Sheffield Children's NHS
NHS Foundation Trust

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REPORT TO THE TRUST BOARD OF DIRECTORS' MEETING HELD IN PUBLIC ON 04 NOVEMBER 2014

Risk Management Activity Report
01 April – 31 July 2014

Trust objectives supported by this paper

The paper supports the achievement of all Trust Objectives through the underpinning strategy of:

- ensuring that the Trust is well governed and works effectively in partnership

Purpose of the paper

To present to the Trust Board of Directors a summary of the activities relating to risk within the Trust during the above period

Summary of key points

- Incident reporting shows most incidents are low to no harm. These principally relate to medication errors, violence and aggression against staff in mental health areas or patient confidentiality.
- The Trust continues to receive approximately 10 complaints per month for all areas. These are dealt with according to national standards
- The risk register is actively managed and in use to mitigate risks.

Board Action required

The Board is asked to review the report and agree any actions required.

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Executive Sponsor:	J Reid, Director of Nursing & Clinical Operations	

EXECUTIVE SUMMARY

The following report illustrates the activity reported through the Risk Management Department during April and July 2014 based upon data held on the Risk Management database on Tuesday 12 August 2014.

The Trust continues to have a robust reporting and learning culture.

There were a total of 1205 incidents reported during April, May, June and July 2014; this breaks down as 315 in April, 316 in May, 336 in June and 238 in July. The majority of incidents reported were no or low harm.

The main category of incidents continue to be;

- Violence and aggression against staff – particularly in Child and Adolescent Mental Health areas. These remain mainly low harm.
- Medication errors – these mainly relate to human error and are mainly no or low harm.
- Patient information – where confidential information has a potential to be unprotected.

The Trust continues to work with Divisions to ensure that all incidents are reported and an action plan obtained to reduce frequency and consequence of each category.

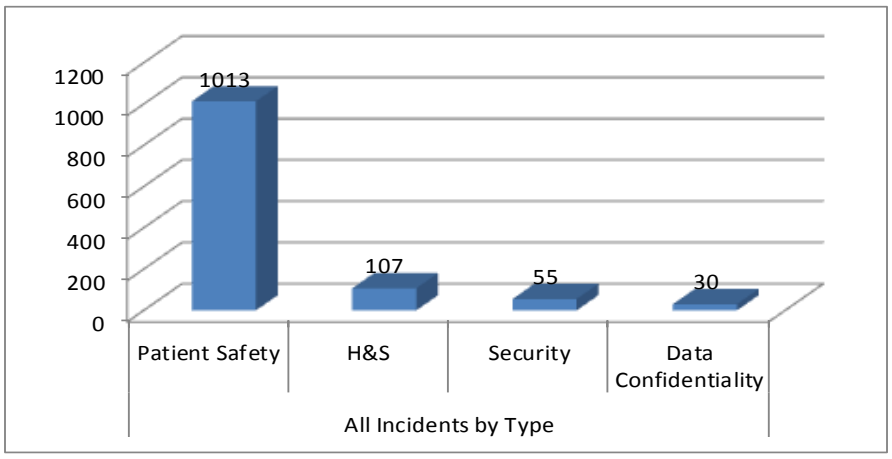
The Trust continues to manage complaints according to national standards and within the guidelines set out by the Health Services Ombudsman.

Section 1

1. All Reported Incidents

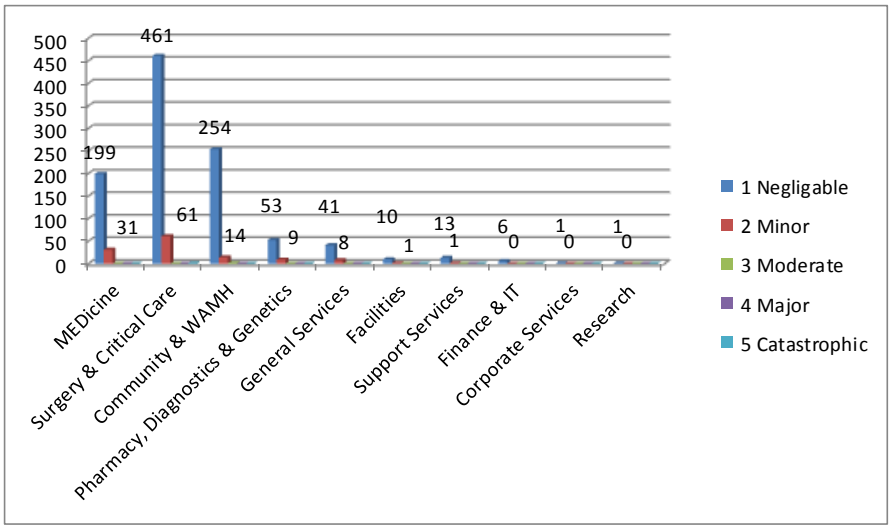
The following report shows the activity reported through the Risk Management Department during April, May, June and July 2014.

1.1 Summary of Total Incidents Reported



A total of 1205 incidents were reported with the highest number of incidents reported related to Patient Safety with Surgery & Critical Care reporting the highest number.

1.2 Severity of All Incidents



The above shows that there were a total of 125 incidents graded as 'Agreed Consequence' Minor (2) or above during the period.

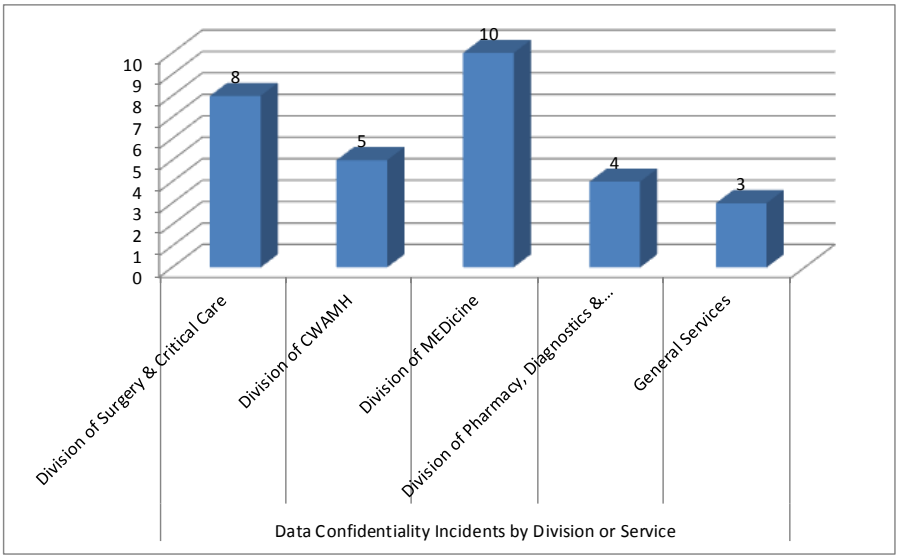
The Minor (2) incidents all involved some minor injury or illness requiring minor intervention or treatment, or minor delay to treatment or medication incident leading to no harm to the patient.

One incident was graded as Moderate (3). This Moderate incident involved a member of staff sustaining a moderate back injury leading to them missing work for a period of time 4-

14 days; this was reported to the Health & Safety Executive (HSE) under RIDDOR reporting.

There was one potential Serious Incident (5) which was reported. This was an unexpected death which is being duly investigated using a Root Cause Analysis approach and has been referred to the Coroner.

1.3 Data Confidentiality Incidents



There were 30 Data Confidentiality incidents during the period April to July 2014; none required reporting to the Information Commissioner. All but one of the incidents was graded as Negligible.

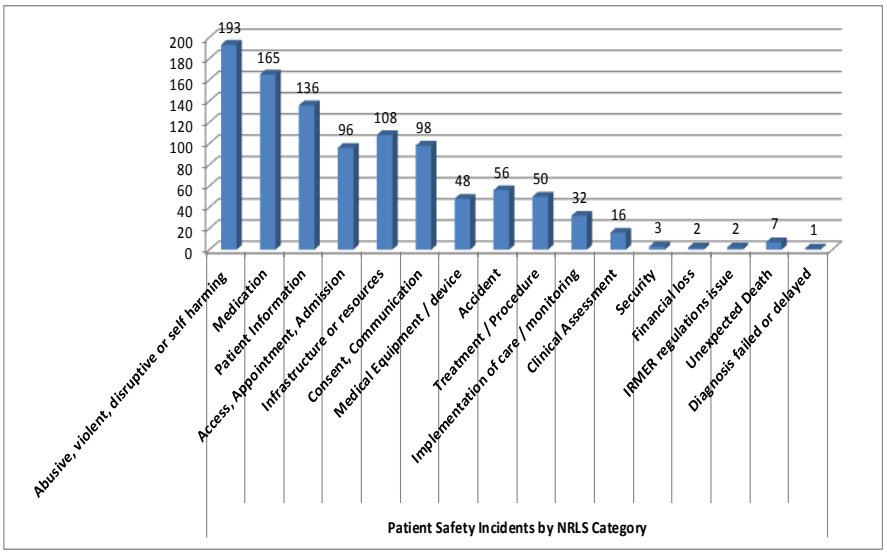
The Trust has taken action to automatically erase any documents inadvertently copied to a trust computer desktop and encrypts documents saved to all directories.

Other incidents involved documents left in a position where the public could have potentially gained access. In each case the department is informed and action taken where a member of staff is concerned.

SECTION 2

2.1 Total Patient Safety Incidents by Division or Service

The graph below shows the Patient Safety incidents by the National Reporting and Learning System (NRLS) classification.

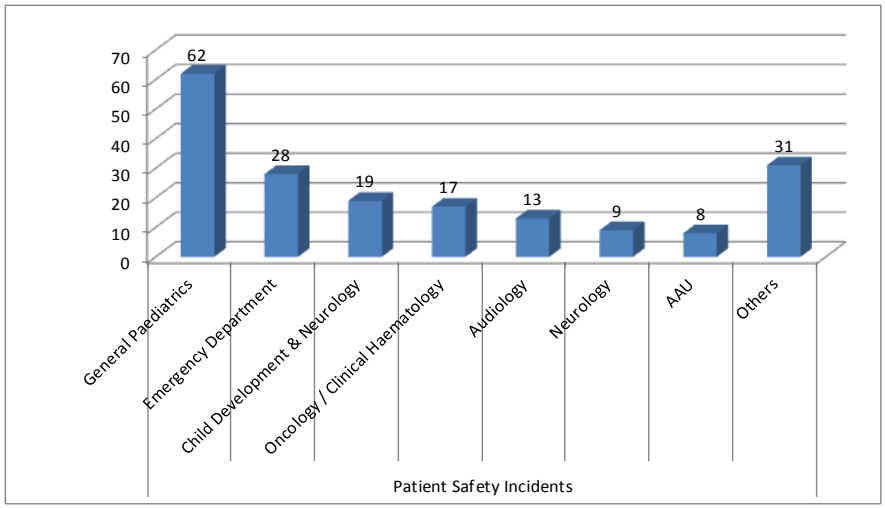


The following sections analyse the above incidents according to occurrence within each of the operational divisions.

2.3 Division of Medicine

Patient Safety Incidents

Trend analysis



The graph above shows the distribution of reported incidents by speciality. The highest reported NRLS Category of incidents was 'Medication' incidents and the main Sub Category was 'Administration or supply of a medicine from a clinical area' – 'Dose or strength was wrong or unclear'. These incidents were reported by the Medical Wards M1, M2 and M3. All, except the three incidents outlined above in Section 2.2, of the Division of MEDicine Medication incidents were graded as 'Agreed Consequence' of Negligible (1).

'Patient Information' incidents were the second highest reported Patient Safety NRLS Category during the four month period. There was no harm reported as a result of these incidents.

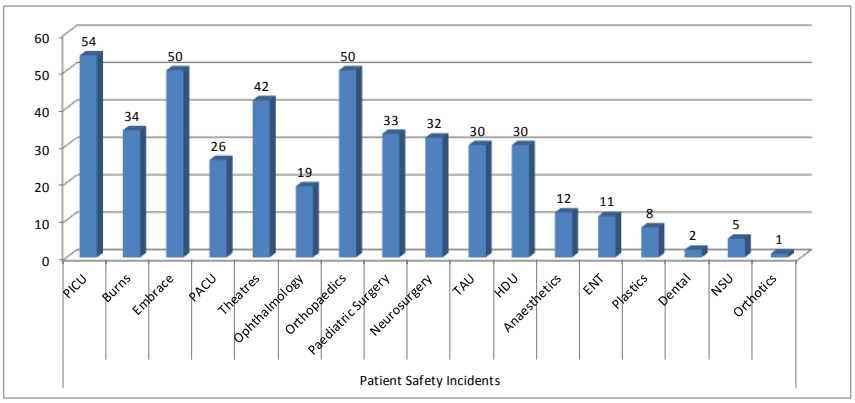
Lessons Learned

- All prescriptions should be based on agreed Trust policy or the British National Formulary (Children)
- All patients should be weighed at the time of admission to the ward and weights from a previous stay should not be used.
- Drug kardex should be with the patient when taken to theatres.
- No unapproved abbreviations should be used on drug kardex.

2.4 Division of Surgery & Critical Care

Patient Safety Incidents

Trend analysis



The highest reported NRLS Category of incident was a tie with 'Medication' incidents. The main Sub Category was 'Administration or supply of a medicine from a clinical area' – 'Frequency for taking of medicine was wrong', and also 'Dose or strength was wrong or unclear'. In all cases medical review was undertaken and advice provided, there was no harm reported to any of the patients.

The next highest Category was 'Patient Information' and also an increase in incidents relating to 'Access, Appointment & Admission'. At the time of the report all but three Division of Surgery & Critical Care incidents were graded as 'Agreed Consequence' of Negligible (1).

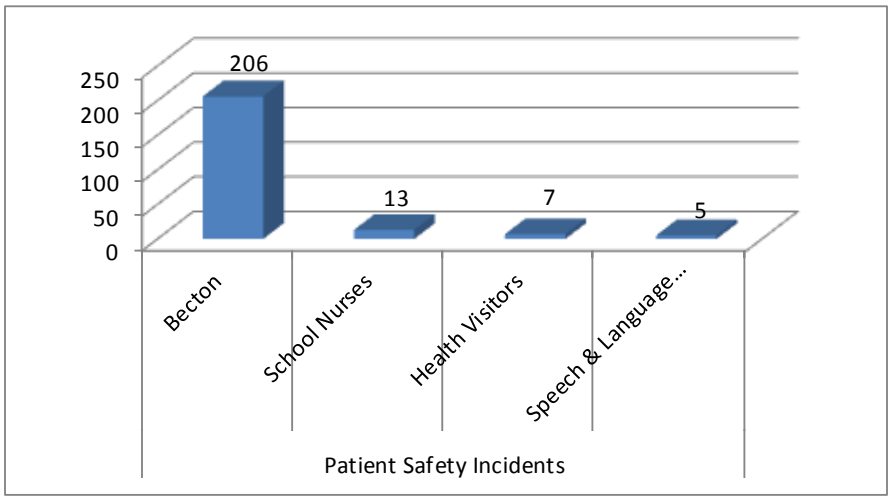
Lessons Learned

- Prescribers should only prescribe drugs that they are familiar with. If the name of the drug is not known, check BNF-c.
- Ward staff should check the allergy status of any patient prior to dispensing medications
- Better communication is required between teams when patients are having two surgical procedures.
- Prescription charts on PCCU change frequently – staff should check against the most recent entry.

2. 5 Division of Community Wellbeing and Mental Health

Patient Safety Incidents

Trend analysis



The highest reported NRLS Category of incident was 'Abusive, violent, disruptive or self-harming behaviour' incidents and the main Sub Category was 'Self harm during 24hr care'. There were one hundred and eighty-six incidents reported classified in the Category above. All occurred at Becton in areas that deal with young people with behavioural disorders. The majority had no lasting consequence but there were seven incidents which were graded as 'Agreed Consequence' Minor (2) involving physical interventions causing minor injury. All of the incidents involved behaviour directed at staff or other patients by an individual patient.

The Community teams continue to report, albeit in lesser numbers, communication issues and documentation remain to be the highest reported incidents for Community Services.

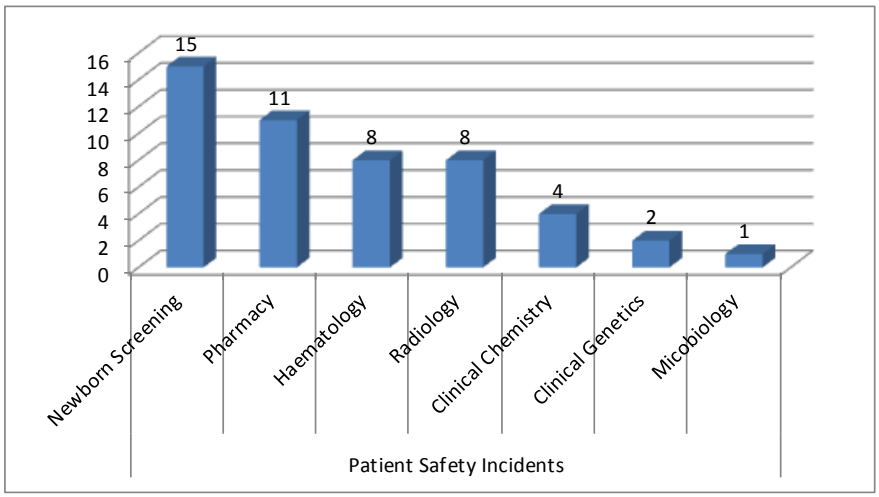
Lessons learned

- All trips off the Becton site require a risk assessment prior to leaving the unit, taking into account staffing ratios, patient mix and the patient behaviour.
- All incidents reported involving escalation of behaviour should be reflected in the patient record and updated patient risk assessment. These updates should be communicated to all appropriate parties.
- School Nurses should continue to be vigilant when checking medications against protocols.

2.6 Division of Pharmacy, Diagnostics & Genetics

Patient Safety Incidents

Trend analysis



The highest reported NRLS Categories of incident were 'Patient Information' and 'Medication' incidents. The 'Patient Information' incidents mainly involved external organisations sending inaccurate/incorrect/inadequately documented sample documentation to Newborn Screening. The 'Medication' incidents main Sub Category was 'Preparation of Medicines/Dispensing in Pharmacy'. The most common error reported involved incorrect labels, amounts and out of date medication being discovered, these did not reach the patients and there was no harm. All incidents reported by or relating to the Division were graded as 'Agreed Consequence' Negligible (1).

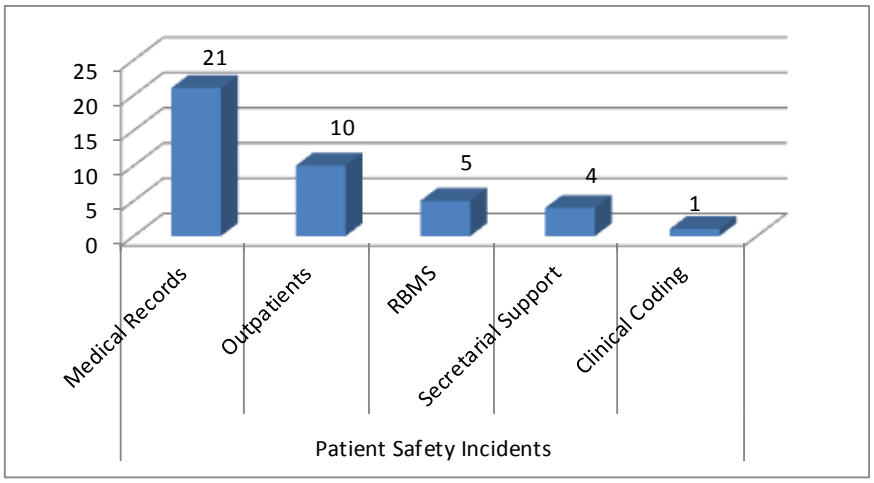
Lessons learned

- Newborn Screening Laboratory has reviewed sample reception procedures.
- Pharmacy are working with other Trust specialities to develop picking lists for specific medications.

2.7 General Services

Patient Safety Incidents

Trend analysis



The highest reported NRLS Category of incident was 'Patient information' incidents and the main Sub Category was 'Documentation misfiled', this is in keeping with previous monthly reporting. All incidents were graded as 'Agreed Consequence' Negligible (1).and there was a decrease in incidents reported compared to previous months.

2.8 Facilities

There were six Patient Safety incidents reported that related to Facilities All incidents were graded as 'Agreed Consequence' Negligible (1).

2.9 Human Resources

There were no Patient Safety incidents reported that related to Learning & Development in April, May, June and July 2014.

2.10 Finance & I.T.

There were five Patient Safety incidents reported in April, May, June and July 2014. One related to the main Trust telephone Switchboard equipment failing for a period of time due to workmen cutting through the main voice circuit. A second after the failure of two servers leading to staff losing certain IT function, a further incident was reported after a prolonged delay on the purchase of two laptops. There was no harm to patients and each of the errors was swiftly rectified.

2.11 Corporate Services

There was one Patient Safety incident reported that related to Corporate Services in the period April, May, June and July 2014 following the temporary inability of a member of staff to access the Quality Assurance department database in order to manage policies.

2.12 Research

There was one Patient Safety incident reported by Research in April, May, June and July 2014 which related to a mix up with two research project patient's and one receiving a delayed full dose of Ceftriaxone, there was no harm as a result of the error.

2.13 Support Services

There were nine Patient Safety incidents reported that related to Support Services in April, None involved patient harm.

2.14 Embrace – External to SCH

Incidents reported by the Embrace Transport Service which have occurred at external hospitals and have been as a result of factors outside of Embrace's control or remit are now reported as outside of the Division of Surgery & Critical Care's statistics. These are reported back to the host organisation at the time of detection.

3 Serious Incidents (SI's) and Root Cause Analysis (RCAs)

3.1 Serious Incidents (SI's)

There were two incidents which occurred in the period April, May, June and July 2014 which have been externally reported as Serious Incidents via STEIS to the Clinical Commissioning Group.

The first incident was reported following the unexpected death of a patient during a surgical procedure, the second was reported as a result of safeguarding concerns.
Investigations are underway and full investigation reports will be presented to the Executive Risk Management Committee in due course.

3.2 Systems Analysis (RCAs)

There were three incidents which will be investigated internally via systems analysis during the period April, May, June and July 2014. The first involved a dentist who extracted a baby tooth in error from a patient and the other as a patient who absconded from the Becton site. A further incident was investigated internally, via systems analysis, relating to UKAS/CPA accreditation of the Flow Cytometry service.

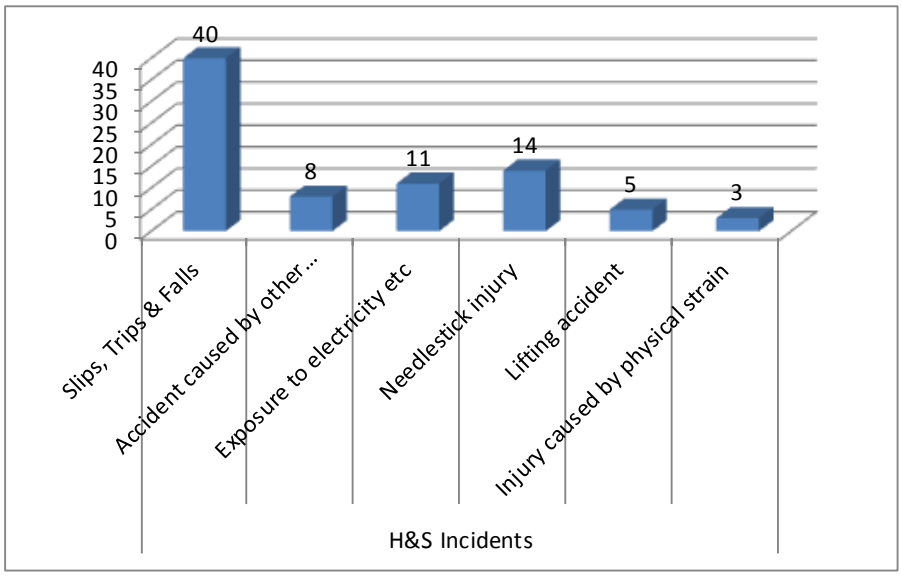
4 Complaints

There were 39 new formal complaints received in April, May, June and July 2014.

New complaints by Primary Subject

	April	May	June	July
Clinical treatment	3	6	4	5
Appointments/delay/cancellation	1		3	4
Attitudes of staff	2			1
Breach of confidentiality	1		1	
Lack of communication/information				3
Racial discrimination			1	
Trust decisions			1	
Policy and commercial decisions	1			
Medical Records				1

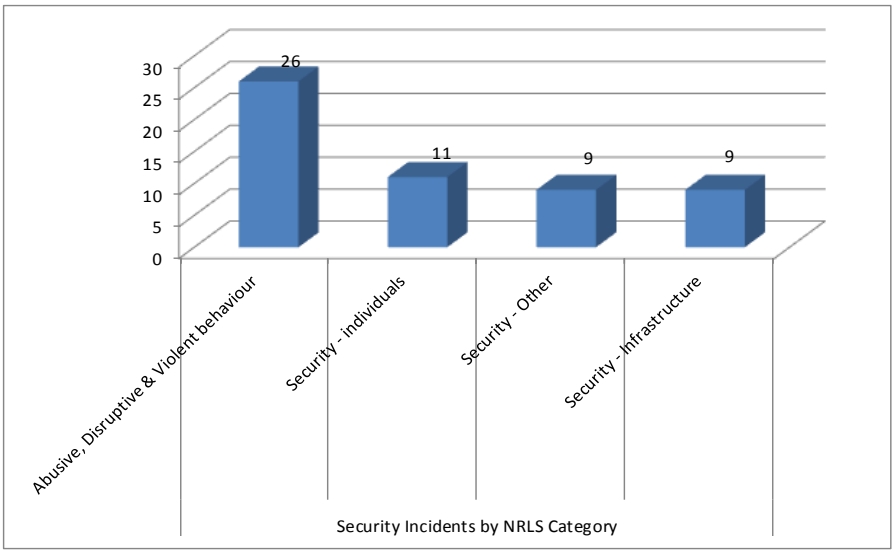
5 Health & Safety Incidents



RIDDOR Reportable Incidents

There were 2 RIDDOR reportable incidents both injuries sustained by Becton staff nurses whilst restraining patients, one staff nurse attended hospital after the event where a hairline fracture of a rib was discovered and another after he fell to his knees causing damage to a recurring back injury.

6. Security Incidents



Security related incidents per month from April to July have remained consistent in terms of number, with a slight reduction in Abusive, Disruptive and Violent behaviour.

Again these mainly involved verbal assault from visitors/parents acting aggressively to staff on the wards or in the Emergency Department. The incidents included three whereby staff were assaulted at Becton before Lodge staff were able to intervene. The assaults did not result in injury.

7. CLAIMS

Clinical Negligence Claims

Three new potential claims in clinical negligence received during April, May and June 2014:

a) No initial allegations provided.
b) Initial allegations related to ENT surgery in 2009.
c) Initial allegations relate to a delay in replacing an ET tube during a transfer.

July to be confirmed.

8. Risk Register

In the period April, May, June and July 2014 a total of **18** new risks were opened and a total of **13** risks were closed. Figure 28 below shows the risks opened and closed by Risk Type and Division or Service for April, May, June and July 2014.

Division	Risks Opened	Patient Safety	Financial	H&S	Security
MEDicine	3	2		1	
Surgery & Critical Care	6	6			
Community & WAMH	1	1			
Pharmacy, Diagnostics & Genetics	4	3		1	
Finance & IT					
Estates					
General Services	2	2			
Support					
Corporate	2	2			
Total	**18**	**16**		**2**	
Division	**Risks Closed**	**Patient Safety**	**Financial**	**H&S**	**Security**
MEDicine	3	3			
Surgery & Critical Care	10	10			
Community & WAMH					
Pharmacy, Diagnostics & Genetics					
Finance & IT					
Estates					
Support					
Corporate					
Total	**13**	**13**			