General Surgery / Paediatrics	Date reported on STEIS	Incident Ref	Incident Description	Lessons Learned	Recommendations
General Surgery	21/06/2023	2023/12087 (Incident 262776 – Anaesthetic or Intra Operative Problems	Elective umbilical hernia repair, discharged the following day. Re-attended 3 days later - bowels not opened since operation, distended painful abdomen, Stage 3 AKI. Had a laparotomy the same evening: admitted to ICU post op as level 3 patient in multi-organ failure.	•Themeatic review undertaken •Expected complications of care were identified, however five patients encountered complications, though this is not uncommon. •All patients had satisfactory post complication treatment. • The number of patients is a factor. The number of patients in the LLP list was 9 patients. This should be reasonable if all the patients are ASA I/II, BMI is 30 or less with primary straightforward hernias or biliary colic in the case of laparoscopic cholecystectomy. Complexity of patients should be accounted for. •In 3 patients an on-lay mesh was used after suture repair. The fourths inguinal hernia repaired using mesh as standard. The fifth patient had suture repair of small umbilical, he was on steroids and he developed seroma. Two of the patients had a documented infection (positive culture), one had a clinically infected haematoma and the fourth had a seroma but was given antibiotics. The fifth had small bowel injury.	• This had been referred to the Medical Director for action. • Theatre list will need to be looked at and the number capped (ASA grade /BMI/ complexity of cases) • A surgical assistant will be required in complex / Laparoscopic cases as the scrub nurse should not be used as an assistant. •*Use of On-lay mesh predisposes to seroma and may be infection in hernia repair, when used prophylactic measures e.g. drainage, abdominal binders, fibrin sealant should be used to minimize complication. This will be left to the operating surgeon’s preference.
General Surgery	29/11/2023	2022/25463 Unwitnessed Fall	The patient arrived in the Emergency Department after having fallen down half a flight of stairs at home sustaining injuries to the ribs, transverse process and lumbar spine. They had a CT scan in the Emergency Department due to the mechanism of injury and the fact that the patient was taking warfarin. The CT scan in ED did not identify any evident bleeding. The patient was transferred to the surgical ward to be observed due to the rib fractures where the patient was on cohort supervision however they were found at the end of the bed having had an unwitnessed fall.	• Lack of understanding around neurological observations and post falls care • Lack of understanding on the expectations of cohorting and supervision • Lack of understanding on the escalation process when staff are not available for cohorting and the risk to patients. • Handover process not robust enough to ensure key information elicited • Medica services did not call through the scan findings and the task on nervecentre was shut down without action.	• Review of the handover process on the ward • Programme of education with ward team around falls and requirements • Education within the senior ward team around cohorting provision and escalation if this provision is not available • Discussion with nervecentre team to establish why the task was completed without action to review the CT scan • Case to be sent to the external reporting company for review

General Surgery	07/09/2022	2022/19265 (Ulysses 236683) Deteriorating Patient	The patient was admitted to the surgical ward via theatres following elective refashioning of colostomy under a general anaesthetic. The post-operative surgical plan was for home in 24 hours. The patient developed a post-operative pyrexia of 39.70C the following morning, and this remained high throughout the day. Late afternoon the patient showed signs of hypotension which was treated with IV fluid. Staff on the ward were concerned about redness and pain to the operation site, which was highlighted to the Doctors. They also suggested that Blood Cultures were taken as the patient had ongoing pyrexia; blood cultures were not taken at this point. The patient continued to deteriorate and required a MET call the following morning as their NEWS was 9. A CT scan was performed showing a subcutaneous collection. The patient returned to theatre later that day and died two days later from multi organ failure. The initial debrief identified missed opportunities to act on ongoing pyrexia and hypotension, and to recognise sepsis.	• Persistent temperatures following a surgical procedure should prompt a septic screen (urine, lines, chest, blood cultures) • Persistent hypotension, and the significant drop in blood pressure, should have raised concerns / been recognised and prompted investigations, including blood gases. • Clinical Digital System used at the time of this incident (NerveCentre) did not support clinicians to view trends in respect of vital sign observation and early recognition of blood pressure dropping, in comparison with the current system (EPR) now in use throughout the organisation • There were multiple reviews by Specialist Registrars with no documented escalation to a Consultant. • Delay in returning to Theatre once it was recognised how unwell the patient had become. • Decision taken to proceed with CT scan and await report when it would have been more appropriate to seek urgent Consultant review on receipt of blood gas results at 07:55 that morning. • Whist the first on-call Consultant was in Theatre, the second on-call Consultant should be have been called to review the patient. • Multifactorial Human Factors evident throughout this episode of care, suggestive at times of “group think” between the junior doctors.	•The presence of persistent pyrexia in the post-operative patient should prompt further clinical assessment and possible investigations. The use of SIRS criteria and the NICE Guideline for the management of sepsis should support clinical decision making. •Appropriate investigations and management plan should be commenced in patients with persistent hypotension. •Nursing staff should escalate concerns at Consultant level if they consider prior escalation has not allayed their concerns. •In the event first on-call Consultant is in Theatre, seek Consultant out in Theatre to discuss or escalate concerns to second on-call Consultant/available Consultant
General Surgery	07/09/2022	2022/19254 (Ulysses 236855) Deteriorating Patient	Patient admitted for an elective cholecystectomy, which was performed on the day of admission with a plan for discharge the following day. The morning after the procedure the patient’s blood pressure had deteriorated and was found to be 76/38. Shortly after this the patient was found to be in a peri-arrest condition, with a blood pressure of 65/47 and required a MET call and immediate fluid resuscitation. The patient was found to have diffuse right upper quadrant tenderness and had a CT scan, CTPA , CXR , no initial signs of bleeding or perforation , suggested incidental finding of a malignancy. The patient continued to deteriorate, with hypotension and a new oxygen requirement. The patient was fluid resuscitated, discussed with ITU team, reviewed by ITU, and later transferred to ITU. Later on the evening the patient returned to theatre for an emergency laparotomy and repair of gastric remnant perforation. Transferred to ITU post operatively and sadly died 17 days later.	• Ensure Prescribing of antibiotics and documentation is clear for patient’s • Review of theatre nurse provision for Emergency lists • Staff waited for type specific blood, Emergency blood could have been administered earlier. • Staff completed a further request when the patient deteriorated however could have utilised the blood samples from the previous day to obtain type specific blood promptly. • Recognition that a patient that is unwell next day after laparoscopic cholecystectomy with this clinical picture has bleeding, a bile leak of a bowel injury. The investigation of choice is a re-laparoscopy at that stage to secure the diagnosis early.	• Communication re obtaining type specific blood • Reflections from medical teams re timeliness of return to theatre • Theatre Nurse provision out of hours needs to be reviewed.

Paediatrics	17/05/2022	2022/9815 – Failure to recognise deterioration	The carer of the young person contacted the on-call Diabetes Consultant to request advice re: concerns over blood sugars of young person and advised to attend Paediatric Assessment Unit (PAU). The patient arrived on PAU at 16:40; initial assessment indicated blood sugars were high and Diabetic Ketoacidosis care pathway was indicated. Standard clinical management included routine blood samples including blood gases, venous access, prescribe and administer intravenous fluids and monitor closely. These intervention did not occur timely. Night staff escalated concerns at 20:00 that initial fluid bolus was still infusing some 90 minutes after commencing, patient was tachycardic, had slow capillary re-fill time with increased respiratory effort. Care pathway was reviewed by Paediatric Specialist Registrar, opinion of Anaesthetist was requested for consideration of intensive management of DKA, care also discussed with NECTAR and decision taken to transfer patient to Adult ITU DMH. Patent recovered, returned to Ward based care following short stay in ITU and has since been discharged	•A meeting took place in relation to the number of Diabetes related incidents between senior nursing and medical staff across Paediatrics and the Diabetes team. The trigger for the meeting was a consultation between a parent and the Out of hours Paediatric Diabetes advice help line during which it later transpired the parent had misinterpreted what the advice had been and had subsequently given a higher dose of insulin than was advised. It was considered that a meeting was necessary to discuss the robustness of the service and potential improvements to standardise what was currently an informal process with no record of conversations or contacts being documented in line with Trust Record Keeping policy.	• Develop a Standard Operating Procedure for telephone advice • Explore recording of calls • Explore how EPR might be more helpful for Diabetes team • Explore the possibility of voice recording consultations