SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Serious Clinical Incident Summary – Q2 Overdue Actions

	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. During the procedure the patient deteriorated and went into cardiac arrest and suffered a massive post-operative haemorrhage. The arrest team was called and all possible interventions were carried out. Multiple bloods were infused 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) No Update from Group.* • Regular Anaesthetist allocation to lists would enable better communication between surgeons and anaesthetists in planning difficult cases in advance. *(Overdue) No Update from Group.* • 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)* • It was documented that the emergency alarm was not functioning in this particular theatre. This could have serious implications for any future case. There needs to be a mechanism put in place whereby these alarms are checked on daily basis. *(Completed)* • 50% dextrose was not available in theatre and was brought from ITU during CPR. All the lifesaving drugs should be available in the theatre for immediate use.

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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 weigh loss. On the 25/04/2017 she underwent an ERCP, which revealed low grade dysplasia. The patient should have been listed to go onto the UGI MDT meeting, but was missed off. 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 – Chased with group, no update received)* • 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.	24/10/2019	STEIS 2019/26015	Medince	Admitted care	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	Patient died on the 24th October 2019. The previous evening, he had developed a gastrointestinal bleed and haemodynamic instability prompting the first of 3 EMRT calls. He had an urgent overnight Upper Gastrointestinal Endoscopy (OGD) in the endoscopy suite at 01:00am undertaken by the Gastroenterology Consultant which identified fresh blood and bleeding duodenal erosions which was treated. Patient returned to D11 following the OGD with significant haemodynamic instability and delirium indicative of hypovolemic shock. 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 recognise the severity of oesphagitis, despite it being highlighted in a discharge letter from Good Hope Hospital. This resulted in inadequate acid suppression therapy.	Investigation Completed Discussion of case review in the quality improvement meetings to reiterate the importance of early identification of deteriorating patient. *Overdue (No update from the Group)* To share the learning with Gastroenterology and beyond to the medical ward teams. *Overdue (No update from the Group)* ITU governance lead – to look at this case where the lactate was high and although outreach was absent what is the mitigation in that case for ITU to follow up day and night. *Completed.*

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4.	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 by car. At the QE, 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. *(Completed)* • 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)* • **Update** - Silver trauma management is part of Trust Trauma guidelines and also national guidelines. There were regular multispecialty sim sessions for trauma pre covid which we will restart once things are back to normal. ED will continue to emphasize to juniors the importance of considering silver trauma in these type of patients. In this particular case major injury was not suspected and trauma policy only kicks in when major trauma is suspected.

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5.	29/10/2019	STEIS 2019/24525	Medicine	Admitted Care	Unsafe Transfer	Patient was found deceased with her face in the pillow on Lyndon 5. The patient was for full escalation and full resuscitation, however it was decided by the medical team that this was not appropriate	• All agency RMN's to have the ability to document care provided within a patient's electronic record. *(Overdue – Chased group – no update)* • Care rounding to be undertaken and documented even when a patient is non-compliant *(Overdue – Chased group – no update)* • Where non-compliance/erratic behaviour is evident, consider use of a behavioural chart for monitoring. *(Overdue – Chased group – no update)* • Mental Capacity assessments to be carried out and documented when there is concern regarding a patient's capacity. *(Overdue – Chased group – no update)* • Care rounding frequency to be increased on patients who are suddenly quiet after a period of noise and activity. *(Overdue – Chased group – no update)* • Written role specification, for anyone undertaking 1:1 care, advising the requirements for that shift and particular patient. *(Overdue – Chased group – no update)*

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6.	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 Lyndon 5 due to lack of capacity at City. There was no documentation of transfer therefore 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 KS 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)* • An update has been received regarding this action. There is a draft version of the policy however this needs to be finalised before going to UCB for sign off. Due to operational pressures this has slipped but the aim is to get this completed for the first week of November

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7.	23/12/2019	STEIS 2020/914	Medicine	Acute Medicine	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	Patient was admitted to SWB Emergency Department at the Sandwell site by ambulance on 29 January 2018. Patient was admitted as an inpatient due to a chest infection and respiratory failure. A CTPA scan was done on 2 February 2018 as part of her care plan. The scan found a small area of opacification in her left upper lung which was probable atelectasis. There was also a small triangular area of opacification with some speculation in the superior segment of the left lower lobe. The scan report advised a follow up CT chest scan in three months to ensure resolution. The suggested follow up scan was not arranged. On 16 December 2019, SG was referred to SWB rapid access lung cancer clinic, internally by the radiology department, as her CT thorax and abdomen showed a lung mass which was suggestive of lung cancer and appeared to have spread to the middle of the chest. SG declined surgical treatment but had agreed to be considered for alternative treatments. SG started her palliative clinic appointments in January 2020. SG was admitted to Sandwell Hospital Emergency Department on 3 February 2020 and passed away on the same day in the Emergency Department.	• To ensure 'the process of recording scan report outcomes in patient records' is included in the on-boarding package for doctors.Process to be aligned with the Trust wide results endorsement project led by the Medical Directors Office. • To explore and develop pathway for highlighting of non-red-flagged potentially cancerous lesions. • Design and implement trust wide robust internal governance system to ensure quality of discharge summary • Explore integrated care approach on inpatients and, to understand GP colleagues' practices on reviewing clinical letters and other critical patient information then develop effective communications pathway in with GP colleagues • ***Group to provide an update on all actions listed above.***

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8.	19/12/2019	STEIS 2020/322	Medicine	Elderly Care	HCAI/Infection control incident meeting SI criteria	SB was admitted into Sandwell on the 15/12/2019. She was transferred to Lyndon 4 on the 16/12/2019. SB presented with body ache, acute kidney injury and dehydration. A blood culture was not carried out until 19/12/19 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 – Group has been chased – no updates recieved)*

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9.	23/03/2020	STEIS 2020/6611	Surgery	Maternity	Neonatal Death	This patient was in her third pregnancy with multiple risk factors including, a previous neonatal death following delivery by caesarean section at 31 weeks gestation for a placental abruption. She was cared for throughout her pregnancy in Consultant-led clinics due to her medical history. At 31+2 weeks gestation she attended City Hospital with reduced fetal movements for two days. The cardiotocograph trace (CTG) was pathological and continued to deteriorate further followed by loss of contact. An ultrasound scan was performed and was inconclusive if the fetal heart was present, the Consultant attended and the ultrasound scan identified a bradycardia (slow heart rate). A decision was made for a category one caesarean section at 23:09. Baby was born at 23:28 with a slow heart rate; resuscitation measures were attempted but unsuccessful. A neonatal death was confirmed at 23:54. Learning: The consultant on call needs to attend the site in order to make the decision for a CAT 1 – C-section.	**INVESTIGATION COMPLETED** • To carry out a reflection with the Consultant on call to identify any learning from this case to prevent this from happening again. *(Completed)* • If Registrar feels that immediate delivery is required but Consultant has differing opinions and other recommendations the Consultant must attend the unit without delay to review the patient and overall clinical picture in person *(Group chased – no response)* • Staff to be aware of escalation process for conflict of decisions – Midwife on call, Clinical Director, Second Consultant opinion *(Completed)* • To be documented within obstetric policy regarding expectations of consultant attendance on site *(Group Chased – no response)*

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10.	16/05/2020	STEIS 2020/9844	Medicine	Elderly Care	Fall resulting in head injury	The patient was admitted onto the Acute Medical Unit (AMU) on the 15 May 2020 following a fall at home. The patient was diagnosed as suffering with sepsis secondary to a severe right leg ulcer. On the 16 May 2020, whilst on Newton 4, she got out of her bed and fell to the floor hitting her head. The patient was found lying on her left side, Her Glasgow Coma scale was 7/15 with unequal and sluggish pupils, no eye opening, there was no verbal response and she was only localising to pain so an Emergency (EMRT) call was put out. The patient had a contusion to the right side of her scalp, and so she was taken for an urgent CT of her head. The CT scan revealed a sub-arachnoid haemorrhage and extradural haematoma, (bleeding on the surface of the brain, within the skull). The patient remained an inpatient, then transferred to Leasowes palliative unit until she passed away on 12 June 2020	**TRUST SIGN OFF**

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11.	21/05/2020	STEIS: 2020/11737	Imaging	Radiology	Organisational : Unity results, acknowledgement	Three incidents were reported in May 2020 and each resulted in patient harm due to missed diagnoses. For each of these incidents the process for undertaking a requested diagnostic imaging procedure and the result being reviewed by the requesting or Lead Clinician had failed because the report was not seen by a Lead Clinician. The investigation identified 13 potential patient safety events that can interrupt the process anywhere between the original request being made and a result acknowledgement notification (for endorsement) appearing in a requester's or Lead Clinician's Unity inbox. The recommendations and action plan to address each of these causes and projects are in progress to correct them. A review of all tests undertaken since Unity was introduced to identify any patients whose radiological test has not been endorsed is also in progress. The Lead Investigator has been given the necessary assurances that any diagnostic radiological tests cancelled as a result of the COVID-19 pandemic are being rebooked and the Unity – CRIS link will be maintained for these tests.	**TRUST SIGN OFF**

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12.	15/06/2020	STEIS 2020/15663	W&CH	Obstetrics	IUD	IUD diagnosed on ADAU at 36/40. Patient was a self-referral from home with diminished fetal movements for 3 days. The patient did not receive antenatal follow-up care with a community midwife. She attended for anti-D and glucose tolerance tests but at these appointments it was never picked up that she had slipped through the net for her antenatal appointments.	**INVESTIGATION UNDERWAY**

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13.	14/06/2020	STEIS: 2020/12493	Medicine	Acute Medicine	Fall with head injury	The patient was an 80 year old gentleman who had a previous medical history of falls at home, Stroke and Epilepsy. The patient has had previous investigations for headaches and for the diagnosis of prostate cancer. On the 14th June 2020, the patient was admitted onto AMU at Sandwell, with a history of two falls at home and hip pain. The patient was mobile and active prior to these falls and had fallen whilst taking the bins out of his garden. Later that night at 18:21 (on 14th June 2020) he fell in the bathroom of the side room whilst in AMU, as he mobilised to the toilet. He was discovered with a small cut to his head and in a state of confusion. The patient was then sent for an urgent CT head scan, revealing a subdural haematoma. A referral to NORSE (A system set up to review neurological patients) was made at 02:01am on the 15 June 2020. Clinical recommendations were made by NORSE and acted upon. The patient was transferred onto Newton 5, but has subsequently passed away from his injuries	**TRUST SIGN OFF**

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14.	02/06/2020	STEIS 2020/19656	W&CH	Obstetrics	Delayed testing and diagnosis	Antenatal serology bloods not taken with multiple missed opportunities to identify that these had not been taken. Serology bloods taken 7 weeks postnatally and fast tracked. The results of the serology identified Positive Hepatitis E-Antigen.	**INVESTIGATION UNDERWAY**