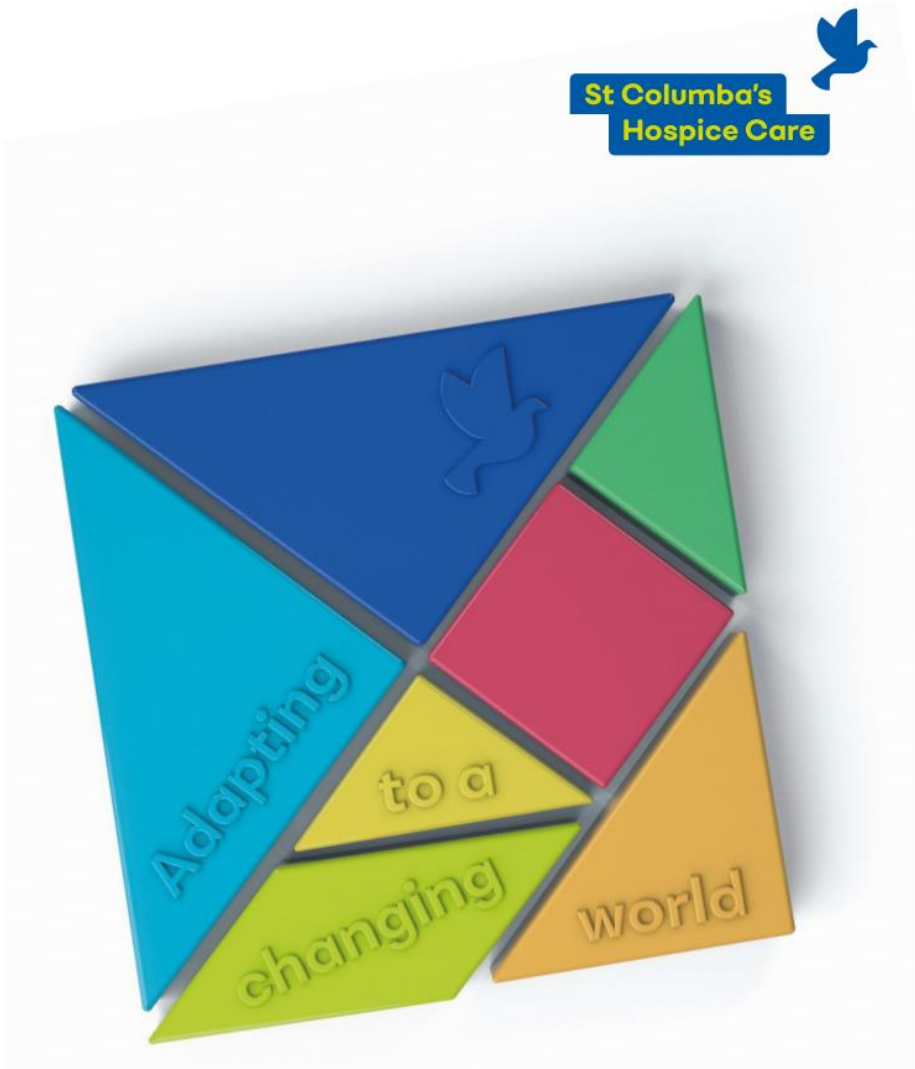
St Columba's Hospice Care



Clinical Services

Quality Report

2021/22 Quarter 4

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Introduction

Welcome everyone to our Quarter 4 quality report which showcases the impact of our clinical services. We hope you continue to find this report helpful.

Our teams continue to adapt and respond to the volatile world around us, working closely together with our partners across health and social care. You will see from each section the progress being made towards the implementation of our strategic plan 'Adapting to a changing world' and the challenges faced along the way.

As the impact of the Covid 19 pandemic lessens, our attention is now much more focussed on our planned service developments and the next 6 months will see us implement the remodelling of our inpatient unit, the extension of our Hospice at Home service into East Lothian and the return of more face to face activities across our clinical services. We look forward to sharing our progress with you.

We are grateful to everyone who takes the time to read and share this report. We value your opinion and would be really grateful for any feedback regarding the report, it's content and anything you think we could do to improve it. Please do not hesitate to email any comments to dpartington@stcolumbashospice.org.uk.

Thank you for taking the time to learn more about our teams and our developments,

Best wishes,

Dot

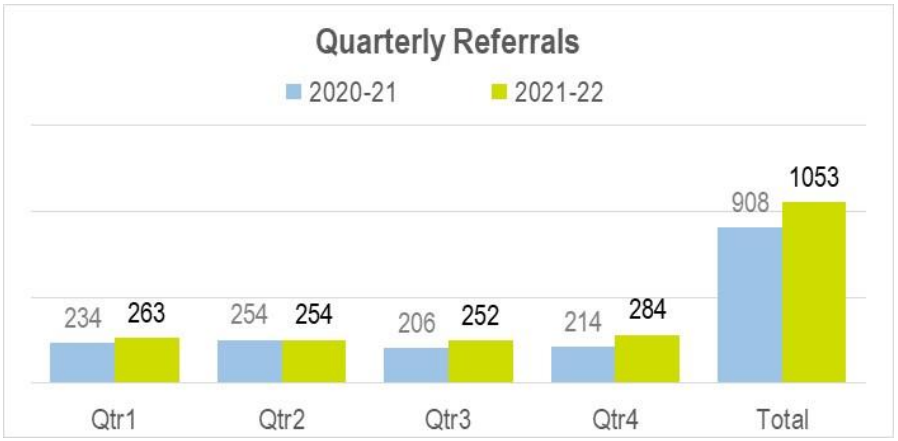
Dot Partington Deputy CEO

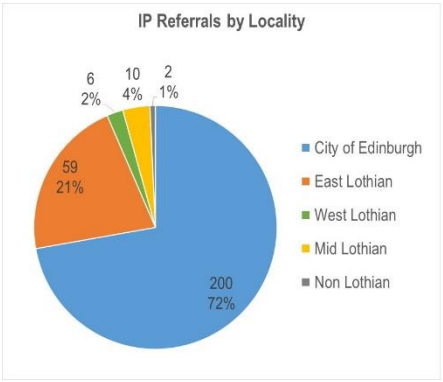
The Access Team

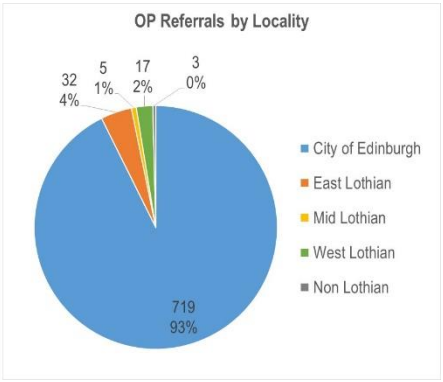
Commentary by Becky Chaddock Access Team Manager

Activity Summary

The chart on the right presents the number of individual people who were referred for hospice care this year. Year to date brand new referral activity is 16% (increase of 145 referrals) higher than that of the previous year and Access Team appointments recorded on TRAK have increased by 84% (435 appointments) on last year. This means that the work undertaken with people already known to the hospice increased significantly.







In addition to referral activity, the Access Team receive advice calls that fall into two categories: those that are routine, and those requiring an urgent same day response from people already known to the Community Hospice Team. In the last 3 months, the team responded to 298 advice calls, the vast majority of which were same day advice community calls.

- 38% were from our people/family/friends
- 45% were from primary care colleagues
- 14% were from the acute sector colleagues
- 3% were from St Columba's Hospice Care colleagues in the community

The majority of these calls related to pain and symptom control, with the next largest category being Social, Spiritual and Psychological concerns. Examples of the issues responded to are:-

- setting up, altering and then switching syringe driver doses in response to changing needs;
- supporting District Nurses and other primary care colleagues;
- helping people regain control of their situations via reassurance, practical support and encouragement.

In one case, the team supported district nursing colleagues to respond to a sudden dramatic decline in the health of someone waiting to be seen by the community team. With the advantage of immediate access to CNS support, together they were able to manage the situation and death of the person at home, ensuring that her family were also supported. The Access Team nurse was able to provide regular and repeated advice on managing the rapidly changing symptoms of the person, quickly changing the medication in her syringe driver, enabling a rapid response to the unfolding situation. In addition the team provided 11 individual support calls for carers, friends and/family.

Impact

As a single point of contact, the team respond to individuals, their families and to their wider communities. We help them to positively impact their quality of life and we provide symptom control for people living at home. Through working in partnership with the person we support, their carer network and the health and social care team, we ensure that they are able to live well with their illness, be where they want to be and remain as comfortable and independent for as long possible.

We routinely ask people for feedback about the Access service via written communication, there were 34 responses in this quarter and these were just some of the comments. 100% of respondents said that they would recommend the Access Service to others in similar situations.

"For me I felt like everything I needed to know was explained."

"Just keep going on with all the good work use and make people's lives comfy and caring."

"After just the one phone call we feel we would be able to cope with whatever presents itself with your support."

"Excellent service, excellent people, cannot praise them highly enough."

"Contact made us feel that we are not alone. A great feeling of security the total honesty is so refreshing."

"The initial contact gave us lots of reassurance that nothing was too much trouble. Just keeping doing this. That first contact by telephone meant so much to us both."

"Made us feel supported and that we are not alone."

"It [contact with the team] has given me comfort and reassurance along with peace of mind."

"On Monday 28th March I had a very comforting conversation with [name of team member] of the Access Team. I was pleased to discuss my wife's present situation and what help we are presently receiving. It was very stressful and worrying time for us. In the event, [she] passed away on Thursday 31st March and it was a great relief and release for her. Thank you all for your concern and we are certain that the Access Team initiative will be of great benefit and comfort to others in the future."

One comment spoke about the difficulty people experience when faced with a lot of information at once and rapidly changing situations: What could we do differently?

"Initially [there was] a degree of confusion as to who did what, i.e Hospice at Home, Access Team, District Nurses etc. Was a bit of information overload at a time when we had just learned of the terminal prognosis, so it took a few days to understand – and we're both reasonably intelligent people; just a hugely emotional time. Cannot fault anyone though just our grasp on what was happening."

This reflects the team's experience in wider practice and whenever possible, we pace the contact, taking note of other scheduled appointments, and the stage of the person's illness.

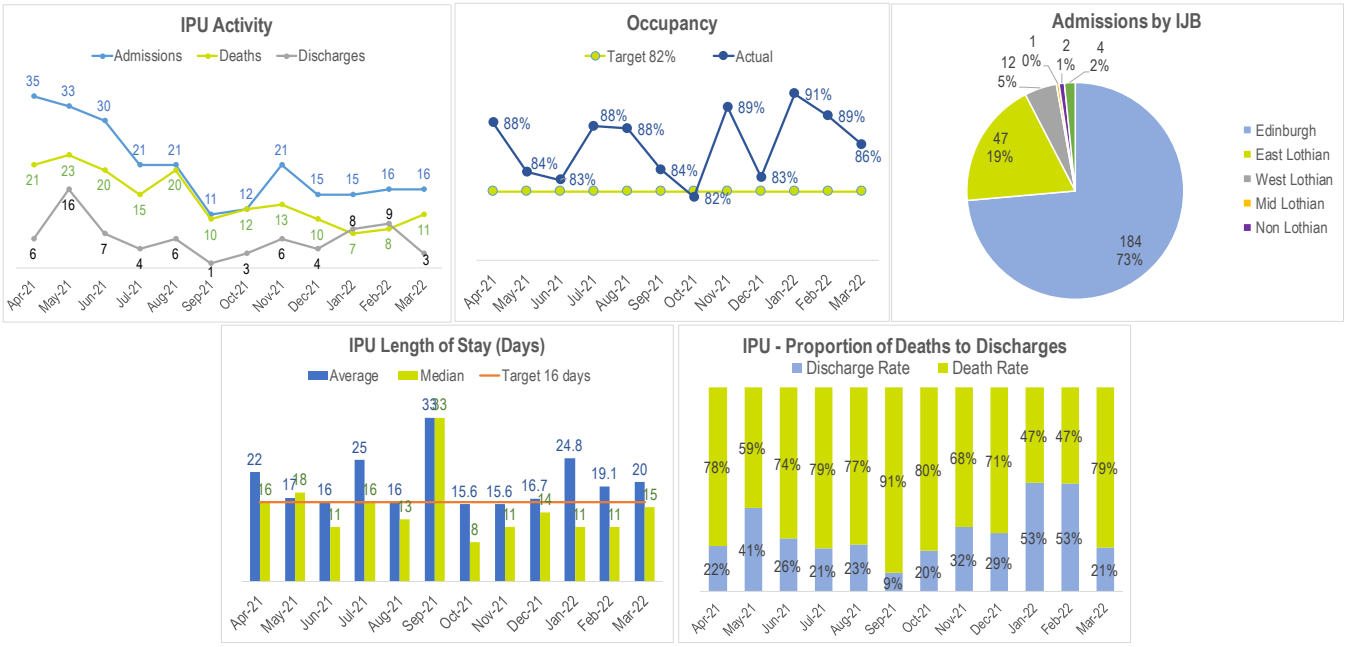
Adapting to a Changing World

The ongoing impact of COVID 19 pandemic on the health and social care workforce has led to a temporary reduction in the number of inpatient hospice beds across Lothian. We are currently working with our colleagues in acute hospital palliative care teams to understand the impact of this.

The launch of the Hospice Wellbeing Service responds to the research evidence surrounding earlier intervention and the aim to improve quality of life. The team have been working closely with the Wellbeing Service team to assist with the implementation of the service.

In-patient Services

Activity Summary



During quarter 4, bed numbers remain at 11 due to the temporary closure of Cedar ward. Occupancy levels for the period remain above target (85% for the quarter), the average Length of Stay for the quarter has increased due to a small number of patients with stays over 40 days. As would be expected, the reduced number of beds have impacted on the overall IPU activity compared to last year.

Admissions	↓	-22% (246 against 316 last year)
Deaths	↓	-32% (170 against 250 last year)
Discharges	↓	-25% (73 against 97 last year)

Pentland Ward

Commentary by Sally Ramage Inpatient Unit Manager

Impact

At this time of increasing pressures due to reduced overall bed availability, it is extremely important that all admissions to the inpatient beds are carefully planned by our access team, in partnership with our medical and nursing teams to ensure that people who would benefit most from a hospice bed are prioritised.

Adapting to a Changing World

Like hospices nationally, our inpatient unit has experienced some challenges with staff recruitment during the last 12 months, however during quarter 4 we have completed a successful recruitment drive and have appointed both staff nurses and auxiliary nurses. Recruitment and retention of staff remains a priority for the clinical teams and we have developed a number of initiatives for staff wellbeing and to support the experience of new staff joining the team

Pentland ward has recently been painted and refreshed by our Facilities team and we have refurbished two bedrooms into patient suites with adjoining family areas to enhance patient experience. These rooms should be available for use by time of next report.
Now that the staff who had been temporarily seconded to hospice at home service have returned to the inpatient unit, we have worked closely with the team to identify which staff wish to work in whish area as we now transition to our new model of care including a new Wellbeing Service and creation of some Nursing Led Care beds. We look forward to updating you all in the next report regarding the exciting progress being made.

Our team have participated in an education program focussing on non-pharmacological approaches to symptom management and the concept of Total Pain. This has proved invaluable for our new staff as they learn the necessary skills and expertise in the specialty of palliative care and the importance of managing complex symptoms with a holistic approach. It has also been a helpful update to our more experienced staff.

Sally Ramage has now been promoted permanently to the role of Inpatient Unit Manager alongside Joanne Weir as the Pentland Charge Nurse and Craig Thomson-Chandler as the Wellbeing Unit Charge Nurse.

Partnership

The option of electronic prescribing and administration of medications is currently being explored with external partners including NHS Lothian. This is a hugely exciting project that could lead to a reduction in medication related errors and improve staff and patient experience.

Over the last 6 months, we have held a series of workshops with the Deputy CEO and Quality Assurance Manager exploring cultural issues in the workplace. These have led to some helpful projects including how better to support staff who have been involved in medication errors, improved access to clinical supervision and wellbeing support as well as a review of staffing levels and night shift routines.

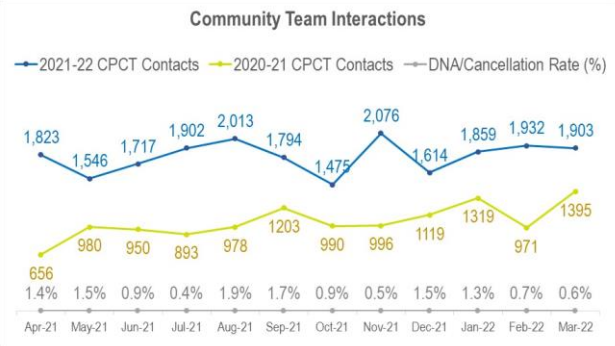
Community Services

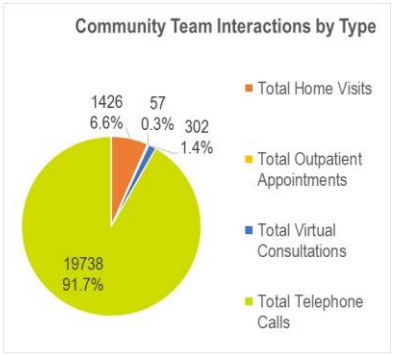
Community Hospice

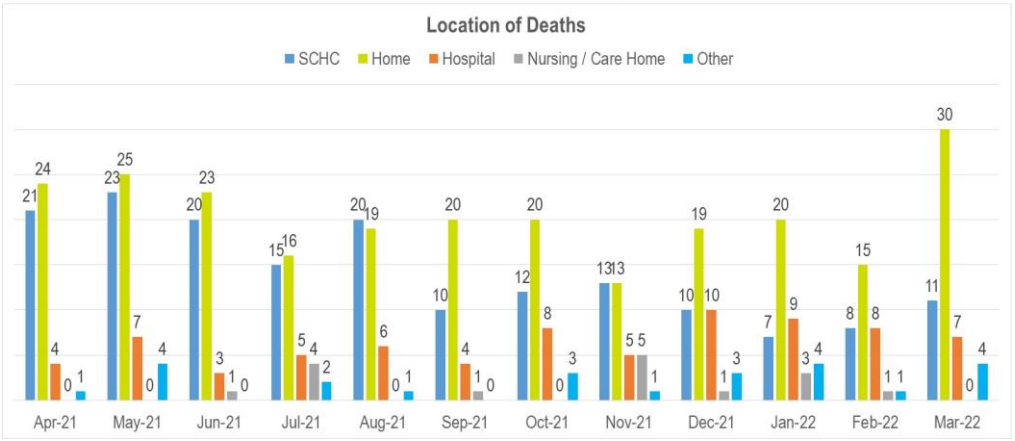
Commentary by Eimear Hallissey Community Hospice Manager

Activity Summary

During quarter 4 our community hospice team provided 5,694 support interactions to 366 people, an increase of 55% (2,009) on the previous year's interactions. Activity for the overall year is up 74% (increased by 9,204) on last year at 21,654 interactions.







Impact

The consistent demand on the community hospice team has been recognised by the senior management team and a successful bid for funding has been approved by the Board of Governors for additional establishment, however we are really disappointed that unfortunately we are having difficulty recruiting to these posts. This has an impact on the existing team and also on the time for patients spent on our waiting lists. The team are supported through supervision and debriefs to support them to continue to provide an excellent standards of palliative care in the community.

Adapting to a Changing World

The strategic aim of moving the balance of care from inpatient to community is now becoming reality. It is recognised however through the figures above that the balance of face to face activities compared to telephone / virtual has yet to return to a more balanced approach following the Covid 19 pandemic. This will be a key priority in the months ahead.

Partnership

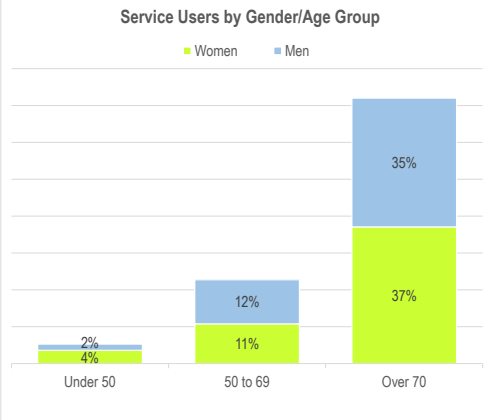
This quarter we met with the team at The Prince and Princess of Wales Hospice and shared information on the development of our community hospice services. We also presented to a group of medical consultants at the local acute hospital, to make them aware of the revised services the hospice now provides and how to access them.

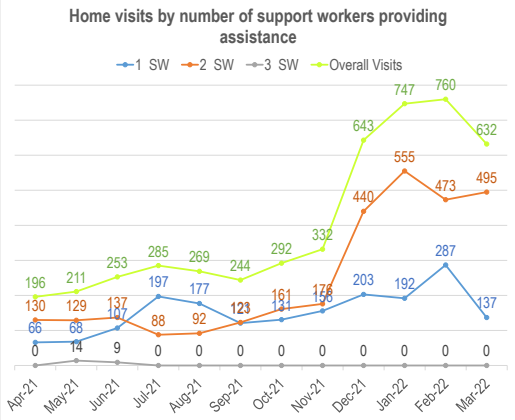
Hospice at Home

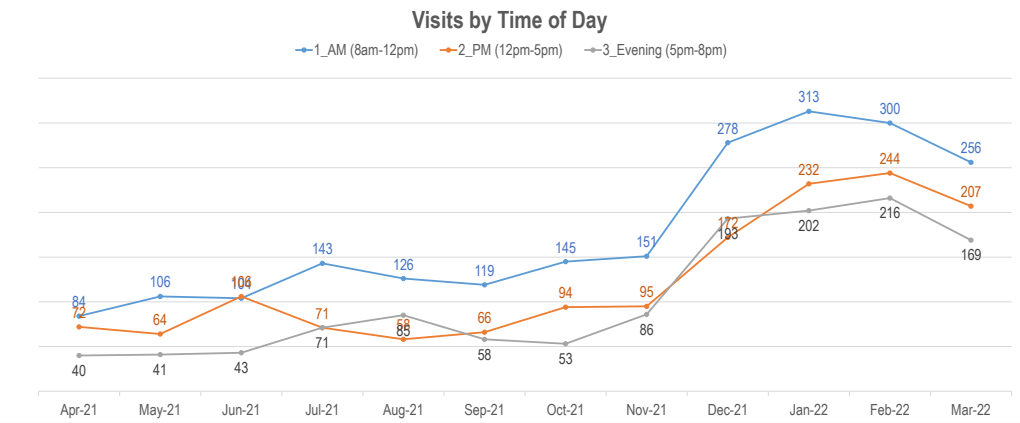
Activity Summary

During Qtr 4, Hospice at Home provided 2,139 home visits for 106 individuals a 69% (872) increase in visit activity on Qtr 3. This was due to enhanced staffing to support winter pressures across the health and social care system which has now been reduced again.

Appointments were more likely to require 2 support workers are were booked more frequently for morning visits.







Impact

Increasing our staffing capacity to provide more Hospice at Home support in the community has helped prevent hospital admissions and to facilitate discharges from the hospice and acute setting. The majority of these visits were provided to bridge the gap in a package of care starting.

Adapting to a Changing World

We have now confirmed funding and begun to recruit towards extending our Hospice at Home team to work across east Lothian area. We also are recruiting for a clinical administrator to support the team. It is anticipated that the extended service will commence in April this year.

Partnership

Throughout the months we increased the service we worked closely with the wider NHS teams and continue to improve patient flow, prevent admissions and facilitate discharges through regular meetings.

We are currently working in partnership with the Care Inspectorate to transition the regulation of the service from Healthcare Improvement Scotland over to them.

The Compassionate Communities Team

Commentary by Roddy Ferguson Team Lead

Activity Summary

Compassionate Neighbours (CN) is now well established with nearly 50 trained volunteers. A mix of new and experienced volunteers have been very active and in the final quarter of the year the number of contacts between Compassionate Neighbours and Community Members rose by 80%. The nomination stream is strong and Maggie, Dariusz and Jacqui value the help and support of other teams within the hospice family which has contributed to this success. Similarly, a strong bond has been built with the ELCPT with regular meetings and shared learning resulting in a steady flow of fresh nominations.

January 2022 - March 2022

CN community contacts	*CN's attending informal support & supervision sessions*	*Number of CN 1:1 review sessions*	*New CNs trained*	*Number of new matches*	*Number of deaths*	*CNs attending additional training / external training*
369	**63**	**17**	**0**	**14**	**6**	**7**

Compassionate Neighbours are also involved in a range of other activities such as:

- Four Compassionate Neighbours filmed short videos talking about their own journey through personal grief and what coping mechanisms helped. These will contribute to resources for a new wellbeing website created by the Scottish Government Mental Health Directorate.
- Five Compassionate Neighbours participated in a series of creative writing workshops run by the St Columba's Arts team. Benefits included team-building, sharing lived experiences, and practising creative writing as wellbeing tool. These sessions also created the possibility of using the Storii platform to enhance the relationships between compassionate neighbours and community members.

Impact

The friendships formed between Compassionate Neighbour volunteers and community members are valued by both. The following feedback from the daughter of community member about her Compassionate Neighbour indicates the significant social and emotional support woven into these relationships.

'Mums mood got lower and lower as time went on, she had no interest or energy left to give. Then (CN) came into her life and that changed. She'd mark the calendar when the (CN) next visit would be, she'd ask me to look out a nice blouse or top and then one day she asked if I could organise the hairdresser to pop by the evening before (CN) visits 'just so I can look nice'. (CN) lifted her in ways we couldn't'

Adapting to a changing world

It is hoped that as the restrictions caused by COVID 19 start to ease, recruitment of a new cohort of Neighbours will build the resource in line with the increasing need for this support.

Partnership

With three new team members now in post, a key focus for the Compassionate Communities team has been establishing networks between the hospice, local communities, and relevant public and third sector partners. The range of partnerships being developed includes:

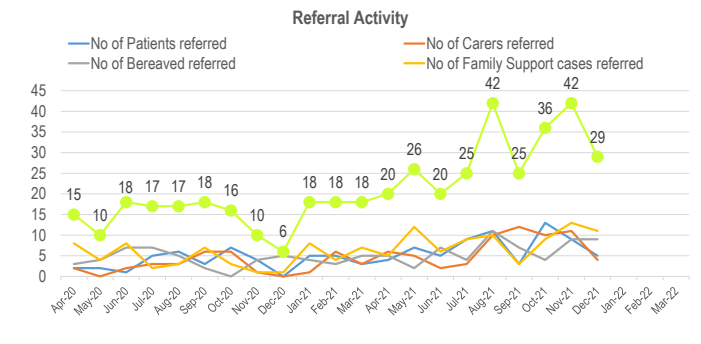
- Community-led groups – e.g. Heart Talk Porty
- Local voluntary organisations – e.g. Granton Parish Church
- Third Sector Interface organisations – e.g. Volunteer Centre East Lothian.
- Cross-sector partnerships – e.g. The Edinburgh Wellbeing Pact
- National agencies – e.g. The Scottish Community Development Centre

We are also working with other hospices such as Marie Curie, Strathcarron, and Highland - as well as the Scottish Partnership for Palliative Care - to build and share knowledge and resources on public health palliative care.

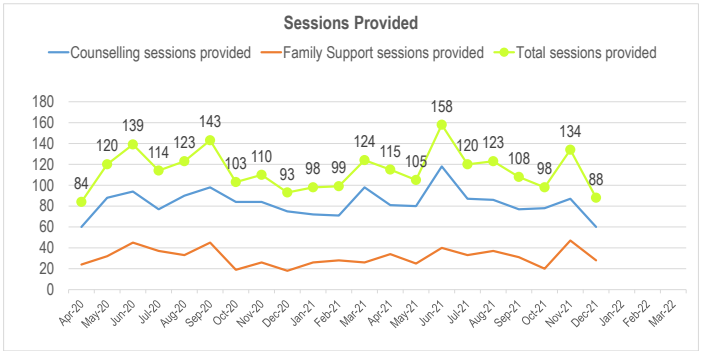
Wellbeing, Family Support & Bereavement Services

Family Support Service

Commentary by Craig Hutchison Family Support Team Manager



Referral activity for Qtr4 is ↑ 80% on last year and up ↑ 100% over the full year



Sessions Provided for Qtr4 are ↑ 11% on last year and up ↑ 3% over the full year

We delivered 355 sessions this quarter (228 adult, 127 child/young person), excluding missed or cancelled sessions, an increase of 11% on last year's quarter. We also saw an 80% increase in the number of referrals compared to the same quarter last year (a difference of 43). Of the 97 new referrals, 31% were patients, 26% carers, 18% bereaved adults and 25% were for the children/young people's service. 63% of the adult referrals were female and 37% male, with an age range from 25 to 89 (average age 59, SD=12.75). 52% of referrals came from our Community Hospice team, 11% from the Access Team, 9% from the Inpatient Unit, 7% from Chaplaincy, 5% from the Child and Families Worker, 5% from GPs, and 11% were self-referred.

26% of those referred were taking prescribed medications for their psychological problems (57% of whom were on antidepressants only, 25% anxiolytics only, 12% on a combination of both antidepressants and anxiolytics, and 6% of a combination of antidepressants and antipsychotics). 89% of referred adults had no suicide risk at assessment but 11% were at mild risk with some thoughts of suicide. When risk of harm was identified, people were signposted to relevant resources (e.g. GP, telephone crisis helplines, and statutory mental health services) and/or were prioritised for time-limited counselling focused on risk management.

Of the 13 children and young people seen this quarter, 62% were boys and 38% girls, with an age range from 6 to 15 (average age 10.6, SD=2.9). The remaining referrals to the Children and Families service were of adult family members wanting some help to explain illness, death and dying to children or young people, and to help think about preparing for their children's future (e.g. memory boxes, guardianship).

Impact

Our most significant impact is at the individual level, helping people as they come to terms with incurable illness and as they learn to cope with bereavement. We continue to work with a wide range of presenting problems, including: depression, anxiety, panic attacks, grief, stress, worry, assertiveness, relationship problems and adjustment difficulties (e.g. coming to terms with the impact of illness), as well as concentration and attendance at school, sleep problems and anger difficulties in children/young people.

We gather routine outcome data using standardised and validated measures of psychological distress (i.e. the CORE-OM and PG-13 questionnaires), which adult clients are asked to complete at initial assessment and then again at every subsequent review session until ending. Clients show improvements across all the four domains measured in the CORE-OM (Subjective wellbeing, Problems, Functioning and Risk), with an average 14 percentage point improvement in adult counselling clients' subjective wellbeing (feeling OK about themselves and feeling able to cope without feeling overwhelmed) as well as an average 14 percentage point reduction in their symptoms of depression, anxiety, insomnia and/or trauma and a 6 percentage point improvement in functioning.

Of the adult bereaved clients assessed this quarter, 53% were experiencing an acute grief reaction following a recent death and 26% a relatively normal grief reaction requiring some general bereavement support, while 21% experienced a complicated or prolonged grief requiring formal counselling intervention. Clients referred for bereavement support typically have lower initial baseline scores on the PG-13 (as they are experiencing an acute or normal grief reaction and no risk of harm) but still demonstrate an average 7 percentage point improvement in their symptoms of grief, while those referred for counselling have higher initial scores and demonstrate an average 9 percentage point improvement. As we gather more routine outcome data we will begin to develop a clearer picture of our impact on client's psychological distress, symptoms, risk and functioning.

Assessing the impact of work with children and young people is still at a relatively early stage. We are piloting the CBSQ (Child Bereavement Support Questionnaire), which has a scale from 0 (low) to 3 (high). Higher scores indicate that the child/young person is managing their grief well. Scores for children/young people increased over the duration of support, from 1.7 or 2.2 at the outset of support to 2.9 or 3 by the end.

Adapting to a Changing World

We offer a blended model of provision. The majority of our work continues to be delivered by telephone or virtual consultation, which continues to work well for almost all clients, but we also offer a small number of in-person sessions, depending on client need. We met with Jolanta Lisicka (Palliative and End of Life Care Senior Policy Manager at the Scottish Government) to discuss our success in developing and providing remote or virtual services during the pandemic and the significant increase in sessions attended and referrals.

This quarter we were also joined by a new counsellor (Duncan MacLaren) and a new Child and Families Practitioner (Jade Finlayson), which will help us manage the significant increase in referral activity over the past year.

We have also seen an increase in referrals of people with complex and/or chronic mental health problems (e.g. personality disorder, paranoid schizophrenia) over the past year. Where this is the case we routinely assess risk and refer to GP and/or statutory mental health services, as appropriate. We delivered training sessions to staff across the hospice on recognising and responding to risk of suicide, to help increase knowledge of how to assess and reduce risk. In addition to our existing counselling services, we are also now offering a limited number of spaces for cognitive-behavioural therapy focused on mild to moderate depression and anxiety (including generalised anxiety disorder, panic disorder and phobias).

Partnership

We continue to work with a wide variety of external partners. We worked with colleagues at the Prince and Princess of Wales Hospice in Glasgow to provide education sessions for schools, and delivered a webinar for the Mental Health Schools Conference in collaboration with Cruse Scotland. We offered input into National Childhood Bereavement Coordinator Denisha Killoh's draft report to the Scottish Government. We continue to be involved in the National Bereavement Charter and working on projects to help raise public knowledge of grief and bereavement. We are involved in an ECHO project to improve young people's transitions moving from child

to adult hospice services. We delivered training on bereavement and grief to learning disability nurses in NHS Ayrshire and Arran to help them recognise and respond to grief reactions.

Feedback

We continue to receive very positive verbal feedback from clients using the service, commenting on how helpful they have found it and how it has helped them to cope at what is often the most difficult time of their lives. Additional comments we received include:

"Excellent suicide training yesterday thankyou. It was very logical, practical, supportive and informative" (Staff member following suicide assessment and intervention training)

"Thank you again for delivering this [training] it was fabulous and the team I know will benefit greatly!" (Learning Disability Nurse)

Chaplaincy & Spiritual Care

Activity Summary

We are working on a new system for monitoring, recording and evaluating chaplaincy activity, which will allow improved reporting of ward visits, staff support activity, and events over the coming year. We have also been reviewing our existing working processes and procedures as we integrate chaplaincy into the wider Family Support Team. Our chaplain facilitated an online event for the National Day of Reflection, to mark 2 years of the COVID pandemic.

Feedback

Chaplaincy has received many very positive comments from colleagues, patients and family members. A small selection of feedback from the last quarter is recorded below:

"Thank you so much for spending time with my husband – I'm so glad he was able to speak to you honestly about his death and it meant a lot that you prayed for him. You've been so kind to me too. Thank you." (Family member)

"I don't know how we'd have got through this without you, Erica. You were just there for us" (Family member)

"Thank you for contacting his minister friend and for looking in on him so often" (Family member)

"Thanks for taking the time to listen to me, it's been really helpful. I feel like my mind is less cluttered. Thanks very much." (Staff member)

"Well done on yesterday – it was lovely, so poignant and very fitting" (Staff member following National Day of Reflection)

Arts Service

Commentary by Dr Giorgos Tsiris Arts Lead

Activity

Between January and March 2022, the arts team offered 26 individual sessions (69% online, 27% face-to-face, 4% phone). We recorded 3 cancelled individual sessions and 8 sessions were people didn't attend.

We also offered 25 online group sessions including our community choir, the music listening group 'Tunes with Tea', the Hospice On-Line Art (HOLA) group, as well as the Arts-Led Staff Reflective Practice group. Overall, we recorded 24 patient and 17 family/carer attendances in individual sessions, and a total of 98 attendances (28% patient attendances) in the group sessions.

We also offered 12 live music sessions in the IPU and we organised 1 online cultural event: 'In conversation with Anne Brodie, Artist'. Anne, who is our current art psychotherapy student from QMU, shared images and talked about her art practice, including a pivotal arts residency in Antarctica. Examples of work from her series 'Edge-Lands' are currently displayed at St Columba's Iona Café.

As part of our collaboration with the Royal Scottish National Orchestra (RSNO) we were given free access to three digital concerts: Beethoven Piano Concerto No3 (19 - 26 January), Beethoven Symphony No6 Pastoral (16 - 23 February), and Dvorak Symphony No8 (23 - 30 March). These digital concerts were available to patients, carers, staff and volunteers, and wider hospice community.

Since January, various changes have taken place within the arts team. Giorgos became Acting Director of Education and Research. Giorgos has paused his clinical role but has retained management responsibilities for the arts. Anna Ludwig, our community choir facilitator, resigned, while Emma Keeling and Hiu Tung Yan - our two music therapy students - completed their practice placements successfully. As such, and due to limited resources within the team, we had to pause the Community Choir and the Tunes with Tea sessions for the time being. Once there is clarity regarding the changing roles within the team and its future direction, we will appoint new arts team members accordingly and resume these activities.

In the meantime, our new volunteer, Taylor Vander Well, started her community life story work. She, together with Anne (art psychotherapy student), co-led a pilot creative writing project with the Compassionate Neighbours team and offered a Hospice Connections session on 28th March.

Impact

In this quarter, Giorgos engaged in diverse impact-related activities:

- Delivered an invited research seminar on "Music therapy, spirituality, and palliative care" (11th Jan) at the University of Graz, Austria.
- Represented the hospice in the first "Musical care international network" meeting (21st Jan).
- Offered an invited presentation at the University of Roehampton on the "Arts therapies in palliative care: Music therapy perspectives" (16th Feb)
- Co-presented at the day-conference of the Hellenic Association of Certified Professional Music Therapists (27th Feb) on "Practice, education and research in music therapy: Towards a new collaborative approach".
- Invited speaker at the online event for celebrating the 2022 World Music Therapy Day in Turkey (8th Mar).

Dr Rachel Drury (Lecturer in Learning and Teaching in the Arts, Royal Conservatoire of Scotland) and Giorgos were also successful in securing a research grant – an Athenaeum Award – for implementing a survey based study to map current arts services provisions across hospices in Scotland.

Adapting to a Changing World

In February 2022, we held our fourth Arts in Palliative Care ECHO Network meeting. This session was led by Katherine Walters (Lead Arts Therapist and Music Therapist) and Sandra Smith (Art Therapist) from East Anglia's Children's Hospices (EACH) who gave an overview of 'skill-sharing' within art and music therapy with parents and care staff. They focussed on how they adapted this work they started pre-pandemic to virtual ways of working to maximise the benefits of using the arts therapeutically for children in the hospice care.

In March we led a Community of Practice meeting for arts therapists and community artists working in hospices across Scotland. This was our first hybrid Community of Practice meeting with some members attending in person at St Columba's Education and Research building.

The evaluation of last year's arts-led reflective practice workshops demonstrated the positive impact of the work. These workshops are now integrated further as part of the Hospice's wider Practice and People Development framework, alongside a new emerging supervision approach for staff.

Partnership

Our biannual Arts Strategy Group meeting took place on 21st March. The group reflected on existing partnerships and developments within the arts service, including our collaboration with Fischy Music and the Galilee palliative care unit in Greece. Going forward, and given the current limited resources of the team, we considered how best to manage our resources and how prioritise some internal developments, such as the arts within the new Wellbeing Unit of the hospice.

Through his joint appointment with QMU, Giorgos continued his work as co-chair of the 12th European Music Therapy Conference. Our arts team is holding an international pre-conference event on "Music therapy in end-of-life care: Relational and community perspectives". This will be a hybrid seminar with some participants attending in-person at the hospice.

Quality Assurance

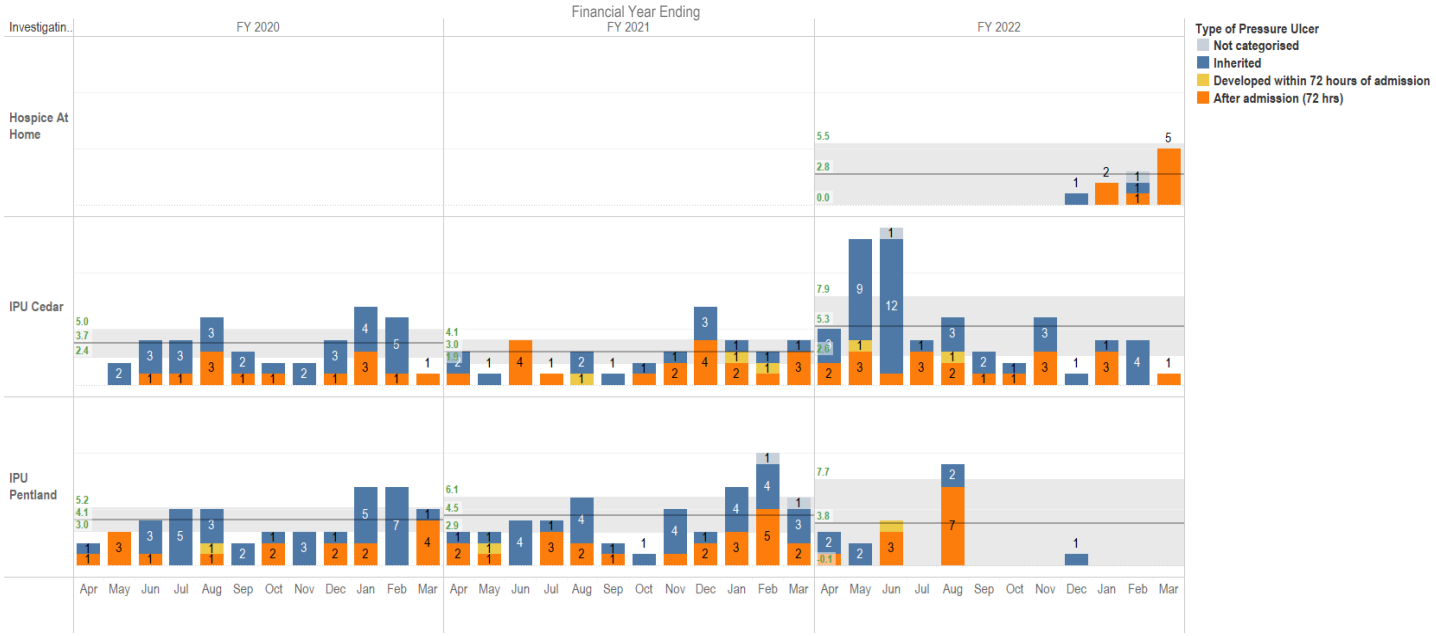
Commentary by Vicky Hill QA Manager, **Orlagh Sheils** QA & Patient Safety Facilitator **& Dave Manion** Information Analyst

Reported Incidents

Pressure Ulcers

Actual Pressure Injury Incidents by Category
3 Year Comparison including month average with 95% CI

5 active incidents have been included for Feb-22 to Mar-22 and subject to change



Pressure Ulcer prevention is led by our IPU manager supported by members of the clinical and quality assurance teams. The Prevention and Management of Pressure Ulcers Standards launched by Healthcare Improvement Scotland in October 2020 have been reviewed and an action plan created to ensure the hospice continues to deliver care outlined as best practice. This action plan will now be delivered and monitored through the monthly Patient Safety Meeting for Pressure Ulcer Prevention and Management.

Quarter 4 shows evidence of the Community and Hospice at Home team beginning to record pressure ulcer activity outside of the hospice environment. The Pressure Ulcer Type categorisation has been adapted to demonstrate the following:-

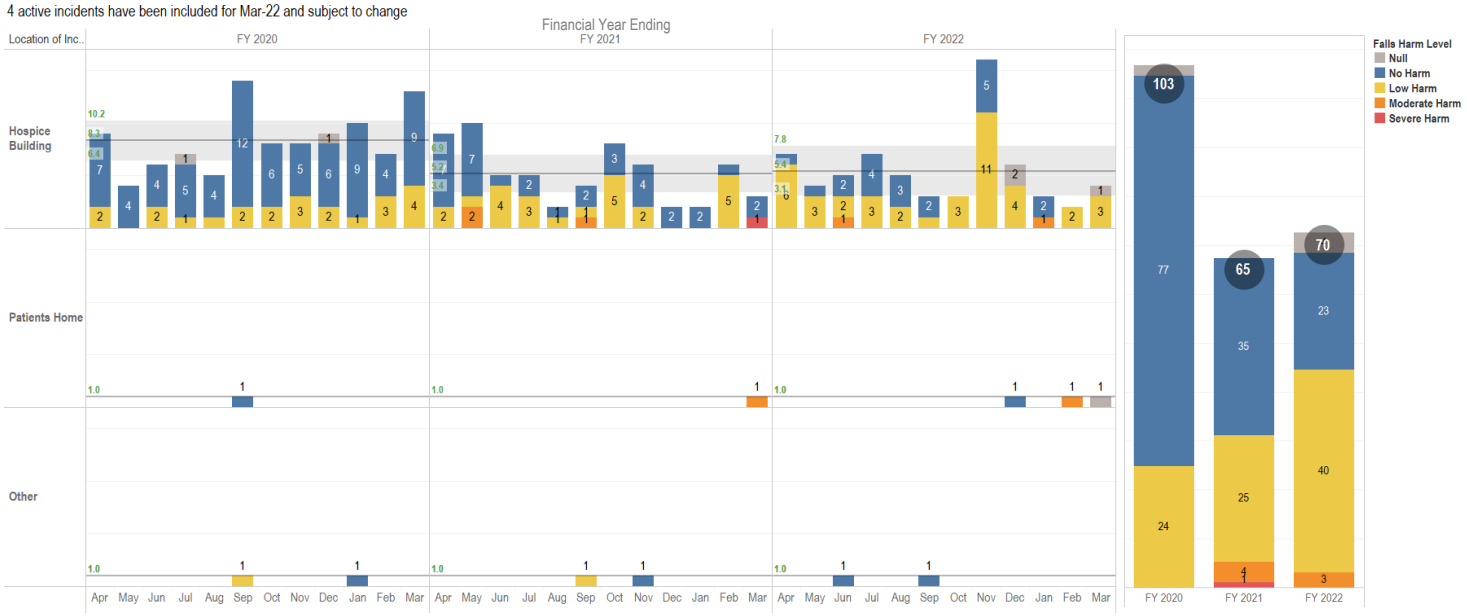
Blue – Inherited	**Orange – After admission (72 hrs)**
Pressure Ulcer developed before SCHC Community involvement	Pressure Ulcer developed while receiving SCHC care

This quarter within the wards shows a continuation of the run of relatively low activity that corresponds with the reduced number of beds.

Patient Falls

Actual Patient Fall Incidents by Harm
3 Year Comparison including month average with 95% CI

4 active incidents have been included for Mar-22 and subject to change



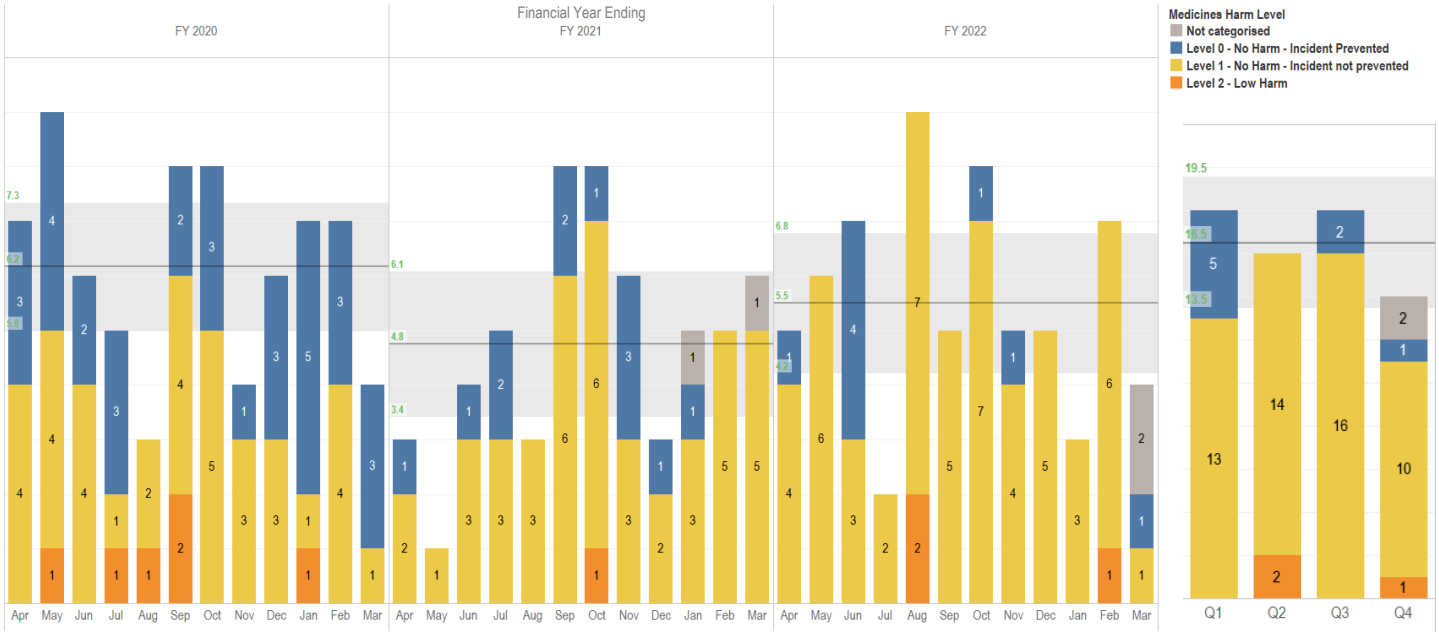
Quarter 4 sees a return to lower levels of falls activity experienced for half of this year. Activity for the year has risen by 4% within the wards and 7% overall. Much of this activity generated by a single patient with complex care needs in quarter 3.

All falls are reviewed at the time of the incident and at a monthly multi-disciplinary patient safety meeting which focuses on falls prevention, management, learning and development. The Falls Leadership Group now attend this meeting and as such have increased attendance from quarterly to monthly.

Medicines Incidents

Actual Medication Incident Trend by Harm
3 Year Comparison including month average with 95% CI

5 active incidents have been included for Feb-22 to Mar-22 and subject to change



Medication incidents are monitored closely and subject to a full review process by the Patient Safety Group, monthly Medicines Incident meeting and the quarterly Medicines Management Group meeting. Quarter 4 saw the lowest level of medication incidents this year (see chart right) and overall there has been a 16% increase (variance of 9) on the previous year. 'Documentation error' and 'Administration error' are the most commonly reported categories however, the incident reporting categories are required for the broader trends and are not detailed enough to capture, the many factors that contribute to a Medicines incident.
Looking at the level of harm we can see the majority of incidents to date resulted in 'No Harm'. The reporting of 'No Harm' incidents shows a good reporting culture where all incidents regardless of harm levels are reported, investigated and reviewed for learning opportunities to prevent future errors.

Accidents

For Quarter 4, **3 accidents** were reported.
10 accidents overall for this financial year were recorded only three of which involved a patient. (Harm Categories - 2 High Risk, 4 were graded at Medium Risk and 4 Low Risk of reoccurrence).
3 further reported accidents were closed as not incidents following investigation.

Incident Reporting

Excluding accidents, at the time of compiling this report Quarter 4 saw **69 total submissions (310 Year to Date)** from across hospice services reported via Sentinel. The incidents are comprised of:-

- **67 Actual incidents. 51** were closed following investigation with the remaining **16** still active.
- **2** Near Misses.
- **1** further submission, not counted in the figure above, were closed following investigation and categorised as 'Not an Incident'.

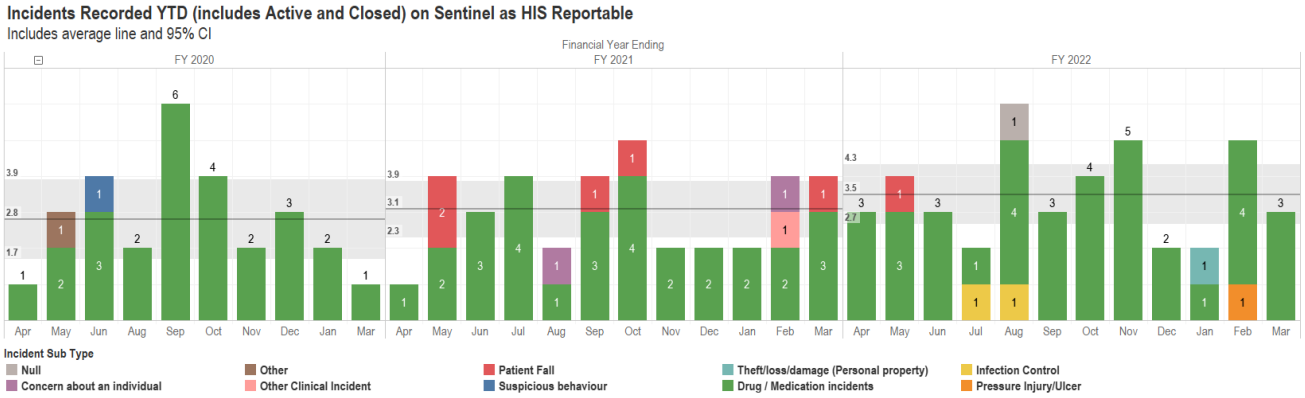
All incidents from the previous quarter have been investigated and closed.

All Notifiable Incidents to Date

Health Improvement Scotland Portal Notifications

The National Health Services (Scotland) Act 1978 and the Healthcare Improvement Scotland (Applications and Registrations) Regulations 2011 require independent healthcare providers to notify Healthcare Improvement Scotland (HIS) of specific events that occur.

The following numbers are indicative of the incidents reported to HIS. The following represents the number of incidents recorded on Sentinel as requiring HIS notification but this can change following the investigation process. HIS have specific rules as to when they are notified (e.g. where a controlled drug is involved) regardless of the level harm level identified. All of the drug medication notifications below are categorised as No or Low Harm.



Reportable to the Information Commissioner's Office	**0**
Incidents recorded on Sentinel as requiring Duty of Candour procedures	**0**
Incidents recorded on Sentinel as RIDDOR reportable (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) to the Health and Safety Executive (HSE)	**4**

April

1. A member of staff tripped and fell at work leading to a reportable injury. RIDDOR requires that certain injuries specified in the guidance, in this case a fracture, are reported to HSE. The incident has been investigated by the Estates and Facilities Manager and categorised as having a Low Risk of reoccurrence.

July

2. A hospice staff member was diagnosed as having Covid-19 with the potential for it to have been attributed to an occupational exposure. There was no evidence however of an outbreak in the hospice and this was most likely community transmission. This also was reported as RIDDOR as required by HSE.

August

3. A hospice staff member was diagnosed as having Covid-19 with the potential for it to have been attributed to an occupational exposure. There was no evidence however of an outbreak in the hospice and this was most likely community transmission. This also was reported as RIDDOR as required by HSE.

4. Member of staff reported hurting her back during a moving and handling manoeuvre. A full investigation into the circumstances has now been completed and individual and organisational learning has been identified

Non Clinical Incidents

For the year, there has only been a slight increase in the non-clinical incidents 6% (an increase of 3 incidents). The categories are varied and sporadic with no particular category trending during the year but overall they average around 5 per month.

The most frequently reported Non-Clinical incidents include IT and Data Protection (53%) such as e-mails being sent to the wrong recipient or information written in error in electronic care records. The majority of these incidents are internal and reported to the Caldicott Guardian for investigation, therefore low risk and require no notification to outside agencies.

Fire Safety

This year SCHC had one fire activation in the kitchen, Sept 21 due to steam setting off the detector above the sink. We continue to carry out Fire training as part of the mandatory training program and have carried out additional training on the ward with scenarios and the use of the “ski evacuation sheets”.

The Fire Service carried out their audit in September, it has been 2 years since their last one and have asked for only two actions, to carry out a Fire Risk Assessment and the addition of some “Fire Door Keep clear” signs. The Risk assessment was already planned but we were waiting on room alterations to be completed and this will be completed April.

Complaints

There was a single clinical complaint submitted in November relating to the quality of financial benefits advice provided by the Community Hospice Team. The complaint was upheld and a learning action plan is in place. There have been no further complaints during Quarter 4.

Appendix 1 – Harm Level Definitions

FALLS INCIDENTS HARM LEVEL DEFINITIONS

No harm	Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving care. Impact not prevented – any patient safety incident that ran to completion but no harm occurred.
Low harm	Harm requiring first-aid level treatment or extra observation only (e.g. bruises, grazes). Any patient safety incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving care.
Moderate harm	Harm requiring hospital treatment or prolonged length of stay but from which a full recovery is expected (e.g. fractured clavicle, laceration requiring suturing). Any patient safety incident that resulted in moderate increase in treatment and which caused significant but not permanent harm to one or more persons receiving care.
Severe harm	Harm causing permanent disability (e.g. brain injury, hip fractures where the patient is unlikely to regain their former level of independence). Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving care.
Death	Where death is directly attributable to the fall. Any patient safety incident that directly resulted in the death of one or more persons receiving care.
References	National Patient Safety Agency 2010 Slips trips and falls data update NPSA: 23 June 2010 NPSA Seven Steps to Patient Safety

MEDICINES HARM LEVELS DEFINITIONS

Level 0	Error prevented by staff or patient surveillance.
Level 1	Error occurred with no adverse effect to patient.
Level 2	Error occurred: increased monitoring of patient required, but no change in clinical status noted.
Level 3	Error occurred: some change in clinical status noted and/or investigations required: no ultimate harm to patient.
Level 4	Error occurred: additional treatment required or increased length of patient stay overdose.
Level 5	Error resulted in permanent harm to patient.
Level 6	Error resulted in patient death.
Reference	Wilson DG *et al* (1998) in Naylor R, Medication Errors, Radcliffe Medical Press, Oxford, 2002