LNWH NHS TRUST SERIOUS INCIDENTS REPORT (PUBLIC)
Report Date: 4 August 2015
Reporting period: 1 July to 31 July 2015

1. Introduction
The report provides a summary of Never Events (NEs) and Serious Incidents [SIs] reported for July 2015 and SIs and NEs with completed investigations and actions which were closed in the reporting period.

2. Never Events
Never Events are defined as '*serious largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers*'. The Trust has reported 0 Never Event's for the month of July. Year to date the Trust has had 2 Never Events, a third Never Event was de-escalated to a Serious Incident and a fourth incident of retained section of gastric band following removal of the gastric band was agreed by the commissioners not to be a Never Event as the surgery was privately funded and therefore does not meet the Never Event criteria of NHS funded treatment.

3. New Serious Incidents Reported
There were 30 Serious Incidents were reported for July (39 were reported for the previous period) (Table 1). As outlined in Table 1, 13 of the SI's were Pressure Ulcers of which 9 were Grade 3, 4 were Grade 4. Of these 6 were acquired in the care of inpatient wards and 7 were acquired in the care of community services.

Of the remaining 17 SI's, 3 relate to delays in treatment. Of these 2 were for patients under the care of Urology services, both the incidents will be investigated giving consideration to information from a similar SI in 2014 and the third relates to the delayed treatment for a patient with a breast nodule/cancer.

Of the remaining 14 SI's, 2 relate to delays in diagnosis of fractures (1 neck of femur and 1 shoulder) following inpatient falls.

There were 3 SI's resulting from sub-optimal care. All 3 occurred in the Division of Medicine, 2 on Jenner ward and 1 on James ward.

This month there were 2 SI's involving breaches of patient confidentiality, the first involved staff accessing patient's records without reason to and the second to the accidental disposal of LNWH Trust community records by GP practice staff.

Of the remaining 7 SI's details are contained in table1.

A total of 28 of the 30 SI's were reported to the Commissioners, within the 2 working day time frame from the date the SI was identified, as required in the National Serious Incident Framework 2015/16. 2 SI's were reported in more than 2 days from the date the SI was identified (1 of the SI's was reported in 7 days, and a further 1 was reported in 13 days post SI identification).

Table 1 – New Incidents Reported for the Period

STEIS No.	Date of incident	Date reported on STEIS	CSU Deadline	Division	Description of incident
2015/23100	04/07/15	07/07/15	30/09/15	Integrated Care Services	A serious fault was identified between Radiology Information System and PACS.

STEIS No.	Date of incident	Date reported on STEIS	CSU Deadline	Division	Description of incident
2015/23067	29/06/15	07/07/15	30/09/15	Surgery/Critical Care	Epidural Haematoma.
2015/25470	09/04/15	30/07/15	23/10/15	Integrated Care Services	Breast biopsies taken on two consecutive patients in clinic; the results for the patients were mixed-up resulting in one patient without cancer had a mastectomy and the woman with cancer subsequently received diagnosis and treatment in an appropriate timeframe.
2015/24829	05/07/15	23/07/15	16/10/15	Medicines	Outcome from misdiagnosis resulted in a plan to perform a below knee amputation – however further review of the patient identified the misdiagnosis and surgery was not carried out.
2015/24940	13/07/15	24/07/15	19/10/15	Medicines	Closure of A&E due to self-inflicted harm: patient allegedly ingested sulphuric acid.
2015/22855	30/06/15	03/07/15	28/09/15	Surgery	A urology patient's urgent treatment was delayed by 77 weeks.
2015/22836	19/06/15	03/07/15	28/09/15	Surgery	52 week delayed treatment of a urology patient.
2015/24707	13/07/15	22/07/15	15/10/15	Integrated Clinical	Delayed treatment for breast cancer patient.
2015/24066	29/12/14	16/07/15	09/10/15	Surgery	Patient fall of resulting in a Fractured Neck of Femur, delayed diagnosis.
2015/24073	01/04/15	16/07/15	09/10/15	Surgery	Patient fall of resulting in a fractured shoulder, delayed diagnosis.
2015/24062	03/01/15	16/07/15	09/10/15	Specialist Medicine	Sub-optimal care, unobserved death.
2015/24055	17/12/14	16/07/15	09/10/15	Specialist Medicine	Sub-optimal care, unexpected death.
2015/24081	27/04/15	16/07/15	09/10/15	Specialist Medicine	Sub- optimal care relating to type of diet resulting in rapid deterioration and requiring transfer to ITU.
2015/24823	07/07/15	23/07/15	16/10/15	ICT	Access of patient records by staff without reason to - Breach of Patient Confidentiality.
2015/25648	14/07/15	30/07/15	26/10/15	Harrow Community Services	Community diabetes records stored at a GP practice have been disposed of in error by practice staff (approx. 78 patients).
2015/24926	22/07/15	24/07/15	19/10/15	Ealing Community Services	Patient fall resulting in fractured neck of femur.
2015/23389	30/06/15	09/07/15	02/10/15	Harrow Community	Pressure Ulcer Grade 4.
2015/24798	20/07/15	23/07/15	16/10/15	Medicines	Pressure Ulcer Grade 3/4.
2015/24811	20/07/15	23/07/15	16/10/15	Critical Care	Pressure Ulcer Grade 4.
2015/22579	08/06/15	02/07/15	25/09/15	Vascular Surgery	Pressure Ulcer Grade 3.
2015/25551	11/07/14	30/07/15	23/10/15	Surgery	Pressure Ulcer Grade 3.
2015/23933	14/07/15	15/07/15	08/10/15	Surgery	Pressure Ulcer Grade 3/4.

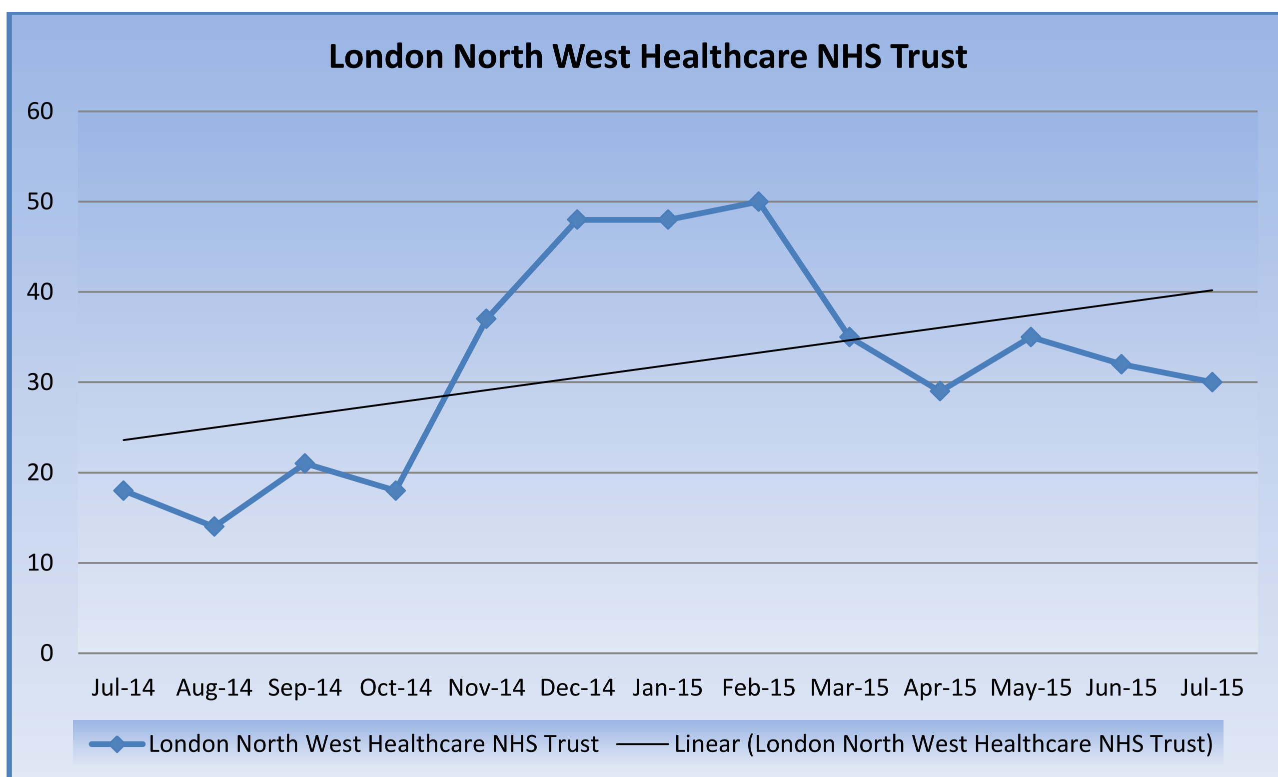
STEIS No.	Date of incident	Date reported on STEIS	CSU Deadline	Division	Description of incident
2015/25379	06/07/15	29/07/15	22/10/15	Surgery	Pressure Ulcer Grade 3.
2015/23395	08/07/15	09/07/15	02/10/15	Ealing Community Services	Pressure Ulcer Grade 3.
2015/22571	29/06/15	01/07/15	24/09/15	Ealing Community Services	Pressure Ulcer Grade 3.
2015/22574	28/06/15	01/07/15	24/09/15	Ealing Community Services	Pressure Ulcer Grade 3.
2015/24763	19/07/15	23/07/15	16/10/15	Ealing Community Services	Pressure Ulcer Grade 3.
2015/23391	01/07/15	09/07/15	02/10/15	Ealing Community Services	Pressure Ulcer Grade 3.
2015/23398	10/05/15	09/07/15	02/10/15	Ealing Community Services	Pressure Ulcer Grade 3.
2015/22651	20/06/15	02/07/15	25/09/15	Surgery	Medication Incident.

It is of note that Ealing Community Services has well established process for reporting pressure ulcers and reports and investigates all unavoidable as well as avoidable grade 3 and 4 pressure ulcers. The Chief Nurse has requested a look back exercise to explain the difference number of pressure ulcers reported across the 3 community services.

4. Serious Incident Reporting Trend

As of July 2015, in line with the changes in national SI reporting the Trust will no longer report and include in this report the delay of handover from LAS to A&E staff of more than 1 hour. The trend for other SI's continues to increase. The Trusts the top 2 categories of SI's for July are Pressure Ulcers 43% (n=13) and Delayed treatment of Diagnosis 17% (n=5).

Chart 1



5. Serious Incidents Currently Under Investigation

There are 34 SI's under investigation. As outlined in Table 2, 24 are patients that have developed Pressure Ulcers in our care.

The Trust has introduced increased scrutiny of SI reports before submission to the Commissioners; specifically those with outstanding actions. There are 2 incidents under investigation that have exceeded the submission deadline (highlighted in red in table 2) for this reason and the remaining 3 are still awaiting final reports to be drafted.

Table 2 - Serious Incidents Currently Under Investigation

STEIS No.	Date of incident	Date reported on STEIS	CSU Deadline	Division	Description of incident
2015/16925	07/05/15	14/05/15	10/08/15 (extended deadline)	Surgery	Delay in obtaining blood product during a AAA case.
2015/18716	24/03/15	28/05/15	20/08/15	Surgery	Unexpected Death of a patient during elective

STEIS No.	Date of incident	Date reported on STEIS	CSU Deadline	Division	Description of incident
					surgery.
2015/17992	10/05/15	21/05/15	14/08/15	Medicine	NEVER EVENT – Transfusion of ABO Incompatible Blood.
2015/20706	04/06/15	15/06/15	08/09/15	Surgery	Wrong Blood Transfusion (ABO Compatible)
2015/20119	09/06/15	09/06/15	02/09/15	Trust wide	Investigation in to the employment of an agency doctor without the relevant registration - Operation Gibraltar.
2015/17355	17/05/15	18/05/15	11/08/15	Medicine	NEVER EVENT - Medicine Administered Wrong Route IV instead of orally.
2015/18005	09/04/15	22/05/15	17/08/15	Medicine	Patient Fall resulting in a fracture femur.
2015/12812	01/03/15	08/04/15	02/07/15	Women and Children	Intrauterine Death – Report required additional information before Executive sign off.
2015/14305	20/04/15	21/04/15	25/06/15	Women and Children	Retained abdominal swab - Report required additional information before Executive sign off.
2015/22008	22/06/15	25/06/15	18/09/15	Women and Children	Unexpected admission to NNU
2015/21682	04/06/15	23/06/15	16/09/15	Women and Children	Incorrectly labelled baby
2015/21626	20/06/15	23/06/15	16/09/15	Women and Children	Unexpected admission to NNU
2015/21249	14/06/15	18/06/15	11/09/15	Women and Children	Unexpected admission to ITU
2015/20493	07/06/15	12/06/15	07/09/15	Women and Children	Unexpected admission to NNU
2015/14139	27/02/14	20/04/15	13/07/15	Integrated Care Services	Missed diagnosis following virtual colonoscopy.
2015/21508	18/06/15	22/06/15	15/09/15	Brent Community Services	Grade 4 Pressure Ulcer
2015/21296	02/06/15	19/06/15	14/09/15	Ealing Community Services	Grade 4 Pressure Ulcer
2015/21307	12/06/15	19/06/15	14/09/15	Ealing Community Services	Grade 4 Pressure Ulcer
2015/23389	30/06/15	09/07/15	02/10/15	Ealing Community Services	Grade 4 Pressure Ulcer
2015/21298	07/06/15	19/06/15	14/09/15	Medicine	Grade 4 Pressure Ulcer.
2015/21234	27/05/15	18/06/15	11/09/15	Harrow Community Services	Grade 4 Pressure Ulcer
2015/1844	24/05/15	27/05/15	19/08/15	Medicine	Grade 3/4 Pressure Ulcer.
2015/22330	29/04/15	30/06/15	23/09/15	Surgery	Grade 3/4 Pressure Ulcer.
2015/21301	11/06/15	19/06/15	14/09/15	Surgery	Grade 3 Pressure Ulcer.
2015/16339	07/05/15	08/05/15	13/07/15	Medicine	Grade 3 Pressure Ulcer.
2015/16627	11/05/15	12/05/15	15/07/15	Medicine	Grade 3 Pressure Ulcer.
2015/20271	05/06/15	10/06/15	03/09/15	Medicine	Grade 3 Pressure Ulcer.
2015/20878	15/06/15	16/06/15	03/09/15	Medicine	Grade 3 Pressure Ulcer.
2015/22323	08/06/15	30/06/15	23/09/15	Medicine	Grade 3 pressure Ulcer.
2015/21232	21/04/15	18/06/15	11/09/15	Medicine	Grade 3 Pressure Ulcer.
2015/21294	21/04/15	19/06/15	14/09/15	Ealing Community Services	Grade 3 Pressure Ulcer
2015/23398	10/05/15	09/07/15	02/10/15	Ealing Community Services	Grade 3 Pressure Ulcer
2015/21505	15/06/15	22/06/15	15/09/15	Ealing Community Services	Grade 3 Pressure Ulcer
2015/22571	29/06/15	01/07/15	24/09/15	Ealing Community Services	Grade 3 Pressure Ulcer
2015/22574	28/06/15	01/07/15	24/09/15	Ealing Community Services	Grade 3 Pressure Ulcer
2015/21303	05/06/15	19/06/15	14/09/15	Ealing Community Services	Grade 3 Pressure Ulcer
2015/21237	28/05/15	18/06/15	11/09/15	Ealing Community Services	Grade 3 Pressure Ulcer
2015/21297	05/06/15	19/06/15	14/09/15	Ealing Community Services	Grade 3 Pressure Ulcer
2015/21300	10/06/15	19/06/15	14/09/15	Ealing Community Services	Grade 3 Pressure Ulcer

6. Completed Serious Incidents

Table 3 shows the SI reports that have been completed and submitted for meeting the reporting deadlines, thus supporting timely implementation of actions to reduce the risk of reoccurrence. In this reporting period there were 10 Serious Incident investigations completed.

The 10 completed SI investigations were all Pressure Ulcers (of which 4 were categorised as Unavoidable*)

- The 10 Pressure Ulcers developed whilst patients were in our care, of these 4 were unavoidable*, the evidence supports the conclusions that all care was delivered as per national and local guidance. After investigation 6 were categorised as avoidable*. 1 was developed in an inpatient ward and 5 were developed in the patient's home under the care of District Nursing. Key themes from all the Pressure Ulcers was a lack of timely and thorough assessment of the patient's skin at admission and subsequent follow-up reviews. Subsequent delays in referral to the Tissue Viability Nurse Services. As a result all staff in the teams involved are required to undertake their Tissue Viability training. The Trust Tissue Viability group is reviewing the Skin Bundle (a package of assessment and care techniques designed to reduce the risk of patients developing Pressure Ulcers), to ensure it meets current best practice and standards.

Table 3 - Completed Serious Incidents

STEIS No.	Date of incident	CSU Deadline	Division	Description of incident
2015/15746	20/03/15	07/07/15	Community Services	Patient developed an Unavoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/15751	16/04/15	07/07/15	Community Services	Patient developed an Avoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/15803	04/05/15	08/07/15	Community Services	Patient developed an Unavoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/15805	04/05/15	08/07/15	Community Services	Patient developed an Avoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/16275	07/04/15	10/07/15	Community Services	Patient developed an Avoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/16276	22/04/15	10/07/15	Community Services	Patient developed an Avoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/16576	08/05/15	14/07/15	Medicine	Patient developed an Unavoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/18833	24/03/15	21/08/15	Community Services	Patient developed an Unavoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/18838	27/05/15	21/08/15	Community Services	Patient developed an Avoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.
2015/18845	07/05/15	21/08/15	Community Services	Patient developed an Unavoidable* Grade 3 Pressure Ulcer whilst under the care of the Trust.

*Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had:
Evaluated the person's clinical condition and pressure ulcer risk factors;
Planned and implemented interventions that are consistent with the person's needs and goals recognised standards of practice;
Monitored and evaluated the impact of the interventions revised the approaches as appropriate; or
The individual person refused to adhere to prevention strategies in spite of education of the consequences of "non-adherence".

7. Review of Internal Critical Incidents

An Internal Critical Incident (ICI) is an incident when a patient suffers serious injury or major permanent harm (or the risk of serious injury or death). The key difference to declaring an incident an ICI rather than an SI is it is believed that all Trust policies and procedures where adhered to in the instance of the ICI, but serious injury (or the risk of serious injury or death) still occurred.

Following the review in June 2015 that identified 4 ICI's that were escalated to SI's work was undertaken to review the position of all outstanding ICI's. There are 24 ICI's requiring final submission of an investigation report:
Women and Children 7;
Surgery - 7, Medicine – 5;
Integrated Care Services - 2 and;
Community Services – 3.

The senior Divisional managers have been provided with spread sheets with details of the ICI's and have been requested to provide updates on all by September 18th for reporting in the next Serious Incident Report.