The Shrewsbury and Telford Hospital NHS
NHS Trust

Reporting to:	**Trust Board – 1 December 2016**
Title	Recent Never Events at SaTH - an important opportunity for improvement
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Previously considered by	
Executive Summary	This paper presents a summary of the recent Never Events that have occurred at SaTH during a twelve month period and the investigations and action points identified. It outlines the proposed response of the Trust in the short and medium term. It also identifies actions to further develop and maintain safety standards within SaTH.
Strategic Priorities 1. Quality and Safety 2. People	☒ Reduce harm, deliver best clinical outcomes and improve patient experience. ☐ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☐ To undertake a review of all current services at specialty level to inform future service and business decisions ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme ☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation 4 Community and Partnership 5 Financial Strength: Sustainable Future	☐ Support service transformation and increased productivity through technology and continuous improvement strategies ☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies ☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience

Framework (BAF) Risks	☐ If we do not work with our partners to reduce the number of patients on the **Delayed Transfer of Care** (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges. ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☐ Effective ☒ Caring ☒ Responsive ☒ Well led
☒ **Receive** ☐ **Review** ☐ **Note** ☐ **Approve**	**Recommendation** That this this paper is NOTED and progress in implementing the proposed interventions are monitored by the Trust's Quality and Safety Committee.

Never Events in The Shrewsbury and Telford Hospital NHS Trust
2015 to 2016

Background

This paper relates to a cohort of six incidents that have occurred in SaTH since September 2015.

These Never Events have occurred following a long period in which the Trust has had a very good record for the quality and safety of care for patients, that has included falling mortality (against national and peer comparators), a consistent reduction in patient harm, a fall in patient complaints and consistent delivery of expected patient safety performance, such as compliance with theatre checklists and VTE assessment.

Prior to September 2015 the last Never Event in SaTH was reported in April 2012 (wrong lens implantation in Ophthalmology). It therefore has been of concern that these Never Events have occurred and that certain patterns can be identified.

Four of these Never Events have been fully investigated and two are awaiting Root Cause Analysis (RCA).

Details of the six Never Events are presented in the table below:

SI No.	Reported	Site	Specialty	Issue
30792	23.09.2015	PRH	H&N	Wrong site surgery
36154	19.11.2015	RSH	H&N	Retained throat pack
20815	03.08.2016	PRH	H&N	Wrong tooth extraction
20737	17.10.2016	RSH	H&N	Retained nasal pack
28027	22.10.2016	RSH	Medicine	Retained central line guidewire
28024	27.10.2016	RSH	Urology	Retained piece of urology guidewire

Learning from the Never Events

Investigations completed to date have identified the following root causes:

SI no	**Root Causes**
30792 Incorrect site surgery	1. The Consultant who knew the patient left theatre at the point of draping and 'knife to skin' to attend to another patient who required urgent assessment following earlier surgery. 2. The Staff Grade who performed the surgery, had not marked the patient himself and, although part of the checking procedure, did not recognise the correct lesion. 3. The marking arrow was not visible after draping the operative site. 4. The patient had several obvious lesions on his head, including an ulcerated area, directly next to the more discreet nodule that should have been removed. 5. The Trust's marking policy was not adhered to in this case.

36154 Retained Throat swab	1. The theatre list was predicted to over-run into the afternoon list which was not recognised until the day of surgery, by which time the patients had arrived on the Day Surgery Unit (DSU) expecting to be operated on that day. 2. The additional time taken to manage the issues identified on DSU through preparing the patients for theatre, led to the theatre session starting 20 minutes late adding additional pressure to the theatre team. 3. The throat swab was not added to the "swab white board" and therefore effectively was invisible to the theatre team. 4. The throat swab sticker alerting that one was in situ was placed on the patient's forehead but there is no evidence to suggest it was visible at the end of procedure or when they were wheeled through to recovery. No member of staff has stated they removed it. It is hypothesised that it had become stuck to the adhesive on the theatre drape and came away when the drape was removed. 5. Theatre staff involved in the case deviated from the Trust's guidelines and procedures.
20815 Wrong tooth extraction	1. All preoperative safety checks were adhered to. 2. It is not possible to mark the site for a dental extraction. 3. There was agreement at the RCA meeting that this incident was human error, due to a "loss of situational awareness" at a critical point of surgery.
20737	1. Moving around of this list and transfer of equipment and staff at a late stage to enable this list to go ahead. 2. Standard operating procedure for the final swab check was not adhered to. 3. It was this surgeon's individual practice to prepare the nose with two different set of ribbon gauze and neurological patties. The surgeon recognised that the practice was a significant factor in this case and has stopped using the gauze with immediate effect.
28027 Retained Central Line guidewire.	Incident declared. Investigation in progress.
28024 Retained piece of urology guidewire	Incident declared. Investigation in progress

A thematic analysis of these Never Events in the theatre environment revealed the following:

1. No commonalities with staff involved
2. All have been day case minor or intermediate procedures.
3. Four of the five involve head and neck patients.
4. Three involved theatre list changes
5. The harm to patients was low to moderate
6. Individual practitioner error – three cases
7. Inadequate team checking – three cases

Potential contributory factors involved in the six Never Events are summarised in the fishbone diagram in Appendix 1.

Opportunities for Improvement

This series of Never Events presents us with an opportunity to implement our vision to be the safest and kindest organisation in the NHS. We should be thankful that our staff have reported these events and we need to mindful that we do not damage an emerging, healthy safety culture. In taking any further actions, we need to balance improving safety with personal accountability.

"Trying to increase discipline and accountability in the absence of a just culture has precisely the opposite effect. It destroys morale, increases defensiveness and drives vital information underground. It is like trying to revive a stricken patient by hammering him on the head with a mallet." Matthew Syed – "Black Box Thinking."

Actions completed to date

1. The six Never Events have been investigated and declared to the Trust's Commissioners and to NHS Improvement.

2. Discussions have been had with the General Medical Council regarding individual doctors involved in these Never Events.

3. The awareness of the earlier Never Events and the causes in the theatre environment has been raised using the Trust's "Message of the Week" (by the Medical Director). This highlighted the Never Events, and also ways that these can be prevented: conscious review by the operating practitioner and checks by the team before action.

4. A presentation on Never Events has been made to permanent medical staff at the Medical Director's "Doctors Essential Education Programme".

5. Additional safety checks have been instigated to check the post-procedure integrity of guidewires in Urology.

6. The fractured urology guidewire has been reported to the MHRA.

7. A Trust-wide group has been involved in benchmarking our current procedures and protocols against published National Safety Standards for Interventional Procedures (NatSSIPs). The group are now developing local Safety Standards for Interventional Procedures (LocSSIPs) as adapted for our local procedures.

8. The Trust has trained a cohort of Human Factors Trainers using “Atrainability”, an outside consultancy.

9. The commencement of Human Factors and Team Resource Management training has been planned, starting with those clinical teams that have had a Never Event.

10. A visit to Theatres by the Trust’s Quality and Safety Committee (chaired by one of our Non-Executive Directors) provided assurance on the manner in which required procedures are being followed.

11. The Scheduled Care Group senior leadership team reported to the Trust’s Quality and Safety Committee (including two non-Executive Directors, the Director for Nursing and Quality and the Medical Director) on action being taken following the Never Events.

12. Enhanced monitoring in Theatres has been commenced, by the relevant Governance Lead and Patient Safety Team, in order to review processes and procedures, and compliance with these.

Actions planned

1. The Scheduled Care Group has arranged an education session to raise awareness of safety procedures in theatre and promote a positive safety culture (scheduled for 6th December 2016)

2. The Scheduled Care Group is developing plans for team-based, multi-professional training sessions in Human Factors and Team Resource Management to promote safer team working and better communication in the operating theatres. The initial roll out of the programme will delibertaly target those teams which have been involved in Never Events (specifically ENT, Maxillofacial sSurgery and Urology)

3. Once the LocSSIPs have been completed, there will be an on-going programme of education and training to embed these standards. There will be particular focus on:

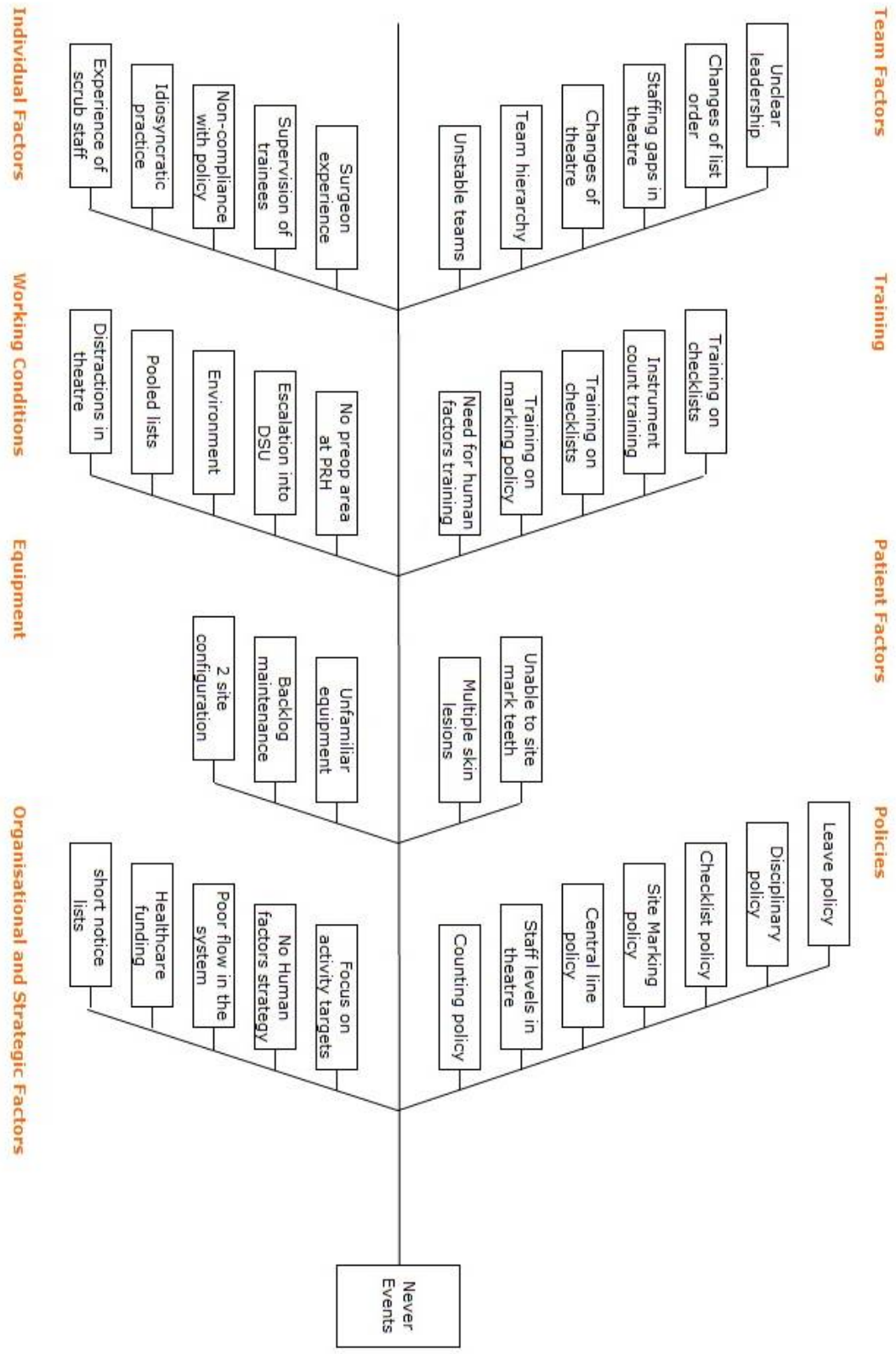
    a. Theatre list scheduling (LocSSIP 4)
    b. Site marking for interventional procedures (Loc SSIP 6)
    c. Staffing levels in theatres (LocSSip)
    d. The use of 5 Steps to Safer Surgery (LocSSIP 7, 8, 9 and 12)
    e. Swab and instrument counting procedures (LocSSIP 11)

4. There will be an on-going Audit of Compliance with 5 Steps for Safer Surgery using the audit tool in Appendix 2 .

Summary

This paper presents a summary of the recent Never Events that have occurred at SaTH during a twelve month period and the investigations and action points identified. It outlines the proposed response of the Trust in the short and medium term. It also identifies actions to further develop and maintain safety standards within SaTH.

Appendix 1: Fishbone Diagram Summarising the Factors Implicated in the 6 Never Events



Appendix 2: Proposed Audit Tool for 5 Steps for Safer Surgery

5 Steps to Safer Surgery Observational Audit Tool

(Please complete 1 form for each patient)

Date:	
Time:	
Observer Name:	
Patient's position on the list:	
Theatre/ room:	
Site:	
Senior Theatre Practitioner:	
Lead Anaesthetist:	
Lead Surgeon:	
Specialty:	
Procedure name:	

For this patient I observed:

Step	✓
1 – Team Brief	☐
2 – Sign In	☐
3 – Time Out	☐
4 – Sign Out	☐
5 – Debrief	☐

1 - TEAM BRIEF

If you observed the start of the list please complete the 'Team Brief' section for the first patient on the list. If the patient is later on the list, please leave this section blank

Audit Question	Observed	Notes for Observers
Team brief was carried out?	Yes □ No □	
Introductions carried out?	Yes □ No □	
All team members present when brief starts?	Yes □ No □	Briefing is not started until all key team members are present to ensure that all types of risks and issues are discussed
All team members attentive throughout?	Yes □ No □	All team members are focused on the briefing throughout (i.e. no distractions or interruptions, no multi-tasking)
Complete briefing carried out for all patients on list?	Yes □ No □	The team brief should include discussion of the following for each patient on the list (where relevant): – Diagnosis and planned procedure. – Availability of prosthesis. – Site and side of procedure. – Infection risk, e.g. MRSA status. – Allergies. – Relevant comorbidities or complications. – Need for antibiotic prophylaxis. – Likely need for blood or blood products. – Patient positioning. – Equipment requirements and availability, including special equipment or 'extras'. – Postoperative destination for the patient, e.g. ward or critical care unit. – The expected duration of each procedure, and contingency plans if the list is expected to exceed allotted time.
Person leading the brief knows the theatre list and is able to discuss risks and issues?	Yes □ No □	Person leading the briefing MUST know the patients on the theatre list and be able to lead a team briefing about potential risks and issues
Anaesthetist and surgeon who confirmed consent with patient shortly before the procedure are present at the team brief?	Yes □ No □	
Person leading the brief invites input from all team members	Yes □ No □	The person leading the team brief encourages input from anaesthetists, theatre nurses, ODP (and other team members e.g. perfusionist, radiographer(s) and does not simply deliver a monologue outlining risks and issues relevant to their own specialty.
Junior team members speak up and actively participate in the brief?	Yes □ No □	Team members speak up and ask questions or seek clarification about potential safety or other issues, including more junior members of the team, i.e. the brief should not simply be a conversation between consultants or senior team members
Comments on Team Brief:		
Safety threats and issues identified and discussed:		

2 - SIGN IN

Notes for Observers

ALL THREE SAFETY CHECKS

- *All relevant team members are focused on the sign-in, time-out and sign out throughout (i.e. no distractions or interruptions, no multi-tasking
- **Team members are proactive in eliminating distractions and interruptions, (e.g. background noise from visitors in theatres, music etc.)
- **The team self-regulates: If team members are not focused on the safety check, another team member tells them to pay attention
- **The safety checks are used as a platform for a team conversation, not performed as a tick box exercise**
- The WHO Surgical Safety Checklist is used to prompt discussion (i.e. theatre teams are not carrying out the checks from memory without referring to the checklist)

SIGN IN

- Did the team use the consent form to confirm the consent?
- Did the team refer to the patient's wristband when checking Patient ID?
- Did the team performing the sign-in view the site mark when confirming the site marking (not just rely on a verbal confirmation from the patient or colleague)
- Side of the block (i.e. STOP BEFORE YOU BLOCK) carried out (if applicable)?

Audit Question	Observation
Patient informed/included?	Yes □ No □
Clear announcement of safety check?	Yes □ No □
***Team paying attention throughout?**	Yes □ No □
Checks omitted?	Yes □ No □
List which safety checks were omitted *(c.f relevant WHO checklist)*	
ALL relevant team members present? *(Sign in carried out by consultant anaesthetist and anaesthetic assistant for general and regional anaesthetics: Lead operator and assistant for procedures where there is no anaesthetist)*	Yes □ No □
****Distractions and interruptions?**	Yes □ No □

Describe good practice and areas for improvement identified:

Briefly describe the safety threats identified, shared and resolved:

3 - TIME OUT

Notes for Observers
ALL THREE SAFETY CHECKS • *All relevant team members are focused on the sign-in, time-out and sign out throughout (i.e. no distractions or interruptions, no multi-tasking • **Team members are proactive in eliminating distractions and interruptions, (e.g. background noise from visitors in theatres, music etc.) • **The team self-regulates: If team members are not focused on the safety check, another team member tells them to pay attention • **The safety checks are used as a platform for a team conversation, not performed as a tick box exercise** • The WHO Surgical Safety Checklist is used to prompt discussion (i.e. theatre teams are not carrying out the checks from memory without referring to the checklist) **TIME OUT** • Team members prompt visitors and new staff present to introduce themselves at the start of the time out. • Potential safety issues and anticipated risks for the patient are discussed. • Team members speak up and ask questions during the time out to clarify information. • Note the NHS England National Safety Standards for Invasive Procedures (2015) state that any team member can lead the time out. • The person leading the time out makes a clear statement inviting other team members to contribute (i.e. the time out is not simply a surgical monologue) • ~One point of vulnerability occurs when members of the theatre team who were present at the team brief change throughout the theatre list. This has contributed to wrong site and retained instrument never events. NHS England's NATSIPs state the time out must be repeated when key team members changeover.

Audit Question	Observation
Patient informed/included?	Yes ☐ No ☐
Clear announcement of safety check?	Yes ☐ No ☐
***Team paying attention throughout?**	Yes ☐ No ☐
Checks omitted?	Yes ☐ No ☐
If yes, list which safety checks were omitted *(c.f relevant WHO checklist)*	
ALL relevant team members present? *(Sign in carried out by consultant anaesthetist and anaesthetic assistant for general and regional anaesthetics: Lead operator and assistant for procedures where there is no anaesthetist)*	Yes ☐ No ☐
****Distractions and interruptions?**	Yes ☐ No ☐
~Time out repeated when shift changeovers of theatre team members occur?	Yes ☐ No ☐ N/A ☐
Surgical pause carried out?	Yes ☐ No ☐ N/A ☐
Describe good practice and areas for improvement identified:	
Briefly describe the safety threats identified, shared and resolved:	

Prosthesis

Notes for Observers
NHS England's NatSSIPs states: *i. Before removal of the prosthesis from its packaging, the operator should confirm the following prosthesis characteristics with the procedural team:* *• Type, design, style or material.* *• Size.* *• Laterality.* *• Manufacturer.* *• Expiry date.* *• Sterility.* *• Dioptre for lens implants.* *• Compatibility of multi-component prostheses.* *• Any other required characteristics.* *ii. Once the correct prosthesis has been selected, any prostheses not to be used for that patient should be clearly separated from the correct prosthesis to minimise the risk of confusion between prostheses at the time of implantation.* **CHECKING PROSTHESES** • Does the lead surgeon stop and actively engage in checking the packaging or is there a cursory check of a prosthesis or implant carried out where the surgeon carries on operating and accepts another team member's assurance that the implant is correct? • Does the circulating nurse/ODP or whoever selects the prosthesis time the check of the prosthesis so the lead surgeon can actively engage in the checking process, i.e. they don't try to hand the prosthesis to the surgeon when he/she is busy managing a complex step of the procedure? • Good checking involves the person handing the prosthesis to the lead surgeon reading out loud key information and the lead surgeon 'reading back' what has been said to them. Is read back used to confirm the size, type and laterality of the prosthesis?

Audit Question	Observation
Size, type, laterality of prosthesis read out loud by team member selecting implant	Yes ☐ No ☐ N/A ☐
Lead surgeon stops operating and checks the prosthesis	Yes ☐ No ☐ N/A ☐
Lead surgeon reads back and confirms size, type and laterality of prosthesis	Yes ☐ No ☐ N/A ☐

4 - SIGN OUT

Notes for Observers
ALL THREE SAFETY CHECKS • *All relevant team members are focused on the sign-in, time-out and sign out throughout (i.e. no distractions or interruptions, no multi-tasking • **Team members are proactive in eliminating distractions and interruptions, (e.g. background noise from visitors in theatres, music etc.) • **The team self-regulates: If team members are not focused on the safety check, another team member tells them to pay attention • **The safety checks are used as a platform for a team conversation, not performed as a tick box exercise** • The WHO Surgical Safety Checklist is used to prompt discussion (i.e. theatre teams are not carrying out the checks from memory without referring to the checklist) **SIGN OUT** • NHS England's NatSSIPs states that any member of the theatre team can lead the sign out. All team members involved in the procedure must be present for the sign out. • One of the challenges theatre teams face when carrying out the sign-out is that team members naturally start to drift off onto the next task on their to do list at the end of a case. Human factors experts call this premature exits (i.e. mentally drifting off onto the next task before the first task is completed). You should therefore be looking for active engagement in the sign-out by theatre team members who have information relevant to the sign-out safety checks. • Is there clear allocation of responsibilities when problems are identified during the sign-out? For example, who is responsible for ensuring an unlabelled specimen is labelled clearly? Who is given responsibility for ensuring safety issues specific to Patient A are documented in the notes and handed over to the team receiving the patient? Who will report incidents that occurred during the procedure on the incident reporting system?

SWAB COUNT

- Teams who are at risk of a retained swab/instrument never event drift into a practice where there is simultaneous closure of an operating site whilst the swab counts are being completed. In such teams one often observes that there is no verbal confirmation between the lead surgeon and the scrub nurse that the count is correct before the next stage of site closure is carried out.
- If the swab count is incorrect does the scrub nurse alert the consultant surgeon straight away? Sometimes theatre nurses become fixated on trying to identify missing swabs and instruments on the instrument trolley and delay communicating there is a problem to the surgical team.
- How do the rest of the team respond when they are alerted to a swab/instrument count issue by the theatre nurses? Do the surgeons stop and work as a team with the theatre nurses to resolve missing swabs/instruments? Is there pressure from other team members to get the case finished and sort the problem out later?

Audit Question	Observation
Patient informed/included?	Yes □ No □
Clear announcement of safety check?	Yes □ No □
***Team paying attention throughout?**	Yes □ No □
Checks omitted?	Yes □ No □
List which safety checks were omitted *(c.f relevant WHO checklist)*	
ALL relevant team members present? *(Sign in carried out by consultant anaesthetist and anaesthetic assistant for general and regional anaesthetics: Lead operator and assistant for procedures where there is no anaesthetist)*	Yes □ No □
****Distractions and interruptions?**	Yes □ No □
The scrub nurse and lead surgeon VERBALLY CONFIRMED the swab and instrument count?	Yes □ No □ No swabs/ instruments used □
Was this communicated to the rest of the team?	Yes □ No □ No swabs/ instruments used □
The swab and instrument count took place BEFORE site closure?	Yes □ No □ No swabs/ instruments used □
If the swab/instrument count was incorrect did the scrub nurse IMMEDIATELY inform the lead surgeon?	Yes □ No □ N/A □
When informed did the lead surgeon stop and help locate missing swabs/instruments?	Yes □ No □ N/A □
Describe good practice and areas for improvement identified:	
Briefly describe the safety threats identified, shared and resolved:	

5 - DEBRIEF

If you observed the end of the list please complete the 'Debrief' section for the last patient on the list. If the patient is later on the list, please leave this section blank

Notes for Observers

- NHS England's NATSIPS report (2015) states that the lead operator and anaesthetist, (if an anaesthetist has been involved in the procedure), must be present for the debrief. All team members involved in the procedure should also be present (Note we have interpreted this as not meaning staff whose shift ended midway during the list).
- Good debriefing involves exploration of things that went well as well as areas for improvement. All too often healthcare teams miss the opportunity to learn from things that go well because we are so focused on what went wrong.
- Do the team clearly allocate responsibilities where safety issues are identified or where something happened during the procedure that other healthcare teams caring for the patient need to know about? For example, is one team member identified who will report incidents via the incident reporting system or escalate equipment or operational problems to the relevant managers? Is there clear allocation of responsibility for documenting issues that are identified in the debrief which are relevant to the patient's on-going care in the patient's notes?
- Do all team members speak up and have the opportunity to contribute to the debrief?
- Does the person leading the debrief encourage junior members of the theatre team to contribute?
- Is the tone in which the debrief is carried out one that supports learning or is there a tone of blame throughout the debrief?
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Audit Question	Observation
Debriefing carried out?	Yes □ No □
Were things that went well discussed?	Yes □ No □
Were any problems with equipment or other issues that occurred discussed?	Yes □ No □
Were any areas for improvement discussed?	Yes □ No □
Lead operator (surgeon) and anaesthetist present?	Yes □ No □
Clear allocation of responsibility for resolving issues	Yes □ No □

Please summarise your thoughts and reflections on the debrief: