# Patient Story – Never Event

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

# 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.

2. Today Mrs. Veronica Parsons (likes to be identified as Anne) is attending Trust Board herself to present her story. On the morning of 7 November 2018, Anne a 76 year old lady was admitted to the Emergency Department (ED) at the Leicester Royal Infirmary site of University Hospitals of Leicester (UHL) NHS Trust via ambulance following a fall on the stairs. Following initial assessment, Anne was reviewed by the Trauma and Orthopaedic Consultant in the Emergency Department and admitted under their care with a fractured left hip (neck of femur) and an open right ankle fracture dislocation. Anne was consented for left hip fracture reduction and internal fixation and washout of right ankle and fracture fixation. Anne was taken to Theatres that afternoon for the surgical procedure to be completed as an emergency.

   It was discussed during the team brief in Theatres that the ankle would be fixed first followed by the hip surgery. The right ankle was successfully fixed. The left hip surgery followed immediately afterwards. Due to a national shortage of supply from the medical equipment supplier, a decision was taken to use a longer nail but this was found to be too long and so a shorter nail was then selected. This implant was checked and approved by the Theatre Circulator and Orthopaedic Specialist Registrar rather than the operating surgeon and scrub nurse which should have been the case. The prosthesis was implanted by the Consultant Orthopaedic Surgeon.

   When it came to the point in the operation where insertion of the distal locking screw was to be undertaken, it became apparent that the curvature of the nail was bowing backwards (instead of the normal anterior curvature) and there had been a perforation of the anterior distal femoral cortex by the nail.

   After checking the implant packaging it became evident that a right side nail had been inserted into a left femur which had caused the cortical perforation. This incident has resulted in a wrong implant being inserted during the surgical procedure and this caused a perforation out of the patient's femur needing an additional metal plate insertion for stabilisation of the perforation.

## Questions

1. Is the Trust seeking to hear the human stories behind incidents?
2. Is the Trust learning when things go wrong?
3. Have sufficient actions been identified and implemented since this patient safety incident?

## Conclusion

The full impact of a safety incident on the patient is sometimes little understood by an organisation. The patient story behind it, seeks to expose the patient's and family's experience, anxieties and concerns. Following the incident, Anne who lived independently prior to her accident, had 13 weeks that she had to live without Poppy her guide dog whilst having to have carers to look after her every need.

## Input Sought

Trust Board members are invited to listen to this patient 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:** **4th APRIL 2019**

**SUBJECT:** **PATIENT STORY**

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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.

## 2. ANNE'S STORY

2.1 Today Mrs. Veronica Parsons (likes to be identified as Anne) is attending Trust Board herself to present her story. On the morning of 7 November 2018, Anne a 76 year old lady was admitted to the Emergency Department (ED) at the Leicester Royal Infirmary site of University Hospitals of Leicester (UHL) NHS Trust via ambulance following a fall on the stairs. Following initial assessment, Anne was reviewed by the Trauma and Orthopaedic Consultant in the Emergency Department and admitted under their care with a fractured left hip (neck of femur) and an open right ankle fracture dislocation. Anne was consented for left hip fracture reduction and internal fixation and washout of right ankle and fracture fixation. Anne was taken to Theatres that afternoon for the surgical procedure to be completed as an emergency.

It was discussed during the team brief in Theatres that the ankle would be fixed first followed by the hip surgery. The right ankle was successfully fixed. The left hip surgery followed immediately afterwards. It was planned to undertake a closed reduction of the fracture and internal fixation using a short intramedullary proximal femoral (hip fracture) nail. Due to a national shortage of supply from the medical equipment supplier Zimmer Biomet, a decision was taken to use a longer nail but this was found to be too long and so a shorter nail was then selected. This implant was checked and approved by the Theatre Circulator and Orthopaedic Specialist Registrar rather than the operating surgeon and scrub nurse which should have been the case. The prosthesis was implanted by the Consultant Orthopaedic Surgeon.

When it came to the point in the operation where insertion of the distal locking screw was to be undertaken, it became apparent that the curvature of the nail was bowing backwards (instead of the normal anterior curvature) and there had been a perforation of the anterior distal femoral cortex by the nail.

After checking the implant packaging it became evident that a right side nail had been inserted into a left femur which had caused the cortical perforation. Prolonged attempts were made to remove the nail and exchange it for a left nail. A second Orthopaedic Consultant was called to assist with this but it was not possible to remove the nail as the proximal femoral neck screw had become "cold welded" meaning that the nail could not be extracted. Therefore a decision was taken by the two Orthopaedic Consultants to leave the nail in place and perform a distal fixation of the lower end of the femur (thigh bone). This was done using a metal plate and locking it with screws to stabilise the perforation and prevent a fracture increasing.

This incident has resulted in a wrong implant being inserted during the surgical procedure and this caused a perforation out of the patient's femur needing an additional metal plate insertion for stabilisation of the perforation.

For Anne, this meant a prolonged period in theatre under anaesthetic and an additional metal plate insertion which is still obvious to the touch on her left leg.

2.2 Anne will tell of the impact that this incident has had on her life. Anne is registered blind and has a guide dog called Poppy (also in attendance), who lived independently prior to her accident. Anne will tell of the 13 weeks that she had to live without Poppy whilst having to have carers to look after her every need.

2.3 This incident was investigated as a Never Event within UHL, with Andrew Furlong, Medical Director as the Chair for this investigation.

2.4 The principal issue was that the theatre safety checking process failed due to a deviation from standardised checking procedures in theatres prior to implantation of the nail.

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

i. Lack of availability of the required prosthesis sizes due to an urgent medical device field safety notice from medical equipment supplier for the removal of the hip fracture nails because of complaints indicating that when the product was opened in surgery, the sterile packaging was already open.

ii. Team factors which included the check not occurring with the Scrub Practitioner or Operating Surgeon. The prosthesis packaging was opened based on the checking that had occurred by the Circulator with the Specialist Registrar. There was no pause before implant insertion. No-one in the theatre team insisted upon the correct checking process being followed.

iii. Design of Storage Environment and Packaging.

iv. Working conditions as the nurses and doctors had worked over and above their shift hours as this patient's case took longer than originally anticipated.

## 3. LEARNING AND ACTION POINTS

3.1 This patient story and incident investigation are rich in learning points, many of which have been addressed. Lessons learned from this incident are;

- The prostheses are stored on the correct shelving to prevent selecting the wrong implant.
- If the optimum prosthesis is not available or there are gaps in certain sizes of implant, senior clinicians involved in the care of the patient must consider whether it is safe to proceed with the procedure.
- It is essential that there is no deviation from the checking processes in place. These checking systems are barriers to prevent incidents occurring.
- It is important to ensure that there is an appropriate "time out moment" to pause and check with the theatre team before implant insertion.
- It is important that all theatre team members behave in a manner that supports good team working; ensuring standards of practice are maintained and encourage others to do the same.

3.2 Following this incident, refresher stop and pause training has taken place with the team involved. There is a plan to review the layout of the theatres store rooms taking into account human factors and stock return processes. There is also a plan to amend the Safer Surgery

policy to acknowledge that packaging of implants/prosthesis should not be opened prior to the stop and pause moment.

3.3 The Health Service Investigation Branch (HSIB) independent investigation into the implantation of wrong prostheses during joint replacement surgery (2018) makes the following Safety Recommendations, which are not aimed at providers but at national bodies for national solutions:

i. Recommendation 2018/001: NHS Improvement amends the national Prosthesis Verification Standard to incorporate the specific aspects of verification practice developed to mitigate error identified in this investigation.

ii. Recommendation 2018/002: The British Standards Institute amends existing standards for prosthesis labels to include details of design that make them easier to read in operating theatres.

iii. Recommendation 2018/003: The National Joint Registry changes the response when data is entered into the registry suggesting the wrong prosthesis has been implanted due to incompatible manufacturers, so that it is consistent with the response when data indicates the wrong size or side has been implanted.

iv. Recommendation 2018/004: The Department of Health and Social Care expands the remit of the working group consisting of Derby Teaching Hospitals NHS Foundation Trust's Scan4Safety Programme, the National Joint Registry, and the Medicines Healthcare products Regulatory Agency to include alerts to identify wrong prostheses prior to implantation.

v. Recommendation 2018/005: The Department of Health and Social Care commission the development and implementation of an interim basic scanning system to identify wrong prostheses prior to implantation."

3.4 Safety improvement work to try and reduce Never Events and improve learning from these remains a key priority to reduce harm and has been included in the priorities within the new Becoming the Best Strategy for 2019/20.

## 4. RECOMMENDATIONS

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

**Claire Rudkin,**
**Senior Patient Safety Manager**
**April 2019**