Part 1 Board Meeting 26th July 2012

Agenda Item 07/12 - 17

Serious Incident (SI) Summary Report

The table below sets out the serious incidents reported since the previous Board meeting (appendix A provides further detail), the current status of open investigations and details of incidents closed since the last report. The Board can take significant assurance from the current position regarding Serious Incidents.

Assurance Assessment

1. The majority of serious incidents reported relate to the requirement to report all Grade 3/4 pressure ulcers. Those reported are currently being investigated to determine whether they were avoidable. Pressure ulcers deemed to be unavoidable are downgraded.

2. Part of the Trust process following a serious incident is to ensure immediate risks are managed and that timely action is taken to minimise recurrence – this is core to the management of serious incidents.

3. All serious incident reports are reviewed at the Serious Incident Group and learning shared as relevant. Where appropriate, serious incident reports form the basis of case studies presented at governance meetings and at Patient Safety Grand Round meetings.

4. Learning from incidents is shared through the CLIP summary reports and through regular articles in the In-Focus and On the Pulse publications.

Summary of Incidents

5. Since the last report,**12** Serious Incident (SI) cases have been declared to the PCT:

- SI29542 Near Miss: Urology Procedure on Wrong Patient
- SI29456 Norovirus
- SI29108 Grade 3 HAPU
- SI29107 Grade 3 HAPU
- SI28875 Grade 3 HAPU
- SI28824 Grade 3 HAPU
- SI28573 Grade 3 HAPU
- SI28643 Grade 3 HAPU
- SI28263 Grade 3 HAPU
- SI28138 Theatre Drug Incident
- SI28264 Grade 3 HAPU

- SI28095 Grade 3 HAPU

6. As indicated, the majority of the incidents reported are for pressure ulcers and not all will be deemed avoidable. The Trust's performance in identifying and managing pressure ulcers remains exemplary.

7. **Twenty nine** SI cases are progressing through various stages of investigation. Of these:

   - **2 for 2010/11, 14 for 2011/12 and 13 for 2012/2013.**

   - The PCT agreed that **2 HAPUs were unavoidable** and are no longer SIs:

     1. SI27564 Grade 3 HAPU
     2. SI28095 Grade 3 HAPU

   - **1 SI is being put through the closure process**

   - **7 SIs require the submission of evidence of action plan implementation** once the actions are complete in order to be considered for closure by the PCT.

8. **22 SIs were closed** by the PCT in June/July 2012

   - 26375, 26240, 65206, 24326, 24332, 25715, 23800/23659, 22449, 23715 & 19187 grade 3 HAPUs
   - 26218 march 2012 maternity unit closure
   - 16821 wrong site discectomy (NE)
   - 21777, 18711 & 19857 retained tampons (NEs)
   - 21778 Feeding pump fault
   - 22430 AAU death certificate book
   - 23424/23 AAU Staff abuse
   - 24955 Discharged Patient fall
   - 25106 HHGH Norovirus ward closure
   - 24751 WGH Norovirus ward closure
   - 16530 Maternity Processes (CTG)

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