Portsmouth HealthCare NHS
NHS Trust

LEARNING FROM EXPERIENCE

ACTION FROM COMPLAINTS AND PATIENT BASED INCIDENTS 1998-2001

1. Introduction

Portsmouth HealthCare NHS Trust is one of the largest mixed community and in-patient Trusts in the country. It will be dissolved by the Department of Health in March 2002, hence the Commission for Health Improvement review comes at a period of considerable change as services move to Primary Care Trusts and a Specialist Mental Health Trust. Since it achieved Trust status the values of the Trust have underpinned all of its actions and performance. The "people first" value has led to its strive towards a meaningful "no blame" culture - one in which staff feel able to share mistakes made in order for wider Trust based learning to take place.

2. Developing Clinical Governance Processes in the Trust

There are many areas that the Clinical Governance Panel, the Risk Management Group and the Trust Board wished to develop further, building on the work of Trust wide and service specific Clinical Effectiveness Groups and Quality Forums. The changes in the structure of the local health economy have interrupted these. For example, clinical governance development sessions have taken place with most senior nurses. These were aimed at further engendering a culture in which the "loop" of incident-learning-monitoring-evaluation was established more firmly. Linking audits more closely to events, staffing and training programmes have been important components of discussions in the past and plans were being drawn up to develop these.

The dissolution of the Trust is a major event for most staff and the process is taking much effort, at a time when senior staff resources are diminished as the process progresses. With all this effort invested in the process of change and maintenance of services, there is little scope left for further development at this time.

3. Identifying Errors

In recognition of the importance of clinical governance in the provision of safe and effective patient care, several systems have been implemented which permit

- the identification of problems
- monitoring of the situation
- change management
- evaluation of actions

in response in particular to patient related events.

While these have already been explained in other documents the following is a reminder of the basic process:

- Patient based incident (reported by staff on risk event form) classified according to agreed criteria, e.g. low, medium, high or critical.
- Forwarded to manager - reclassified as appropriate.

- Sent to the risk management team - inputted into data base.
- If critical, reported immediately to Trust Executive, action report follows.
- All incidents reported in quarterly divisional reviews as overall numbers for division.
- All incidents reported numerically to Clinical Governance Panel and to the Trust Board.

Key learning points from incidents and complaints have been shared with the District Clinical Governance Committee to encourage wider learning and practice development.

4. **Responding to Errors - Trust Wide Systems**

The Clinical Governance Panel, which includes user representation, considers the implication of the overall numbers of incidents and in particular those which present high risk to patients. Actions taken as a result of the deliberations of this group include:

- The development and commissioning of a Clinical Governance Postgraduate Certificate, funded by the Trust, with the University of Portsmouth. To date fifty staff have participated in this highly evaluated programme.
- The instigation and funding of a Royal College of Nursing review into aspects of nursing in an in-patient ward.
- Training in, and the development of, a record keeping policy throughout the Trust.
- Specific clinical governance training sessions for senior nurses.
- Follow up in specific ward areas by the risk management team and the Nursing Director with reports to the Trust Board and the Clinical Governance Panel.
- An extension of the Trust's risk management training programme, with a focus on areas with specific issues.
- Rotating staff roles to extend their experience of conditions such as dementia and stroke.
- The creation of clinical governance groups in all service areas to provide local feedback to staff on key issues and performance benchmarked against other areas in the Trust.
- A bi-annual conference programme, developed with service users.
- The development of ward user groups in many areas of the Trust and the involvement of service users in actions plans relating to their complaints.
- Change from the use of multiple types of syringe drivers to one type only across the Trust.

5. **Responding to Errors - Community Hospital Ward Level**

Between April 1998 and October 2001 there were nine formal complaints in respect of Daedalus, Dryad and Sultan wards at Gosport War Memorial Hospital. These were against over four hundred letters of thanks in the same period, most of which complimented staff on the quality of care provided.

The complaint history for these three wards is as follows:

Date	Ward	Event
August 1998	Daedalus *	Mrs. L. regarding care of Mrs. R.
October 1998	Dryad	Lt. Cmdr. F. regarding Mr. C
November 1998	Dryad *	Mr. W. regarding Mrs. P.
December 1999	Daedalus	Mrs. S. regarding Mr. S
January 2000	Dryad *	Mrs. R. and Mr. D. regarding Mrs. D.
June 2000	Sultan	Mrs. R regarding Mr. R.
June 2000	Dryad *	Mrs. B. regarding Mrs. G.
August 2000	Sultan *	Miss W. regarding Mrs. W.
May 2001	Sultan	Mr. P. H. regarding Mrs. H.

Analysis of five of the above complaints (marked *) revealed a number of themes which formed the basis of a workshop with senior clinicians from Gosport War Memorial Hall on 27th February, 2001. The themes were

- communication with relatives
- staff attitudes
- fluids and nutrition.

At the workshop there was agreement that communication with relatives was the most significant area, given its impact on relatives' perception of the other two themes. In particular communication about treatment and care management at the end of a patient's life. A decision was therefore taken to pursue an action plan in relation to improving communication with relatives.

A report by the Health Service Ombudsman, including independent medical and nursing opinion, and an Independent Review Panel Report associated with two of the above complaints have revealed similar key issues. It should be noted that whilst the Ombudsman and the Independent Review Panel raised issues for the Trust to pursue, both were supportive of the clinical care provided.

6. Responding to Errors - an Example of Trust Wide Learning

Local response to incidents is triggered by the risk management and the complaints reporting systems. The following example demonstrates how all levels of the Trust respond to and learn from incidents and complaints .

A key theme of several complaints and incidents reported throughout the Trust has been that of sub-optimal communications with relatives. This is also a common issue raised in national complaints.

In Gosport War Memorial Hospital, the lack of documented discussion with relatives regarding the use of opiates was an important theme behind several complaints and incidents. The response to this was to develop policies, guidelines and training on the management of pain, and training on communication with relatives. Other related documents/initiatives include the Trust policy on resuscitation and national guidelines on consent to treatment.

Action taken Trust wide

- Piloting of pain management charts and prescribing guidance, including standards for communications with relatives; these were approved in May 2001.
- The issue was discussed at the Medicines and Prescribing Committee to disseminate shared learning across the health economy.
- A decision was taken not to employ a locum consultant because of the risk of professional isolation and supervision in Gosport. However a staff grade doctor was appointed and commenced duties in September 2000.

Action taken at ward level

In team and ward meetings, consideration was given to an acknowledged lack of effective documentation of family contact details and of discussions held with family members. The resulting changes included:

- Nursing documentation now more clearly identifies family contacts, the next-of-kin, and where appropriate the prime contact for communication.
- All conversations with families are now documented. The time, date and name of individuals concerned, their relationship to the patient, and the content of the conversation are clearly documented.
- Additional training was provided for senior nurses at special clinical governance sessions, and reminders were given at staff information exchanges.

7. Monitoring and Evaluation

Monitoring of incident and complaint trends and associated action plans is undertaken through quarterly divisional reviews, and at the Clinical Governance Panel and Trust Board meetings. Questions raised as a result of numerical and severity trends are investigated by the Risk Manager and the interventions taken are reported at subsequent meetings, or earlier in critical cases.

Action plans produced as a result of major incidents or complaints are also the subject of Executive Board level review.

8. Related Developments

Previous and ongoing associated issues:

- Feeding people - A Trust wide feeding people group was set up in 1996 in response to national concern regarding the nutritional status of hospitalised patients. The group was chaired by the Operational Director for the Trust (now chaired by the Nurse Director) and had representatives from across the Trust as its membership. The group produced a policy entitled 'prevention and management of malnutrition within Trust residential and hospital services'.

This policy was the result of an audit of current practice, development of standards and re-audit of the standards. Link nurses were trained for each department so that a network existed and there was a forum for sharing good practice. Link nurse meetings were established across community hospitals in 1998 with representatives from Daedalus and Dryad wards at Gosport War Memorial Hospital. These local link meetings ceased with the change of service manager in March 2000. Consideration is being given to their reinstatement.

- Clinical Nurse Leadership Programme - Led by the Director of Nursing, this programme (which has gained national recognition), established a development path for senior nurses to facilitate the development of leadership skills, clinical effectiveness and reflection in practice. Two members of staff from Gosport War Memorial Hospital attended the programme. One of these individuals has since retired and the other has moved on. However the Gerontological Nurse Programme (see below) contains a significant leadership component.

- Intermediate Care - This was a district wide initiative with local Primary Care Groups working with their providers during 2000 to develop locally based intermediate care services. In Fareham and Gosport just over £1 million development money was invested in changing the use of some community hospital beds, enhancing community nursing and therapy support via a community enabling service and improving access to social care packages. Specific developments include:

Additional consultant sessions	Five in total (one associated with Gosport War Memorial Hospital).
ALERT Training September 2000	There is now one course a month and by the end of November 2001 all qualified staff in Fareham and Gosport will have undergone training. ALERT is a simple technique for assessing quickly and describing effectively changes in patients' conditions to provide an early warning of changes.
Automated External Defibrillators and related training September 2000	Automated external defibrillators - now managed via one emergency number at Gosport War Memorial Hospital with a team drawn from departments who are trained to respond.
Appointment of an H grade nurse (practice development) November 2000	This appointment has facilitated clarity in the nursing structure and the postholder functions as a role model, nursing leader and supervisor working directly with the clinical managers.

- Gerontological Nursing Programme - This Trust wide programme commenced in Community Hospitals in September 2001. All F and G grade nurses in Fareham and Gosport are participating. The programme was developed by the Royal College of Nursing in conjunction with the Trust and is specifically geared toward the principles of individual care, reflection in practice and clinical effectiveness, and utilises an action learning model. It is a work based programme supported by a group of specially trained critical companions who in turn are supported by the Royal College of Nursing programme leads. The H grade at Gosport War Memorial Hospital is one of the critical companions.

9. Conclusion

This brief paper aims to demonstrate how the Trust has developed processes to ensure that learning about complaints and incidents is shared throughout the organisation and beyond into the wider health economy. In common with most Trusts, this process has been developmental and dynamic. When a common theme emerges from complaints or incidents these result in a process of policy development and staff training.