Clinical Risk Management April 2005 – October 2005

1.1 Structure and organisation

Litigation and legal services continue to be led by the Head of Legal Services, Keith Ellis. Paula Reeves, who took over the organisational aspects of risk management, is now on maternity leave. Deborah Clatworthy, who has been seconded for one year to the post, is covering her post. Health and safety is now established within the directorate and a programme of health and safety training for staff in clinical areas is complete. This includes training on risk assessment. Key staff from non-clinical areas will be targeted for training in the coming year.

The Clinical Risk Advisor post was filled for a short period in September, but due to personal circumstances, the post holder left in October. In addition to this, the Risk Management Facilitator post is becoming vacant in January 2006. This will present an opportunity to review the Team structure and implement any change that is deemed necessary.

The structure of clinical risk groups is strong in some areas, but less so in others. What is required is that a group of multidisciplinary clinicians and managers review incidents in their area and take appropriate action. A review will take place in February-March 2006 (following the CNST assessment) to implement a more robust system that engages staff and improves quality.

1.2 Reporting Incidents and Near Misses

Since April 2005 the Trust has submitted a total of 427 incidents to the National Patient Safety Agency.

1.3 Feedback

This continues to present some obstacles. Acknowledging incident forms by e-mail has proved to be unsuccessful, with most managers reporting that it was not useful. A structured feedback system is required and will be examined during the review of the service.
Some initial ideas about the use of feedback forms that can be used and shared between managers, clinicians and risk Management are being explored.

1.4 Inspection

Maternity services achieved level 2 CNST last year. The general side will be reviewed in January 2005.The initial evidence is under review by the assessor and the decision will be made in the coming week if the assessment will be at level 1 or 2. The cost savings are estimated at £77,386 if level 2 is achieved. Maternity services can then apply for level 3, which is where the real savings of the premium are to be found.

2. Reported clinical incidents April 2005 – October 2005

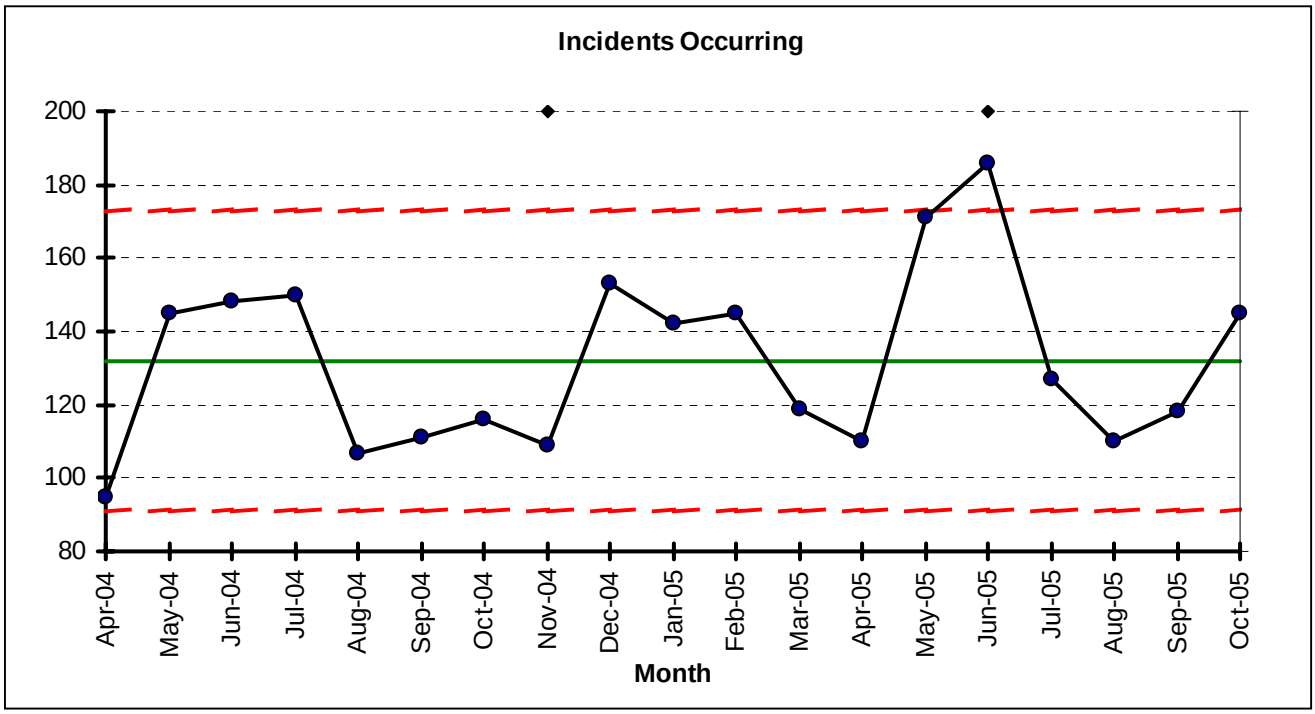
2.1 Introduction

This section describes the clinical incidents reported by staff between 1April 2005 to the 31 October 2005.

2.2 Performance

Graph 1 indicates the number of incidents and near misses reported each month. The average number of incidents reported per month since April 2005 to the end of October 2005 was 138 (124 for April to October 2004).

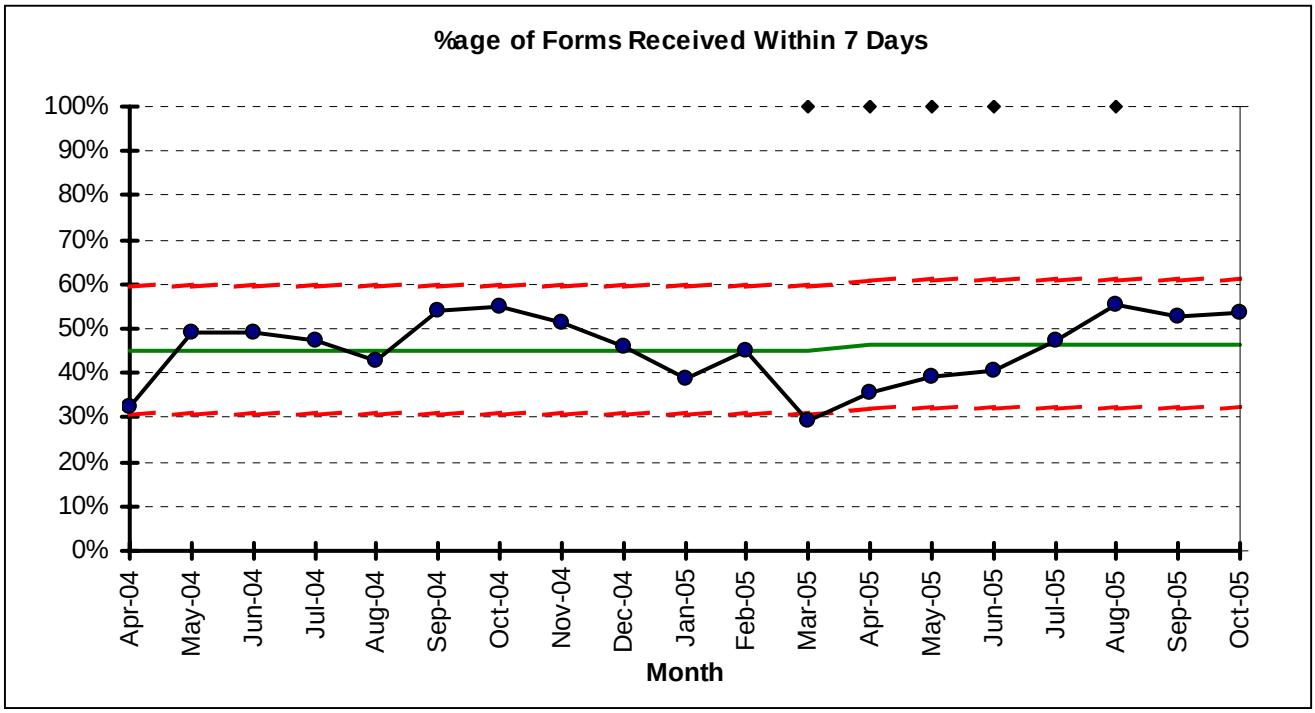
Graph 1: Number of incidents and near misses reported



The Trust's Incident Reporting Policy and Procedure stipulates that incident forms should be returned to the Risk Management Office within 7 days. During 2004/2005 45% of incident forms were returned within 7 days. As indicated in graph 2 there has been a steady increase in the number of forms being returned within the 7 day period since April 2005. Currently the return rate stands at 46% for 2005/2006.

The Trust has taken a tougher stand regarding the late return of forms. Ward/departmental managers have been informed that late return of forms may lead to disciplinary action.

Graph 2: Time to receive incident/ near miss reports



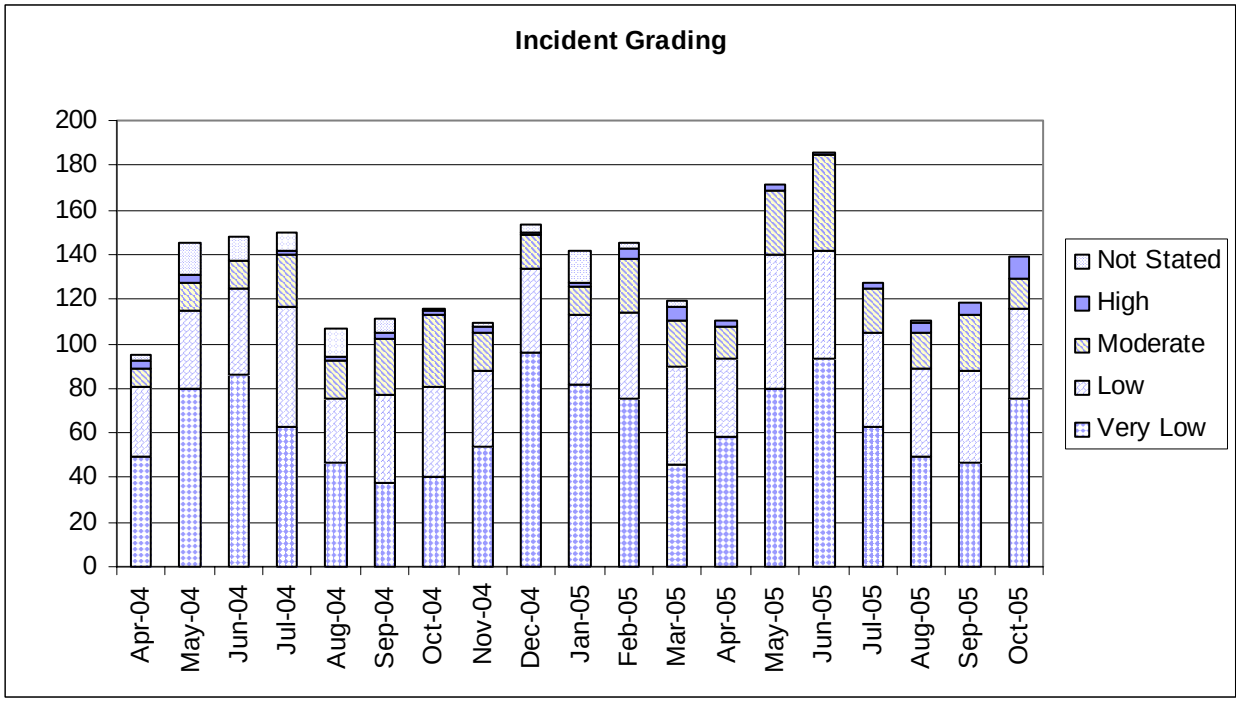
The Medicine Division accounted for over 50% (249 forms) of the forms returned to the Risk Management Office outside the 7 day standard. Table 1 shows a breakdown of the ward/departments returning more than five forms after seven days.

Table 1 – Dept/ wards returning More than 5 forms after 7 days

Medicine	Total	Surgery	Total	Women & Children	Total
Emergency	54	Theatres (Main)	32	Ifor Ward	27
Critical Care	43	Victoria Ward	23	Murray Ward	12
Meyrick Ward	33	Coyle Ward	22		
Cloudesley Ward	28	Thorogood Ward	12		
Cavell Ward	25	Theatre (DSU)	6		
McCarthy Ward	14				
Reckitt Ward	12				
ISIS Ward	11				
Nightingale Ward	7				
Medical Assessment Unit (Ward)	6				

2.3 Grading of Incidents

Graph 3 – Incident grading

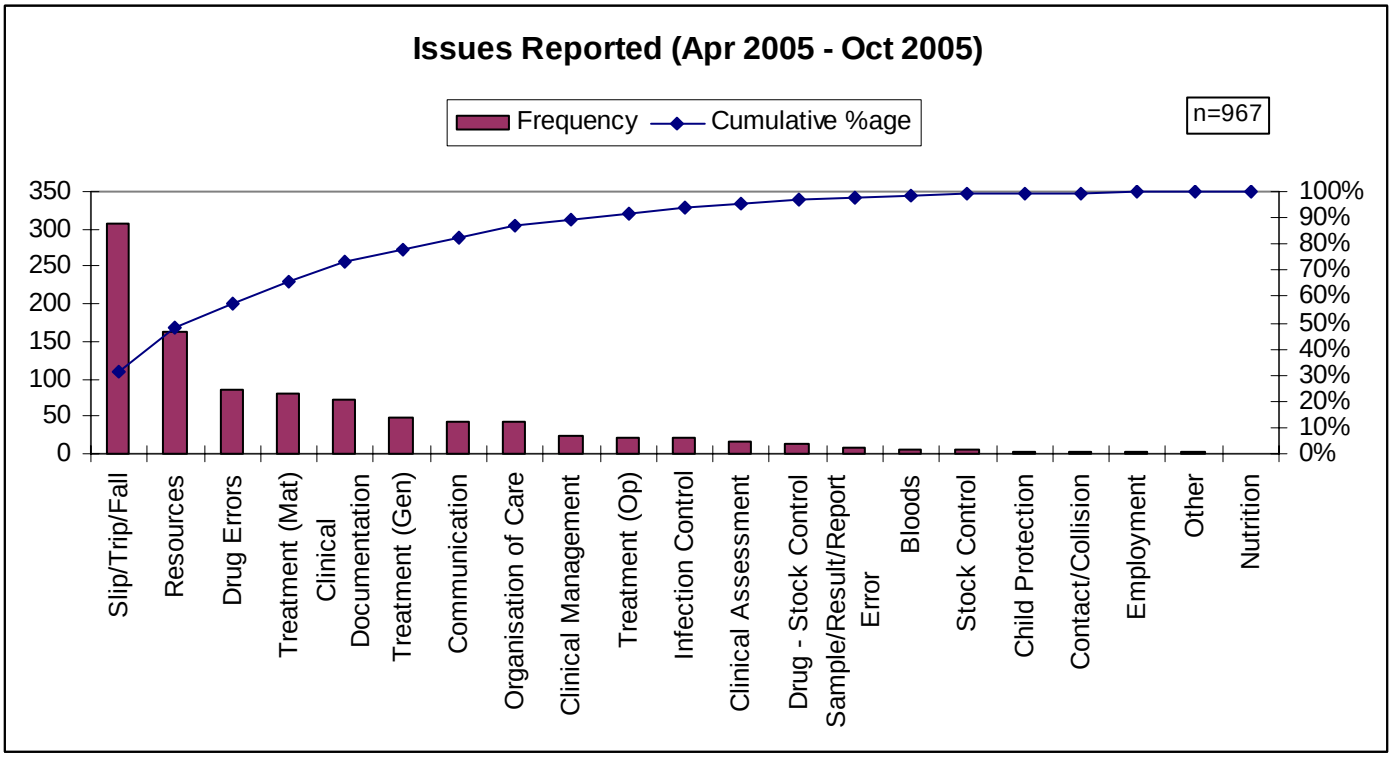


Between April 2005 and October 2005 there were 25 (3%) incidents graded as high risk and 161 (17%) graded as moderate in risk. 7 (1%) incidents are still waiting to be graded.

2.4 Reported incidents and near misses

Between April and October 2005 the three most frequently reported issues have been slip/trip/falls, resources and drug errors. Together these three categories accounted for 57% of incidents reported to the Risk Management Office.

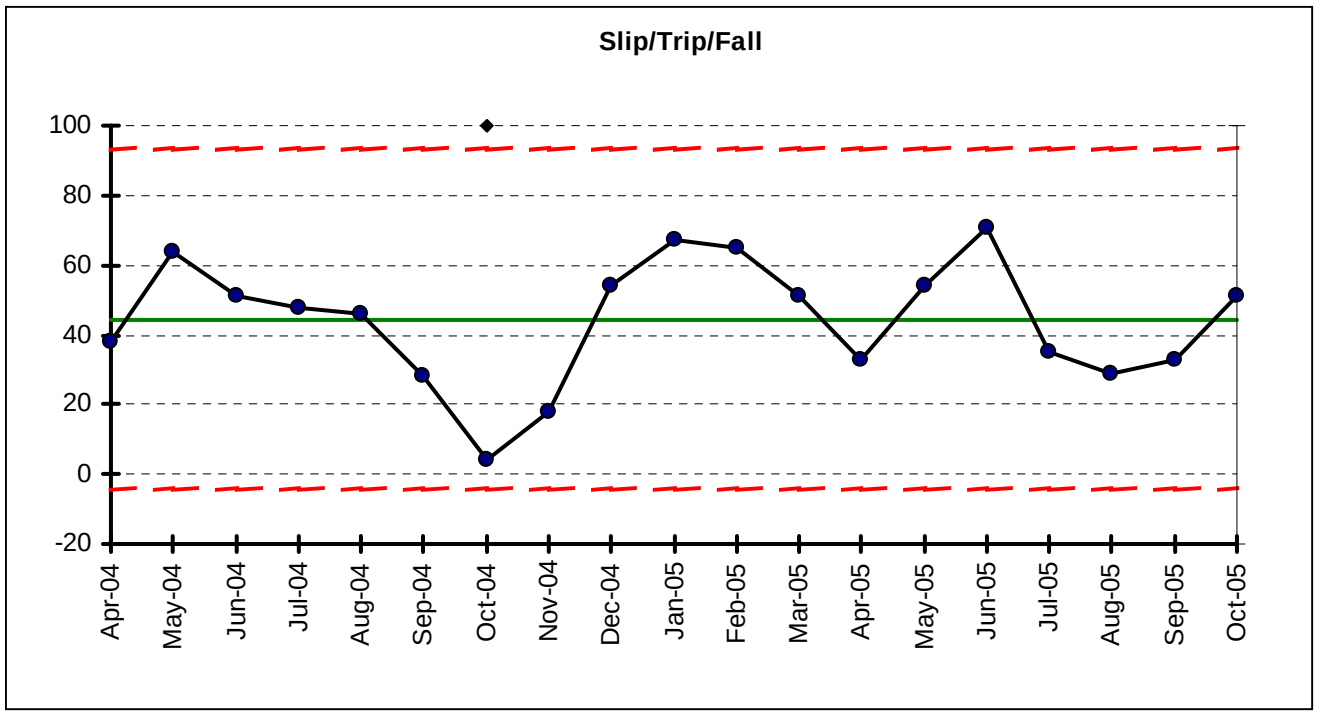
Graph 4 –Reported incidents and near misses



2.5 Slip/Trip/Fall

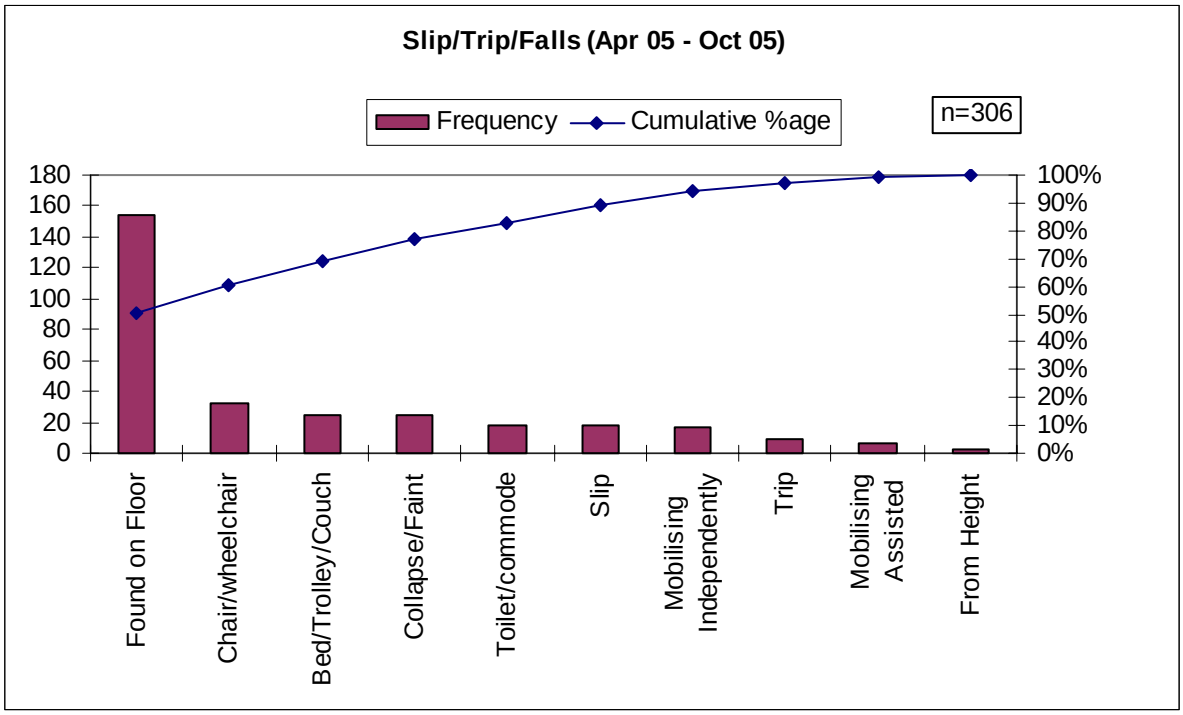
During April 2005 to October 2005 a total of 306 incidents/ near misses involving slip/trip/falls were reported. This is in comparison to 279 reported incidents/near misses for the same period the previous year.

Graph 5- Number of reported incidents relating to Slip/Trip/Fall



A reason for the falls occurring could not be ascertained in 50% (154 incidents) of the incidents.

Graph 6: Type of incidents/ near misses relating to Slip/Trip/Falls



Three incidents were graded as high risk. The first incident involved a patient who was mobilising independently and fell and fractured their left hip. The second incident involved a patient who fell when getting out of bed and sustained a fracture to their left leg. The third incident involved a mother visiting the Trust taking a pushchair onto the escalator. Both mother and baby were seen in the Emergency Department and then discharged home.

Graph 7: Grade of incidents/ near misses relating to slip/trip/fall

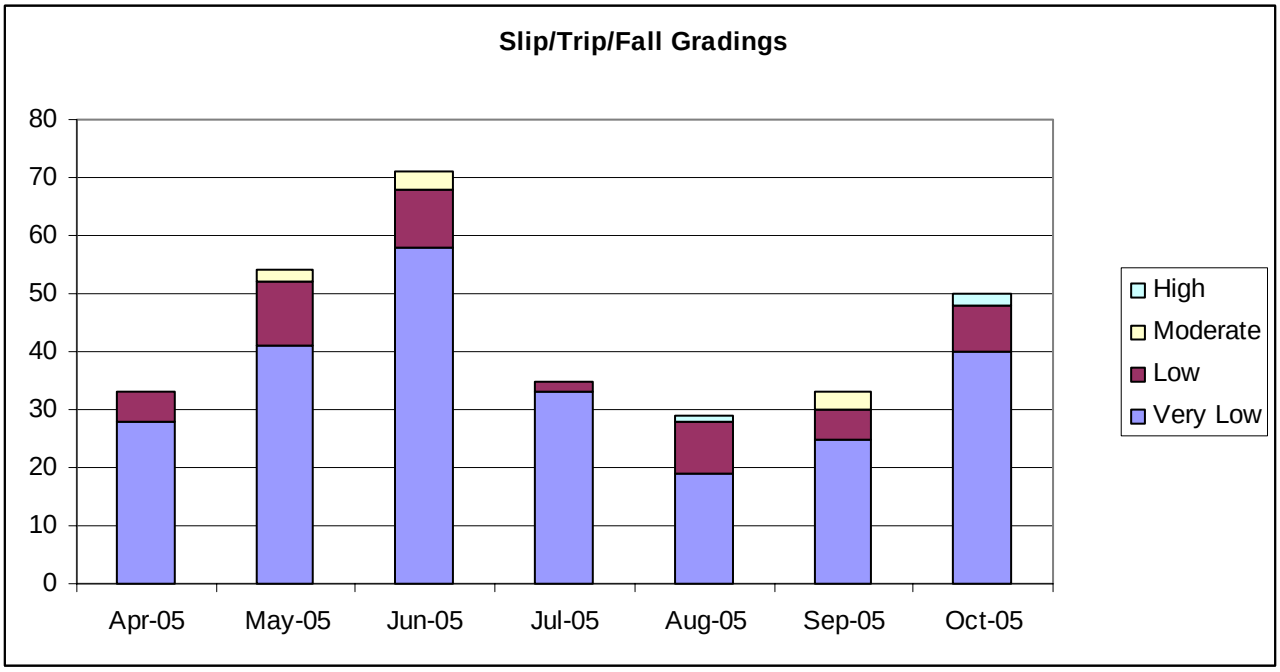


Table 3 shows the departments that reported more than five incidents involving slip/trip/falls. The highest reporting areas remain the older peoples wards. There is always a fine balance between allowing patients to mobilise independently as part of a rehabilitation programme, and the risk of them falling.

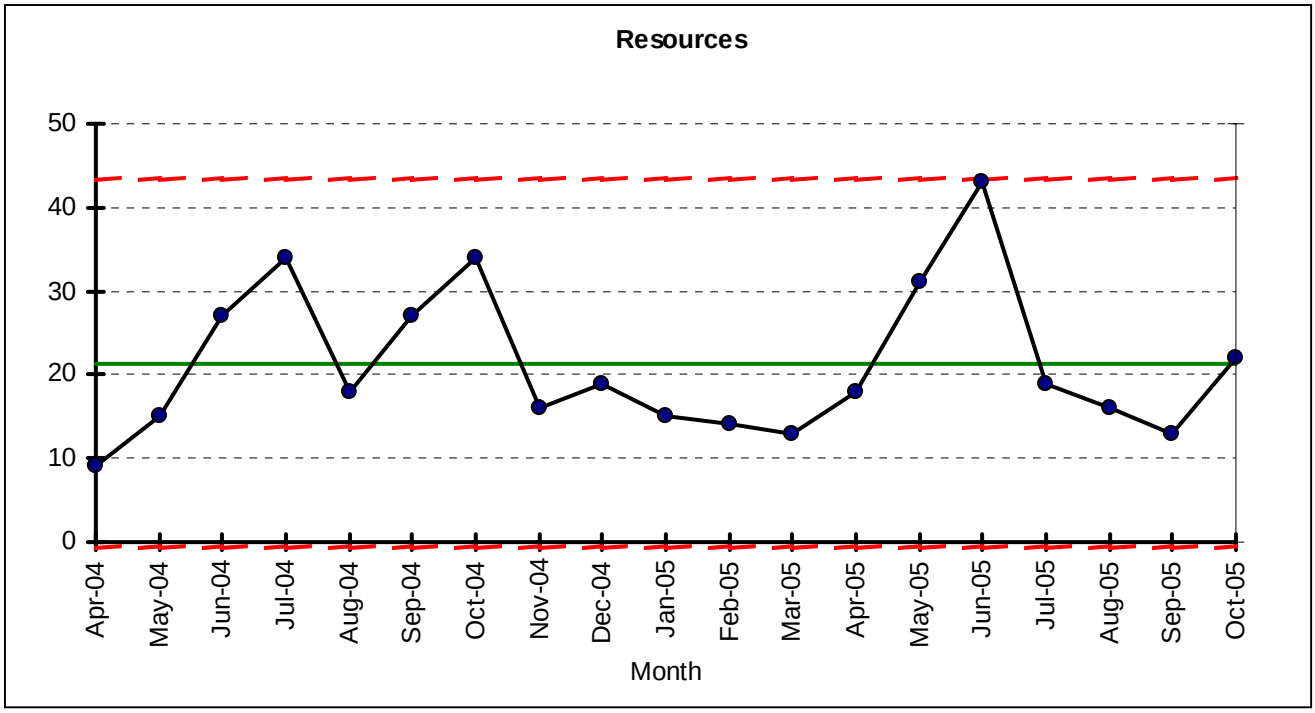
Table 2 Slip/Trip/Fall incidents by department

Medicine	Total	Surgery	Total
Cloudesley Ward	53	Victoria Ward	29
Meyrick Ward	38	Coyle Ward	27
Cavell Ward	27	Thorogood Ward	12
McCarthy Ward	17		
Reckitt Ward	14		
Nightingale Ward	13		
Medical Assessment Unit (Ward)	9		
Montuschi Ward	8		

2.6 Resources

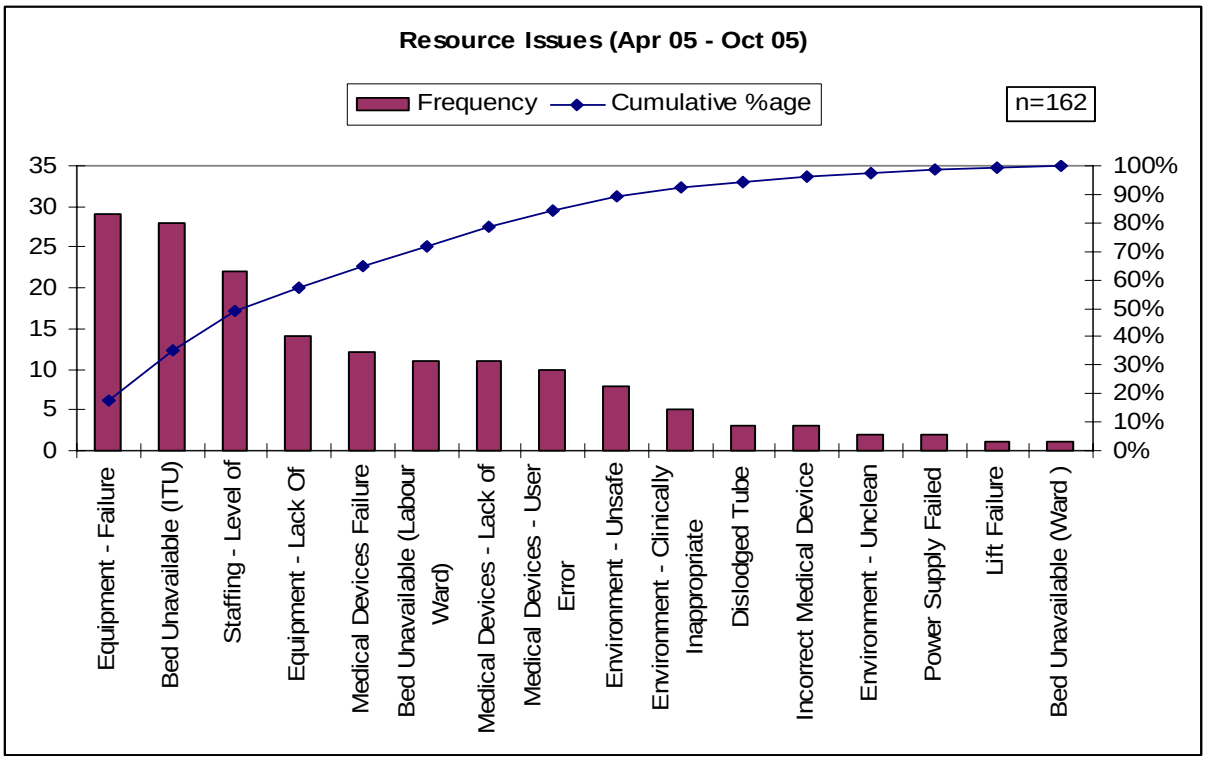
Graph 10 shows the number of incidents and near misses reported that have been reported each month. 162 incidents were reported during April 2005 to October 2005. In comparison to the same period the previous year 164 incidents were reported.

Graph 8 – Reported resource incidents/ near misses



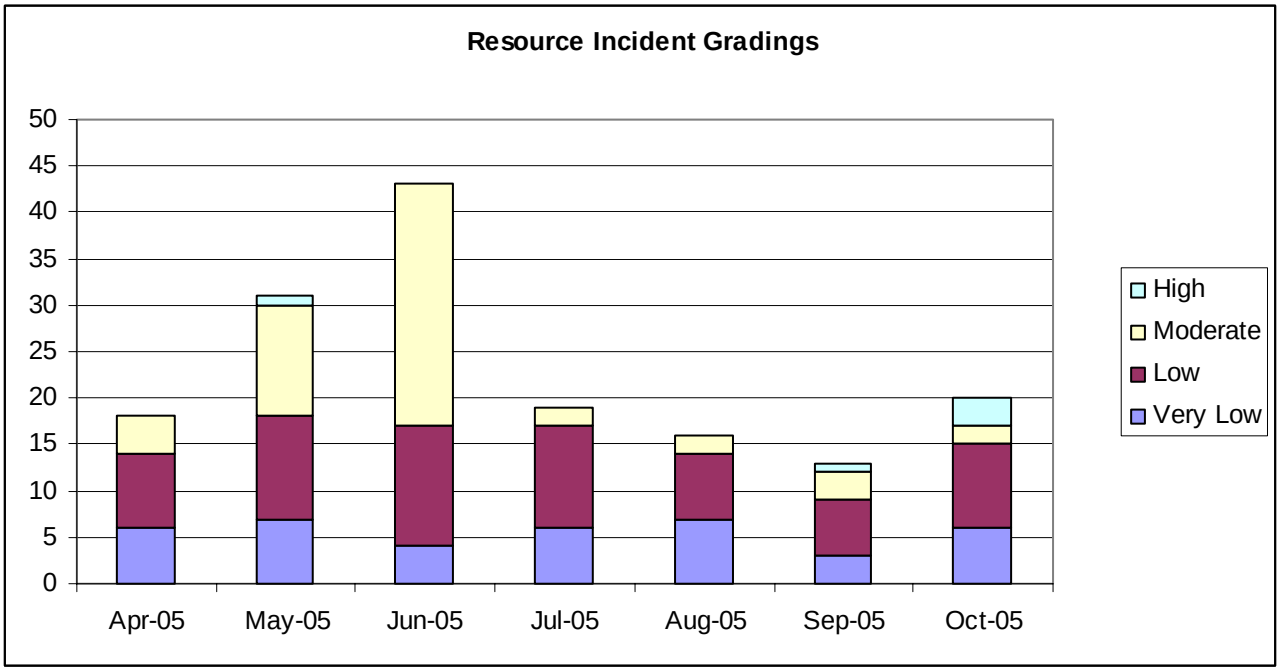
There has been a fall in the number of reported incidents since June 2005.

Graph 9 – Resource incidents and near misses



Graph 9 shows that equipment failure accounted for 28% (29 incidents) of the incidents reported during April to October 2005. In comparison to the same period last year equipment failure accounted for 6% (10) of resource issues.

Graph 10 – Grade of Resource incidents and near misses



Five incidents were reported as high risk, each resulting in no harm to the patient. Two of the incidents involved the ventilation of patients while in theatres. In the first incident Medical Physics examined the equipment and no fault could be found. In the other incident the anaesthetic machine's wheel had occluded the breathing system.

The other three incidents included:

- a member of staff administering oxygen to a patient but connected the oxygen tube to the air supply. The staff's competency is under review.
- No monitoring equipment or laryngoscope available in one of the theatres for an emergency operation
- Reuse of a disposable ambu bag that was previously used on a Hepatitis C positive patient. The department involved has reiterated to staff that the ambu bags are single use only.

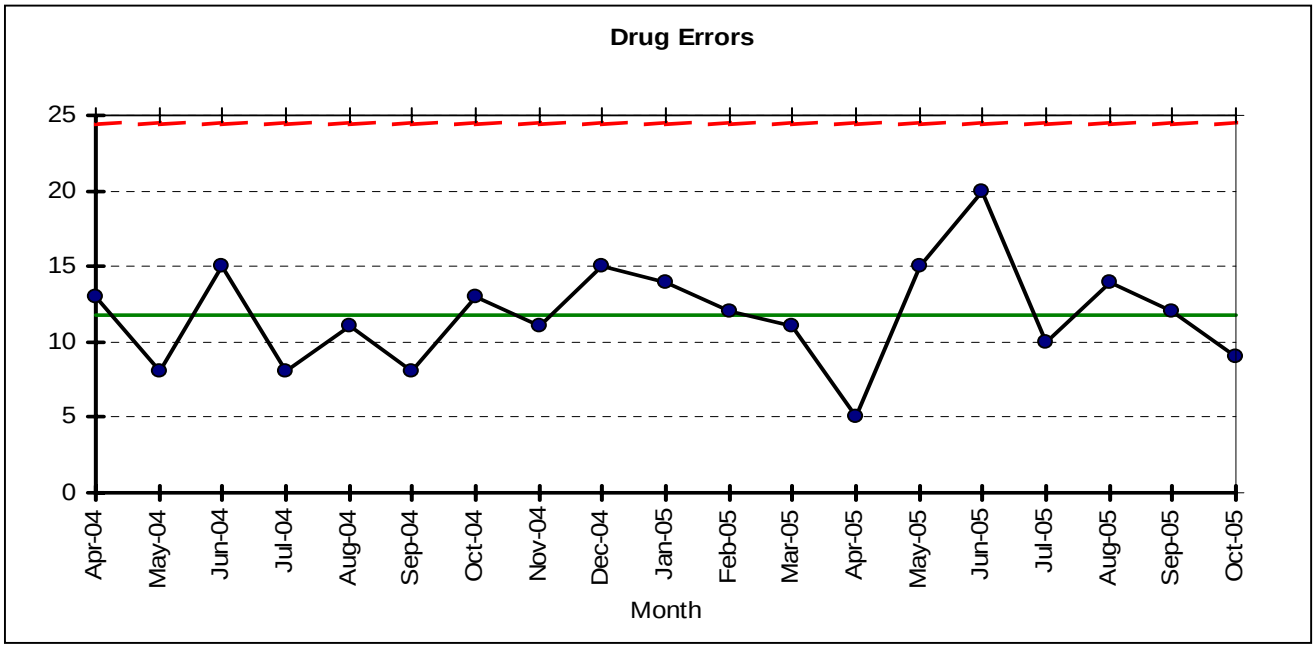
Table 3 – Resource incidents and near misses reported by ward

Surgery	Total	Medicine	Total	Women & Children	Total
Theatres (Main)	18	Critical Care	45	Labour Ward	37
		Emergency	7	Ifor Ward	7

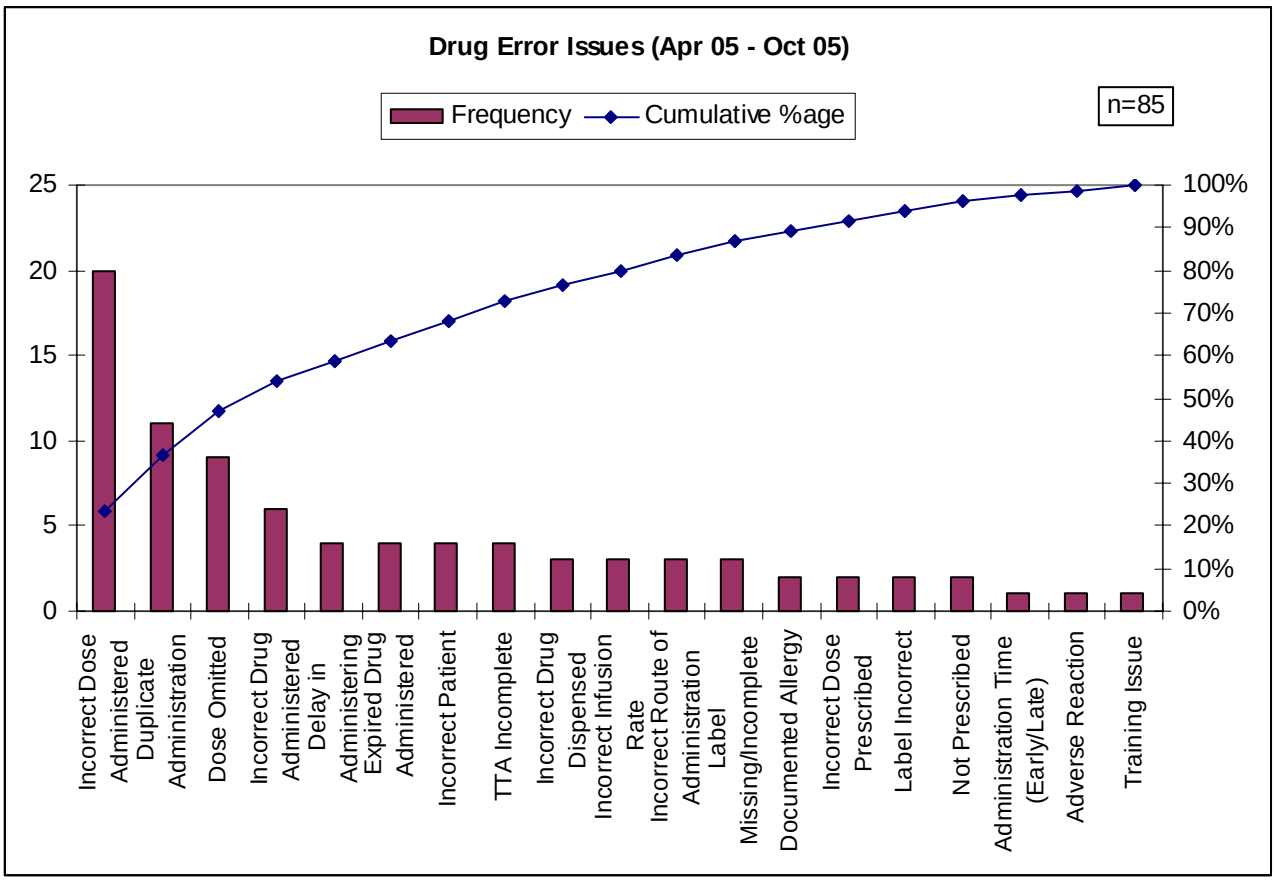
2.7 Drug Errors

A total of 85 drug errors were reported during April 2005 to October 2005. In comparison to the same period the previous year a total of 76 errors were reported.

Graph 11 – Reported drug error incidents and near misses

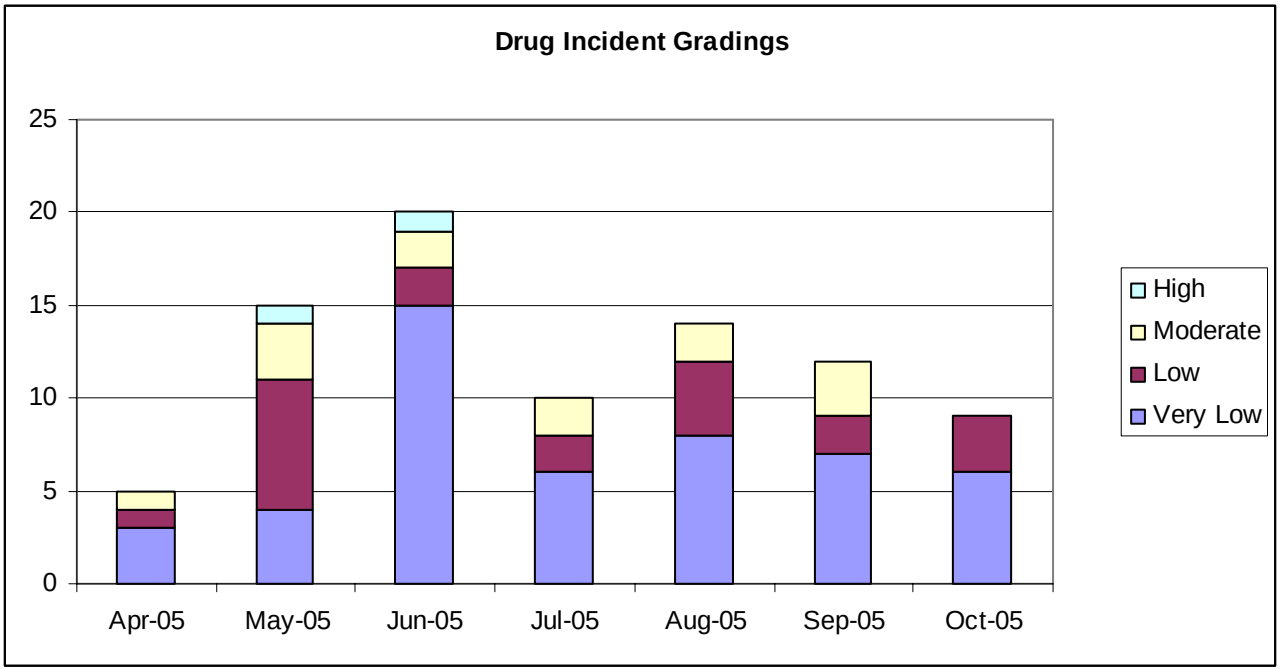


Graph 12 – Drug Error Issues



The incorrect dose of medication being administered accounted for 24% (20 incidents) of the incidents reported during April 2005 to October 2005. In comparison to the same period the previous year the incorrect dose of medication accounted for 26% (20 incidents) of the incident reported.

Graph 13 – Drug Error Incident Grade



Two incidents were graded as high risk. These were:

- the discovery of methadone in the property of a patient that had died.
- Patient who was incorrectly prescribed and took 10x 200mcg Misoprostol tablets. The prescription should have been 1x200 mcg. The patient appeared not to have suffered any adverse effect (the maximum advised dose in the British national Formulary is 800mcg).

Table 4 shows the ward/departments that have reported more than five drug related incidents.

Table 4 – Drug error incidents/ near misses by dept/ ward

Medicine	Total	Women & Children	Total
Emergency	18	Ifor Ward	18
Critical Care	6	Neonatal Intensive Care Ward	6