

Trust Board Report
Meeting Date: 29 May 2012
Serious Incidents Requiring Investigation (SIRIs)

Report Date: 14/05/2012

Information in this report is based on the date an incident is reported to the PCT or the date it was closed, as appropriate. No information is based on the date the incident occurred.

Applied for Closure is the status given when an investigation has been completed. The outcomes are updated on the Department of Health PCT database (STEIS) and the Trust then requests closure by our commissioning PCT. Incidents remain in this category until they have been **Closed** by the PCT.

Status Ongoing* = This includes SIRIs under investigation or held open on advice of PCT pending Coroner and/or Policy enquiry or implementation of Learning Outcomes.

1. Update on Reported SIRIs: 12 March 2012 to 14 May 2012

New SIRIs Reported:	3	Ambulance (General)	2
		Drug Incident (General)	1
Directorate Review Process:	7	Ambulance (General)	4
		Confidential Information Leak	2
		Drug Incident (General)	1
Applied for Closure:	8	Ambulance (General)	4
		Confidential Information Leak	1
		Hospital Transfer Issue	1
		Other	2
Closed by PCT/SHA:	10	Ambulance (General)	5
		Ambulance Delay	2
		Other	2
		Hospital Transfer Issue	1

2. Summary of SIRIs reported by financial year

1 April 2012 to 31 March 2013 (YTD)			
Total number of SIRIs reported	1	Ambulance (General)	1
Ongoing:	1	Ambulance (General)	1

1 April 2011 to 31 March 2012			
Total number of SIRIs reported	40	Ambulance (General)	19
		Ambulance Delay	8
		Ambulance (Accidental Injury)	1
		Confidential Information Leak	4
		Drug Incident (General)	2
		Hospital Transfer Issue	3
		Other	3
Ongoing:	2	Ambulance (General)	1
		Hospital Transfer Issue	1
Quality Assurance Process:	3	Ambulance (General)	1
		Drug Incident (General)	1
		Hospital Transfer Issue	1
Directorate Review Process:	8	Ambulance (General)	5
		Drug Incident (General)	1
		Confidential Information Leak	2
Executive Review Process:	1	Ambulance Delay	1
Applied for Closure:	5	Ambulance (General)	2
		Ambulance (Accidental Injury)	1
		Confidential Information Leak	2
Closed:	21	Ambulance (General)	10
		Hospital Transfer Issue	1
		Other	3
		Ambulance Delay	7

3. Improvements to be implemented as a result of investigated SIRIs

Completed investigations into SIRIs which have been closed by the PCT/SHA have identified learning points and requirements for improvement across the Trust to reduce the likelihood of recurrence. Action plans have been created to ensure implementation.

One SIRI investigation was closed following agreement with the PCT that Trust action had not affected patient outcome, as such no action plans for improvement were developed.

One SIRI investigation was closed following agreement with the PCT/SHA that an Acute Trust were the correct organisation to undertake the investigation.

3.1. Adherence to protocols: Emergency call taker advice Date of incident: 04/08/2011

An emergency call was received for a patient in cardiac arrest, no CPR advice was given and the call was referred for police attendance only. The emergency call operator requested that all Trust attendance be cancelled from the call. Ambulance resources continued to scene, arriving within 8 minutes. The attending ambulance crew reported the patient to be in a potentially treatable cardiac rhythm. Despite treatment the patient was declared dead at the scene.

The root causes of this incident were identified as:

- NHS Pathways not well enough understood by emergency call taker, who lacked confidence in using the system to drive assessments.
- Emergency call operator failed to pick out salient points during the call and had made an incorrect assumption.
- NHS Pathways is not clear enough to assist in making suitable decisions upon when to commence CPR.
- The training of NHS Pathways failed to highlight safe working practices surrounding the identification of patients beyond any help and when to offer CPR advice.

The learning outcomes of this incident were:

- Need for further training for EDC staff on recognising workable/non workable cardiac arrests.
- Trust should not stand down on cardiac arrest calls unless from a Health Care Professional.
- Emergency call takers to confirm with Duty Dispatch Manager /Clinical Advisor before treating a call as a non-workable cardiac arrest.

3.2. Adherence to protocols: Scope of practice
Date of incident: 11/08/2011

This incident concerns a member of staff performing an internal rectal examination on a patient; this procedure was outside the member of staff's scope of practice.

The root cause of this incident was identified as a deliberate variance from Trust policy by the member of staff.

3.3. Delayed ambulance response: recording of patient's location
Incident date: 20/09/2011

This incident concerns an emergency call for a patient in cardiac arrest. The emergency call operator did not correctly record the location of the incident on the Computer Aided Dispatch system resulting in an ambulance being dispatched to the wrong area. Response time to the patient was 30 minutes. Despite continuous CPR being carried out by a bystander and the treatment provided by the crew the patient did not regain an output and was pronounced dead at the scene.

The root causes of this incident were identified as:

- Lack of post-training mentorship for new call-takers.
- Call-taker training does not involve voice simulated address.

The learning outcomes of this incident was the provision of audio dictation training and a mentoring scheme for new emergency call operators to ensure they are competent and confident in their role.

3.4. Patient diagnosis
Incident date: 20/11/2011

This incident concerns an emergency request for ambulance attendance to a patient in a public place. A member of the responding ambulance crew made a phone call to a relative of the patient informing them that patient was intoxicated. The patient was later found to have multiple injuries that had not been identified by the attending crew.

The root cause of this incident is considered to be the violation of Trust protocols and procedures by the crew. No system or Trust processes were identified as a root cause of this occurrence.

The learning actions identified by this incident were:

- Production of an anonymised article to be published in the Trusts clinical magazine regarding patient assessment where mechanism of injury is unknown.
- Clinical instruction implemented regarding importance of skin deep examinations.

3.5. Power outage
Incident dates: 31/07/2011 and 24/08/2011

These incidents concern power outages which caused the temporary failure of the Computer Aided Dispatch systems in all three Emergency Dispatch Centres. Emergency fallback procedures were introduced (paper resourcing) which enabled continued service provision.

The root causes of these incidents were identified as:

- Maintenance records not updated sufficiently.
- Power points provided with no concern to loading
- Lack of sign-off process for electrical work.

A full electrical survey of the three administrative headquarters / emergency dispatch centres was undertaken and action plan to prevent recurrence developed.

3.6. Delayed ambulance response
Incident date: 30/11/2011

A call was received to an unresponsive patient. An ambulance resource was dispatched arriving at the patient 21 minutes after the initial call. It appeared the patient had suffered a stroke. The patient was transferred to hospital within the Trusts policy timeframe for stroke thrombolysis of up to 2.5 hours pre-hospital.

The root cause of this incident was the impact of industrial action on the Trust ability to provide a response within 8 minutes.

3.7. Delayed ambulance response / treatment provision
Incident date: 05/03/2011

This incident concerns a request for ambulance attendance received from the Fire and Rescue Service, at the time of the call the Fire and Rescue Service could not establish whether anyone was injured and were unable to provide the origin caller number. Nearest ambulance resource (single responder, ambulance technician) was assigned. On arrival the single responder found patient with significant burns. The patient was treated and pain relief in the form of Entonox gas was provided. It was outside the ambulance technician's scope of practice to administer morphine for stronger pain relief. The single responder requested emergency back-up and made a request for the Air Ambulance. Pain relief in the form of morphine was provided by the attending air ambulance personnel. Concerns were raised regarding delayed ambulance attendance and provision of pain relief.

The root causes of this incident were identified as:

- Insufficient information passed to the Emergency Dispatch Centre by the Fire and Rescue Service on the initial phone call.
- Fire and Rescue Service did not have the complete phone number to enable the Emergency Dispatch Centre to phone the original caller back.

- Stronger pain relief could have been provided earlier had the request for an air ambulance been followed up with consideration for a paramedic to make scene by ground.
- The helicopter emergency medical service (HEMS) desk did not task the police helicopter which had a paramedic available who could have administered pain relief.

The learning outcomes identified by this investigation were:

- Emergency Dispatch Centre staff must insist on taking an origin phone number from Fire and Rescue Service.
- Clinical staff on scene must give clear and precise details to the Emergency Dispatch Centre of any back-up they require, including clinical skills.
- Development of guidance relating to the tasking and dispatch of Clinical Operations Manager to serious incidents.

Geraint Davies
Director of Commercial Services

Definition of a Serious Incident Requiring Investigation (SIRI)

A Serious Incident Requiring Investigation (SIRI) is defined as “a serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- 1.1. Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- 1.2. Serious harm to one or more patients ,staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm);
- 1.3. A scenario that prevents or threatens to prevent a provider organisation’s ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
- 1.4. Allegations of abuse;
- 1.5. Adverse media coverage or public concern about the organisation or the wider NHS;
- 1.6. One of the core set of ‘Never Events’ as updated on an annual basis and currently including:
 - wrong site surgery
 - retained instrument post-operation
 - wrong route administration of chemotherapy
 - misplaced naso-gastric or orogastric tube not detected prior to use
 - inpatient suicide using non-collapsible rails
 - escape from within the secure perimeter of medium or high security mental health services by patients who are transferred prisoners
 - in-hospital maternal death from postpartum haemorrhage after elective caesarean section
 - intravenous administration of mis-selected concentrated potassium chloride
- 1.7. **Supplementary terms**
 - 1.7.1. Incident – an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.
 - 1.7.2. NHS-funded services and care – healthcare that is partially or fully funded by the NHS, regardless of the location
 - 1.7.3. Unexpected death – where natural causes are not suspected. Local organisations should investigate these to determine if the incident contributed to the unexpected death.

- 1.7.4. Permanent harm – directly related to the incident and not to the natural course of the patient’s illness or underlying conditions, defined as permanent lessening of bodily functions, including sensory, motor, physiological or intellectual.
- 1.7.5. Prolonged pain and/or prolonged psychological harm – pain or harm that a service user has experienced, or is likely to experience, for a continuous period of 28 days.
- 1.7.6. Severe harm – a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- 1.7.7. Major surgery – a surgical operation within or upon the contents of the abdominal or pelvic, cranial or thoracic cavities or a procedure which, given the locality, condition of patient, level of difficulty, or length of time to perform, constitutes a hazard to life or function of an organ, or tissue (if an extensive orthopaedic procedure is involved, the surgery is considered ‘major’).
- 1.7.8. Abuse – a violation of an individual’s human and civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm or exploitation of the person subjected to it. This is defined in No Secrets for adults and in Care Quality Commission (CQC) guidance about compliance. Working together to safeguard children (2006) states that ‘abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by ‘inflicting harm’ or by failing to act to prevent harm’.