Reported	Division & Care Group	Ward/Department/ Unit	Description	Action taken (Investigation)	Lessons learned	Severity	Does this event meet the Never Event criteria?
Dec-16	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	Retained Nerve Vessel Retractor used during robotic partial nephrectomy There was no harm cause to the patient it was not intentionally left in the patient so therefor report as a never event.	xxxx16 panel held and upgraded to a never event CR to do full report. Watch-out notice to go up in theatres and posters to go in all theatre expect ortho highlighting this and changes in practice. SOP 51 (swab needle and instrument count) is under review and will be amended to reflect this.	Theatre staff to * one sloop is cut the count need to be update to 2 sloop * once removed the sloop need to be measure against an uncut one.	None (no harm caused)	
Dec-16	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	Pt attended for steroid injection to Left thumb CMCJ and Right Middle MCPJ under image intensification. Consented and marked on nail and written on arm. Consent checked at WHO. Left thumb injected first. Right middle PIP injected instead of MCP. Error noted by patient as dressing applied.	xxxxx/2016 IRP held, decision to report as an NE as meets NE policy critieria - KD Incident fully investigated by SP report completed and signed off by executive panel on xxxx17. Error occur due to lapse in concentration. SP as reflection on incident and developed a poster for the c-ram and x-ray machine to remind staff to point to the joint - to re focus prior to a procedure.	Before starting a procedure surgeons to re focus.	Near Miss (Event identified and stopped before it reached the patient)	
Mar-17	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	Undiagnosed cardiomyopathy decompensated peri-operatively leading to multiple cardiac arrests following the end of surgery.	panel to be arranged. Panel on xxxx-17 SK to investigate DOC letter sent Executive panel booked xxxxx. Final Panel of xxxxxx - further evidence from the investigation report suggesting incident may need to be upgraded to SIRI. Exec panel for xxxxx cancelled and further initial panel with an exec chair arranged for decision on grading. xxxxxx - Further panel held - decision to upgrade to SIRI. Family meeting already arranged and to go ahead on xxxxx. Advised for representative of the Patient Experience Team to attend. The SIRI process has been initiated. xxxxx Further panel commenced, some final information to be obtained prior to exec sign off relating to the requested ECG. SH requested a final CSC sign off panel to be arranged once this information has been obtained - KD xxxxx final panel held a few amends then to be circulated to the panel for final sign off and sent to CCG.	Training on routine CXR interpretation for surgical trainees and all specialty teams. Training on ECG interpretation for relevant groups including all team members who undertake Pre-Operative assessment. Improve the communication of changes to patient management and the documentation in patient notes through human factors training Highlight importance of clinical handover to include closed loop communication of relevant changes in management, important investigations and requested clinical reviews. To support further training for staff, training to include the lessons learnt from this incident. Document all investigations and indications by team members in the main notes to include signatures and dates of the outcomes e.g. ECG's/CXRs Diagnosis raised/considered should also be documented and formally closed or confirmed after the investigations and patient review has occurred. Clarify roles and responsibilities for groups requesting investigations specifically responsibility for reporting outcomes and documentation Training on surgical assessment to enquire about family history and review paperwork to include this.	Severe (permanent or long term harm caused)	
Aug-17	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	Incision was made over the IP joint of the little toe on the left hand side in error (approximately 2 cm) required 2 sutures to close. Patient listed for bilateral bunionette correction and IP fusion of right 5th toe. When she attended the clinic for pre-assessment her right 5th toe IP joint was not painful therefore I consented her for just bilateral bunionette correction and as her notes were a complete mess- multiple sets of notes including multiple temporary sets I gave the patient both copies of the consent form to bring with her on the day of surgery as otherwise there was a high risk of them being lost (previous experience). On the day of surgery I attended at 7.45am to see the patients, however as my registrar and fellow are very enthusiastic they had already seen and consented/ confirmed consent for the patients as required the patients, however the patient did not show them the consent form we had already filled out and they therefore completed a new consent form and she stated that the right 5th toe was painful and thus she was consented for surgery to the IP joint as originally planned by the registrar. By the time I arrived the registrar had already gone to do a ward round and the fellow mentioned that the IP joint was painful (I thought she meant both sides as both little toes looked very similar). When the patient came to theatre I had to see an emergency patient on the ward with one of my plastic surgery consultant colleagues. When I returned to theatre the patient was prepped and ready for surgery and the part 2 of the WHO had been completed. I assisted the fellow performing the surgery on the right foot and once the bony work had been completed she closed the wounds while I assisted the registrar with surgery to the left foot; having completed the bunionette correction I asked him to make an incision over the 5th toe thinking we were performing surgery to that IP joint as well. After we had made the incision the fellow pointed out that we were not correcting that IP joint. The registrar then closed the wound- no intervention was made to the tendons or the bones/ joints.	upgraded to moderate this will need a 48 hour - never event. Panel arrange xxxx at 1000 Panel decision to report as SIRI - Never Event but with low harm to patient. Final panel xxxx then virtually signed off by JK. Full investigation under taken and the root cause found to be Human error One of the Operating surgeons joining after Part 11 (Time Out) completed	'Time out' when moving sides/ starting second or further procedure to refocus and re-check the consent is essential 'Time out' should occur if an operating surgeon leaves theatres and re-joins the operation at any point during a case. Incorporate both of the above recommendations in the new WHO safety policy and checklist	Low (Minimal harm - patient(s) required extra observation or minor treatment)	Yes
Sep-17	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Day Surgery Unit QA	Patient underwent TURBT on the morning of the xxxx 2017. Post operative Mitomycin and catheter inserted. Catheter removed in day surgery. Patient fluid input in day surgery recorded as 2000mls. Patient unable to void and only 15mls in bladder on bladder scan. Patient sent home despite these findings. Readmitted as emergency following day with bladder perforation and sepsis.	panel arranged xxxx/17 xxxx/2017 IRP held decision to report as a SIRI. Lead investigator has been appointed (D O'L Surgery)DoC to be implemented and letter sent. Full investigation to be carried out and final/exec sign off panels to be arranged - KD Final exec panel booked for 9th November 2017 final ex panel 20/12/17 signed off	Individual discharge criteria for day surgery patients should be clearly documented in the operation note The discharge criteria for patients undergoing endoscopic surgery in day surgery need to be updated to include scenarios where fluid intake has been sufficient but output too low, what staff should do when the fluid balance is not as expected and if bladder scan is empty when patient has not passed any urine, and how much urine needs to be passed prior to discharge Discharge criteria / recommendations for all patients (not just within urology) passing through the day surgery department should be reviewed and updated to ensure similar events to do not occur in other specialities.	Severe (permanent or long term harm caused)	
Oct-17	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	Patient having ankle procedure under GA plus popliteal block. Suffered sciatic nerve palsy which was not recognised until the following Monday. the patient was in pain in recovery and the block was repeated and she was given fentanyl which relieved her initial pain.	xxxx/17 - Panel held today and downgraded to moderate with a view to reconvening in 8 weeks time after patient has been reviewed in clinic. xxx/17 - panel reconvened on xxxx/17 - RM representative unable to attend. Patient still has not regained full function and is likely to have long term/permanent deficit as a result. The Chair and panel reached a consensus of opinions, based on the evidence, that this should be upgraded and reported as a SIRI due to the likely severe permanent harm that the patient sustained. This information was not fed back to the Risk Management Department, with confirmation of the decision from the chair via Gov Lead for CHAT only being received today (xxxx17) hence a delay in reporting onto STEIS. Investigator assigned as PF. Reported onto STEIS and SIRI process initiated. CA Final report completed and signed of by executive panel difficult to determine cause patient still under Stanmore hospital.	1.Limited audit to assess the reliability of combining intraoperative notes with main hospital case notes in file. 2.With respect to anaesthetic consent, a.Ensure documentation: i.By pre-operative assessment nurses that a leaflet on appropriate limb blockade has been accepted by the patient ii.By Anaesthetists that they have discussed the patient-specific benefits / risks / alternatives of nerve blockade with the patient pre-operatively b.Evaluate the possibility of offering video information to patients as per RA-UK suggestion 3.Assess feasibility to develop a foot / ankle school for patients to attend. There is a possibility that this could be developed as a "virtual" school, though there would be benefits of a face-to-face school for Orthopaedic / physio reasons. 4.Evaluate a trial of local anaesthetic injection pressure monitors. Regional anaesthesia group to consider a trial / review / evaluation of currently available injection pressure monitors 5.Alter consent documentation on anaesthetic paperwork to alter consent documentation to include plan for performing block - awake / asleep etc. and discussion of risks 6. Training and education recommendations: a.Refresher training / education of anaesthetists / surgeons about patients at higher risk of neuropraxias and their management options, and of treatment / investigations, also on pain as a presenting feature of neuropraxias - this would be ideally delivered by specialist e.g. From nerve injury team at Stanmore. b.Watch out training for ward staff / day surgery staff / recovery staff on pain as a presenting feature of	Severe (permanent or long term harm caused)	
Oct-17	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	Thoracic epidural inserted at the end of a laparoscopy converted to laparotomy, xxxx/17. Required second anaesthetist but no particular difficulties and no complication experienced. Persistent weak right leg from the first evening. Falsely reassured by partial return of sensation when epidural stopped.	panel arranged for xxx/17 xxxx/17 - Initial review panel held chaired by SW - declared as a SIRI and reported onto STEIS. SH to be approached as Lead Investigator. Full DOC carried out at time of event by SE (consultant anaesthetist) and also on follow up of patient; Official DOC letter to be drafted by SE and provided to patient. Timescales for investigation sent to TM (Nurse Gov Lead for CHAT) xxxx-18 report completed and sent to CCG	Revision of acute pain guidelines Re-education of anaesthetic, theatre recovery and SHCU staff about the potential significance of motor function loss. Change of Epidural infusion observation chart	Severe (permanent or long term harm caused)	

Apr-18	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	The patient was admitted to TSA for day case surgery to insert a left ureteric stent prior to endoscopic retrograde stone surgery o nxxx/18. He was appropriately consented and marked on his left anterior thigh. He came to theatre. Part I of WHO safe surgery checklist was completed by the anaesthetist and he was anaesthetised. A Scrub practitioner completed Part II of WHO safe surgery checklist with consent form in hand and surgeon in attendance. Surgeon scrubbed and patient was draped. There was an approximate 10 minute delay waiting for the radiographer to arrive and set up an image intensifier (radiographers are timetabled to cover theatres from 0900hrs although lists start at 0830hrs). A cystoscope was passed and the procedure began. Surgeon had difficulty passing guide wire through cystoscope because sheath/scope was bent. A ureteric catheter was required to allow guide wire to pass correctly through the cystoscope emerging at the 6 O'clock position to allow cannulation of the ureteric orifice. This maneuvering took time and took the cystoscope away from the ureteric orifice. The surgeon cannulated the wrong ureteric orifice and performed an uneventful stent insertion. The drapes were removed and Part III of the WHO safe surgery checklist completed with the surgeon stating a left stent had been inserted. The surgeon completed TheatreMan coding for a left stent insertion and left theatre to type up the operation note. The surgeon returned very quickly to theatre and stated that the stent had been placed in the wrong kidney. The patient was on a trolley by tis time but had not been extubated. The anaesthetist stated the patient was still asleep and he was transferred back onto the operating table where the image intensifier was used to confirm the stent was in the right (but not correct) kidney. The surgeon and scrub nurse re-scrubbed and laid up a new trolley. The patient was	initial panel held xxxx-18 Mel H investigating Thank you for reporting this incident it has been fully investigated The RCA Task factors: No surgical pause prior to entering ureter to recheck the operation side. Human error due to not refocusing and not reconfirming side following delay after the time out completion. Key themes •Lack of documentation on the sign out of the WHO safety check list. •Staff fatigue. •Entire team not available at time out to ensure all aware of the planned procedure. •Inconsistency of marking for these procedures.	Recommendations 1.Avoid delay from point at which part 2 of the WHO checklist completed and commencement of procedure. 2.All sections of the WHO Surgical Safety Checklist must be completed and signed as per policy. 3.Further robust measures to confirm site/side to be treated prior to commencement of procedure. 4.Stop, pause and check side prior to entering the ureteric orifice. Verbal confirmation from surgeon and theatre team against previous confirmed markers (four point checks). The Surgeon on just entering the orifice prior to starting the procedure asks a neutral question to the team. What side I am doing? 5.Radiographer to re-confirm correct side with surgeon if imaging equipment is moved or re-positioned prior to entering site or if patient position is changed. 6.Even though the staff would not know the surgeon had entered the wrong side ureter we need to empower staff to challenge if they have any concerns. 7.Consider availability of continuous PACs imaging in Urology theatres. 8.This incident needs to be shared trust wide to highlight the risk of staff fatigue with other specialities where learning from this incident will be relevant I.E. Gynaecological surgery.	None (no harm caused)	Yes
Nov-18	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Department of Critical Care (E5) (DCCQ)	Patient had large 5cm hiatus hernia and had developed oesophageal stricture requiring 2x dilatations - xxxx/2017 and xxxx/2017 Listed for surgery to repair hernia and prevent further strictures and to cure his reflux symptoms. xxxxx/2017 Seen in anaesthetic consultant clinic xxxxx/2018 Uncomplicated laparoscopic hiatus hernia repair xxxxx/2018 Mr C & Dr R. Pronounced fit for discharge next morning xxxxx/2018. Arrested around 1400 xxx/2018 when got up to leave. Intubated, had echo and CT scan. Transferred to ITU. Working diagnosis of pulmonary hypertension and heart failure. Rapid deterioration and deemed unsurvivable and treatment therefore withdrawn xxx2018 and patient died. ITU staff unable to contact NOK.	HON C reports she is arranging panel for this incident. Initial Panel held on xxxx/2018 chaired by deputy medical director PS. Incident graded as SIRI and reported onto STEIS on xxxxx/2018 HB informed of SIRI xxxx/18. Investigation commenced immediately. Interviews undertaken and awaiting coroner's report The patient had a severe underlying chronic respiratory condition with associated pulmonary hypertension with the significant risk associated with that not fully recognised at the time of surgery. D/W Matron CI appropriate review process, and actions taken. incident to be closed. Have emailed CA fro update-xxxx/2019- GH. Just awaiting exec sign off	Presentation at Morbidity and mortality meeting To produce anaesthetic guidance on the management of patients with chronic lung disease. To review and amend SOP 61 Recovery Discharge Criteria. Once updated to disseminate to the recovery team. To review the scheduling of anaesthetic assessment clinic appointment for Non-cancer patients to 2-4 weeks prior to surgery.	Death (caused by the Patient Safety Event)	
Jan-19	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	After a successful excision of acne keloids from occipital scalp/neck, the open wound was washed with alcohol spirit very carefully by the operating surgeon. The alcohol only went within the wound and was given time to evaporate. Some of the alcohol must have pooled however from the wound into the swabs situated below the wound to absorb any run-off. Nobody had spotted any run off and so the surgeon carried on the operation. When the surgeon next used diathermy, the swabs caught fire. The short exposure of the scalp and neck to the fire had caused partial thickness burns to the back of the patient's head and neck and caused small areas of full-thickness burning.	xxxxxx initial panel held. xxxxxxxx - Incident reported onto STEIS. CA 1)No practice occurred that was contrary to nationally recognised recommendations: The NICE guideline CG74 states on the subjects of Antiseptic and Diathermy: Antiseptic skin preparation: 1.3.7 Prepare the skin at the surgical site immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine are most suitable. 1.3.8 If diathermy is to be used, ensure that antiseptic skin preparations are dried by evaporation and pooling of alcohol-based preparations is avoided." The review of evidence in 2017 states that: "Currently both chlorhexidine and povidone iodine are recommended for skin antisepsis and both alcohol and water-based solutions may be used" The evidence to inform the choice of antiseptic in surgical procedures is inconsistent. There is a lack of clarity in some abstracts about what solvents are used in the antiseptic preparations. Several studies specified the use of chlorhexidine in alcohol but did not state whether the comparator, povidone-iodine, was in alcoholic or aqueous solution. Because alcohol is a well-known antiseptic agent, a chlorhexidine-alcohol preparation has 2 active ingredients whereas aqueous povidone-iodine has only 1 active ingredient. An update of this review question is needed to determine whether chlorhexidine and povidone-iodine should both be recommended for skin antisepsis, and whether alcohol solvents should be preferred over aqueous solvents 2)Nice Guidelines published in April 2019 (NG125) state that the first choice for anti-septic skin preparation is alcoholic chlorhexidine. Overall, the evidence showed that chlorhexidine in alcohol was associated with the lowest incidence of surgical site infections, whereas aqueous povidone-iodine was associated with the highest incidence. If diathermy is to be carried out use evaporation to dry antiseptic skin preparations and avoid pooling of alcohol-based preparations. 3)I am confident from all witness statements that the above recommendations were adhered to.	Immediate message to all staff across the theatre complex to highlight the flammability of alcoholic surgical prep and the risk of ignition from diathermy. Standardisation of the use of different skin preparations at different stages of operations – guidelines to be produced inline with NICE guidelines April 2019. To include advice that when alcoholic are solutions are used precautions must be taken to prevent pooling or absorption in surrounding materials. Diathermy to be turned off while alcoholic prep in use with a pause of 3 minutes to allow drying Update to speciality specific fire training to ensure risk of alcoholic prep fire is highlighted In addition to Duty of Candour ensure that a patient involved in an incident has a contact of someone that was involved who can answer questions in the short term before the patient safety team involvement	Severe (permanent or long term harm caused)	No
Feb-19	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Department of Critical Care (E5) (DCCQ)	In critical care with respiratory failure. At the time of the incident his bedside nurse was on her break. He was being supervised by another of the ITU nurses who was caring for 2 other patients meaning he was not directly observed. When the covering nurse went into the cubicle the patient was unresponsive, not breathing and in cardiac arrest.	LT update- Report submitted to CC, JC and RC , just awaiting final panel- xxxxxxx Final Report submitted to CCG and closed on STEIS xxxxxxx. CA	LT update- Report submitted to CCI, JC and RC , just awaiting final panel- XXXXXX Final Report submitted to CCG and closed on STEIS XXXXX. CA	Severe (permanent or long term harm caused)	No
Mar-19	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	Patient attended Day surgical unit for elective left trapeziectomy. SpR prepped draped and started case. Consultant scrubbed and came to table after 5 mins and reviewed approach; happy with progress. Operation continued with Consultant stood behind scrub trolley, supervising but not assisting. Incorrect joints identified by registrar and bone adjacent to trapezium (scaphoid)excised. Consultant realised when bone handed out. Took over and confirmed error with on table xray. Consultant asked for other hand surgeon to be called into theatre. Discussed with colleague- no further action appropriate surgically. Wound closed and plaster applied as normal. Patient transferred to recovery.	Incident meets both Never Event and STEIS reporting criteria - reported onto STEIS on xxxxxx CA	Incident meets both Never Event and STEIS reporting criteria - reported onto STEIS on xxxxx. CA	Severe (permanent or long term harm caused)	Yes
Aug-19	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	at the time of laparoscopic hysterectomy I (as we all do) put the sterile glove with Sanitary Towel in the pt vagina to maintain pneumoperitoneum once the specimen is removed to suture the vaginal vault. On this occasion this was not removed at the end of surgery and the patient passed it at home and brought it in. I saw the patient immediately when I was told that this happened, apologized profusely, made sure that the patient came to no harm. The patient accepted apologies and understood the situation. This self made "device" to maintain pneumoperitoneum is commonly used, but there is no formal way of counting it in and out as a standard practice. I have also disseminated the learning through the MAS surgeons in the department.	as per details overleaf, on investigating with Theatre team it appears there was not enough Surgical assistants to support this procedure, so a member of the Theatre scrub team helped out, it is unknown whether this had an impact for this patient. As detailed by surgeon there should be some process in place that if this vaginal pack is inserted there is a check to ensure it is removed prior to leaving the Theatre •Item not part of the count in theatre so not written up the white board. Nothing documented in the peri-operative notes about the glove and pack being used. Roles and responsivities' – No second surgical assistant available – scrub practitioner steeped into this role, possible contributing factor as second surgeon would routinely remove this devise.	Watch out Poster to be developed for theatresIncident to be added to daily mentions. Added to daily mentions making all staff aware of the incident and to think about what else requires to be added to the whiteboard count. Teaching / relaunch of SOP 51 which states anything inserted into body needs to be added to the white board surgical count and verbalised to the team once removed. To do give the team time to embed this practise and to audit in the new to confirm compliance. Team brief conversations regarding professional boundaries of the first assistant role and principle surgeon if scrub practitioner is requested to assist. Escalation process to be put in place if highlighted if there is no second assistant available. For Gynae surgeon to ensure standardised practice regarding maintaining pneumopertoneum pressure.Gynae surgical to review and agreed a standard practice for maintaining pneumoperitoneum pressure during these procedures. Investigate whether a more purpose designed product is available for use.	None (no harm caused)	Yes

Sep-19	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	Surgeon was carrying out a Primary Hybrid Total Hip Replacement on the patient (cemented acetabular cup/uncemented femur). After the femur was prepared the surgeon asked for the prosthesis which comprises of a femoral stem and femoral head. Once then implants were brought into theatre as the scrub practitioner, I read aloud the manufacture, type of prosthesis, size of prosthesis and expiry date of both components. Mr C then checked the implants and told the circulating staff to open them. He then proceeded to implant the prosthesis. After the operation once Mr C had left theatre he sent the healthcare into theatre to ask me to check if the head was compatible with the stem.	Thank you for reporting this has been fully report and report is attached with the actions.	1Considered the feasibility of introducing a scanning system in MSK theatres for prostheses. As recommended by the HSIB. 2Simplified stock selection, in close collaboration with surgical / theatre staff - with increased quantity of each item (suggest holding 2 extra per component) 3Simplified orthopaedic theatre kit / set up for regular operations such as total hip replacement 4aTeam brief - to be updated in conjunction with all orthopaedic theatre staff to include their needs 4bIf not all members of the Theatre Team are present at Team Brief, then there should be a clear process for communication in place to impart vital information. 5Training package for HCSW in the procedures commonly being performed 6Improve room layout in stock room 7Standardise theatre layout - especially when new theatres come on board 8Review of system for flagging private patients on Theatreman and to the Anaesthetic department 9Review system to streamline the communication to theatre's team about the availability of beds and releasing them as early as possible. 10Trust to consider employment of Human Factors / Ergonomist qualified chartered professional to advise on similarly complex areas across Trust 11Trust to reframe response to Never Events by wide dissemination of the systems learning that can come from NEs 12Restart Safer Procedure Steering Group 13Inform HSIB of further occurrence 14Contact MHRA device department to inform of issues re	None (no harm caused)	Yes
Oct-19	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	PATIENT HAVING AN EMERGENCY THORACOTOMY PROCEDURE POST ROBOTIC OESOPHAGECTOMY, A THREE INCH PIECE OF A JACQUES CATHETER WAS FOUND FROM THE PREVIOUS SURGERY IN THE CHEST	thank you for reporting this has been fully investigated and shared with the patient report attached.	1.Perform a scoping exercise to review whether a more suitable product is available to retract the oesophagus (risk-assessment needs to be completed if no suitable alternative is available) 2.Ensure that Jacques catheter is measured/checked pre and post insertion to ensure that all pieces have been removed. 3.Review feasibility of adding 'hem-o-lok' clips to the surgical count if they are attached to the Jacques catheter (or alternative device pending the scoping exercise). 4.All Theatre Teams twill be required to review their 'high-risk' moments for the retention of objects and apply key practice changes that will mitigate the risk of this. 6.A re-focus/briefing amongst the surgical team should be encouraged if there are any staff changes towards the end of the list. 7.Implement new strategies for disseminating learning via the following mechanisms: •Adopting a new approach to MDT training on Clinical Governance Mornings. •Disseminate learning from incidents at Safer Procedure Steering Group. •Establishing the Theatre Patient Safety Team.	None (no harm caused)	Yes
Mar-20	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Department of Critical Care (E5) (DCCQ)	A NG was placed by S/N M after my request at ward round. She was unable to aspirate it therefore a CXR was requested. Once the CXR was taken Dr T has called up a CXR to review it. He has reviewed a CXR taken at 12:05. He then asked Dr H (Clinincal Fellow) to review the film that was already up. This showed an appropriately sited NG tube. The CXR that was taken after the repeat NG insertion was taken at 22:30. This CXR shows the NG going into the left lung. Unfortunately it was not this CXR that they reviewed. When recording the siting of the NG tube Dr T has not put in the time of the CXR on the Clinical Information System (CIS). The clinical team have signed off the incorrectly placed NG tube. Mr J has received gabapentin, paracetamol and senna syrup via the NG tube. He has then had his feed started. This led to him coughing and an increased oxygen requirement and so the feed was stopped. The feed was running at 10ml and hour I have been told it was running for less than an hour before it was stopped. The team have then requested another CXR to see why he was needing more oxygen. It was at this point that the clinical team noticed the error. The NG was immediately removed at this point.	Dr B involved in investigating Care delivery: •The doctor who reviewed the x-ray did not allow sufficient time to elapse between the x-ray being taken and looking for the image on the electronic system. •The reviewing medical staff did not check the time stamp on the x-ray, which would have indicated that this image was from earlier in the day. •The doctor did not complete the time box on the NG tube documentation within the electronic medical record. Service delivery: •Incorrect chest x-ray opened in radiology viewing software. Contributory Factors •Lack of staff confidence to escalate concerns about the incorrectly sited NG tube. •Confirmation bias – the clinical fellow told this was the chest x-ray that required to be reviewed and therefore did not check the date and time.	1.Medical staff involved temporarily restricted from signing off NG tubes. 2.Medical staff involved to re-complete the relevant on-line learning module. 3.Medical staff involved to undertake a period of supervised practice. 4.Written reflection to be completed and discussed with educational supervisor. 5.E-mail sent to all junior doctors and advanced critical care practitioners about the importance of time/date of x-ray interpretation. This e-mail also encourages them all to remind themselves of the departmental SOP on NG insertion. 6.To be discussed at the morbidity reviews meeting to ensure lessons learnt are shared with the multidisciplinary team. 7.Discussions to be had with senior medical and nursing team and IT team to see if it is possible to make the date and time boxes mandatory on the Clinical Information System. 8.Link with the new Theatre Patient safety matron to ensure close link with the Safety to Speak up objectives, and give staff confidence to highlight concerns around clinical practice and to work with the trailing team to share learning.	Moderate (Short term harm - patient(s) required further treatment, or procedure)	Yes
Mar-20	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Department of Critical Care (E5) (DCCQ)	patient attended Emergency Department documented shut down peripherally Temp 39 CRP 330 HR up to 146 discharged with diagnosis of gastroenteritis re-admitted with gram negative sepsis, portal vein thrombosis, multiple micro liver abcesses	ED attendance xxxxxx Discharged xxxxxx AMU GP admission xxxxx Review of ED notes on Oceano on first presentation to ED xxxxxx 20:18 Triage : abdominal pain and fever for few days (self presented to ED) EWS 2 HR 121 BP 132/75 T 37 Pain Score 0 21:58 Seen by ST 1 Emergency Medicine - History and examination undertaken. Abdomen found to be soft but with tenderness in upper abdomen. Diagnosis : Viral illness. Plan for bloods/flu swab 23:51 EWS 4 HR 128 BP 111/55 T 39.8 Pain Score 0 00:50 Clinical review "looks a little better" CRP 330 (WCC normal). Plan to continue IV fluids (1L Hartmanns) 01:47 EWS 3 HR 100 BP 99/40 T 36.8 Pain Score 0 02:48 Urine dip ketones/blood/prot. Clinical review. Thought to be likely viral gastroenteritis. Discharged with advice regarding fluids 03:07 Discharged home Referred to AMU by GP xxxx (5 days after discharge) and subsequently admitted to DCCQ	There does not appear to be any issues with systems/processes in the ED for this case. The patient was seen in a timely manner, bloods undertaken and treatment provided on initial attendance in an appropriate timescale. The decision to discharge the patient given the very high CRP was based on a clinically improvement in symptoms and improvement in HR/Temp (although BP remained low. Given symptoms the diagnosis of gastroenteritis was not unreasonable however expectation would have been that the case was discussed with an ED senior prior to discharge (given inflammatory markers where so high). The outcome (discharge) may have been the same however it is probably admission for observation would have been advised. The patient remained at home for a further 5 days and so it is likely the clinical picture deteriorated. It is unclear what safety net advice the patient was provided with. LEARNING The case has been discussed with the clinician involved by their clinical supervisor for personal reflection. The case will be shared with the ED team via M&M process and daily safety huddles/teaching	Severe (permanent or long term harm caused)	
Jun-20	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Theatres QA	The theatre team brought the patient in and Anaesthetist and myself carried out the patient checks; gained consent, checked wristband and operation site marking in accordance with the WHO Checklist. The Anaesthetist was standing on the patients Left side which was the operation site, Then we covered the patient up with a blanket. I applied patient monitoring whilst the Anaesthetist collected the block trolley from the end of the bed and started getting the patient ready for the block by positioning the leg and feeling for key markers for the block. The Anaesthetist went to the wrong side of the bed after collecting the trolley, which we did not notice at the time. During the administration of the second syringe of local anaesthetic by the Anaesthetist I realised we were blocking the wrong leg and voiced this to the anaesthetist and HCA present.	never event relating to wrong sided nerve block in a patient being prepared for repair of a fractured neck of femur. No harm came to the patient. Human factors including the contribution of covid-related changes to practice contributed. Failure to use the STOP before you BLOCK protocol in this case was a significant contributor.	Full roll-out and implementation of Theatre Procedures SOP during Covid-19. De-escalation of enhanced PPE where appropriate for extended procedures following an assessment of the risks. Review of 'STOP before you block' process to see if any improvements can be made. Consider the risks of it not taking place and identify an action plan to address these. Consider re-introducing visual aids that might act as a reminder to engage in 'STOP' moments and/promote awareness of high-risk moments. Consider the feasibility of using additional markers to highlight the location of the block (if is not near the surgical incision site). Theatre Patient Safety Team will complete a safety culture questionnaire and evaluate the results to inform an action plan for improvement. Consider the feasibility of delivering multi-disciplinary human factor training that promotes situational awareness and reinforces the importance of 'STOP' moments throughout surgical procedures. Explore different ways of sharing learning across the theatre department/division/Trust to ensure that real change becomes embedded and makes a difference to patient care delivery.	Low (Minimal harm - patient(s) required extra observation or minor treatment)	Yes

Aug-20	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Department of Critical Care (E5) (DCCQ)	Right radial arterial line inserted by seldinger technique by SHO Unrecognised retained guidewire Difficult to flush and aspirate line, Registrar help requested. Registar flushed manually with syringe via the transducer set. Line then flushing and aspirating without difficulty. This flushed the unrecognised, retained guidewire further into the radial artery.	Staff member DS AA asked for statements. Duty of candour being processed.- Possible Dr M/B Patients been to theatre on 27/8/2020 and had guidewire removed via ACV patch placed on artery. Uneventful procedure. Mr G. SB has discussed with risk- SP . updated on incident. 11/9/2020- update from Dr B, NJ to undertake RCA. Dr T has met with trainee involved on 11/9/2020. Incident discussed today at MDT SLER feedback and governance meeting. Attached investigation which has been sent to patient safety team for review. Discussed with SK, she is happy for incident now to be closed- 1/12/2020	A method of forced confirmation of removal of guidewire should be present on CIS for any procedure involving this technique. This will encourage early recognition by recall of the process by the clinician. The clinician involved should be supervised and supported in line insertion to regain confidence so there are no negative effects on their long term practice. Evaluation of the training given to new doctors on ICU in local policies for insertion of lines. Discussion at consultant level as to whether a set number of lines is required under supervision for techniques which are new to the clinician. Equipment: A departmental review of the alternative methods of arterial line insertion A 'watch out for' notice on ICU for guidewire retention – a system that is already well recognised and supported in improving patient safety on ICU. Learning should be shared with theatres and the wider hospital as this incident could be mirrored in other environments.	Moderate (Short term harm - patient(s) required further treatment, or procedure)	Yes
Apr-21	Clinical Delivery Division - Critical Care, Theatres, Anaesthetics & HSDU	Department of Critical Care (E5) (DCCQ)	NG placed on 18th April. Noted on CXR today (20th April) that likely intra-bronchial placement of NG (had NOT been used for feeding). Removed and patient immediately desaturated. Pneumothorax seen on repeat chest x ray.	Emailed JS re IRP- SB able to attend.		Severe (permanent or long term harm caused)	Yes