West Hertfordshire Hospitals NHS
NHS Trust

Trust Board Meeting
12 February 2015

Title of the paper:	**Serious incident summary report - month 8 and 9**
Agenda Item:	**14/24**
Lead Executive:	**Dr Mike Van der Watt, Medical Director**
Author:	**Mel Withero, SI Lead**
Trust objective:	**Provide safe patient care**
Purpose:	**The aim of this paper is to provide a summary of SI Management since the last meeting**

Name:	Patient Safety, Quality and Risk Committee
Date:	3 February 2015

Benefits to patients and patient safety implications
To improve patient safety via reporting and learning from incidents.

Risk implications for the Trust Risks to patient safety if the Trust does not effectively manage SIs by investigating and learning lessons from SI investigations.	**Mitigating actions** (controls) Clear SI Process embedded. SI Panels devised to improve the quality of reports and ensure actions are SMART and a centralised action tracker.

Links to Board Assurance Framework, CQC outcomes, statutory requirements

Legal implications (if applicable)

Financial implications (if applicable)

Recommendations (delete as appropriate)

For information and assurance - The Board is asked to receive the report for information and assurance.

Agenda Item: 25/11

Trust Board meeting – 12 February 2015

Serious incident summary report – month 8 & 9

Presented by: Dr Mike Van der Watt, Medical Director

1. Purpose

1.1 The purpose of this report is to provide an update on the management of Serious Incidents (SIs).

2. Background

2.1 SIs are reported by the Trust in line with NHS National Framework for Reporting and Learning from Serious Incidents 2010 and the commissioning update in June 2013 to the CCG. The process supports continuous quality improvement and learning across all Divisions and Departments.

3. Analysis/Discussion

3.1 **Number of Serious Incidents and Never Events**

3.2 The Trust has 83 open SIs.

3.3 There is currently 1 Never Event incident open (Wrong Prosthesis)

3.4 From 1 April 2014 to 31 December 2014, the Trust has reported a total of 138 SIs to the CCG.

3.5 The table below presents the SIs reported for 2014/15 under their incident category and month reported to the CCG

SI Category	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Assault by Inpatient (in receipt)	1	0	0	0	0	0	0	0	0
Allegation Against HC Professional	0	0	0	1	1	1	0	0	1
Attempted suicide									1
C.diff and HCAI	2	0	0	0	0	1	1	2	0
Confidential Information Leak	1	3	0	0	0	1	1	1	0
Delayed Diagnosis	2	1	0	1	0	1	0	0	0

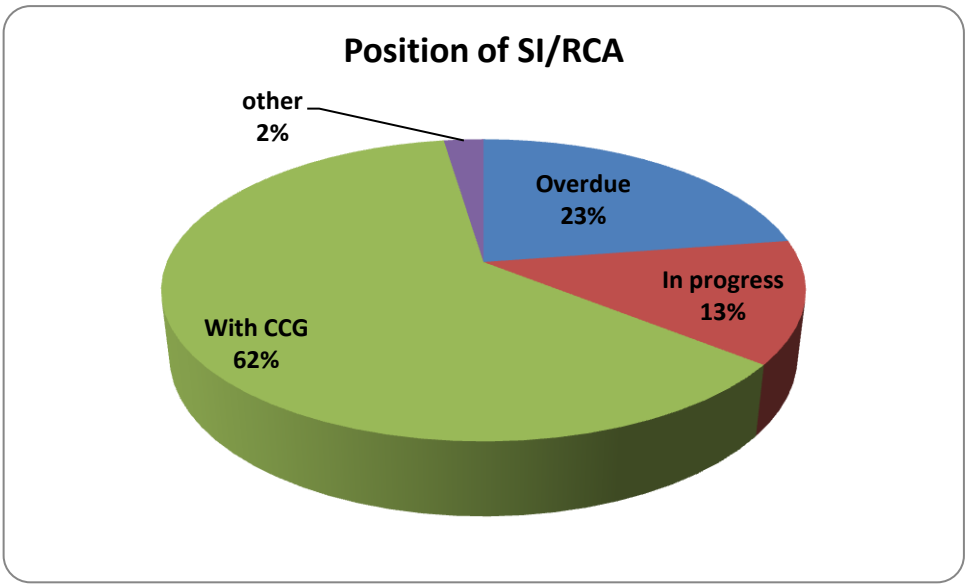
Drug Incident (General)	2	2	0	0	0	1	1	0	0
Failure to act on results	2	0	3	0	1	4	1	0	0
Other									0
See below	2	1	4	0	0	0	0	2	1
Pressure Ulcer Grade 3	11	2	5	5	7	6	2		0
Premature Discharge	0	0	0	0	0	1	1	1	0
Slips/Trips/Falls	2	1	1	1	0	0	0	2	0
Safeguarding Vulnerable Child	0	0	1	0	1	0	0	0	1
Safeguarding Vulnerable Adult	0	0	1	1	0	0	0	1	0
Surgical Error	1	0	0	0	0	1	0	1	0
Unexpected Death	1	1	1	1	1	1	1	0	1
Security Threat	0	0	0	1	0	0	0	0	0
Maternity Services	0	1	1	0	0	0	0	0	0
Maternity Services - Suspension	0	0	0	0	0	1	0	0	0
Never Event	0	0	0	0	0	0	1	0	1
Outpatient Appointment Delay	0	1	0	0	0	0	0	0	0
Unexpected Death of Outpatient (In receipt)	0	0	0	1	0	0	0	0	0
Communication Issue	0	0	0	1	1	0	0	0	0
Sub-optimal care of the deteriorating patient	0	0	1	0	1	0	0	0	0
Hospital Transfer Issue	0	0	0	0	1	0	0	0	2
Hospital Equipment Failure	0	0	0	0	0	1	0	1	0
Maternity Services - Maternal Death	0	0	0	1	0	0	0	0	0
Health and Safety	0	1	0	1	0	1	0	0	1
Communicable Disease and Infection Issue	0	1	1	0	0	0	0	1	0
Total	**27**	**15**	**19**	**15**	**14**	**21**	**8**	**12**	**9**

3.6 Others = Failure to follow policy – storage of kitty money; Retinopathy diagnosis case, missing prescription (FP10) pad, delay in surgery, Retained Drain, Deep Vein Thrombosis and Pulmonary Embolism.

The November and December use of 'other' is for 1 event of a lost foetal specimen and for one event of a locum Dr being employed without the appropriate level of clearance.

3.7 This data is pulled from a live database which is constantly updated and can be updated with retrospective data.

3.8 The chart below presents the position summary of all the SIs open for the Trust as of 31 December 2014.



3.8 Outstanding SI reports

There is currently a significant back log of RCA reports which are overdue; these can be grouped into two sections.

a.) reports which are overdue and are awaiting submission

b.) reports which have not been closed due to the CCG requiring further information and assurance prior to submission to the panel for closure.

Significant progress has been made against the number of outstanding RCAs. In the 2 week period prior to the Christmas break, 11 completed RCA investigations were completed and submitted. Along with the thematic review of pressure ulcers (32) which was also submitted.

This reduced the numbers of outstanding SIs by 43 in a two week period.

3.10 The primary reasons offered by staff as to delays in investigation and responses include:

- Challenges in ensuring they are released from clinical activities
- Expertise to undertake investigations
- Difficulties obtaining medical notes
- The investigation uncovering additional issues
- Failure of staff to engage in the investigation (delays in submitting statements)
- Staff taking annual leave during the investigation period

4. Summary of Lessons Learnt and Recommendations

4.1 Below is a summary of the lessons learnt and recommendations following the RCA investigations of some SIs that have been submitted to the CCG:

4.2 50387 - On the 29th April 2014, a 75yr old lady was brought to A&E by ambulance, following a fall which resulted in amnesia and loss of consciousness. The patient was identified as taking Warfarin and a CT scan undertaken which showed an occipital fracture, bloods were reviewed and the patient subsequently discharged by Doctor. The patient represented to hospital on the 29th May 2014 and was diagnosed with a subdural bleed.

The lessons learned for this incident were that the head injury pathway was ambiguous and open to an element of interpretation. Also the documentation completed by the nursing staff was not up to the standard expected.

4.3 53014 – A young female patient attended A&E reporting pain similar to a previous event of a ovarian torsion. She had taken significant amount of pain relief at home. Whilst in A&E she received appropriate doses of morphine, however she suffered an unresponsive episode which appeared to have been triggered by overdose of morphine. The investigation found that although the patient's cannula was poorly managed, the reaction could have been a vasovagal attack.

The lessons learned concentrated on the poor management of the cannula and failure to consider alternate methods of pain relief.

4.4 52059 - A GP referred a baby who was subject to a child protection plan (neglect) to the Trust. The GP did not follow usual process for referral and so there was a delay (5 days)in triggering the review of the child. The investigation also determined that the Trust does not have a robust process in place to ensure that any urgent referrals are picked up and actioned at the first opportunity. The lessons learned and action plan are centered on ensuring that a failsafe processes is in place which does not rely on one individual.

4.5 49922 – this SI was initially triggered as an unsafe transfer. The investigation determined that the transfer of the child to the Lister Hospital was in line with the guidelines for managing ENT emergencies out of hours. This SI has since been stood down. However the lessons learned were linked to the failure to ensure that skills for rarely used equipment are kept up to date. Had the skills been current, this transfer may have been avoidable which would have presented a more positive patient experience.

5. Recommendation

5.1 The Board is asked to note the report for information and assurance.

Dr Mike van der Watt
Medical Director
19 January 2015