

Learning from Patient Safety Investigations

**Thematic Analysis of the Concerns Identified in
Completed Investigations from 2020 – July 2024:
Identifying Key Themes and Using Data to Inform Future
Safety Priorities.**



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Introduction



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In alignment with the implementation of the Patient Safety Incident Response Framework (PSIRF), a comprehensive five-year analysis of reported incidents was conducted.

This review analyses 411 completed investigations of serious incidents (SIs) and patient safety incidents (PSIIs) reported in the Trust from 2020 to July 2024

With patient safety as a top priority, this analysis examines whether key issues identified in these investigations have shown recurring patterns over time.



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Quantitative and Qualitative analysis

The breakdown of investigations reviewed by year is as follows:

Year	Number of Completed Investigations
2020-2021	127
2021-2022	124
2022-2023	119
2023-2024	41 (Up until July this year)



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Key Themes



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Key Themes and Sub-Themes utilised for this review



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Key Themes	Sub-Themes
Clinical Care & Management Problems	<ul style="list-style-type: none"> • Delayed Treatment for Physical Health Issues, • Inadequate Monitoring of High-Risk Patients, • Suboptimal Pressure Ulcer Care, • Not detecting Deteriorating Patients • Missed Opportunity for Intervention in Self-Harm, • Inconsistent Therapeutic Observation
Inadequate Record Keeping	<ul style="list-style-type: none"> • Documentation Not Logged or Not Completed, • Incomplete or Inaccurate Documentation, • MDT Meeting Notes Not Documented or Logged Correctly, • Falsified Clinical Observations, • Poor Documentation of Risk Assessments
Communication Involving Service Users, Family, Relatives	<ul style="list-style-type: none"> • Breakdown in Communication with Family, • Lack of Involvement of Service Users in Care Decisions, • Failure to Share Critical Information During Handover
Non-Adherence Policies	<ul style="list-style-type: none"> • Non-Adherence agreed protocols/policies.
Safeguarding Concerns	<ul style="list-style-type: none"> • Not Recognising and Raising Safeguarding Alert • Not Liaising with Local Authorities



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Key Themes and Sub-Themes utilised for this review



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Staffing & Resource Issues	<ul style="list-style-type: none"> Inadequate Staffing Levels Delayed Response to Staffing Needs, Non-Escalation of Staffing Shortages, High Turnover Affecting Care Continuity 	Violence and Aggression	<ul style="list-style-type: none"> Patient-on-Patient Violence, Violence Towards Staff
Physical Health Issues	<ul style="list-style-type: none"> Concerns around NEWS2 application, Undiagnosed Physical Health Condition, Diagnosed Physical Health Condition but No Follow-Up 	Partnership/Interface Concerns	<ul style="list-style-type: none"> Not Liaising Effectively with External Agencies (Local Authorities, Health Partners). Adherence to agreed protocols by all partners Effective communication between external agencies
Self-Harm and Suicide Attempts	<ul style="list-style-type: none"> Missed Opportunities for Self-Harm Interventions, Incomplete Risk Formulation for Suicide Prevention 	Carers' Assessment & Support	<ul style="list-style-type: none"> Inadequate Support for Carers Not Linking Carers' Assessment to Patient Care
Transition in Care Concerns	<ul style="list-style-type: none"> Transition Planning between Services, Not Completing 72-Hour Post-Discharge Assessments Not Providing Adequate Follow-Up Care Post-Discharge 	Autism and Learning Disability	<ul style="list-style-type: none"> Inadequate Support for Autism and Learning Disability Patients, Poor Recognition and Adjustment of Care for Learning Disabilities
Access Problems & Delays in Care	<ul style="list-style-type: none"> Waiting List Concerns Delayed Response to Absconding Patients, Lack of Emergency Response 	Staff Induction & Training	<ul style="list-style-type: none"> Inadequate Awareness of Safeguarding Concerns, Inadequate Training on Care Policies and Protocols
Concerns Around Medication	<ul style="list-style-type: none"> Inconsistent Medication Management Delayed Administration of Critical Medications Patient Compliance with medication regime Adequate Monitoring of patients on medication and side effects Polypharmacy Risk 		



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Finding & Analysis



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•Clinical care and
management

•Safeguarding
application

•Adherence to
policy

•Communication/
involving services
and family

•Falsification of clinical observations

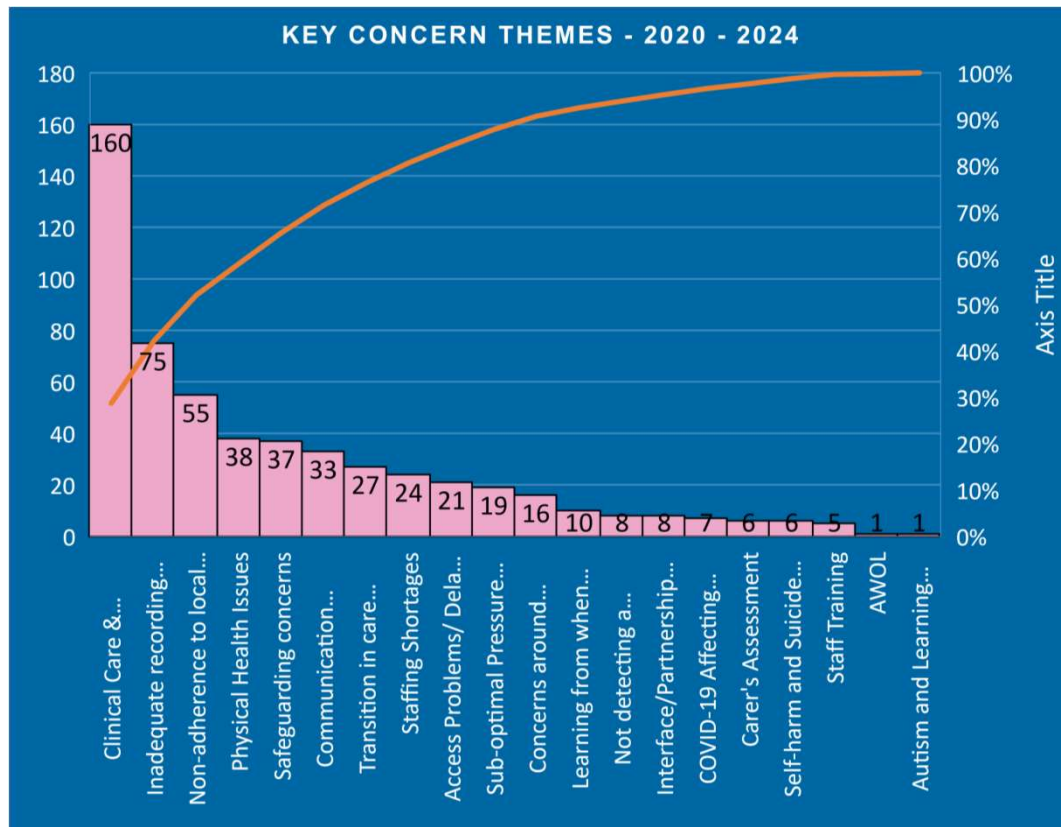
•Documentation
of risk
assessments

•Record-keeping quality



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Key Concern Themes 2020-2024



The 10 themes identified are as follows –

- Clinical care and management issues,
- Inadequate record-keeping,
- Non-adherence to local policies,
- Physical health considerations,
- Safeguarding concerns,
- Communication involving service users, families, or relatives,
- Transitioning care concerns,
- Staffing shortages,
- Access issues,
- Delays in care,
- Suboptimal pressure ulcer management, Concerns around medication handling.



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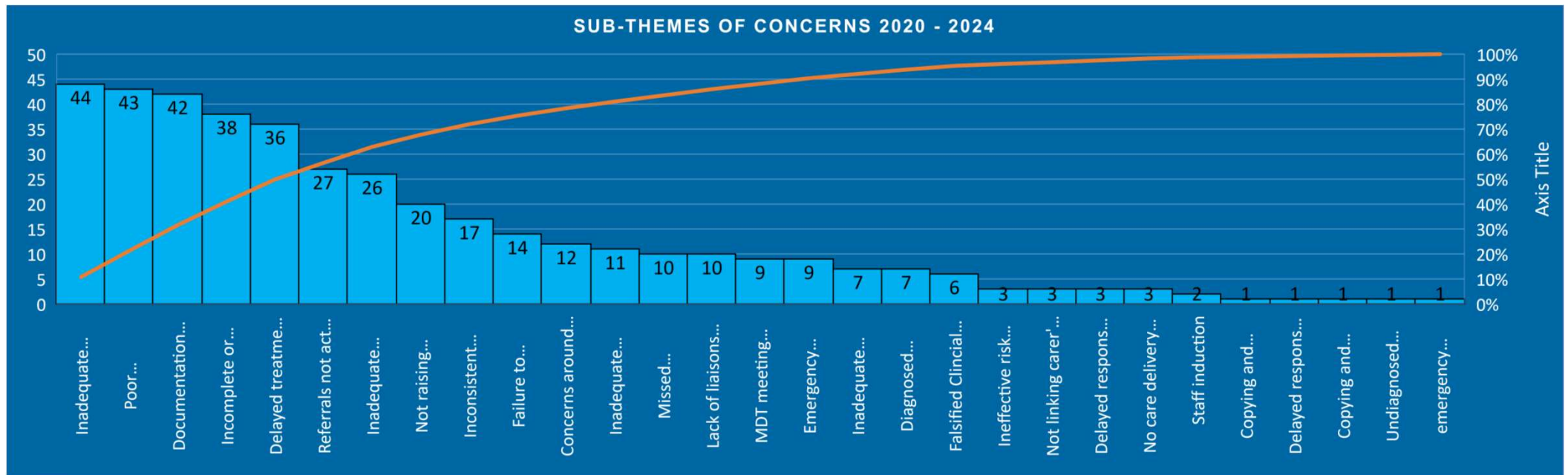
Sub-Themes of Concerns 2020-24



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Similarly, sub-themes within these categories offer additional insights into the specific areas that require focused attention.

Addressing these sub-themes could strengthen the Trust’s ability to prevent recurrence and improve overall performance.



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Theme 1: Record-Keeping: Overview and Trends (2020 – 2024)

Record-keeping has consistently emerged as a complex, recurring theme across key Trust functions, intertwining with other areas such as patient safety and continuity of care. From 2020 to 2024, record-keeping issues were identified in approximately 142 cases, with concerns ranging from inadequate risk assessments, incomplete documentation, and failure to log MDT notes to non-adherence to policies.

Theme 2: Clinical Care and Management Problems: Overview and Trends

At a broad level, this was the most reoccurring theme identified. Between 2020 and 2024, the Trust identified a range of clinical care and management problems. These issues included referrals not being acted upon (27 instances), inadequate monitoring of high-risk patients (24 instances), and concerns around the application of NEWS 2 for deteriorating patients (12 instances).



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Theme 3: Non-Adherence to Policy: Overview and Key Themes (2020 – 2024)

From 2020 to 2024, there were 55 instances of non-adherence to policies, primarily involving risk assessment policies, documentation policies, and safeguarding protocols—again these themes were interconnected with documentation/recording keeping concerns highlighted in the analysis above. The most commonly reported lapses were in adherence to risk assessment procedures, followed by not maintaining documentation standards and safeguarding policies.

Theme 4: Safeguarding Concerns: Overview and Key Trends

From 2020 to 2024, 36 instances of safeguarding concerns were recorded. At a sub-theme level the main themes observed were challenges in liaising with local authorities, raising concerns, not raising safeguarding alert when required or inadequate awareness of safeguarding concerns in some instances.



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Theme 5: Communication Involving Service Users, Family, and Relatives

Between 2020 and 2024, communication involving service users, family members, and relatives was identified as a recurring issue, with a total of 33 instances recorded.

Theme 6: Physical Health Management and Year-on-Year Trends with SEIPS and Technological Integration.

From 2020 to 2024, 38 physical health-related incidents were reported. A key issue identified was delayed treatment, often linked to referrals to other services, including specialist services, acute providers, and GPs. Additionally, some monitoring concerns were connected to the interface with acute providers and GPs, highlighting the complexity of managing physical health across different services.



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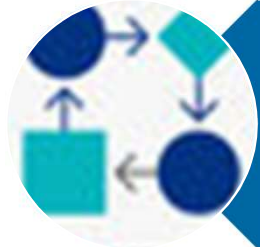
Theme 7: Transition in Care Year-on-Year Trends

Over the past three and half years, there have been 14 instances of incomplete assessments, and 27 transition-related issues were identified, pointing to valuable insights into how we can better coordinate care packages and strengthen communication with families.



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Recommendations



As part of the **Incident Management pathway**, the Trust will standardise the classification of incidents using the sub-theme headings identified in this review.



Expand and Target Staff Training: Strengthen training on broader safeguarding categories, including financial safeguarding, to ensure staff confidently identify and escalate concerns.



Enhance Coordination with Local Authorities: Improve collaboration with local authorities to ensure safeguarding concerns, particularly Section 42 referrals, are raised and followed through to resolution, particularly in cases with overlapping responsibilities



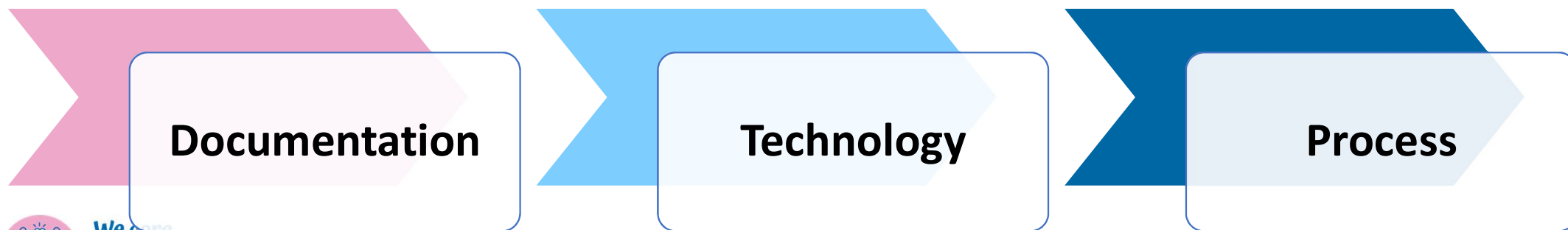
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Recommendations

Documentation: Improving documentation is key to reducing delays in referrals and monitoring. By integrating systems like SystemOne and RiO more effectively, the Trust can ensure that referrals and follow-ups are consistently tracked, preventing missed escalations and supporting timely interventions.

Technology Integration: Streamlining technology will improve coordination with GPs and acute providers, allowing for automated tracking of referrals and escalations. This will reduce the administrative burden and improve response times for both routine care and emergency situations.

Administrative Processes: Automating routine tasks, such as referrals, will minimise delays and free up staff for direct patient care. Ensuring adherence to therapeutic observation protocols and improving pressure ulcer management will enhance overall physical health care delivery.



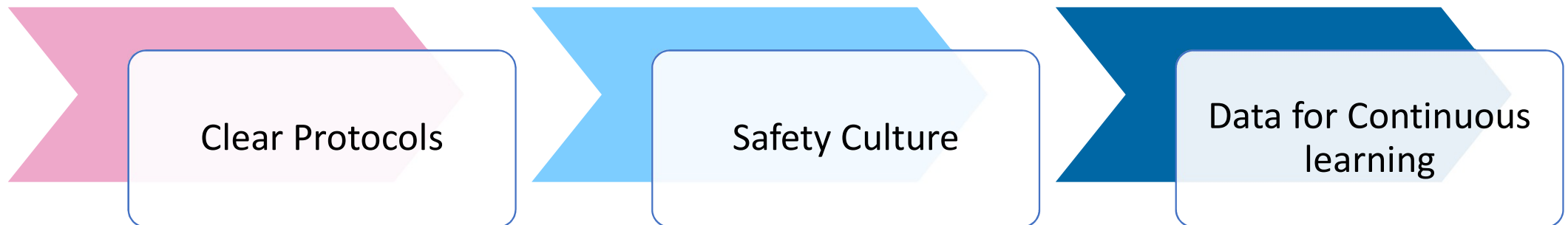
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Recommendations

Establish Clear Protocols: Create standardised processes for managing transitions in care, especially during discharge.

Promote a Culture of Safety: Encourage reporting and learning from incidents to enhance transparency and accountability.

Utilise Data for Continuous Improvement: Leverage incident report data to drive targeted interventions and improve care delivery.



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Any questions



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Thank you.

If you have any questions, you can email

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or

**Speak to someone in our Incident Team
Governance & Risk Department**

Feedback



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