Never Say Never

ASGBI 8th May 2017

Andrew Miles
Consultant Surgeon Winchester
RCS Regional Director of Professional Affairs
“In some parts of the United States, events that are serious and largely preventable such as ‘wrong-site’ surgery have been designated ‘Never Events’, and payment withheld when they occur. The NPSA will work with stakeholders in this country to draw up its own list of ‘Never Events’.”
The original 8 never events

1. **Wrong site surgery**
2. **Retained instrument post-operation**
3. Wrong route administration of chemotherapy
4. Misplaced oro/nasogastric tube not detected prior to use
5. Inpatient suicide using non-collapsible rails
6. Escape from within the perimeter of medium or high secure mental health services by patients who are transferred from prison
7. In-hospital maternal death from post-partum haemorrhage after elective caesarean section
8. Intravenous administration of mis-selected concentrated potassium chloride
WHO surgical safety checklist

Check-in
- Correct patient & site marked
- Allergies recorded

Time-out
- Correct patient & planned procedure
- Anticipated critical events
- Antibiotics & VTE prophylaxis
- Equipment & imaging

Sign-out
- Correct swabs and instruments count
- Specimens labelled
- Specific instructions for recovery
## Never events data 2010-12

<table>
<thead>
<tr>
<th>Never Events 2010-11</th>
<th>Reported to SHA</th>
<th>Reported to NRLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong site surgery</td>
<td>60</td>
<td>19</td>
</tr>
<tr>
<td>Retained instrument</td>
<td>67</td>
<td>22</td>
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<th>Never Events 2011-12</th>
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<tbody>
<tr>
<td>Wrong site surgery</td>
<td>70</td>
<td>41</td>
</tr>
<tr>
<td>Retained foreign object</td>
<td>161</td>
<td>86</td>
</tr>
</tbody>
</table>
“Almost always avoidable with existing best practice”
The silent scandal of patient safety

“Firstly we need to foster an open and transparent culture where problems are always aired and never swept under the carpet.

“It is important to recognise that even the best motivated people do make mistakes.”
Never Events Data

- Wrong site surgery
- Wrong implant or prosthesis
- Retained foreign object
Never Events Data

- Wrong site surgery
- Wrong implant or prosthesis
- Retained foreign object
- Retained vaginal swab

Graph showing trends from 2011 to 2016.
Wrong site surgery 2016-7

April – December 2016

• 143 reports in 9 months
  • Wrong sided block (33)
  • Wrong tooth (33)
  • Wrong skin lesion (11)
  • Wrong spinal level (10)
  • Wrong eye (6)
Wrong level spinal surgery

- 35 year old morbidly obese patient with persistent thoracic back pain due to herniation of T8/9 disc on MRI
- Consented for microdiscectomy at T8/9
- Pre-operative imaging and radiology report displayed in theatre
- Fluoroscopy to count vertebral levels both up from 12th rib and down from 1st rib
- Several counts made as poor imaging quality
- Skin marker placed under fluoroscopy to confirm position of incision
- Anaesthetist asked to double check rib counting
- Uneventful operation except T7/8 disc excised
- MDT case review identified the presence of a cervical rib as a possible confusing anatomical variation
A surgeon accused of killing a patient by removing the wrong kidney was warned he was making a mistake by a medical student watching the operation, a court heard yesterday.

A medical student told a court yesterday how a surgeon accused of killing a patient by removing the wrong kidney ignored her warnings that he was making a mistake.
Flight BEA 548
Flight BEA 548

LHR - Brussels
18\textsuperscript{th} June 1972

- Fully laden then asked to accommodate a relief crew
- Overweight therefore some luggage removed
- Still overweight but by this time fuel burn off was thought to have compensated
- On the flight deck were the Captain, co-pilot and engineer plus the captain of the relief crew
Flight BEA 548

- Safe climb speed achieved and undercarriage retracted
- Autopilot engaged at 63 seconds
- At 93 seconds engine power reduced by the Captain and flaps retracted
- Visible and audible warning activated
- At 117 seconds the stick pushed forward disconnecting auto-pilot and the recovery system dropped the nose to increase speed.
- After a second and then a third warning from the stall warning system it was over-ridden
- At 129 seconds the nose was brought upwards to assume the normal climb position
- At 133 seconds it stalled and 17 seconds later hit the ground
- All 118 people on board were killed
Why?
The human factors on-board

1. Worldwide protest strike against hijackings was planned for the following day
2. British pilots had been balloted regarding the strike. Mostly senior pilots opposed it, junior pilots were in favour
3. On going dispute with BEA about pay and conditions for the SFO’s
4. Violent outburst prior to take off about the strike
5. Captain has an acute coronary event
Alarms

Turned off

• Too loud
• Frequent false alarms
• Too many alarms

Ignored

• Familiarity with the sound

Unrecognised

• Too many different alarms

Alarms and human behaviour: implications for medical alarms

Crew Resource Management

Five principles

- Communication
- Situational awareness
- Problem solving
- Decision making
- Teamwork
CRM – training video
CRM – 5 simple steps

1. Get attention – “Hey Chief”
2. State your concern – “I’m worried that we won’t make it”
3. State the problem – “We are running out of fuel”
4. State a solution – “We need to land”
5. Get agreement – “Does that sound right to you too, Boss”
Death by horsekick

Number of cavalry units with the death rate vs. Number of deaths by horsekick

Bortkewitsch L. Das Gesetz der Kleinen Zahlen. Leipzig: G. Teubner, 1898
Never events are rare random events

Tip of the iceberg

“Never events are the tip of the iceberg. The iceberg is a trust’s overall approach to safety.”

Professor Danny Keenan CQC

“Rather than focus on an arbitrary list of never events, which serve no one and distort public perceptions, the NHS would be better to focus on implementing initiatives that are proven to work to help improve patient safety”

Dr Michael Devlin MDU
NatSIPPS

Individual Patient Pathway

- Site marking and consent
- SIGN IN
- Prosthesis verification
- SIGN OUT
- Handover from procedure area
- Handover to procedure team
- TIME OUT
- Prevention of retained foreign objects
- Handover to post-procedure team

List Pathway (example with 4 patients)

- Confirm appropriate workforce
- BRIEFING
- 1
- PAUSE!
- Perform another briefing whenever the patients, order or procedures change
- 2
- 3
- 4
- DEBRIEFING
- PAUSE!
- Perform a handover whenever the team changes

Every ⚠️ is an area of particular vulnerability – the team must follow LocSSIPs to ensure patient safety

Every 🔄 should be documented

LocSSIPs compliance must be audited
The Second Victim

Doctors are the second victim

• Prevalence of second victims between 10 - 40% following a surgical error

• Become more risk averse and health or family life negatively impacted

• 9% of US surgeons reported concern that they had made a major error in the last 3 months (n=7905)

Shanafelt TD Burnout and career satisfaction among American surgeons

Wu A. Medical error: the second victim.
Surgeons personalities

Surgeons have higher levels of stress immunity (PPI-SF scores; n=172)

Pegrum J. A stressful job: are surgeons psychopaths? RCS Bulletin 97: 8,331-334
Support for surgeons

Support is not good

• Strong blame culture within NHS
• Lack of support from seniors/management
• Morbidity and mortality meetings exacerbating negative impact on surgeon

Formal mentoring needed

• No UK directive for medical directors
Summary

- All surgeons are human
- Surgical errors are inevitable
- Checklists alone are not the answer
- Individual never events are not sentinel events
- Human factors are important
- Team working is essential
Modern surgery in the NHS

- Flat Hierarchy
- No place for arrogance and disengagement
- Compassion and empathy to teams where errors have led to harm
- Never say never
With thanks

Mr Kevin Turner
Catherine Johnson
Professor Peter McCulloch
Capt Brian Doran
Michelle Smith