Patient Story

Author: Director of Safety and Risk Sponsor: Medical Director **Trust Board paper E**

Executive Summary

Context

1. As part of the Board's wish to regularly hear the patients' voice and really understand and learn from when things go wrong, it was agreed that the Director of Safety and Risk would bring patient stories quarterly to the Board which detailed a safety incident with the purpose of hearing and understanding the human story behind it. Today we are presenting a team staff safety story to the Board to hear how being involved in a Never Event incident has impacted on them.

2. Today we will be sharing with you a safety video made with the Interventional Radiology Team at Glenfield who were involved in 2 Never Event wrong site surgery incidents in May/June last year. The team will tell of the impact that this incident has had on them, how they have learned from this and what learning can be shared with others.

   The principal issue was the failure of staff not working as a cohesive team and lack of leadership in the procedure room when undertaking the checking processes. It also became evident that the current Standard Operating Policy did not reflect the process as worked in practice. This incident occurred at a time when the Interventional Radiology team faced severe staffing challenges.

   This safety story and incident investigation are both rich in learning points, many of which have been addressed. Following this incident, the entire patient journey is being process mapped to facilitate a review of all documentation used for both inpatients and outpatients.

Questions

1. Is the Trust seeking to hear the human staff stories behind incidents?
2. Is the Trust supporting staff that have been involved in serious incidents?
3. Is the Trust learning from when things go wrong?
4. Have sufficient actions been identified and implemented since this patient safety incident?

Conclusion

1. The full impact of a safety incident on staff is sometimes little understood by an organisation. The staff story behind it, seeks to expose the team's experience as there were two wrong site surgery Never Events in this speciality within weeks of each other.

Input Sought

Trust Board members are invited to listen to this safety story and discuss the issues raised. The Board is also asked to note the learning and actions detailed in the paper.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following governance initiatives:

Organisational Risk Register	No
Board Assurance Framework	Yes

3. Related Patient and Public Involvement actions taken, or to be taken: [Insert here]

4. Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5. Scheduled date for the next paper on this topic: Quarterly

6. Executive Summaries should not exceed 1 page. My paper does comply

7. Papers should not exceed 7 pages. My paper does comply

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

REPORT BY: **MEDICAL DIRECTOR**

DATE: **10th JANUARY 2019**

SUBJECT: **STAFF STORY FROM INVOLVEMENT IN A NEVER EVENT INCIDENT**

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1. INTRODUCTION

1.1 As part of the Board's wish to regularly hear the patients' voice and really understand and learn from when things go wrong, it was agreed that the Director of Safety and Risk would bring patient stories quarterly to the Board which detailed a safety incident with the purpose of hearing and understanding the human story behind it. Today we are presenting a staff safety story to the Board to hear how being involved in a Never Event incident has impacted on them.

2. INTERVENTIONAL RADIOLOGY TEAM STORY

2.1 Today we will be sharing with you a safety video made with the Interventional Radiology Team at Glenfield who were involved in 2 Never Event wrong site surgery incidents in May/June last year.

2.2 The team will tell of the impact that this incident has had on them, how they have learned from this and what learning can be shared with others.

2.3 A full root cause analysis investigation was undertaken for both of these serious incidents, with the Deputy Medical Director as the Chair for both of the investigations.

2.4 The principal issue was the failure of staff not working as a cohesive team and lack of leadership in the procedure room when undertaking the checking processes. It also became evident that the current Standard Operating Policy did not reflect the process as worked in practice. This incident occurred at a time when the Interventional Radiology team faced severe staffing challenges.

The root cause for this incident was identified as;

- System issues predisposing to human error

2.5 The investigation also acknowledged that the contributory factors in relation to this incident were;

- Failure to carry out the second stage of the safer surgery checklist effectively because members of staff were not all focussed on this final check because they continued to carry out other tasks.
- No clearly defined separate "stop" moment
- Lack of clarity of roles and responsibilities during the safer surgery checklist
- Extra pressure of workload due to shortage of interventional radiologists.

3. LEARNING AND ACTION POINTS

3.1 This staff story and incident investigation are both rich in learning points, many of which have been addressed. Following this incident, the entire patient journey is being process mapped to facilitate a review of all documentation used for both inpatients and outpatients.

3.2 Since this incident, the Interventional Radiology safer surgery checklist has been reviewed and revised based on Stop the Line including a multi-point check at the stop moment and the Standard Operating Procedure is been reviewed and revised based on safer surgery policy to include debriefs at the end of every list. All staff within Interventional Radiology have received Stop the line training. This will improve the consistency of practice across the three sites.

3.3 The consent process is still under review and site marking has already commenced.

3.4 In regards to learning and embedding actions, a process has been put in place in Interventional Radiology to share the learning from Never Events / Serious Incidents that occur across the Trust and there will be an evaluation of compliance with the revised safer surgery process when pathway complete.

3.5 The new NHSI Serious Incident Framework is due to be published in April 2019. It is expected that this will have a strong focus on the support of staff involved in incidents within this. The Corporate Team will be considering a Staff Liaison/Support type post as part of potential changes to the team to reflect the direction of travel proposed in the new framework.

3.6 Stop the line and LocSSIPS remains a key safety improvement priority to reduce harm and has been included in the safety plan in the Quality Commitment for 2018/19 and proposed plan for 19/20.

4. RECOMMENDATIONS

4.1 Trust Board members are invited to listen to this safety story and discuss the issues raised. The Board is also asked to note the learning and actions detailed in the paper.

Moira Durbridge,
Director of Safety and Risk
January 2019