Board of Directors' Meeting 10th August 2023

Agenda item		100/23		
Report Title		Incident Overview Report		
Executive Lead		Hayley Flavell, Director of Nursing (presented by Medical Director)		
Report Author		Peter Jeffries, Patient Safety Specialist		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF2, BAF4, BAF7, BAF8, BAF9
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	328/1353
Well Led		Our partners		
Consultation Communication		Quality Operational Committee – 16th May 2023 Quality and Safety Assurance Committee – 31st May 2023		
Executive summary:		1. The Board's attention is drawn to sections: **6** – relating to overdue incident reports which have shown improvement **8 and 9** – outlining the themes and trend identified from serious incidents raised and closed in May and June 2023		
Recommendations for the Board:		The Board is asked to: **Note** the issues highlighted		
Appendices:		N/A		

1. Introduction

This report highlights the patient safety development and forthcoming actions for Aug/Sept 2023 for oversight. It will then give an overview of the top five reported incidents during May and June 2023. Serious Incident reporting for May and June 2023 and also rates year to date are highlighted. Further detail of the number and themes of newly reported Serious Incidents and those closed during May and June 2023 are included along with lessons learned and action taken.

2. Patient Safety Development and Actions planned for Aug/Sept 2023/24

Following the release of the **Patient Safety Incident Response Framework (PSIRF)** on 16th August 2022 the following work has been completed and next steps detailed.

2.1 Phase three – Patient Safety Incident Response Planning

The programme been progressing through to third phase described as 'Patient Safety Incident Response Planning'. This phase is focused on the detail of the overall reponse the Trust will deploy as an organisation in terms of PSIRF and bringing together the four key principles of PSIRF:

1. Compassionate engagement and involvement of those affected by patient safety incidents

2. Application of a range of system-based approaches to learning from patient safety incidents

3.Considered and proportionate responses to patient safety incidents

4. Supportive oversight focused on strengthening response system functioning and improvement

A combination of outputs from the diagnostic stage (including mutiple discussions with a variety of stakeholders and teams and decision making 'sim' sessions) were shaped into key questions which were considered by working groups at a PSIRF away day on the 28th of June. The working groups on the day began to shape the elements of the Patient Safety Incident Response Plan and Policy based on the four key principles above.

Next steps to develop these aspect of the plan are outlined below.

2.2. *Next steps in development of the Patient Safety Incident Response Plan and Policy*

Compassionate engagement and involvement of those affected by patient safety incident:

This key principle was split across two working groups:

1- *Compassionate engagement of patients and families*:

- The group broadly outlined key features of the response plan and policy relating to this.
- Via PACE, Healthwatch and a Telford patient group these elements will be further tested and co-designed with patients and families.

- The group reiterated support for exploring a Family Liaison Officer role to support families involved in safety investigation. It was understood this would need to be subject to further discussion and business case.

2 – *Compassionate engagement of staff*

- The group outlined detail around the key principles and support offer for staff.
- This groups is being brought back together to work up further details and high-level drafts of key information for staff including signposting to support, guidance for managers and what staff can expect in the event of a patient safety incident.

2. *Application of a range of system-based approaches to learning from patient safety incidents/Considered and proportionate responses to patient safety incidents*

These two principals were amalgamated into a single working group which reviewed initial drafts of decision-making trees and tools for proportionate response.

- The group broadly agreed the decision-making pathway for incidents under PSIRF with specific discussion around maternity processes.
- Further discussion and initial thoughts have been captured relating to incidents that fall under regulatory processes but involve investigation such as IRMER and SHOT.
- The group reviewed formats for after action reviews and an initial template has been drafted for further comments.
- The outputs of this group are being further reviewed by a wider stakeholder group to develop the operational detail, particularly the detail of triaging incidents into a pathway based on PSIRF guidance.

3. *Supportive oversight focused on strengthening response system functioning and improvement*

- The group broadly agreed the overarching Governance framework which was outlined to Quality Operational Committee in June with further suggestions for the roles of key groups which will be used to inform the draft framework and terms of reference for key groups.
- Based on experience from the Maternity Transformation Programme an outline process in terms of linking safety insight to quality improvement was drafted. This needs further development and will be discussed further with the Head of Service Improvement. The group will be brought back together with other stake holders to work up additional detail.

Although there remains significant detailed work to be done it was felt the away and working groups had significantly assisted in developing the overall approach to the Patient Safety Incident Response Plan.

2.3 Assumed timeline.

Pending further discussion with the Medical Director and Director of Nursing it is assumed sign off on the Patient Safety Incident Response Plan, Trust Priorities and Policy will be at Board in October. This is in line with wider feedback from organisations and ICB's across the region

based on information from the AHSN PSIRF network (based on an assumption of being prepared for go live by the end of September 2023 pending full sign off in October).

A number of additional stakeholder forums have been suggested in terms of oversight and review which will be finalised into a 'pathway' for review and sign off before the end of July.

2.4 Deteriorating Patient Improvement Plan Away Day

The overall diagnostic work undertaken by the patient safety team comprised of:

- A literature review of key information and publications relating to the deteriorating patient.
- A thematic review of serious incident findings over two years aligned under the Systems Engineering Initiative for Patient Safety (SEIPS) framework.
- Direct observations of clinical 'work as done' using a structured observation tool across a number of wards and assessment areas both medical and surgical.
- Use of FRAM a modelling tool to understand dynamic connections between elements of a work system and the conditions needed to support positive outcomes.

Background

The work undertaken was intended too add to the overall understanding of the current work system and issues relating to the deteriorating patient. This was seen to have two key benefits:

- Support the definition of key interventions in terms of quality and safety improvement and contribute to an overall improvement plan which could be overseen by the Deteriorating Patient Committee and reported to Quality Operational Committee.
- Act as a 'test case' for thematic review of a corporate safety priority to inform the implementation of the Patient Safety Incident Response framework.

Assessment

The overall review of the system relating to deteriorating patient outline issues across all of the six domains of the SEIPS framework. The most significant issue which was highlighted related to the level of reponse that could be reliably sought when an escalation of a deteriorating patient was made.

A significant number of observations and discussions with frontline staff indicated issues relating too:

- The capacity of medical staff to respond at registrar level (both medical and surgical but most signifcantly in medicine).
- 'Escalating down' in relation to Trust policy to lower tiers of medial cover to achieve a reponse.
- Confusion on who to call first across mutiple potential responders (medial teams, hospital at night, critcal care outreach).
- Significant capacity issues across teams who can respond related to staffing pressures (particularly critial care outreach and hopsital at night).
- Issues around clarity on bleep numbers in terms of escalation.

These observations were consistant and aligned with the existing insight amongst key members of the deteriorating patient committee.

Next Steps

It was agreed given that deteriorating patient is a key quality priority and the complexity of the issues outlined time was needed with a key group of internal stakeholders to assess and agree the the key improvement interventions that would form the basis of a longer term improvement programme.

This group will be meeting over two half days in September in facilitated sessions to develop the improvement plan. Support is being sought from the improvement hub and programme management office to assist in development of the programme plan.

Work is already being undertaken to develop a dashboard of metrics (with process, outcome and balancing measures) to enable review of performance and assessment of the impact of planned improvement interventions.

It is assumed oversight of the ongoing delivery of the improvement plan will be via the Deteriorating Patient Committee with ongoing reporting to Quality Operational Committee focussed around the dashboard of key metrics.

3. 2023 Patient Safety Incident Reporting

The top five patient safety concerns reported via Datix for May and June 2023 are listed below. Any deviation in reporting, outside that which could be reasonably be expected, is analysed to provide early identification of a potential issue or assurance that any risks are appropriately mitigated.

3.1 Review of Top 5 Patient Safety Incidents

During May and June 2023, the top five reported patient safety incidents are outlined in Table 1. There has been an ongoing increase in capacity related incidents (as shown by the bed shortage and admission of patient's categories) reported which reflects the capacity and patient flow challenges faced by the Trust.

The top five reported incidents are explored in more details below, along with a review of improvement work underway in each section.

Table 1

Top 5 Patient Safety Incidents
Pressure ulcer/skin damage
There is an overarching pressure ulcer prevention plan which includes actions from previous RCA/SI investigations, and this continues to be implemented across all divisions.
All RN staff are completing the mandatory tissue viability training and compliance with training is monitored via the monthly nursing quality metrics meetings.
Spot checks by ward managers and matrons are undertaken to ensure Waterlow assessments are accurately completed and that the prevention actions implemented via care plans continue to be implemented.

Targeted additional education and support is being provided by the tissue viability team for wards with increased numbers of pressure ulcers.
Inpatient Falls A yellow falls blanket to highlight falls risk being trialled in ED. A Yellow tabard for co-horting being trialled on medical wards. Overall falls numbers have reduced during May and June. Work continues to deliver the ongoing falls improvement plan.
Bed Shortage These incidents include 12-hour breaches for patient admission from ED, it is important to note that 1 incident report for 12-hour breaches may contain multiple patient detail and delay in discharge from Intensive Care Unit to a ward bed.
Admission of patients This category covers a wide range of concerns relating to the admission of patients, such as ambulance offload delays and delay with allocation of beds out of the Emergency Department and this reflects the significant and ongoing pressure within the Emergency Department and capacity concerns within the Trust. Significant work is being undertaken under the banner of the Trust's Flow programme to improve flow through and movement of patients from the ED setting. The Acute Floor configuration is in place at RSH to support flow and timely review of medical patients.
Communication problem between staff, teams, depts There is no clear trend or pattern across the incident reports which cover a wide variety of issues across the theme of communication between teams.

4. Incident Management including Serious Incident Management

4.1 Serious Incident Reporting May and June 2023

There were 5 serious incidents reported in May 2023, see table 2.

There were no new HSIB reportable serious incidents during May 2023.

Table 2

Incident 1	
Classification	Fall
Incident ref. no.	2023/9112
Incident Summary	Unwitnessed fall resulting in head injury
Immediate Actions Taken	Fall review undertaken to identify areas for immediate action. De-brief with staff.
Duty of Candour Met	Initial duty of candour met – full support and apologies offered to daughter
Impact on Patient/Family	The head injury was managed conservatively however the fall was distressing for the patient and family – full support provided.
Patient/Family involved in investigation	Yes

Incident 2	
Classification	Fall
Incident ref. no.	2023/9206
Incident Summary	Unwitnessed fall in the ward toilet resulting in head injury.
Immediate Actions Taken	Full review post fall
Duty of Candour Met	Yes – initial duty of candour met
Impact on Patient/Family	Patient very anxious and full support was provided
Patient/Family involved in investigation	Yes

Incident 3	
Classification	Category 3 Pressure Ulcer
Incident ref. no.	2023/9239
Incident Summary	Hospital acquired category 3 pressure ulcer
Immediate Actions Taken	Tissue Viability Specialist Nurse involved with assessment and appropriate actions taken.
Duty of Candour Met	Initial duty of candour met with daughter
Impact on Patient/Family	Patient very wea and frail – full care provided
Patient/Family involved in investigation	Yes

Incident 4	
Classification	Delayed Diagnosis
Incident ref. no.	2023/9566
Incident Summary	Potential delayed diagnosis of rectal cancer due to delay in responding to blood results.
Immediate Actions Taken	Review of the care for this patient
Duty of Candour Met	Initial duty of candour met with patient and family
Impact on Patient/Family	Patient anxious due to the diagnosis – support provided
Patient/Family involved in investigation	Yes

Incident 5	
Classification	Category 3 Pressure Ulcer
Incident ref. no.	2023/10656
Incident Summary	Hospital acquired category 3 pressure ulcers to both heels
Immediate Actions Taken	Full review by Tissue Viability Nurse

Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Patient is confused but communication with wife confirms that he is doing well.
Patient/Family involved in investigation	Yes

There were 11 serious incidents reported during June 2023, See Table 3.

Table 3

Incident 1	
Classification	Delayed Diagnosis
Incident ref. no.	2023/10932
Incident Summary	Delayed diagnosis and treatment – system wide care issues involving primary and secondary care
Immediate Actions Taken	Initial review including with system colleagues
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Distress caused to family
Patient/Family involved in investigation	Yes

Incident 2	
Classification	Fall
Incident ref. no.	2023/11060
Incident Summary	Unwitnessed fall from high low bed resulting in a fracture which was managed conservatively
Immediate Actions Taken	Falls review undertaken
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Patient is confused and supported. Family supported.
Patient/Family involved in investigation	Yes next of kin involved.

Incident 3	
Classification	Delayed Diagnosis
Incident ref. no.	2023/11719
Incident Summary	CT scan report did not include all relevant information to support appropriate treatment
Immediate Actions Taken	Incident reviewed.
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Patient sadly died due to multiple health issues – family provided with support

Patient/Family involved in investigation	Yes

Incident 4	
Classification	Delayed Diagnosis
Incident ref. no.	2023/11688
Incident Summary	Delayed diagnosis in relation to altered limb sensation
Immediate Actions Taken	Consultant review – raised awareness of sign and symptoms of altered limb sensation
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Distress caused and support provided
Patient/Family involved in investigation	Yes

Incident 5	
Classification	Delayed Diagnosis
Incident ref. no.	2023/11684
Incident Summary	Delayed diagnosis due to escalation of condition via GP and then overcrowding and capacity within the emergency pathway. Concerns involve both primary care in relation to patient management prior to arrival in ED.
Immediate Actions Taken	Reviewed with system colleagues to ensure full and holistic review of care pathway – multi-agency approach
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Patient sadly died and support has been provided to the family.
Family involved in investigation	Yes

Incident 6	
Classification	Maternity/Obstetric affecting baby – did not meet HSIB criteria
Incident ref. no.	2023/11850
Incident Summary	Caesarean delivery, delivery of head noted to be difficult. Baby transferred to Neonatal Unit. CT head identified birth trauma injuries. Baby recovered well.
Immediate Actions Taken	Case and care reviewed.
Duty of Candour Met	Yes
Impact on Patient/Family	Family have been supported
Patient/Family involved in investigation	Yes

Incident 7	
Classification	Category 3 Pressure Ulcer
Incident ref. no.	2023/11999
Incident Summary	Hospital acquired pressure to ankle, potentially device related
Immediate Actions Taken	Tissue Viability Specialist review. Alternative orthotic device provided.
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Support provided and pressure ulcer healing well
Patient/Family involved in investigation	Yes

Incident 8	
Classification	Delayed Diagnosis
Incident ref. no.	2023/12135
Incident Summary	Delayed diagnosis and treatment of osteomyelitis
Immediate Actions Taken	Full review of pathway of care
Duty of Candour Met	Yes
Impact on Patient/Family	Distress and pain to child and distress for mother – support provided
Patient/Family involved in investigation	Yes

Incident 9	
Classification	Delayed Diagnosis and treatment
Incident ref. no.	2023/12191
Incident Summary	Potential omissions in care and management of cardiac arrest
Immediate Actions Taken	Review of care
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Yes
Patient/Family involved in investigation	

Incident 10	
Classification	Fall
Incident ref. no.	2023/12287
Incident Summary	Unwitnessed fall resulting in head injury

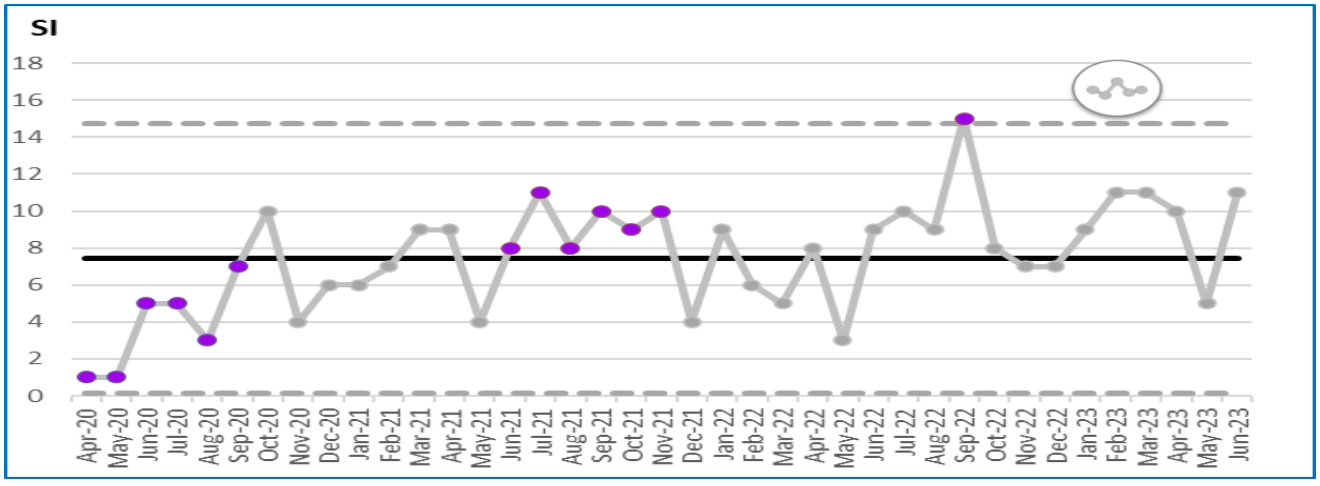
Immediate Actions Taken	Falls review completed
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Patient and daughters have been supported
Patient/Family involved in investigation	Yes

Incident 11	
Classification	Fall
Incident ref. no.	2023/12291
Incident Summary	Unwitnessed fall in the toilet resulting in head injury and fractured hip
Immediate Actions Taken	Falls review completed
Duty of Candour Met	Initial duty of candour met
Impact on Patient/Family	Patient underwent surgery to hip and is recovering well.
Patient/Family involved in investigation	Yes

4.4 Serious Incident Reporting Year to Date

In May 2023 the Trust reported 5 serious incidents. In June the Trust reported 11 serious Incidents. At the end of June 2023, the Trust had reported 26 serious incidents for financial year 2023/24. After special cause variation in September 2022, serious incidents have returned to common cause variation.

SPC Chart 1



5. Never Events

There have been no Never Events reported in May and June 2023.

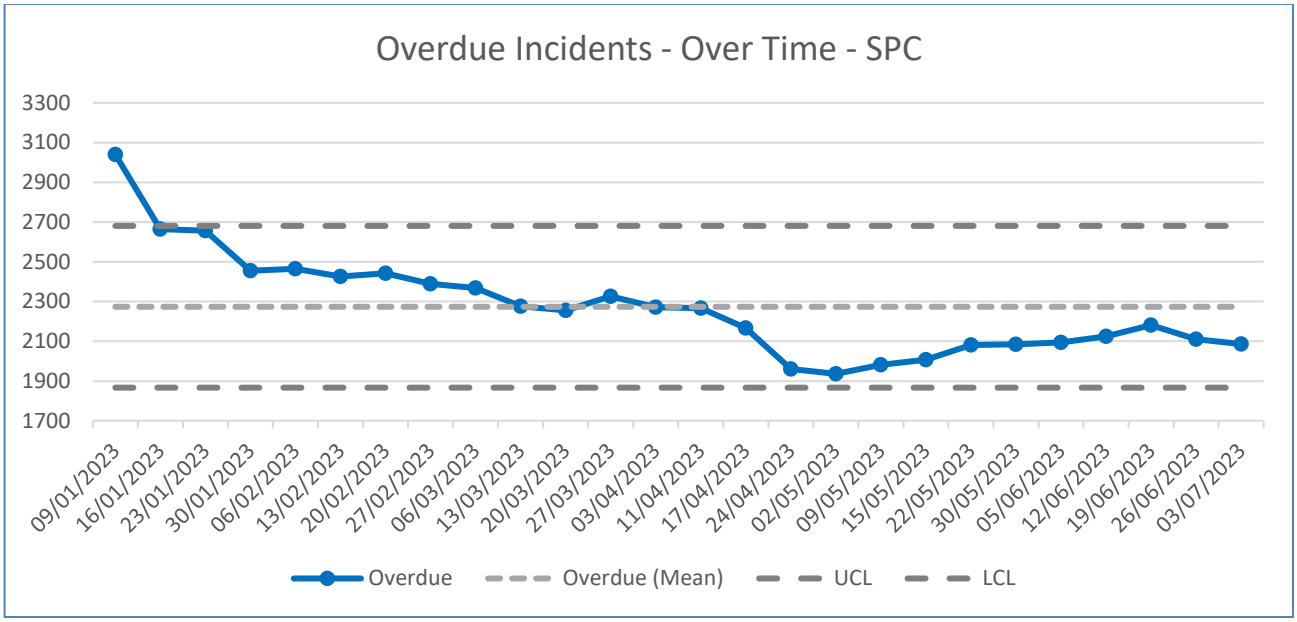
6. Overdue Datix

SPC 2 shows that concentrated work within the emergency and neonatal centres particularly had begun to reduce numbers of overdue Datix reports. Work is on-going to continue to review the overdue datix by the Division and supported by the Quality Governance team.

Mitigation and trajectory for improvement

All datix are reviewed daily by the Quality Governance/Safety teams who filter out those datix that require immediate actions. Moderate harm or above incidents are reviewed at the weekly Review of Incident Chaired by the Assistant Director of Nursing. All Divisions have a weekly incident review meeting to prioritise and escalate incidents, such as Neonatal and Obstetric risk meeting, Medicine incident review group, Emergency Department weekly incident review.

SPC Chart 2



7. Serious Incidents Closed during May and June 2023 - Lessons Learned and Action taken

There were 4 Serious Incidents closed in May 2023. A synopsis of the incident and learning is identified below in Table 4

There were no HSIB reportable incidents closed during May 2023.

Table 4

Incident 1	
Classification	Never Event
Incident ref. no.	2023/817
Incident Summary	Retained Piece of Equipment following Trans Urethral Resection of Prostate (TURP), due to a piece of the resectoscope breaking during procedure
Duty of Candour Met	All aspects met
Impact on patient/family	Increased pain and anxiety Extended period of catheter insertion
Investigations findings/actions	• When the piece of equipment was thought to be lost, the correct procedure, as per the Trust's theatre count policy, was not adhered to • Resectoscope loops have always been manipulated by urology surgeons for some patients where a better cut is required. It is not uncommon for the loop to lose its integrity and break, but the side electrode is not expected to break.

	• Apart from manipulation of the loop, user technique was not considered an issue in this case. **Actions taken** • Storz equipment training increased and monitored. • Ensured all staff are aware and follow the correct process regarding lost equipment following a surgical procedure. • Training module to be developed and added to LMS for all theatre staff, including bank and agency, to ensure theatre staff review pertinent theatre documentation and policies. This will also incorporate NaTSiPPs 8. • Review of the current induction program for agency staff to ensure it is robust in ensuring adherence to all theatre and trust policies and procedures.

Incident 2	
Classification	Fall resulting in fractured neck of femur
Incident ref. no.	2023/102
Incident Summary	Patient found on the floor following an unwitnessed fall. X-ray confirmed a fractured neck of femur.
Duty of Candour Met	All aspects completed.
Impact on patient/family	The patient was recovering well from surgery however he sadly died a few days later however this was not as a result of the fall. The family have been supported.
Investigations findings/actions	• Neurological observations were not completed beyond the first set, post unwitnessed fall • Post identification of injury analgesia was not provided in line with pain score and analgesics not prescribed as a regular medication. • Hourly falls bundle and plan of care not completed in line with policy. • ED Adult Risk of Falls Assessments and Interventions not updated. • Staffing was stressed due to clinical demand, extremis and several allocate on arrival staff who were not used to working in ED • He was known to be very independent and did not like to call for the team to assist him (the department being busy compounded this) **Action taken** Hourly checks including falls interventions to be completed in the ED in line with the falls policy. Training to be delivered and refreshed for the timings and requirement of neuro-obs in the post falls pathway. Further training/support provided on the post falls pathway, relating to the importance of completing the neuro-observations according to the trust policy.

	Nursing and Medical staff to ensure patients pain is managed while they are in the ED. ED to appoint a medical lead for falls.

Incident 3	
Classification	Delayed Diagnosis
Incident ref. no.	2022/26975
Incident Summary	Delayed diagnosis of malignancy following delayed imaging report, this was due to a malfunction in the reporting process. It is likely that the delay allowed time for the malignancy to grow and/or spread causing disease to reach a more advanced stage, which meant surgical intervention or radical radiotherapy which may have improved treatment outcomes was no longer an option.
Duty of Candour Met	All aspects met.
Impact on patient/family	Delay has caused increased anxiety and concern about the impact the delay may have had on prognosis. The patient and family have been supported throughout the process.
Investigations findings/actions	• The diagnosis given during hospital admission was reasonable with the information known at the time • The delay in reporting of the x-ray was due to an error in the x-ray archiving and communication system. The compounding reason for the error and delays in detecting this error was an unprecedented backlog in reporting due to workforce capacity and demand on the service • The delay in reporting and therefore diagnosis of lung cancer, likely caused his disease to progress which limited his treatment options and impacted his prognosis **Action taken** • Improved staffing levels – Since July 2022, there has been additional recruitment of 3.2 WTE Radiologists. The team have utilised international recruitment to improve their vacancy rate. • Increased outsourcing capacity by utilising a second outsourcing company – 4 Ways. • All images on the escalation lists were moved and the worklists were made visible to all reporters. • Regular system checks completed by the PACS team including a review of all images that are more than 2 months old and don't have a report. In addition, there is a daily check of any investigations that have been completed, but do not have an image attached or scan location entered. • Statistical reports run from CRIS (radiology information system) are being checked on a weekly basis to ensure any administration tasks have been completed.

	• The Radiology Secretarial team follows up any unreported imaging over a week old with the outsourcing companies • Reporting trajectories are reviewed and published weekly so referring clinicians are aware of expected timescales.

Incident 4	
Classification	Inappropriate discharge
Incident ref. no.	2022/25724
Incident Summary	Concern regarding an unsafe and premature discharge.
Duty of Candour Met	All aspects met.
Impact on patient/family	Patient and family supported through the investigation and are assured that whilst the discharge process was poor that the outcome for the patient was not related to this experience. Patient involved and able to ask all his questions which were included in the investigation.
Investigations findings/actions	Aspects of the patient's discharge were sub optimal, and the issues identified are being addressed, however, these discharge related issues did not contribute to the readmission or progression of the medical condition, which later required surgery. **Action taken** 1. Raise awareness of Transfer of Care Around Medicines (TCAMS) if it is felt a patient could require further support and counselling on the management of their medications following discharge. This service is picked up by the patient's community pharmacy. 2. Review of safety netting advice provided to patients being discharged. 3. Share learning re awareness that erratic blood sugars could indicate underlying sepsis. 4. Share case with lead anti-biotic pharmacist to highlight issues experienced by the patient that are potentially linked gentamicin, with a view to reviewing first line antibiotics and trust policy.

There were 8 Serious Incidents closed by in June 2023. A synopsis of the incident and learning is identified below in Table 5.

There were no HSIB reportable incidents closed during June 2023.

Table 5

Incident 1	
Classification	Fall resulting in fracture neck of femur
Incident ref. no.	2023/5664
Incident Summary	Patient fell whilst attempting to stand from wheelchair to attend an outpatient appointment.
Duty of Candour Met	All aspect met
Impact on patient/family	Pain and distress caused by fracture neck of femur. The patient remained an inpatient for 8 days and was not able

	to be discharged home but spent a further 14 days in with ongoing rehabilitation
Investigations findings/actions	• No falls bundle was completed in the outpatient department. The Trust Falls Lead Nurse has met with the OPD managers and they were aware this should be implemented if a fall occurred in the department.

Incident 2	
Classification	Delayed Diagnosis
Incident ref. no.	2023/5691
Incident Summary	Delayed diagnosis and treatment due to overcrowding and capacity in the ED. Delay led to a deterioration in the patient condition resulting in cardiac arrest. On completion of the review and in discussion with several speciality teams, although there were some areas of learning identified and associated recommendations made to address these issues, it was determined that these did not affect the sad outcome and the death could not have been prevented.
Duty of Candour Met	All aspect met
Impact on patient/family	Distress due to sudden and unexpected death. Family supported.
Investigations findings/actions	• This case has raised awareness in the ED of the on-call availability of SaTH Cardiologists out of hours, although the patient was correctly discussed with UHNM as per policy. • Issues with completion of documentation is not unique to ED and training in this area is ongoing.

Incident 3	
Classification	Fall resulting in fracture neck of femur
Incident ref. no.	2023/5520
Incident Summary	Unwitnessed fall, resulting in fractured neck of femur.
Duty of Candour Met	Full duty of candour met
Impact on patient/family	This injury and subsequent prolonged stay in hospitals have cause a substantial decline in physical and mental ability. The patient is mostly bedbound and is disengaging with therapy services. At present it is unlikely that she would be able to return to her pre-fall level of independence
Investigations findings/actions	• The patient was in a new environment, having only been transferred in the late afternoon of the day before and she was known to have hypoactive delirium. • The ED handover document had conflicting information. • There was a tick between boxes for assistance with one staff member and assistance with two, that

	made it unclear which was needed. The document was not signed and it was not possible to confirm who had filled it in. • On arrival to the ward, the admitting nurse was on a team that was short staffed and the patient was one of three admissions at that time. The admission paperwork and risk assessments were not fully completed in places, and was not accurate and did not always acknowledge that the patient had delirium which led to an incorrect bed rails assessment. • A lack of MCA being properly completed may have contributed to the risk not being identified. **Actions taken** • ED handover to contain all relevant information • Admitting nurses should ensure that time and care are taken over patient admissions and that should they not be able to complete the admissions in the policy timeframe they should escalate their concerns to the NIC and complete a datix, rather than an inadequate and incorrect admission. • Lying and Standing blood pressures must be recorded and any postural drop actioned • Staffing levels must be reviewed by the relevant Matron when caring for a patient with complex needs, such as EPS requirement or bariatric care needs.

Incident 4	
Classification	Delayed Diagnosis
Incident ref. no.	2023/4147
Incident Summary	Delayed diagnosis and treatment of testicular torsion resulting in surgery.
Duty of Candour Met	Full duty of candour met
Impact on patient/family	Unfortunately, recovery has not been an easy one, the patient has suffered with pain which took time to settle. The patient is making slow but steady recovery, but he feels the impact has caused him to withdraw and become depressed.
Investigations findings/actions	The patient was triaged quickly on arrival, unfortunately the recommendation for triage nurses to ascertain if males presenting with abdominal pain had any testicular pain, had not filtered down to all staff. Pain levels were not escalated to the senior team. The department was in extremis with long delays and high acuity of patients. **Actions taken** • Triage nurses need to be aware that testicular torsion can present as abdominal pain and ask the patients if they have any testicular or groin pain-in line with best practice.

	• All ED, Urology and Paediatric staff to be made aware of the new testicular pain pathway. New pathway to include how to contact the teams 24 hours a day. • Paediatric pain pathway to be reviewed and shared with all ED staff. • Urology to respond to referrals out of hours in a timely manner according to their policy. • Audit of the CAS Cards in ED for those who have presented with testicular pain/lower abdominal pain to establish if the learning to ask patients if they have any testicular pain and to ensure they are escalated has been embedded. • The Trust investigating if there are any national torsion reviews taking place that we can link in with. • ICB team is going to investigate if there is information that families can access relating to health promotion and testicular health.

Incident 5	
Classification	Delayed Diagnosis
Incident ref. no.	2023/3964
Incident Summary	Delayed diagnosis and treatment of testicular torsion resulting in surgery.
Duty of Candour Met	All aspects met
Impact on patient/family	Significant distress caused to the patient and family – support provided
Investigations findings/actions	**Main findings:** • Had an ultrasound been completed on first presentation, a diagnosis of testicular torsion may have been made and treatment given. • During this investigation, a consultant urologist has reviewed the notes and confirms that his initial presentation was indicative of epididymo-orchitis. • Despite a documented diagnosis of query tumour on the second presentation, there was no urgency to complete an ultrasound scan (the scan was not documented as urgent and so followed the usual in-patient scanning pathway). • At each presentation, he was seen timely by both Emergency Department (ED) staff and the Urology team. **Recommendations include:** • All ED, Urology and Paediatric staff to be made aware of the new testicular pain pathway. New pathway to include how to contact the teams 24 hours a day. • All urology staff to be reminded regarding consideration of testicular torsion.

Incident 6	
Classification	Category 3 Pressure Ulcer
Incident ref. no.	2023/3790
Incident Summary	Hospital acquired category 3 pressure ulcer
Duty of Candour Met	All aspects met
Impact on patient/family	Patient was on end of life care and family were supported
Investigations findings/actions	• There was a lack of autological bed or use of nimbus mattress due to spinal cord compression which was clearly documented. Two assessments took place and autological bed was requested, there were supply issues in relation to the beds and a shortage of supply. • Skin inspection charts were completed but with some potential inconsistency of grading when the pressure ulcer was identified • Waterlow (a method of scoring the risk of a patient developing a pressure ulcer) was not assessed as his condition deteriorated but 2-4 hourly repositioning would be considered suitable. • There were some gaps in documentation that would indicate that repositioning did not occur as per the care plan in place. • It was not clear if the dressings were removed, so that it was accurately reviewed. Nursing notes do not comprehensively record staff removing the dressing to review the wound. • There were inconsistencies in grading of the pressure sore which suggests additional training is required. **Actions** • Increase education and monitor compliance, to include skin assessments and comprehensive documentation when a pressure sore is identified. • Compliance in weekly assessment of Waterlow scores, through weekly ward Manager checks and Matrons quality metric audits. • Ensure that Assessments provided by the Tissue Viability Assessment team are made available and communicated to staff through daily huddles, handovers etc

Incident 7	
Classification	Delay in treatment
Incident ref. no.	2023/2458
Incident Summary	Delay in treatment due to length of waiting lists
Duty of Candour Met	All aspects met
Impact on patient/family	The disease was removed completely, the patient has recovered well. Patient and family supported
Investigations findings/actions	• Waiting lists are continuously being revalidated for clinical priority

	• There were several delays in appointments from 2018 up until surgery was performed in February 2023. **Recommendations include:** • Information to be given to the patient when they are listed for surgery including a timescale of when to contact the department if they have not heard about an appointment date or if their symptoms deteriorate. • Extend the current extra theatre time to help further with patients on the waiting list.

Incident 8	
Classification	Delay in diagnosis and treatment.
Incident ref. no.	2023/22676
Incident Summary	Delay in diagnosis following biopsy, which led to inappropriate treatment
Duty of Candour Met	All aspects met
Impact on patient/family	Unlikely that the surgery could be have been prevented however patient supported throughout.
Investigations findings/actions	▪ Review and monitoring of CMV testing in comparative periods between 2022 and 2023 resulting in increased levels of testing for CMV. ▪ CMV should have been diagnosed on the initial biopsy ▪ If CMV had been identified in the first biopsy, then infliximab would not have been prescribed. ▪ It is unlikely that the surgery could have been prevented even if CMV had been identified earlier due to the severity of symptoms. **Actions** • Proceed with the suggested audit later this year to ensure that CMV testing levels remain at the increased level. • If CMV is clinically suspected, then CMV testing should be specifically requested by Gastroenterology. • On the introduction of new endoscopy software, Medilogik, the request form to be updated to include (under clinical indications): "ulceration; query CMV".

8. Themes identified from closed serious incidents in May and June 2023

Themes identified from the serious incidents closed in May and June include:

Incidents across the emergency pathway: a wider theme has been noted of incidents across the emergency pathway. This is thought to be related to pressures in the emergent department and the medical pathway. This relates to the priority for improvement of flow across the organisation.

Torsion of the testes: following serious incidents which have been raised relating to torsion of the testes. A complete review has been undertaken of the emergency pathway and a revised pathway has been signed off with a plan for ongoing audit of effectiveness.

9. Themes identified by serious incidents raised in May and June 2023

Themes identified by the serious incidents raised in May and June 2023 include:

Although there are a few new serious incidents relating to delayed diagnosis there is no clear theme within this group.

Unwitnessed falls – there have been a few unwitnessed falls resulting in injury during this period and although the overall number of falls have reduced the witnessed falls are under review as part of the ongoing falls prevention programme.

Category 3 Pressure Ulcers – There has been an increase in reported category 3 pressure ulcers during this period, all of which are fully investigated and feed into the overarching prevention plan.

Incidents across the emergency pathway: a wider them has been noted of incidents across the emergency pathway, including a couple of falls. This is thought to be related to pressures in the emergent department and the medical pathway. This relates to the priority for improvement of flow across the organisation.