STRIVING TO REDUCE AVOIDABLE HARM:
Learning From Mistakes

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INTRODUCTION

Continuous emphasis on quality care and the development of standards with an evidence base is fundamental to the provision of safe, compassionate patient-focussed care. We can only advance practice and ensure that we continue to deliver the Gold Standard of Care if we learn from our mistakes.

Ever since the global recognition of the fact that healthcare sometimes harms patients in considerable numbers, we have been seeking methods of reducing risk and harm. We know that around 10% of adverse incidents that happen to patients are preventable. Can we say that we work in hospitals or health trusts that have a culture of safety? Do we know that if the worst situation occurs, that lessons have been learned and that no further patients will be harmed in this way?

There are a variety of systems and frameworks in place to record adverse incidents and to enable examination of the detail. Is it confusing to have multiple possible means by which to record an incident?

NEVER EVENTS

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations have been implemented by healthcare providers. That being said, Never Events that do occur highlight potential weaknesses in how an organisation manages its fundamental safety processes.

Never Events are different from other serious incidents as the overriding principle of having the Never Events list is that even a single Never Event acts as a red flag that an organisation's systems for implementing safety advice and alerts might not be robust[1]. The inherent concept within the Framework which guides Never Events management is that it is not about apportioning blame when incidents happen, but learning from them. However, there are also some common (although ultimately preventable) mistakes that occur as part of the Never Events List.

Take, for example, the misplaced naso-gastric tube. The tube is deceptively simple, the process very uncomfortable for the patient but nonetheless can be justified in many clinical situations. They are very easily slid down into the wrong orifice and in the absence of a clear X-Ray or no X-Ray to check placement, the patient can receive liquid food straight into their lungs.

There are numerous patient safety alerts, the first appearing in 2005, and then three further alerts coming to the fore between 2011 and 2013. Between 2011 and 2016, 95 incidents were reported through to the patient safety reporting system in known as the National Reporting and Learning System (NRLS) or the more recent Strategic Executive Information System (StEIS). Errors are identified as straightforward communications failure, lack of robust training and competency and failures to check the placement[2].

A review of local investigations suggest issues with organisational processes for implementing previous alerts. The key implementation issues relate to:

- Problems with systems to ensure staff who were checking tube placement had received competency-based training
- Problems with ensuring bedside documentation formats include all safety critical checks
- Problems maintaining safe supplies of equipment, particularly radio-opaque tubes and CE-marked pH test strips

NHS Improvement helpfully provides a resource set for identifying issues and finding solutions, on its website; easily found with a short topic search. However, the document is 54 pages long. I cannot see how a junior doctor or indeed an experienced nurse who might undertake the next naso-gastric tube placement, has time to read so much information, however helpful it may turn out to be. The resources provided have to fit the time poor clinicians have available to them. The foreword to the resource says that they hope to provide, through the extra resources, reasons why it is vital to act on what has been learned the hard way - through lives lost, damaged respiratory systems and traumatised families, patients and staff[3].

It is a complicated situation and there must be executive accountability for ensuring that safer systems of work are in place. We need a just culture in organisations where we work, so that there is a proper balance between 'no blame' and 'accountability'. This is easier said than done.

Many Never Events are regularly reported and recently the report was published with data from March 2016 to April 2017[4]. The report indicated that 424 serious incidents seemed to meet the definition of Never Event, when they were reported. 10 serious events did not meet that definition, one was still in draft form and six events occurred that happened in a time frame before the reporting year.

In the 2016/2017 report, it was distressing to read that of the 424, 178 of these were wrong site surgery, a further 109 were retained foreign objects post procedure, and 49 were the wrong implant or prosthesis. **This means that 79% of the Never Events reported last year were surgical or invasive-treatment related**. As a peri-operative practitioner, that feels personal. It feels as though despite years of team briefings, refining systems for safe care, teams still need to be regularly reminded of black holes in the quality of care provided to surgical patients.

SERIOUS INCIDENTS

How are Never Events and Serious Incidents related? One could be forgiven for forgetting the definition. The framework for serious incident management provides one definition.

Serious Incidents in NHS include:
Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past
- Unexpected or avoidable injury to one or more people that has resulted in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: the death of the service user; or serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self neglect, domestic abuse, human trafficking and modern day slavery where:
  - Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring
  - Where abuse occurred during the provision of NHS-funded care

  This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS-funded care caused/contributed towards the incident
- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. *See Never Events Policy and Framework for the national definition and further information*
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
  - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
  - Property damage
  - Security breach/concern
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS)
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/unit closure or suspension of services
  - Activation of Major Incident Plan (by provider, commissioner or relevant agency)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation
  Source: Serious Incident Policy and Framework

Serious Incidents in healthcare are those events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant our particular attention. These investigations should ensure that the incidents are identified correctly, investigated thoroughly and - most importantly - trigger actions that will prevent them from happening again. Never Events are a particular type of serious incident that meet all the following criteria:

- They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers
- Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event
- There is evidence that the category of Never Event has occurred in the past, for example through reports to the NRLS and a risk of recurrence remains
- Occurrence of the Never Event is easily recognised and clearly defined. This requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety. *Source: Never Event Policy and Framework*[5]

Over the last decade the NHS has made significant progress in developing a standardised way of recognising, reporting and investigating when things go wrong and a key part of this is the way the system responds to serious incidents. Identifying the manner in which patient safety adverse events are managed, has shifted significantly from a blame culture to one of reviewing the context in which the incident occurred. However, much more could still be done to recognise and tackle some of the systemic fallibilities in healthcare and reduce blame being apportioned to individual professionals.

The provision of healthcare is a complex issue. It represents a huge challenge where the claritying of understanding relating to the daily stresses and strains of the system, individual clinicians rebelling against the team and the system, and the quality of safety management and leadership within the health trust is always a challenge. There is a great deal more work to be done!

NATIONAL GUIDANCE ON LEARNING FROM DEATHS

During March 2017, the National Quality Board provided a framework for Trusts that has been implemented since April 2017[6], requiring NHS Trusts to report, investigate and learn from deaths occurring that might not have been clinically expected. One of the key recommendations is that families and carers are treated with more sensitivity, honesty and care than they have been in the past regarding an unexpected death. The other main reason for the new framework is that it was found by the Care Quality Commission that NHS investigations were inconsistent and variable. This acts as a barrier to identifying opportunities for learning. The report also has no systems in place to ensure that learning is implemented locally or shared with others, following an untoward death. The report also focuses attention on more sensitive management of bereaved families and local governance structures, so that learning opportunities are not missed.

HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB)

The Healthcare Safety Investigation Branch (HSIB) is a new organisation that started very recently[7] and was established to provide external and independent expertise to guide and support NHS organisations on investigations and conducting safety investigations. The team of people working within the organisation are experts drawn from NHS, aviation and military investigations, human factors experts and other experts in investigations.

The role of the organisation is to review local investigations and focus on whether there are wider opportunities to learn from exploring where harm may, or has, happened. They only intend to work on incidents that have happened since April 2017 and will not expect to investigate more than 30 incidents in the whole year. They will report their findings and publicise them on their website. They say they are not interested in blame or culpability but are primarily there to support learning and make improvements in the healthcare system. Based on the Air Accident Investigation Branch, the HSIB will have a great deal of serious reporting and sharing to undertake.

CONCLUSION

We have to continue all efforts to learn from patient safety incidents. It is only by providing feedback to all practitioners that changes will be able to be made. Systems analysis is essential and appropriate governance measures must be in place so that the pathways and frameworks for delivering care are as safe as they can possibly be.

We all need to ensure that we are transparent and candid with patients' families and relatives if the worst happens. It is to be hoped that all the reporting systems and new frameworks for investigation provide all the learning they all purport to provide. The culture of learning, moving away from a culture of blame has been long called for. It is to be comprehensively welcomed and supported.

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References:

1. *NHS Improvement Provisional publication of Never Events reported as occurring between April 2016 and March 2017.* Acessed at https://improvement.nhs.uk/uploads/documents/Never_events_April_2016-Jan_2017.pdf
2. *Patient safety alert. Nasogastric tube misplacement: continuing risk of death and severe harm.* July 2016. Accessed at https://improvement.nhs.uk/news-alerts/nasogastric-tube-misplacement-continuing-risk-of-death-severe-harm/
3. *NHS Improvement Resource set.* Accessed at https://improvement.nhs.uk/uploads/documents/Resource_set_-_Initial_placement_checks_for_NG_tubes_1.pdf
4. *Never events policy and framework 2015.* Accessed at https://improvement.nhs.uk/uploads/documents/never-evnts-pol-framwrk.pdf
5. *Serious incident policy and framework.* Accessed at https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf
6. *National Quality Board March 2017 National Guidance on Learning from Deaths.* Accessed at https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
7. *HSIB.* Accessed at http://www.hsib.org.uk/about-us/