

Patient Safety



Sussex Community
NHS Foundation Trust

August 2022

Welcome to the Patient Safety Newsletter...

This month's shout out goes to Horizon Unit who earlier this year took part in a table top meeting for a thematic review to discuss falls on the unit, what measures were in place and working well, and what more could be done around falls prevention. Several ward staff attended, including both therapy and nursing staff, as well as the ward sister, ward manager and ward matron, and the Physiotherapy Clinical Lead as well as others. An anonymous poll was also sent out ahead of the table top meeting asking about falls prevention on the unit to ensure as many staff were able to contribute. The poll has over 30 responses, which was brilliant, and the table top meeting created lots of great discussion. All of this was collated and used to identify themes which made the basis of the thematic review report. The staff engaged brilliantly, and it was great to have the involvement of so many ward staff in a thematic review. Thank-you to all staff involved!

Best Wishes,

Debbie, Charlotte, Hannah and Mary Jo

Duty of Candour Requirement

Or what we know better as saying sorry. Duty of Candour is a legal requirement and must be carried out with the patient and/or their relative after an incident/episode of care has resulted in moderate

harm to that patient. It is also known as being open, and it involves an initial verbal conversation with the patient after the incident which includes a verbal apology. This conversation is then followed up with a letter to the patient and/or their relative which should be sent within 10 days. It allows staff to be honest with patients and/or their relatives about what has happened and gives them the opportunity to ask any questions that they might want addressed as part of the investigation. Both the conversation and the letter should then be recorded on the Datix.

The Patient Safety Team can also help to answer any questions and can be contacted via our team inbox (see below), and NHS Resolution have a useful video that provides further information and can be accessed [here](#).

Location, location!

When reporting a pressure ulcer on Datix it is important to ensure that the location of the incident is set as the service the patient was under when the pressure ulcer developed. For example the acute hospital the patient was transferred from if a pressure ulcer is found on admission to an ICU, or when assessed by responsive services following the patient being discharged. This should be selected instead of SCFT to ensure that the correct location of the incident is identified and followed up if needed.

If there are any questions on this please contact the Quality and Safety Support Team (see below).

Patient Safety News Flash!

If you have a concern about a risk to patients or a patient safety issue then please contact us for support via the team inbox (sc-tr.patientsafetyteam@nhs.net) to ensure that all patient safety issues, queries and questions are managed centrally by the team. If a query is related to Datix please do contact the Quality and Safety Support Team on sc-tr.qualityandsafetydept@nhs.net

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UTC and learning disability health facilitation team table top

A tabletop meeting took place to review an incident that involved a patient who is known to the learning disability (LD) health facilitation team (LDHFT). The patient has a confirmed learning disability and has emotional dysregulation and autism and is registered blind. They live in a care home and have a social worker and a psychiatrist. The patient has a hospital passport and a positive behavioural support plan which they carry and has the assistance of two carers. Following an injury at home and following an assessment by the ambulance service the patient needed to attend the UTC for an x-ray. Whilst waiting the patient became distressed due to several reasons and this developed into agitation and the patient hit a nurse. The police were called and the patient was arrested. The tabletop attendees talked through the events to understand what had happened and identify the learning.

Several actions were put in place, including that all UTC staff to be advised they are required to make reasonable adjustments for patients with a learning disability or autism when attending the department. Tailor-made training by the LDHFT for the UTC. LDHFT will provide resources. The UTC will develop a toolkit for staff to reference. A LD care pathway will be initiated by LDHFT and UTC to identify a LD champion who will complete further training. UTC will develop easy read leaflets for patients that attend the UTC.

Mascot of the month— Mustard Returns

Having taken a brief step away as the Patient Safety Mascot, Mustard continues an important role within the community in supporting our Nursing and Residential Homes.

The sun has been shining, the temperatures are rising, and panting is the best way to keep cool. The humans of this world, like us dogs, need to ensure they lap up plenty of fluids to keep hydrated and well. My daddy is a Care Home Matron in the West Hove area, he works with the GP surgeries to identify residents within care homes who are at risk of getting unwell and could end up in the hospital. All the Care Home Matrons, provide advice, support, and guidance to staff and keep the residents in tip-top good shape.

Visiting care homes is an important business, the Matrons look at all aspects of an individual's health, perform physical assessments and work with their Dementia Matrons to oversee mental health. Part of their role is to support the staff in the care home too, there is no end of advice and support, which they are incredibly grateful to receive.

Care Home matrons are all about getting it right for the individual and this also includes producing a very important document called [ReSPECT](#) and ensuring they have equal access to healthcare and biscuits, of course.



For further information on all things Patient Safety please visit our team page on [The Pulse](#), or follow us on twitter at @scft_quality. You can also contact the team on: sc-tr.patientsafetyteam@nhs.net