Part 1 Board Meeting 29th November 2012

Agenda Item 22 /12

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 that serious incidents are managed robustly, that investigations are undertaken and reported to PCT within the required timescales. All SI reports for the year 2011/12 have now been closed.

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. The most recent meeting of the SIG was on 15th October. 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.
5. Further work is being undertaken to improve the processes for cascading learning within divisions and a staff survey is being developed to determine the effectiveness of existing arrangements for organisational learning from incidents.

Summary of Incidents

6. Since the last Trust Board meeting in September, 24 Serious Incident (SI) cases have been declared to the PCT:

- SI32827 Pathological CTG Escalation
- SI33093 HAPU Grade 3
- SI32957 HAPU Grade 3 x 2
- SI32942 HAPU Grade 3
- SI32919 HAPU Grade 3
- SI32883 HAPU Grade 3

- SI32921 Hepatitis B Reactivation
- SI32361 53 DEXA Breaches
- SI32695 Phototherapy Burn
- SI32698 Phototherapy Burn (No Visor)
- SI32687 C-Diff Outbreak Stroke
- SI32579 #NOF Cassio
- SI32412 C-Diff and SI32077 C-Diff (Joint Investigation)
- STEIS 24179 Medication Misconduct Allegation
- SI31752 HAPU Grade 3
- SI31750 HAPU Grade 3
- SI31753 HAPU Grade 3
- SI31732 HAPU Grade 3
- SI31646 NND
- SI31193 HAPU Grade 3
- SI31526 Allegation of Abuse (HCA)
- SI31513 HAPU Grade 3
- SI31551 Delay in ureteroscopy

7. As indicated, the majority of the incidents reported are for pressure ulcers and not all will be deemed avoidable. The number of pressure ulcers reported is of concern but work is ongoing to improve detection and timely intervention. The phototherapy burn incidents have triggered a review of practice. The DEXA breaches relate to a failure in administrative processes to maintain requirements in managing information in a timely manner.

8. **Thirty Two** SI cases for 2012/2013 are progressing through various stages of investigation. Of these:

   - The PCT agreed that **5 HAPUs were unavoidable** and are no longer SIs:

     1. SI28573 Grade 3 HAPU
     2. SI28263 Grade 3 HAPU
     3. SI30844 Grade 3 HAPU
     4. SI30357 Grade 3 HAPU
     5. SI68463 Grade 3 HAPU

   - **5 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.

9. **18 SIs were closed** by the PCT in October 2012

   - SI29456 Norovirus
   - SI29107, 28095, 28643, 25720, 25669, 20930 Grade 3 HAPUs (Avoidable)
   - SI28138 Theatre Drug Incident
   - SI26153 HCT/WHHT C-Diff death
   - SI25757 Maternal Death
   - SI23366 Iodine Blisters
   - SI23695 Asbestos
   - SI22356 Overdose Phototherapy
   - SI19353 Retained Seasorb Swab **(NE)**
   - SI19230 Absconded AAU Patient
   - SI18706 Unexpected admission to NICU of a term baby
   - SI15814 Maternity Processes

- SI16334 CED admission in CA of LDYP

The Serious Incident Requiring Investigation Policy has been subject to further review to update guidance in relation to investigation panels, being open and external investigations.

The Trust remains robust in its identification, reporting and investigation of serious incidents but continues to work to improve the organisational learning emanating from investigations.

The Risk department has been awarded funds from the Gurney Bequest to run an externally delivered intensive training course in root cause analysis which is being targeted at consultants and senior nurses and will be scheduled for Q4.

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