Board of Directors

Date:	26 September 2018	**Attachment Number:**	**F**
Title of Report:	**Serious Incident Learning Report Quarter 1 2018/19**		
Purpose of the report and the key issues for consideration/decision:	The attached report provides the Board of Directors with an overview of causative factors from serious incident investigations completed during Q1 2018/19, along with the learning identified. 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 form the basis of the wider learning. The individual learning from 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. The following key areas are for consideration and to note: One of the themes noted in the Q4 2017/18 report *'Dual processes for a patient's pathway in place (paper and electronic)'* remains a theme in Q1 2018/19. The report overviews the learning from the completed Never Event (Wrong Site Procedure) and themes from the two previous Wrong Site Surgery incidents reported and investigated in 2013 and 2017.		
Prepared by:	Mrs Helen Kelly, Assistant Director, Healthcare Governance Ms Tracy Kershaw, Quality & Safety Lead		
Presented by:	Mr Karl Mainprize, Executive Medical Director		

Strategic Objective(s) supported by this paper:

Financial Sustainability		**Empower & Engage Staff**	X
Quality of Care	X		

Is this on the Trust's risk register:

No		**Yes**	X	**If Yes, Score**	9

Which CQC Standards apply to this report:

Have all implications related to this report been considered: (please X)

Finance Revenue & Capital		**Equality & Diversity**	X
National Policy/Legislation	X	**Patient Experience**	X
Human Resources	X	**Terms of Authorisation**	
Governance & Risk Management (BAF)	X	**Other:**	

Action Required: (please X)	**Approve**		**Discuss**		**Receive for information**	X	**Decision**	
Previously Considered By:	Executive Assurance Group				**Date:**	19/09/2018		
Recommendations:	The Board of Directors is asked to receive and note the contents of this paper							

Serious Incident Learning Report
Quarter 1 2018/19

1. Context / Background

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 Q1 2018/19 and how this has been 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 investigations have been aligned to these factors to ensure systemic learning within the Trust.

2. Executive Summary

Causative factors from Serious Incidents investigations completed during Q1 2018/19

2.1 Medication/Discharge:

Task factors:

- Dual processes being used (paper/electronic);
- Electronic Supplementary letter discharge process is complex with multiple steps;

Communication factors:

- Lack of alert in electronic system if supplementary process not fully completed;

Organisational factors:

- Dual processes being used (paper/electronic);
- Relevant Trust Polices did not identify the supplementary discharge process within the roles and responsibilities.

2.2 Delay in treatment:

Task factors

- Lack of written clinical documentation in line with Trust Policy.

Staff factors:

- Lack of clinical escalation;
- Accountability and responsibility within sphere of role;

Communication

- Lack of documented risk assessment and patient consent;

Organisational factors:

- Lack of departmental procedures identifying clear escalation processes;

Education factors:

- Importance of timely performance of Duty of Candour.

2.3 Never Event – Wrong Site Procedure

Task factors:

- Trust Consent Policy was not adhered too/consent not reconfirmed on the day of procedure
- Lack of formal robust process for checking consent against procedure list;
- Informal processes for checking and determining side by patient positioning;
- Lack of team brief performed for procedural lists.

Work environment factors:

- A number of distractions were noted on the day including performing other tasks whilst checks taking place;

Organisational factors:

- Lack of use of site and side marking in interventional radiology;
- Lack of consistent application of five steps to safer surgery.

3. Trends and Themes Identified

One of the key issues identified from the completed Serious Incident Investigation during Q4 was the dual documentation processes using paper and electronic pathways being run side-by-side as the Trust moves to wholly electronic documentation. This has been identified again in the Q1 completed investigations. The risk is captured within the corporate risk register, managed by the Medical Records Group and reviewed at each Executive Assurance Group. The Executive review ensures issues are known at an earlier stage and support and facilitation provided to keep patients as safe as possible. It is anticipated this will remain in place during the transition. The Quality and Safety Team are supporting the Digital Team and Quality Improvement with incident information on the key issues surrounding dual documentation.

The report would like to overview the learning from the completed Never Event (Wrong Site Procedure) completed in Q1 2018/19, that had similar trends/themes to identified learning from the Never events reported by the Trust within theatres 2013 and 2017 (Wrong Site Surgery).

In 2013 the investigation identified inconsistent use of the 'sign out' process on the WHO checklist and that side/site markings were not used for tooth extractions and required a regional network discussion to the benefits/downsides on introducing this step into the process.

In 2017 the investigation identified that there was a lack of defined process within the Trust Consent Policy if the patient's consent required changing on the day of procedure and how this is pulled through onto the procedure list. That there was a lack of formal robust process for checking the consent form against the operation list. The team brief within the five steps to safer surgery was not sufficiently robust.

The Never Event (Wrong Site Procedure) concluded in June 2018 identified similar themes from the Wrong Site Surgery from 2013 and 2017 around lack of formal standard process, lack of agreed site/side marking and that the five steps to safer surgery was not consistently embedded across the area.

Similar to the 2013 Never Event there was learning around site/side marking. The side on which the procedure is to be performed is determined primarily by patient positioning which is determined primarily by the initial entries on the electronic system. Site and side marking was not currently performed for interventional procedures with laterality as recommended by National standards.

Similar to the 2017 Never Event there was learning around a formal standard process of the consent form and the procedure list being checked to ensure they are correct and that this checking process is pulled through into the safety checks.

The Medical Directors Unit is receiving the learning from the never event as part of the Steps to Safer Interventional Procedures programme which has already commenced and continues as part of the Quality Programme. The 5 Steps to Safer Surgery, and Safer Interventions task and finish group is leading on the improvement work that requires implementing from the learning identified.

4. Conclusions

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 with the revision of the Clinical Quality Learning and Improvement Group into the Clinical Learning Forum, it is anticipated the changes made that improve care to our patients will support the broader organisational learning.

Quality & Safety Matters published during August 2018 and quarterly in the future will have as the lead item the learning themes from serious incidents following reporting to the Board of Directors.

Two rapid improvement notices were communicated Trust-wide following two of the reported Never Events in March and August 2018

The learning from completed investigations has been shared within the Clinical Group Structures by the relevant clinicians. This has afforded the affected staff the opportunity to discuss the recommendations and confirm the agreed actions will deliver the required improvements.

Within six months following the completion of Serious Incident Investigations, the clinical group governance leads present the evidence of completed action plans to the Assurance Panel for scrutiny of sustained compliance and improvements in care.

5. Recommendations

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