SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Serious Clinical Incident Summary Reported between 1st October 2019– 31st March 2020

	Date of incident	Reference	Clinical Group	Specialty	Type of Incident	Case synopsis and Contributory Factors	Summary of key changes Implemented/ Solution
1.	01/07/2019	STEIS 2019/21595	Surgery	Urology	Surgical/invasive procedure incident meeting SI criteria	Patient was admitted for planned removal of his right kidney due to renal cancer. Complicated by bleeding from operative. Multiple bloods were transfused and all necessary drugs were administered to reverse the condition of the patient which was unsuccessful. This incident resulted in death.	• **INVESTIGATION COMPLETE**Referral to anaesthetic pre op clinic especially in complex cases should be considered; this will help to improve the optimisation of patients pre op and may also trigger presence of more senior anaesthetic staff/consultant on the day. (Overdue). • Regular Anaesthetist allocation to lists would enable better communication between surgeons and anaesthetists in planning difficult cases in advance. (Overdue) • Referral to other relevant specialties at the time of pre op assessment should be considered. For example, in this case haematology opinion and advice should have been sought well before the day of the surgery. (Completed) • This investigation found that the emergency alarm was not functioning within this theatre. This did not have an impact of this particular case, but could have serious implications for future incidents. This investigation recommended that there should be a system of daily checks conducted on the alarm systems prior to the theatre being used. (Completed) • It was noted during the investigation that 50% dextrose was not available in the theatre and had to be brought down from ITU, whilst the patient was having CPR. Ultimately this did not impact upon this incident, but could potentially have ramifications for similar incidents in the future. Whilst it was recognised that 50% dextrose is not part of the 'normal' emergency drug requirement, there should be a supply of 50% Dextrose kept within theatres. (Completed) •

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2.	11/10/2019	STEIS 2019/23002	Surgery	General Surgery-Colorectal	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	This patient was admitted in April 2017 following a period of jaundice and weight loss. She underwent an ERCP, which revealed low grade dysplasia. No follow-up was arranged. The patient reattended in septemer 2019 with severe weight loss and anemia. She was subsequently diagnosed with invavsive duodenal cancer and died on 03/12/2019. **Learning:** This investigation found that there were a number of missed opputunities for this patient to be listed in the UGI MDT meeting. Had anyone of them listed the patient, then she would have been seen and an earlier diagnosis could have been made. It's important to note that this kind of multi-level failure is rare, however it is something that could occur anywhere within the trust.	**INVESTIGATION COMPLETED** • A reminder at QIHD and then the ward departmental induction for the Gastroenterology team in light of this incident to ensure that junior doctors, are aware of the MDT contacts (coordinators and CNS) to ensure these patients are referred for discussion in the appropriate MDT meeting and also are booked into the appropriate follow-up Gastroenterology clinic for review. Once this has been completed with Gastro, it is important that this is rolled out across the trust, as part of the QIHD and induction programs (Completed- within Gastro) • Ensure that all histopathologists have additional training in reporting of dysplasia and flagging this to the relevant MDT. (Not yet Completed – due September 2020) • An audit of upper GI & hepatobiliary, and the flagging and subsequent referral for review in the UGI MDT meeting to determine how often one or more of the steps (failsafe's) are actually missed. (Completed)

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3.	09/02/2019	STEIS 2019/23445	Medince and Emergency	24/10/Acute Medicine	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	Patient self-presented into the Emergency Department on 09/02/2019 following a suspected stroke. Following Clinical examination he received a CT scan of his head. The CT scan report described an abnormality, possibly indicative of metastatic disease. Further investigation was recommended. The further investigation did not take place, and when patient re-presented he had significant spinal abnormalities, suggestive of widespread and advanced metastatic disease. **Learning:** The investigation also found that, there was a missed opportunity for a chest X-ray to have been carried out. All patients who attend ED with a history of smoking and a suspected stroke, should be given a chest x-ray as standard practice. This did not happen, and this investigation concluded that this was a missed opportunity	**INVESTIGATION COMPLETED** • A clarification around the flagging of serious findings in radiology, and the process by which this occurs (Completed) • A review of the manner in which radiology reports are written. In particular, a consideration as to putting 'positive' conclusions at the top of the report. (Completed) • A general reminder that all reports must be read in their entirety (Completed) • Departmental training, to ensure that all patients attending ED with a suspected stroke and a history of smoking get a chest X-ray (Not yet Completed – Due 01/08/2020) •

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4.	24/10/2019	STEIS 2019/26015	Medince	Admitted care	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	The patient had developed a gastrointestinal bleed and haemodynamic instability. He had an urgent overnight Upper Gastrointestinal Endoscopy (OGD) bleeding duodenal erosions which was treated. He had further attacks of haematemesis and melena. He subsequently deteriorated further and suffered a cardiac arrest with an unsuccessful resuscitation attempt. **Learning:** This investigation found that there had been a failure to fully recognise the severity of the patient's oesophagitis, despite it being highlighted in a discharge letter from Good Hope Hospital. The team chose to treat the patient with Aspirin for his suspected acute coronary syndrome; this, coupled with a failure to follow the advice regarding increasing the patients Lansoprazole, likely contributed to the gastrointestinal bleed Had the team fully recognised the severity of the patient's condition (as indicted in the discharge letter from Good Hope) then other courses of treatment would have been investigated.	**INVESTIGATION COMPLETED** • Discussion of case review in the quality improvement meetings to reiterate the importance of early identification of deteriorating patient. (Completed) • Dissemination of learning points to the relevant team members. (Completed)

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5.	17/10/2019	STEIS 2019/27800	Medicinde	Emergency care	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	Patient was involved in a road traffic accident. He was assessed, deemed medically fit at Sandwell ED and sent home. Following discharge the patient began to vomit and his wife called 111 who told her to take him back to ED. The patient was taken to the QE, where he was assessed, a brain scan was done. This found a large bleed and 2 small ones on his brain. **Learning:** This investigation concluded that there had been a failure to fully review the past medical and drug histories. This would have helped in identifying the risk factors for significant major trauma. The investigation went on to state that if there had been a lower threshold for the investigation of injuries in elderly patients; a CT scan may have picked up the subdural bleed (if it had been present during his time within SWBH)	**INVESTIGATION COMPLETED** • ED to ensure adequate review of past medical and drug histories of all trauma patients to identify risk factors for traumatic injuries. (Overdue) • ED to review Major Trauma Standard Operating Procedure (SWBH/SOP/ED/01) and include guidelines for elderly trauma triage with clinical triggers (Not yet completed – due 31/08/2020) •

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6.	07/10/2019	STEIS 2019/23073	Women and Child Health	Maternity	Maternity/Obstetric incident meeting SI criteria: baby	At 41+1 week's gestation, patient presented to triage in the early hours of the morning with a history of reduced fetal movements all day. An ultrasound (USS) scan was carried out and an Intra Uterine Death (IUD) was confirmed.	**INVESTIGATION COMPLETED** • Improve the referral process from Antenatal Day Assessment Unit (ADAU) to Fetal Medicine Unit (FMU). (Completed) • Adequately staff Fetal Medicine Unit (FMU) clinic to reduce appointment delays and to enable early counselling regarding fetal risk and opportunities for early induction of labour. (Completed) • Include communication with Community Midwifery (CMW) in the Did Not Attend (DNA) escalation policy for fetal medicine clinic especially if CMW is based at an external trust (Completed)
7.	29/10/2019	STEIS 2019/24525	Medicine	Admitted Care	Unsafe Transfer	Patient was found deceased in bed on the ward The patient was for full escalation and full resuscitation, however it was decided by the medical team that this was not appropriate due to likely duration since death occured	• All agency RMN's to have the ability to document care provided within a patient's electronic record. (Overdue) • Care rounding to be undertaken and documented even when a patient is non-compliant (Overdue) • Where non-compliance/erratic behaviour is evident, consider use of a behavioural chart for monitoring. (Overdue) • Mental Capacity assessments to be carried out and documented when there is concern regarding a patient's capacity. (Overdue) • Care rounding frequency to be increased on patients who are suddenly quiet after a period of noise and activity. (Overdue) • Written role specification, for anyone undertaking 1:1 care, advising the requirements for that shift and particular patient. (Overdue)

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8.	17/11/2019	STEIS 2019/25477	Medicinde	Admitted Care	Unsafe Transfer	Patient attended ED at CITY and were seen by a Medical Registrar. Decision was made suitable for non-clinical transfer to Sandwell Hospital due to lack of capacity at City. Patient was not seen by any doctor at Sandwell Hospital despite significant co-morbidities. Patent was found unresponsive in bed. Team note that rigor mortis was present. **Learning:** The investigation found that the events of the 36 hours that the patient was in both City and Sandwell Hospitals did not contribute to the unexpected turn of events. However there were important lessons to be learned. In particular the Trust's treat and transfer policy only covered transfers from the two AMU's.	**INVESTIGATION COMPLETED** • Transfer policy to be updated to include treating and transferring of patients from ED, AMU and other wards and clarity on who made the decision. (Not yet Completed – Due August 2020) • The treat and transfer process to ensure that patients are only admitted to AMU from ED, regardless of site. (Not yet Completed – Due August 2020)

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9.	26/08/2019	STEIS 2019/27013	Women and Child Health	Paediatrics	Maternity/Obstetric incident meeting SI criteria: baby	Unexpected sudden infant death on ward D19 of child who had been inpatient for 18 hours for treatment of jaundice. **Learning:** This investigation concluded that received excellent care, and that this was a very unfortunate, unexpected death in infancy. This is supported by the testimony of the staff involved and by the coroner's report that ruled this as a Sudden Unexpected Death In Infancy.	**INVESTIGATION COMPLETED** ▪ During the course of the investigation it was noted that the top drawer of the resus trolley had jammed during the EMRT resus efforts. This did not have any impact at all on the overall outcome of the event, but was something that needed to be looked into, in order to ensure smooth access into the Emergency trolley. (Complete) ▪ Reminders for all staff to escalate potentially unwell Neonates immediately upon recognition. (Complete) ▪ A reminder for all staff to fully familiarise themselves with the Enteral Feeding in Neonates policy. (Complete)

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10.	16/12/2019	STEIS 2019/27754	Medicine	Acute Medicine	VTE meeting SI criteria	Patient was admitted with sub massive PE following recent Achilles tendon rupture. Patient was given treatment dose clexane that evening (once only dose) but 2 subsequent doses were not prescribed, though warfarin was. Reviewed in AMU - INR therapeutic, therefore no further clexane prescribed. Shortly after transfer to ward, patient went into hypoxic cardiac arrest, received thrombolysis without success and subsequently passed away. **Learning:** This investigation concluded that despite extensive interventions undertaken, death was tragic but unavoidable. His limited mobility following his presumed Achilles tendon injury could have caused the development and progression of the pulmonary embolism. The outcome unfortunately was unchanged despite the missed doses of Enoxaparin due to the underlying massive clot burden.	**INVESTIGATION COMPLETED** • Trauma and orthopaedics to perform a review and formalisation of the policies regarding VTE assessments in patients with ankle injuries. (completed) • Trauma and Orthopaedics to demonstrate evidence of VTE prophylaxis discussion and documentation in future consultations in patients with ankle injuries (Overdue) • Ongoing audit to review VTE prophylaxis in ankle injuries (Completed) • Shared learning of audit findings at future Quality Improvement Half days (Completed) • Further training to be offered up to all prescribers around the prescribing of VTE prophylaxis medications on UNITY. Information has already gone out to medical staff about prescribing for VTE, in order to reduce the risk of future occasions when one off as opposed to continuous dose enoxaparin prescribed. As well as a reminder to review the drug chart at every ward round to make sure all prescribing is as intended. (Completed)

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11.	23/12/2019	STEIS 2020/914	Medicine	Acute Medicine	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	Delayed cancer diagnosis The patient attended Sandwell ED with a chest infection and respiratory failure. As a part of her care plan she received a CTPA. This scan found a small area of opacification in her left upper lung. The scan report advised a follow up chest CT in three months. This Follow up scan was not arranged and when the patient was referred back to the trust she had a CT scan that was suggestive of lung cancer and had spread to the middle of her chest.	**Investigation not yet completed**

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12.	19/12/2019	STEIS 2020/322	Medicine	Elderly Care	HCAI/Infection control incident meeting SI criteria	SB presented with body ache, acute kidney injury and dehydration. A blood culture was not carried out until later and the patient was found to be positive for MRSA bacterium. Screening completed and the patient was confirmed to be MRSA positive. **Learning:** The investigation was unable to determine why the MRSA swab was not done as there is no documented evidence in the case notes to establish the reason for none compliance with the requirement for blood cultures and MRSA screening.	**INVESTIGATION COMPLETED** • The ward area are required to communicate to all staff when a patient is admitted they will need to ensure that an admission MRSA has been completed. • This should be checked on unity and if not completed then a screen to be taken: (Overdue)

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13.	06/02/2020	STEIS 2020/4007	Surgery	Trauma & Orthopaedics	VTE meeting SI criteria	Patient fell at home and was brought into Sandwell Hospital and admitted as a Trauma and Orthopaedics (T&O) patient. Her Venous Thromboembolism (VTE) assessment was carried out at and it was noted in Unity as 'decision deferred to morning ward round'. However no decision around her VTE prophylaxis was made on the morning ward on either round. This resulted in no enoxaparin being prescribed until a few days later. 2 days later she sadly suffered a cardiac arrest and passed away.	**INVESTIGATION COMPLETED** • Further training to the clinical teams regarding completion of VTE assessments and prescribing options including suspending prescriptions. This should focus on the Unity aspects. (Completed) • Consider reviewing the VTE assessment policy through the responsible clinical lead to take Unity into account more. (Not yet Completed – Due August 2020) • Consider looking at the way in which UNITY is used around VTE. This should be holistic and consider the assessment, the advice given, documentation for deviation from advice and prescribing and administration of medications. It should also cover the training and level of understanding of all aspects from the end users. (Not yet Completed – Due August 2020)