Meeting:	Board of Directors			
Date of Meeting:	31 January 2018			
Report Title:	Serious Incident Learning Report: Q2 2017/18			
Status: (tick one box)	Information ■	Discussion ☐	Approval ☐	Regulatory ☐
Classification	NHS Confidential	Yes ☐	No ■	
Lead Director	Mr Karl Mainprize, Executive Medical Director			
Report Author	Mrs Helen Kelly, Assistant Director, Healthcare Governance Ms Tracy Kershaw, Quality & Safety Lead			
Appendices	Not applicable			
Links to strategic objectives	Board Assurance Framework Reference and description	2.1; Delivering Quality, Safety & CIPs		
Links to corporate risks	Corporate Risk Register Reference and description	Not applicable		

Purpose of the Report

The attached report provides the Board of Directors with an overview of causative factors from serious incident investigations that have been completed and signed off by the Trust's governance processes during Q2 2017/18.

In order to maintain patient confidentiality the detail has not been included but the identified causative factors from the investigations in relation to these serious incidents are the basis of the wider learning. The individual learning from these incidents pertaining to specific staff, departments and services has been directly shared with them for reflection, improvement and discussion. This will be internally monitored to ensure sustained improvement.

Key points for discussion

There are two themes identified from the investigations during Q2 2017/18 relating to task factors:

- Trust escalation procedures were not adhered too, and subsequent incidents/potential risks were not reported:
- Dual processes for a patient's pathway in place (paper and electronic).

Other themes identified were as follows:

- Prevention of pressure ulcers;
- CTG interpretation.

Learning from a theme was identified in a recent serious incident, where staff escalated as per Trust Policy for a patient eight hour breach in the emergency department.

Recommendation

Board of Directors are asked to receive and note the contents of this paper

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Learning from Serious Incidents : Q2 2017/18

1. Introduction

Airedale NHS Foundation Trust is committed to learning when the care given is not as exemplar as required. The Trust believes learning must be shared across the Trust for understanding and the provision of consistent high quality, compassionate and effective care. As a result this paper describes the key points of learning from completed Serious Incident Investigations during Q2 2017/18 and how this has or is planned to be shared with colleagues.

The National Patient Safety Agency Framework (2010) categorised the contributory factors to patient safety incidents into nine factors;

- Patient factors
- Staff factors
- Task factors
- Communication factors
- Equipment factors
- Work Environment factors
- Organisational factors
- Education & Training factors
- Team factors

It appears that when mistakes happen, it is as a result of one or more of these factors and the learning from the completed investigations have been aligned to these factors to ensure systemic learning within the Trust.

2. Causative factors from the completed investigations

2.1 Pressure Ulcer Cluster hospital:

- Task factors : Trust escalation procedure not adhered to / incident reports not completed;
- Task factors : Workload task orientated;
- Education & Training Factors: Delayed opportunities to react to red; recognising, responding and reporting.
- Team factors: Failure to seek support in relation to deteriorating skin conditions.

2.2 Medication Incident (treatment not prescribed)):

- Task factors: On line assessments deferred on more than one occasion;
- Task factors: Dual processes being used (paper/electronic);
- Communication: Handover of information;
- Equipment factors: Correct equipment not available at source (EPMA);
- Organisational factors: Dual processes being used (paper/electronic);
- Education & Training factors: Appropriate use of 'defer' on line.

2.3 Diagnostic incident (echocardiograms):

- Staff factors: Bookings taken by single individual.
- Task factors: Trust escalation procedure not adhered to / risk assessment not completed;
- Task factors: Dual processes being used (paper/electronic);
- Work Environment factors: Inappropriate office design/disorganisation;
- Organisational factors: lack of risk management plans in relation to increase in demand, and subsequent insufficient resources/establishment;

- Team factors: formal monitoring of waiting lists not undertaken.

2.4 Maternity incident:

- Staff factors: Lack of situational awareness;
- Communication factors: Lack of escalation to a Consultant;
- Education and training factors: CTG interpretation. Incorrect use of CTG stickers to classify tracing.

3. Trends and themes identified

The detail in section two demonstrates *'task'* factors as a theme throughout the investigations in Q2.

Inconsistent reporting of incidents was an identified theme in previous quarters, and also noted throughout the cluster investigation in Q2. Training continues to be reviewed in line with the identified themes and the issues flagged via Local Governance Forums.

The Quality and Safety Team have completed the review of the incident categories which were relaunched on 1 January 2018. Following benchmarking of other Trust's incident reporting systems and staff surveys, emphasis has been to focus on easily identifiable reporting categories, to promote a positive reporting culture. The work has been two-fold with the Quality and Safety Team also reviewing the categories against the quality agenda so that learning can be easily extracted and fed back into the appropriate governance forums.

Clinical Leads who are leading on quality issues (e.g. sepsis) are promoting the incident reporting system for extraction of learning through their work. A review of these category changes will be undertaken in the next quarter.

A second theme identified in 'task' factors relates to issues with dual processes being in place from paper and electronic pathways being run side by side. It was identified that the majority of the paper processes had been superseded by the on-line system, but remained in place operationally. Due to the dual processes there was a lack of a standardised approach in the patient's pathway.

Each Core Service Group is reviewing and updating the process of the paper assessments on the patient's pathway and updating how it interacts with the on-line assessment. The appropriate Trust Policy will be updated with the changes in the pathway. Learning from the risk of dual processes being in place is the need for risk assessments when changes are made from paper to electronic and how the risks are managed, mitigated and reduced.

Further themes identified in this quarter were throughout the hospital pressure ulcer cluster; there were themes that had been identified throughout the community pressure ulcer cluster in Q1. Targeted training continues by the Tissue Viability Nurse, the impact of this is currently being evaluated. The Assistant Director Nursing & Safety meets weekly with the Tissue Viability Nurse, and the Quality and Safety Team. An analysis is undertaken of trend and themes across areas, and targeted actions agreed.

Previous quarters have also identified themes in relation to CTG interpretation and the use of stickers to classify the tracing. A further approach to CTG training will be included into the lesson plan by February 2018. This will incorporate awareness of human factors through mandatory training.

A theme was identified in the two previous 12 hour breach serious incidents reported by the Trust where lack of escalation of Trust Policy was agreed as the root cause. The completed investigation

in Q2 identified notable good practice during the investigation, including escalation of the patient's eight hour breach as per Policy. It must be noted that external factors were influential in this breach despite internal processes being undertaken.

4. Conclusion

There are a number of mechanisms for the sharing of learning including face-to-face between immediate colleagues, opportunities for reflection regarding the issues discovered during the investigations and formal support from line managers, mentors and supervisors.

In addition the edition of Quality & Safety Matters to be published in February 2018 and quarterly in the future will continue to lead on the learning from serious incidents following presentation to Board of Directors.

The learning from these completed events has been shared within the Clinical Group Structures by the relevant clinicians and the affected staff given the opportunity to discuss the recommendations.

Following this the action plans from the investigations have been scrutinized to ensure the actions are deliverable and more importantly will result in sustained improvement.

5. Recommendation

The Board of Directors are requested to receive and note the content of this report.