Paper ref:	TB (03/19) 017

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Summary Never Event Investigation Reports		
Sponsoring Executive	Dr David Carruthers, Medical Director		
Report Author	Dr David Carruthers, Medical Director		
Meeting	Trust Board	**Date**	7th March 2019

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

There have been 2 recent Never Events, one related to wrong site injection in ophthalmology (previously presented to Trust Board) and a more recent event of a retained guide wire after central line insertion in Critical Care. Neither resulted in harm to the patient. These are summarised here along with approach to learning from the events and the plans to reduce further similar events.

The Trust Board is asked to consider:

- The summary report of the investigation into the retained wire and the actions and learning from this investigation as well as the earlier wrong site injection event.

- The general learning points from the two never events and their application across the Trust

We may also discuss a prior legacy never event which did result in patient harm and the wider learning from that.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	x	Public Health Plan		People Plan & Education Plan	
Quality Plan	x	Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

Never event (wrong site injection) report to Trust Board February 2019

4. Recommendation(s)

The Trust Board is asked to:

a.	**Note** on the summary investigation report of the retained guide-wire
b.	**Discuss** the approach to the proposed general learning actions from the 2 recent never events by reference to our agreed welearn approach

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register							
Board Assurance Framework							
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 7th March 2019

Never Event investigation summary and actions

1. **Introduction**

Here we report further on the 2 recent never events, the actions taken and wider development actions that ensue from the events.

2. **Wrong site eye injection** (25th October 2018)

2.1 During an intravitreal injection list for lucentis, an elderly patient attended for injection to her Right eye. The normal checking process is a joint check by the Injector and the HCA. The process is that both go through the operating list, consent form, documentary records, positive patient ID and then mark the correct eye. Both fill their own forms.

2.2 This process was not followed. Instead, after the positive ID, the patient was asked about the side of injection. The patient had been having Left side injections for the last 12 months and was due to have a further Left eye injection in 2 weeks. Hence, she wrongly indicated to the Left eye. The electronic record and printed records showed that it was the Right eye that needed injecting for this attendance, not the Left eye as indicated by the patient and accepted to be correct by the operator.

2.3 The injection was undertaken on the left eye without complication. While completing the documentation after the injection, it was realised the incorrect eye had been injected. The patient was immediately informed and an optical check (OCT) and fundal examination were completed and patient reviewed by the Medical Retinal Lead. These assessments confirmed that no harm has been caused to the patient.

2.4 **Root cause:** failure to follow standard operating procedure

2.5 **Contributory factors:**

- There was no secondary check by the HCA with the patient record and operating list that the correct eye was being injected
- The HCA trusted the injector to be correct and was in addition not sure how to check the procedure on Medisoft.
- It was a very disrupted list with many changes and repeated interruptions
- The provision of lucentis®, on the day, for the injections is cumbersome and generates a distraction
- Near misses are not reported

2.6 **Actions taken:**

- Process changes:
    - Hard stops/challenges to be reiterated to all staff during pre-clinic huddles and QIHD meetings. Staff will always be supported when calling a hard stop
    - Implement additional signage on doors – "Injections in Progress – DO NOT DISTURB"
    - Doors to be locked internally when injection is taking place
    - Supply of lucentis® for injection lists to be reviewed
- Education changes:
    - Learning tool to be created – to ensure SOP is followed in a standard way with a requirement to follow it
    - All injection staff to have training on how to access and read Management Plan
    - Review of practice within other departments
- Monitoring
    - Review requirement for a qualified Clinic Assistant for Medisoft checking
    - Require near miss reporting and discussion at local governance meetings
    - Team brief/debrief allows reporting of procedural irregularities
    - All injectors and assistants to go through audit of practice to assure the Directorate of safe and consistent practice

3. Retained Guidewire (19th December 2018)

(full detail available within Private Trust Board Paper)

3.1 The patient required urgent central venous access for which a WHO checklist sign in was completed for a central line. The Registrar then inserted a 2nd line (Vas-cath) into the same vein. A new WHO checklist was required but not completed for this 2nd procedure.

3.2 After the procedure, the nursing staff asked if the guide-wire was removed and were informed it had been. A routine chest x-ray was then performed to check the placement of the line and it was at this point the retained guide-wire was seen. It was removed and no harm was caused to the patient.

3.3 **Root cause:** Failure to complete the WHO surgical safe checklist for the vas-cath second line insertion.

3.4 **Contributory factors:**

- Extremely busy unit
- Patient was critically unwell and needed urgent treatment
- Distraction within the clinical area at the time of the patient's procedure
- Communication within the team was sub-optimal to ensure all team members were aware of the treatment plan for the patient
- Staff leaving to attend other emergencies

3.5 **Actions:**

- Process changes:
  - Review and update CVAD insertion policy
  - High visibility reminder for guide-wire removal on the CVC insertion kit and in the Doctors' room in ITU
  - Standardising a two-person approach to visually confirm complete removal (i.e. wire fully intact) and correct disposal of the guide wire

- Educational changes:
  - Material for ITU clinicians about CVC insertion and complications (including Simulation training)
  - Same educational material for all Anaesthetists to cover other areas where this procedure is done e.g. theatre and Emergency department
  - Discuss in QIHD

3.6 **Monitoring:**
  - Weekly audit of mandatory WHO checklist compliance

4. Common themes from these never events for wider learning

4.1 **Location based processes:**
- Identify and minimise potential site/location distractions when procedures being undertaken
- Identify other areas in department and in Trust where similar risks may exist (for wrong site procedures and retained guide-wire, but also other procedures prone to error if distraction occurs)

4.2 **Training:**
- Ensure training is complete and upto date for all involved in procedures and that roles are clearly defined
- All operators to be aware of standard operating procedures for the intervention
- Support re-training or redeployment for those involved in non-compliance with SSOP

4.3 **Reporting:**
- Ensure safety checks in place – including WHO checklist, team brief and debrief
- Encourage an open culture for reporting and reviewing of non-compliance with policy
- Near miss reporting an essential

4.4 **Confirmation of Trust wide process to identify risk elsewhere:**
- Disseminate learning via EQC with requirement for each Group to report back to the following meeting with a report about:
  - procedure undertaken where wrong site or risk of retained wire identified
  - risks identified within the physical area (i.e. potential distractions)
  - are clear processes in place for procedure to be undertaken safely
  - are there any checklists used
  - is a brief/debrief undertaken where needed
  - Are near misses reported

5. For the individual clinician involved in never events, consider the degree to which procedure was not followed and where the balance lies of personal responsibility of clinician versus organisational contribution to the never event and thus actions that may be appropriate against the individual

6. Summary

6.1 The 2 recent never events are summarised here with the root cause, contributory factors and learning from those events reported. Actions have been instituted in both clinical areas where the events occurred, but the wider learning is discussed and how to ensure that other areas in the organisation are identified where similar risk may occur due to standard operating procedures/policy not being followed.

7. Recommendations

7.1 The Trust Board is asked to:

a. **Note** the circumstances that lead to the never events which include organisational and individual error
b. **Discuss** the actions already undertaken from the never events
c. **Consider** the approach to dissemination of the wider learning from these events to identify other at risk areas.

Dr DM Carruthers
Medical Director

26th February 2019