

SSBCN ODN Neonatal Patient Safety Incident Report Quarter 4 2017/18

(Adapted from NHSI - <https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-september-2017/>)

Degree of Harm:	None						Low						Moderate						Severe						Totals	Comments (include any themes noted in incidents in this quarter)
	PR	DG	WM	RW	RS	SW	PR	DG	WM	RW	RS	SW	PR	DG	WM	RW	RS	SW	PR	DG	WM	RW	RS	SW		
Incident Category:																									Brief Details of Incident (anonymous) and Actions to share with network (all incidents in Moderate or Severe)	
Access, admission, transfer, discharge (including missing patient)					0						1						0						0		1	
Clinical assessment (including diagnosis, scans, tests, assessments)	9 ^x		4	1	1				1	1	1						0						0		9	^x 5 of these incidents were due to having no Tissue Viability support within the trust to review babies.
Consent, communication, confidentiality	3		2	7	1				1	1	0						0						0		15	
Documentation (including records, identification)	2			7	0						0						0						0		9	
Implementation of care and ongoing monitoring / review	4				1						0						0						0		5	
Infrastructure (including staffing, facilities, environment)	4		2	13	2				1	2	0						0						0		24	
Medical device / equipment	1			6	1						0						0						0		8	
Medication	3		8	7	2				1	2	0	1 ^z					1 ^x						0		23	^x Details and Shared Learning TBC ^z Drug checking process failure
Patient Accident	0				0						0						0						0		0	
Treatment, procedure	1			7	3					4	2	1 ^z			1	1 [*]	0					1 [*]	0		18	Details and Shared Learning TBC. WMH - 1st oesophageal perforation, Shared Learning: New documentation checklist and SOP ^z Longline insertion issue
All other categories	12			4	3					4	0						0						0		23	
Totals	39		16	52	14				4	14	4		2		1	1	1					1	0		149	
Network Total Incidents	121						22						5						1						149	

	PR	DG	WM	RW	RS	SW	Network
None	39		16	52	14		121
Low	0		4	14	4		22
Moderate	2		1	1	1		5
Severe				1			1