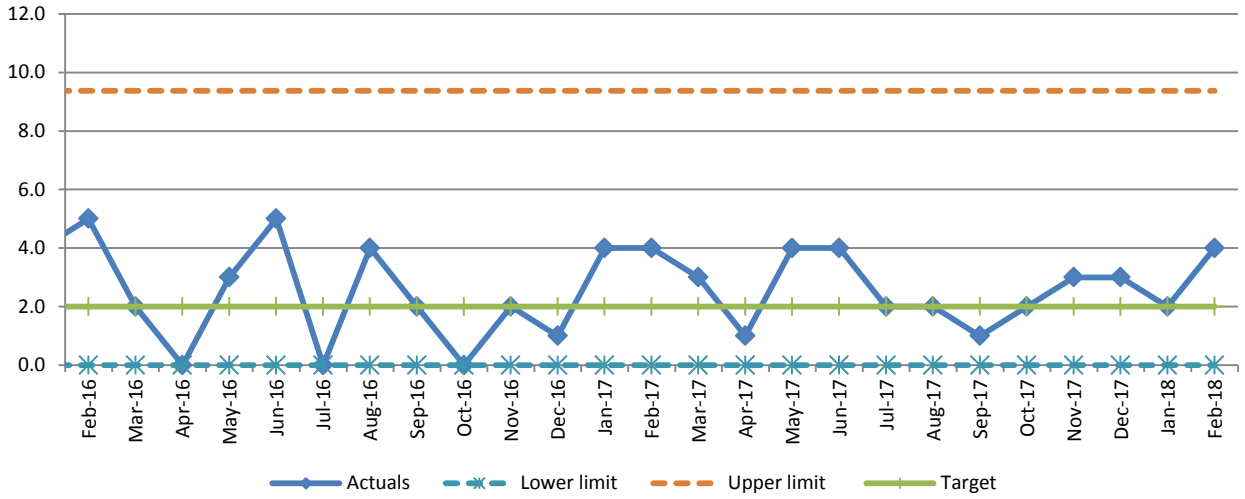
## PART 1: SERIOUS INCIDENT AND NEVER EVENTS

1. To be classified as a serious incident an adverse event must meet one or more criteria set out in NHS England's Serious Incident Framework, the current Framework was last updated by NHS England in March 2015 and is being reviewed at time of report.

2. The number of serious incidents per month (by the date the incident was reported on Datix) is demonstrated in Graph 1 and Table 1. There is no statistically significant change in the number of serious incidents at Sherwood Forest Hospitals in the last 24 months. In the current financial year to date the Trust declared 28 serious incidents. Of those incidents, 2 were classified as Never Events.

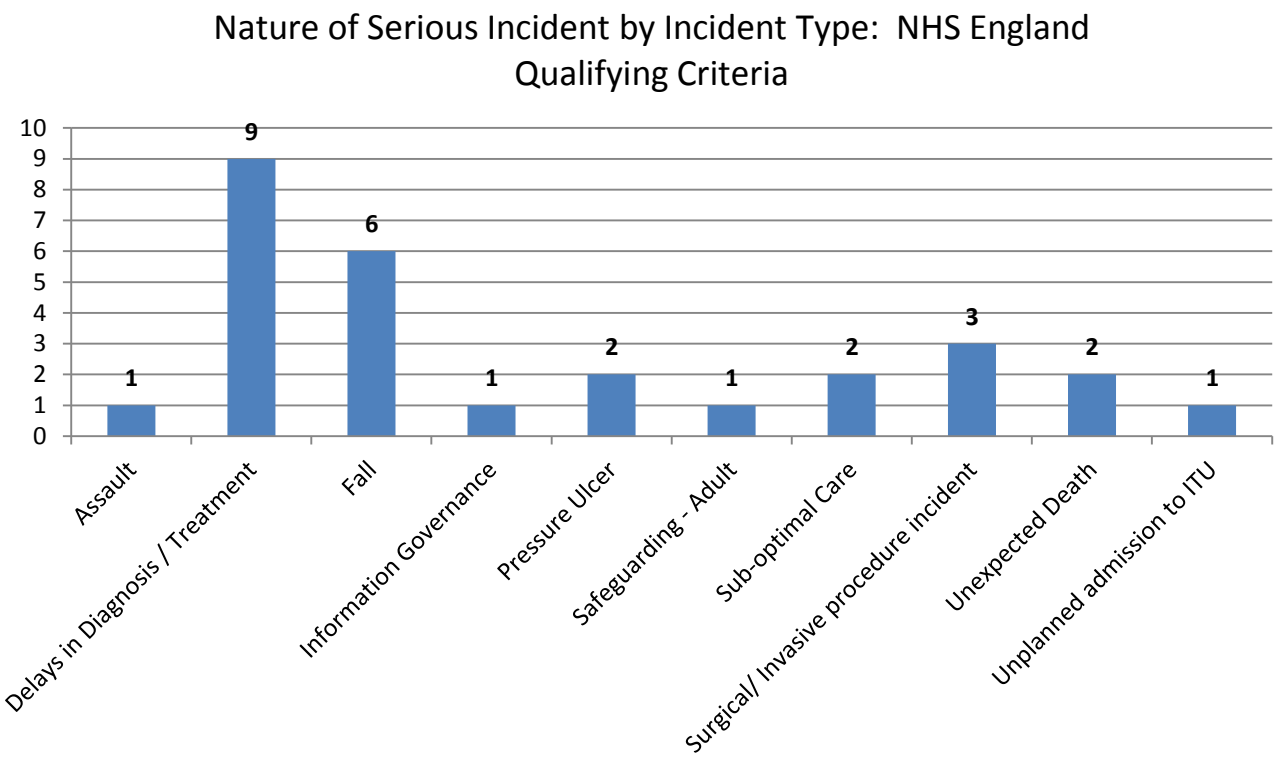
**Graph 1: Serious Incidents (STEIS reportable) by reported date on Datix**




3. **The table below demonstrates the number of Serious Incidents and Never Events by the month the incident was reported on Datix.**

| Type | 2017/18 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A | M | J | J | A | S | O | N | D | J | F | M | Total |
| Serious Incident | 1 | 4 | 4 | 2 | 2 | 1 | 2 | 3 | 3 | 2 | 4 | | **28** |
| From those above, number classified as Never Event. | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | | **2** |

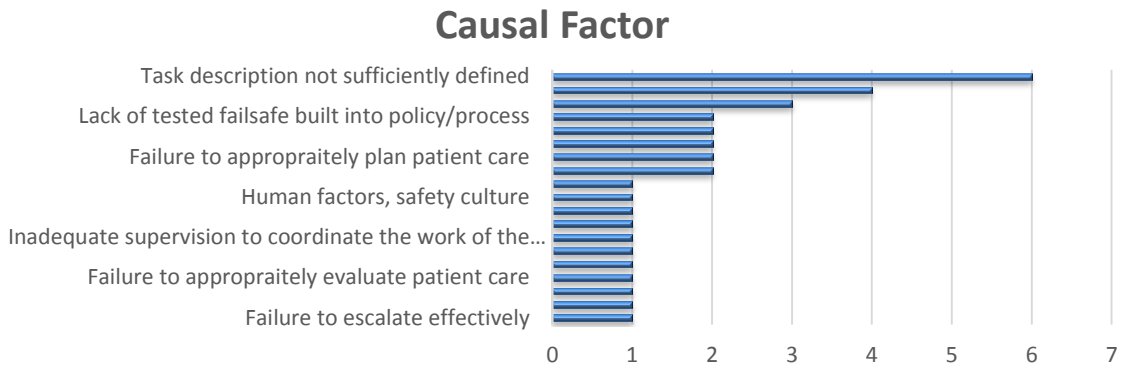
## 4. The nature of the serious incidents by type reported from Apr-17 to Feb-18




## 5. ROOT CAUSE CLASSIFICATION

5.1 Identification and classification of underlying root causes and causal factors develops our understanding and better supports learning and improvement. The Director of Governance & Quality Improvement initiated a Causal Factor Analysis (CFA) for all serious incidents in 2016/17 and those declared in the first 6 months of 2017/18. CFA seeks to isolate the underlying weaknesses within the control framework and help target learning and improvement. CFA has revealed that human factors play a very significant role in both direct and indirect causation. This manifests as: (i) not following policy or procedure at critical points in the patient's care; (ii) poor communication – written and verbal leading to errors; (iii) erroneous clinical decision making; (iv) poor design of control framework; (v) and the nature and complexity of the patient's clinical condition and presentation. Other causal factors have been identified but occur less frequently. These causal factors can be broadly grouped into communication, team working and competence.

**5.2 The table below shows the root cause and the contributory factors identified as part of the 2017 serious incidents investigations**




**5.3 Causal Factor Analysis: Key Themes Identified**

**a. Failure related to Task Factors.**

'Task Description Not Sufficiently Defined' and 'Design of Task creates opportunity for errors' was highlighted in this category.

This related specifically to

- *Patient pathway in ophthalmology*
- *UUUU, XXXX process*
- *Acute Abdomen pathway*
- *AKI and fluid balance*
- *Rigid Cervical Collars*
- *Escalation Policy*

**b. Communication between staff.**

'Written communication', 'record keeping' and 'poor communication between staff' was highlighted in this category.

This related specifically to

- *Medical Handover*
- *Nursing Accountability Handover*

**c. Organisational Factors.**

Lack of tested failsafe built into policy concerning delays in diagnosis was highlighted in this category. 'Lack of failsafe' and 'Policy not routinely followed' highlighted problems with reliability of the Management of Diagnostic Results Policy in particular. This Policy has subsequently been revisited and renewed.

**d. WHO Human Factors**

'Decision Making' was highlighted in this category. 'Human error' was a documented root cause or contributory factor. It was unclear from the data gathered if the Incident Decision Tree had been routinely used to help evaluate culpability. To enable an increased level of

analysis the Root Cause Identifier Framework to be amended to include the elements of the Incident Decision Tree going forward.

## 6. Actions Being Implemented by Divisions

6.1 Medicine Division - 8 STEIS incidents. Actions focus on

- Developing or amending policy/procedures/pathways i.e. Acute Abdomen pathway, Clinical photography, Medical equipment (cervical collars).
- Updating ward staff on PUP, core and individualised care planning, fluid balance, documentation. Senior team reinforcing through real time documentation review by senior team, documentation audits, ward learning boards, focused specialist lead input.
- Personal targeted reflection and review at appraisal.

6.2 Surgical Division - 2 STEIS incidents. Action focus on

- Developing or amending policy/procedures pathways i.e. Escalation Policy, CCU admissions, handover, Pink referral forms and Nervecentre, T&O admission and limb infection pathways, ophthalmology Outcomes Form and patient pathway.
- Training and education on escalation policy,

6.3 D&O Division - 4 STEIS incidents. Actions focus on

- Developing or amending policy/procedures pathways i.e. Management of Diagnostic Results Policy, SOP for each Division for Management of Diagnostic results, SOP for Alerting Urgent Reports, procedure for managing outsourcing of services, Handover of care,
- Training and education

## Part 2: NEVER EVENTS

## 7. Never Events that occurred between 2014 and 2017.

| | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| **Total** | **0** | **1** | **1*** | **3** |

*Detected in 2017

| Year | Event |
|---|---|
| **2015** | Wrong site surgery: Dermatology (paediatric) |
| **2016** | Wrong implant: Orthopaedics (detected Nov 2017) |
| **2017** | Misplaced nasogastric tube (Paediatric) |
| **2017** | Retained Swab post procedure (Maternity) |
| **2017** | Wrong site surgery: Dermatology (adult) |

**7.1 Never Event themes identified following investigation.**

Wrong site surgery - Dermatology - 2015

- Inadequate processes to control Dermatology skin surgery procedures
- No WHO-style safe surgery checklist used for patients undergoing Dermatology skin surgery procedures at that time
- Over-reliance on the Patient as a source of site identification, compounded by inadequate communication and documentation relating to site location and identification
- Different adult family members being present at the initial consenting and on the day of the procedure
- Different staff involved in the initial consent and re-consent on the day of the procedure
- Inadequate confirmation of the site, particularly as under the hairline (no photography or site marking, inconsistent or incomplete drawn diagrams of the site).

Wrong site surgery - Dermatology - 2017

- There was no clear mechanism to adequately label the site for the surgery in this patient who had multiple lesions. On the day of surgery, in the absence of appropriately labelled body maps and clear instructions, inadequate attempts were made to accurately highlight the correct lesion for excision.
- Were the available mechanisms used e.g. photography, family member confirmation or mirrors then the investigation team feel that this incident would not have occurred.

Missed placed nasogastric tube - Paediatrics

- Ineffective communication between Doctor and the Nurse
- Non-compliance with *Nasogastric Tube Feeding in Children Guideline*

Retained swab - Maternity

- Human error in respect to the post procedure count being incorrect.
- The surgeon did not carry out a 2 person count pre and post procedure; the midwife also did not prompt for a 2 person count.

Wrong implant – Orthopaedics

- There was no formal process in place for implant check and no “stop moment” and therefore insufficient controls in place which is the main contributory factor.

## 8. ORGANISATIONAL LEARNING

8.1 To support organisational learning multiple opportunities are used to share the findings from investigations. Evidence is collated to demonstrate the completion of actions which have been agreed on conclusion of Serious Incident Investigations. Compliance with the closure of actions is monitored via Divisional Performance and the data forms part of the Quality section of the Performance Dashboard.

8.2 Investigation reports that relate to a failure to escalate were presented and discussed at the Deteriorating Patient Group and this group is overseeing the review of the Observation and Escalation Policy.

- Where a death has occurred these cases are also subject to a structured mortality review and where required are presented to the Mortality Surveillance Group.
- Investigation findings are shared within Specialty and Divisional Governance forums including cross divisional learning.
- Cross divisional sharing and actions taken in response to incidents is also evident through the Patient Safety and Quality Meeting.

8.3 There are a variety of methods used to communicate the lessons learnt from Investigations. Examples of these are listed below:

- The Emergency department have a staff Wattsapp to communicate changes.
- Findings are presented to Grand Rounds, Learning Events and Risk Summits.
- Emails are sent to reach large groups of staff.
- Learning Matters and Icare bulletins are distributed by the communication team.
- Key messages are relayed within comm cell, board rounds and safety huddles.
- The reporter of an incident receives an Incident feedback email
- All wards and departments have Live Divisional / Specialty / location Datix Dashboards including lessons learned reports.
- The Datix Manager is working with the Surgical division on a (pilot) daily incident huddle to review the previous days incidents, this Datix dashboard will also include a weekly safety message.
- Face to face feedback and professional reflection.

## Part 3: COMPLIANCE WITH DUTY OF CANDOUR

Compliance with Duty of Candour is recorded within the Datix system. The Governance Support Unit tracks progress with this, including the sharing of the findings form investigations with the patient and/or their family.

### Duty of Candour compliance table from 1st April 2017 to 28th February 2018

The table demonstrates compliance with the Duty of Candour notification by the month reported on Datix.

| Type | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | TYD Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1. Number of Qualifying Incidents** | 3 | 11 | 6 | 6 | 4 | 5 | 3 | 5 | 8 | 4 | 6 | | 61 |
| **2. Confirmation of DOC completion** | 3 | 11 | 6 | 6 | 4 | 5 | 2* | 5 | 8 | 4 | 6 | | 60 |

*Not undertaken on the advice of Police.