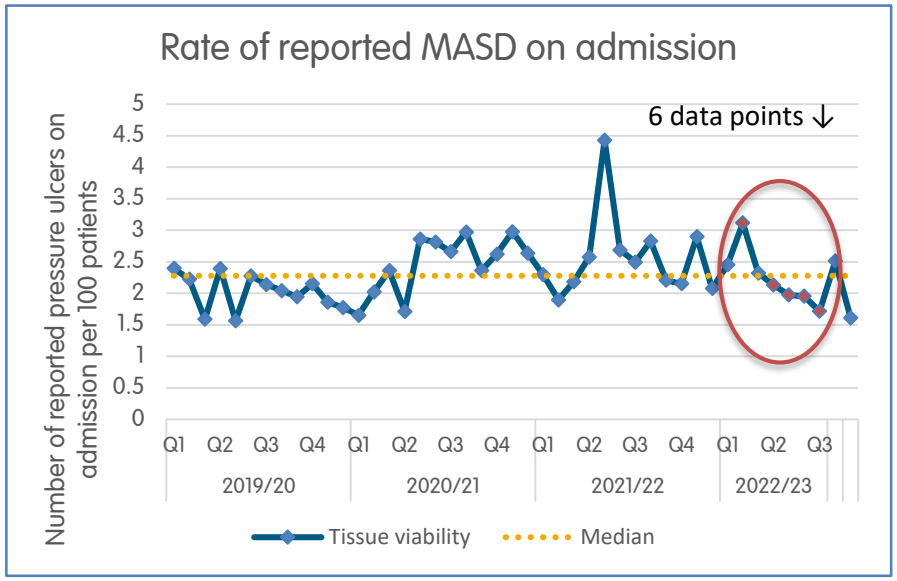

Rate of reported category 1 pressure ulcers on admission
Number of reported pressure ulcers on admission per 100 patients
0
1
2
3
4
5
6
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

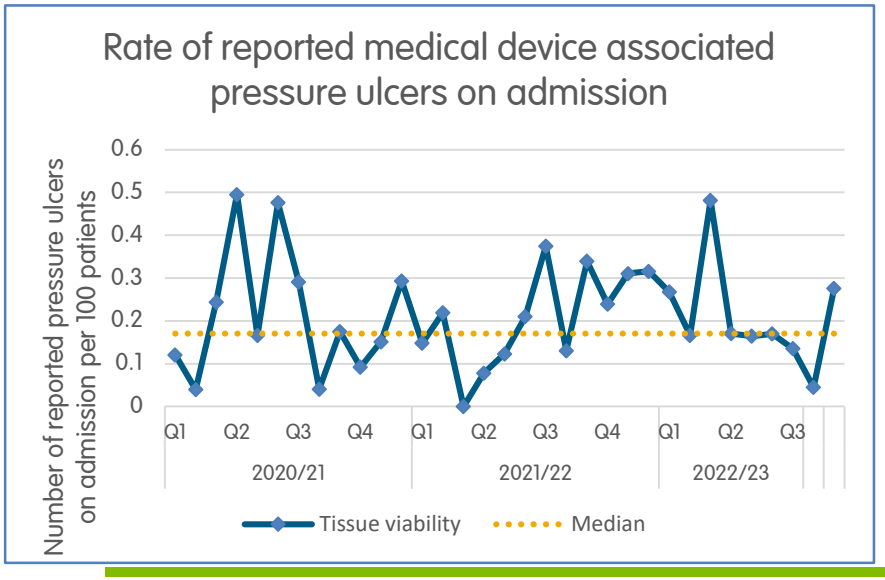

Rate of reported category 2 pressure ulcers on admission
Number of reported pressure ulcers on admission per 100 patients
0
2
4
6
8
10
12
14
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

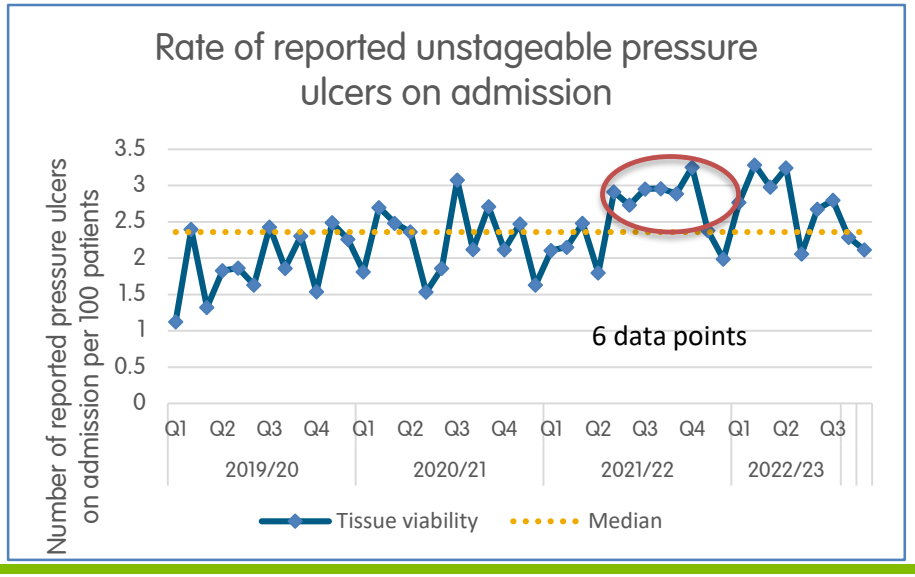

Rate of reported category 3 pressure ulcers on admission
Number of reported pressure ulcers on admission per 100 patients
0
0.5
1
1.5
2
2.5
3
3.5
4
4.5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported category 4 pressure ulcers on admission
Number of reported pressure ulcers on admission per 100 patients
0
0.2
0.4
0.6
0.8
1
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported deep tissue injuries on admission
Number of reported pressure ulcers on admission per 100 patients
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
8 data points
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported MASD on admission
Number of reported pressure ulcers on admission per 100 patients
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
6 data points ↓
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported medical device associated pressure ulcers on admission
Number of reported pressure ulcers on admission per 100 patients
0.6
0.5
0.4
0.3
0.2
0.1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported unstageable pressure ulcers on admission
Number of reported pressure ulcers on admission per 100 patients
3.5
3
2.5
2
1.5
1
0.5
0
6 data points
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

Submit

Submission Dates

	Months	Submission Deadline	Final Reports Circulated
Q1	Apr, May, Jun	14 July 2022	30 July 2022
Q2	Jul, Aug, Sep	14 October 2022	27 Oct 2022
Q3	Oct, Nov, Dec	12 Jan 2023	29 Jan 2023
Q4	Jan, Feb, Mar	14 Apr 2023	28 Apr 2023

Submission link request:
https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/quality-assurance/patient-safety

Webinar Content

Sharing experiences and creating feedback loops

Please share with us:

- Topics for presentations
- Case studies
- Shared experiences
- How you use the data
- Improvements in patient safety

AOB…..

1. Peter Ledwith from AQUA – Collaborative approach and meeting on 25 April – for the North West re PSIRF (see NHS Futures)

2. HIS Podcast on Adverse events The Healthcare Improvement Podcast | a podcast by Healthcare Improvement Scotland (podbean.com)

3. Learn - Patient Safety Learning - the hub (pslhub.org)

4.HUK Conference 6, 7, 8 November in Liverpool. Abstracts open 27 March. Register your interest | Hospice UK (Call for papers launches 27 March on the Hospice UK website)

5. NHS England » Improvement Fundamentals – free on line course on NHS England Platform.

6. Patient Safety and Human Factors Conference for paediatric healthcare professionals - Great Ormond Street Hospital - GOSH Patient Safety & Human Factors Conference

Help shape our national conference

Find out how to join us in the call for papers as mentors and reviewers for our 2023 national conference

On line drop in session on 1 March for a Q + A

NEXT MEETING: 11 May 2023
Q4

Would anyone like to share a case study?

Please contact clinical@hopsicuk.org

Thank you!

Evaluation -

1. One new thing you have learnt today?
2. What will you change as a result of attending today?

Please write in the chat……