TRUST BOARD IN PUBLIC	**Date: 26th October 2017** **Agenda Item: 2.4**	
REPORT TITLE:	Serious Incident Report for Q2 2017/8	
EXECUTIVE SPONSOR:	Fiona Allsop Chief Nurse	
REPORT AUTHOR (s):	Kim Rayment Patient Safety & Risk Facilitator	
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	n/a	
Action Required:		
Approval ( )	**Discussion (✓)**	**Assurance (✓)**
Purpose of Report:		
This paper provides the Board of Directors with a report on the serious incidents declared in Q2 and an update on the overall position with regard to the management of serious incidents within the Trust.		
Summary of key issues		
• The Trust reported 13 serious incidents in Q2 2017/18. All incidents were reviewed and escalated appropriately. • There were no never events • As at 11 October 2017 the Trust has 21 serious incidents open with the CCG, of which 10 have been submitted for closure.		
Recommendation:		
The Board is asked to note the contents of this report.		
Relationship to Trust Strategic Objectives & Assurance Framework:		
SO1: Safe – Deliver safe, high quality care and improving services which pursue perfection and be in the top 25% of our peers **SO2:** Effective – As a teaching hospital, deliver effective and improving sustainable clinical services within the local health economy **SO3:** Caring – Work with compassion in partnership with patients, staff, families, carers and community partners		
Corporate Impact Assessment:		
Legal and regulatory impact	Compliance with CQC, MHRA and Audit Commission	
Financial impact	Serious incidents often become claims	
Patient Experience/Engagement		
Risk & Performance Management	Reporting, investigation and learning from serious incidents informs risk management	
NHS Constitution/Equality & Diversity/Communication		

Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD REPORT IN PUBLIC
Serious Incident Report – period: Q2 2017/18

1. Introduction

1.1 A report on Serious Incidents (SI) is produced each month to provide assurance that they are being managed, investigated and acted upon appropriately and that action plans are developed from the Root Cause Analysis investigations.

1.2 This paper looks specifically at those incidents that are considered as SIs following the guidance from the NHS England's 'Serious Incident Framework" published March 2015.

1.3 A summary of open SIs is published weekly and circulated to Execs.

1.4 SI reports are reviewed by the Sussex Scrutiny Group. The Patient Safety and Risk Lead presents the reports to the panel and provides feedback to the Trust Serious Incident Review Group.

2. Patient Safety Incidents in 2017/18 Q2

2.1 There were a total of 2235 incidents reported on DatixWeb in Q2 2017/18 of which 1879 (84%) were clinical/patient safety incidents. These incidents breakdown as follows:

	July 2017	August 2017	September 2017	Total
None	481	504	447	1432
Low	156	132	115	403
Moderate	5	16	12	33
Severe	6	0	5	11
Death	0	0	0	0
Totals:	648	652	579	1879

Over the quarter 447 of the 1879 incidents (24%) caused harm to a patient.

The last eight quarters are as follows:

	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	Total
None	1149	1298	1315	1389	1350	1420	1612	1432	10965
Low	360	394	372	414	412	428	424	403	3207
Moderate	7	9	13	22	12	20	22	33	138
Severe	7	16	8	13	7	2	5	11	69
Death	2	1	2	0	0	0	1	0	6
Totals:	1525	1718	1710	1838	1781	1870	2064	1879	14385
% of Harm	25%	24%	23%	24%	24%	24%	22%	24%	24%

2.2 The incident categories are shown for those patient safety incidents reported in Q2 2017/18 as moderate harm, severe harm or death.

	Moderate	Severe	Death	Total
Infection control	10			10
Falls	4	5		9
Skin damage	5			5
Appointments	2	2		4
Care implementation	2	2		4
Clinical diagnosis	4			4
Medicines	1	1		2
Treatment / Procedure	1	1		2
Abuse of Patient	1			1
Discharge	1			1
Surgery operations	1			1
Pathology / Samples	1			1
Totals:	**33**	**11**	**0**	**44**

3. Serious Incidents declared in Q2 2017/18

3.1 The Trust declared 13 serious incidents in Q2 2017/18; 6 in July; 3 in August; 4 in September.

Declared	Steis	Category	Description	Outcome / Learning
28/09/17	2017/23965	Appointments	The patient had right wet macular degeneration and was advised they required an anti VEGF injection course into the right eye within 2 weeks. There was a delay of 3 months that reduced their vision significantly. The treatment has been started after discussion with a consultant colleague.	Being investigated
17/08/17	2017/20678	Appointments	The patient has been receiving Eylea injections for right-sided Wet Macular Degeneration – a cause of loss to the central field of vision. The last review was on 1/2/2017 and advised to be seen in 8 weeks as per protocol. The delay of 5 months has resulted in significant reduction of right vision.	The process for rebooking appointments at the time of the incident was to rebook to the next available appointment which would normally be in around 3 months' time, which did not take into account the patient's clinical requirements. This incident has resulted in the immediate escalation of patients who wish to reschedule injections to the Ophthalmology Service Manager and Ophthalmology Service Delivery Co-ordinator to ensure that the appointment is allocated correctly and so reduce the risk of deterioration of the patient's visual acuity.

Declared	Steis	Category	Description	Outcome / Learning
18/09/17	2017/23097	Care implementation	There was a delay in diagnosis of suspected tumour in the head of the pancreas and also of pulmonary emboli.	Being investigated
20/07/17	2017/18227	Care Implementation	Patient was moved to IRU for rehabilitation following chemotherapy and was medically fit for discharge, but needing physio. A high temperature was not acted upon and patient's condition deteriorated over the course of 4 days.	Being investigated
17/08/17	2017/20668	Care implementation	The medical team had to contact the surgical team on a number of occasions before they came to review the patient with acute cholecystitis (inflammation of the gall bladder). A later CT scan showed that the patient had developed a viscus perforation	The patient was admitted as an emergency with abdominal pain but under the incorrect (medical as opposed to surgical) team and there were significant problems encountered by the medical team in communicating with the upper GI surgical team. The key lesson learned is the need to follow established guidelines for the admission of patients with abdominal pain and develop clear standards for referrals and escalation.
29/08/17	2017/21528	Care implementation	Patient was admitted onto the Bowel Scope list for a flexible sigmoidoscopy. The patient was at risk of developing CJD in later life. The Specialist Screening Practitioner (SSP) phoned infection control for advice. She told the team to take in the next patient while she made her phone call. Infection Control said not to scope the patient. When the SSP returned to the room her patient had had their procedure done	At several key points along the patient's pathway and including the WHO checklist, the staff involved omitted to use the correct procedure to correctly confirm the identity of the patient. The key lesson learned is that staff must follow guidance correctly, identifying the correct patient by involving the patient, checking the details on the patient's name band and cross referencing this information with the first name, surname, date of birth and hospital number from the patient notes and procedure consent form.
18/07/17	2017/18033	Falls	Patient suffered an unwitnessed fall whilst confused. Patient later required surgical intervention to insert a chest drain due to a haemopneumathorax. Imaging completed confirmed three fractured ribs which are thought to have likely caused the	Expectations and a reassessment of the level of supervision required to enable the patient to maintain a safe environment was not carried out when his wife left the ward. The patient had been allocated a side room as his wife had been staying overnight to offer

Declared	Steis	Category	Description	Outcome / Learning
			haemopneumathorax.	support, as this was now not going to be the case consideration to the appropriateness of a side room accommodation for a confused patient should have been given. Key lessons learned included the need to complete the falls risk assessment on admission and updated after the fall; the importance of induction of all agency staff with regards to the Falls protocol; the need to reassess patients ability to maintain a safe environment when there is a change in supervision provision (including relative/ carer supervision); the importance of assessing the appropriate use of the side room accommodation in relation to patients cognitive state; and the need to undertake a lying/standing BP on admission for mobile patients over 65years.
20/09/17	2017/23304	Falls	There was an unwitnessed fall on CDU. The patient was assisted back to bed and an x-ray confirmed fractured left neck of femur.	Being investigated
12/07/17	2017/17604	Falls	Patient was admitted with a left peri prosthetic fracture following a fall at home. During her stay the patient was assisted by two staff and pulpit frame, as instructed by physiotherapist. Whilst mobilising and without warning the patient became unresponsive and began to fall. The nursing staffs were able to control the fall and the patient was lowered to the floor.	This was a controlled fall as a result of a vasovagal episode which resulted in a periprosthetic fracture. Key lessons learned included; the need to complete the falls assessment after any vasovagal episode; the importance of the medical staff being aware of the Falls policy and ensuring it is followed correctly; the need to complete lying and standing blood pressure after all vasovagal episodes.
11/07/17	2017/17379	Falls	Patient had an unwitnessed fall and sustained a fractured neck of femur.	The patient was not supervised at the time of the fall. Key lessons learned included; the need for clear communication between staff that they are leaving a bay unattended; the importance of clear expectations and responsibilities of the role of close supervision; and the need for clear documentation of why lying and standing blood pressures have not been

Declared	Steis	Category	Description	Outcome / Learning
				completed
03/07/17	2017/16758	Maternity / Neonatal	Difficult delivery during EMCS This resulted in atonic uterus and significant blood loss. Baby delivered by breech extraction in poor condition and transferred to SCBU. Care was withdrawn by parents and sadly the baby died at 14:15.	Difficult delivery at caesarean section. The obstetrician was an experienced registrar who had performed many caesarean sections previously. The reason for this difficulty has not been determined during the investigation. There were no risk factors present pre-operatively that would have marked this as a potentially difficult delivery. Key lessons learned included; the importance of formal guidance which can be followed during rare events such as this to inform the team and ensure all care is appropriate; the importance of the multidisciplinary team being aware of techniques to utilise in the event of a deeply impacted head at caesarean section; and the need, when a plan is made to transfer care to an alternative ward or speciality, this should only be made consultant to consultant and during the day time.
27/09/17	2017/23906	Medicines Management	The patient was admitted with neutropoenic sepsis. This was diagnosed immediately and treatment commenced. The patient was transferred to Charlwood ward under the medical team and did not receive any further doses of antibiotics until late evening. The patient died the following day.	Being investigated
21/07/17	2017/18322	Treatment / Procedure	On 3 May 2017 the patient was clinically assessed as requiring urgent argon laser treatment in the retina clinic. The patient was seen on 18 July when a significant deterioration in vision was found, the right eye had developed irreversible proliferative diabetic retinopathy and changes in the left eye were worse.	The Royal College of Ophthalmologists Diabetic Retinopathy Guidelines for laser treatment within 2 weeks for a diagnosis of R3A was not followed for the left eye. However, when the patient presented in July 2017 the left eye had remained stable but the right eye had bled and deteriorated to counting fingers that could not be improved with laser. If the patient had been seen earlier, the start of the

Declared	Steis	Category	Description	Outcome / Learning
				deterioration in the right eye may have been present. The key lessons learned included; the need for the process for making an urgent follow up appointment after an outpatient consultation needs to be improved to ensure that ophthalmology patients are treated within the recommended national guideline.

3.2 SI themes over the last 12 months

The serious incidents are shown by the month in which they occurred, not the month in which they were declared. The date of knowledge and therefore declaration may be different.

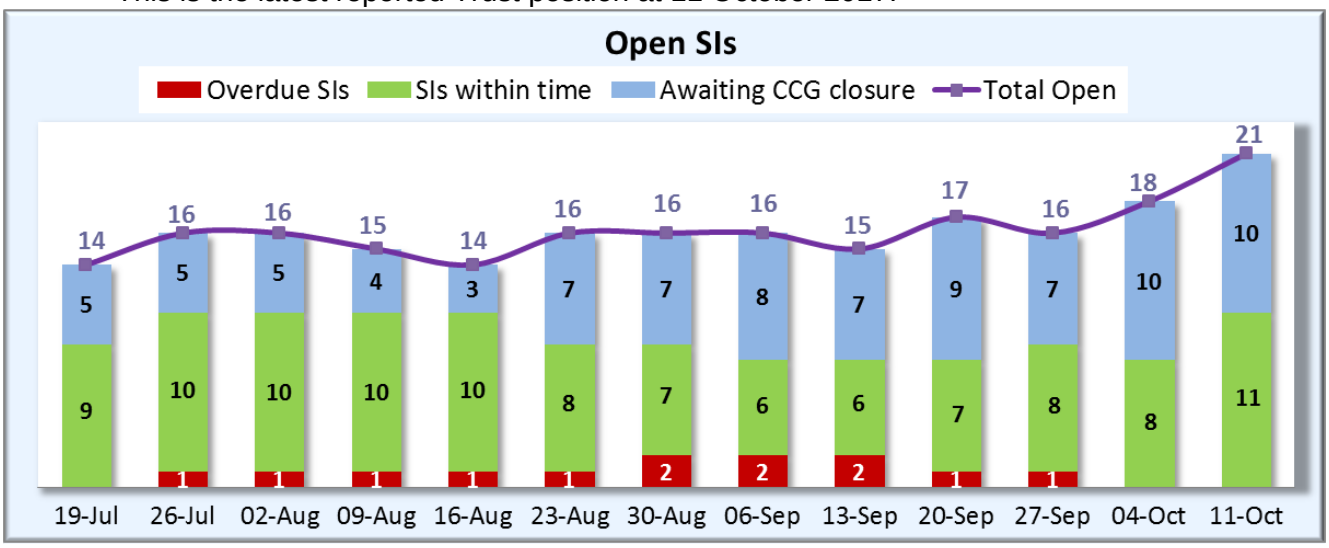
41% (13) of the SIs that occurred in the last twelve months relate to patient falls.

	2016 10	2016 11	2016 12	2017 01	2017 02	2017 03	2017 04	2017 05	2017 06	2017 07	2017 08	2017 09	Total
Falls	3		3	1					2	2		2	13
Maternity / Neonatal				1		1	1	1	1				5
Care implementation									2	1	1		4
Treatment / Procedure							1		1	1			3
Appointments										1		1	2
Clinical diagnosis								1			1		2
Accidents							1						1
Surgery operations		1											1
Medicines												1	1
Totals:	3	1	3	2	0	1	3	2	6	5	2	4	32

4. Weekly overview

A weekly open SIs overview summary is sent to the Patient Safety and Risk Lead and the Chief Nurse which indicates overall Trust and Divisional performance in completing SI investigations within the National timeframe. The Serious Incident Review Group closely monitors the investigation and submission process. The Divisions are asked to include an update on RCA reports to the Patient Safety and Clinical Risk Sub-Committee.

This is the latest reported Trust position at 11 October 2017.



@11/10/2017

Serious Incidents	CANCER	CORP	MEDIC	SURG	WACH	Total
RED - Overdue						**0**
AMBER - due in <=20 days	1					**1**
GREEN - due in >20 days	1		5	4		**10**
Awaiting CCG closure	1		5	3	1	**10**

Total Open SIs	**21**
Total Overdue SIs	**0**
Total SIs on time	11

5. Recommendation

The Trust Board are asked to discuss the report and take assurance regarding the management of SIs and the on-going work to improve performance on completing SI investigations within the National timeframe.

Fiona Allsop
Chief Nurse
October 2017