Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 November 2020
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Thematic Review of Never Events During COVID-19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sian Passey, Assistant Director of Nursing , Quality, Assurance, Safeguarding and Professional Regulation Cathie Steele, Head of Quality and Governance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Since April 2020, the Health Board has reported to Welsh Government 5 never events.

The purpose of this report is to provide the Quality, Safety and Experience Assurance Committee with an overview of the incidents, the learning identified through Root Cause Analysis (RCA) review and themes arising throughout the incidents

Cefndir / Background

"Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers." (NHS Improvement, 2018). The current Never Event List can be found at https://improvement.nhs.uk/resources/neverevents-policy-and-framework/

The full list of Never Events has 16 categories that include wrong site surgery, retained foreign object post procedure, misplaced nasogastric or orogastric tubes and administration of medication by the wrong route. The framework provides a definition for each category and examples of incidents that should be reported.

Within NHS England, regular reports are published which provide a summary of Never Events. The latest report was published on 8th October 2020 and included data between 1st April 2020 and 31st August 2020 (the report can be found at https://www.england.nhs.uk/wp-content/uploads/2020/10/Provisional-publication-NE-1-April-31-August-2020.pdf). Wrong site surgery (37%) and retained foreign object post procedure (24%) were the highest reported Never Events during the period of the report.

Asesiad / Assessment

In 2020/21, the Health Board has seen a rise in the number of never events. 5 never events have been reported to Welsh Government between 1st April 2020 and 30th September 2020.

Financial Year	Category	Reported	Total
2017/18	Wrong site surgery	1	2
	Wrong implant/prosthesis	1	
2018/19	Retained foreign object post procedure	1	2
	Administration of medication by the wrong route	1	
2019/20	Wrong site surgery	1	1
2020/21	Retained foreign object post procedure	2	5
	Wrong site surgery	3	

Whilst incident data is submitted to the National Reporting and Learning System (NRLS) from Hywel Dda University Health Board (HDdUHB) and other LHBs and Trusts in Wales, the reports published by NHS England do not include Welsh data. Therefore, it is difficult to compare the Health Board position with other organisations and confirm whether other organisations across Wales have seen a similar rise during the pandemic. The Director of Nursing, Quality and Patient Experience, the Medical Director and relevant members of their teams have recently met with the Delivery Unit Quality and Safety Team as part of their regular quarterly meetings. The Delivery Unit has agreed to review the number of Never Events reported during the COVID-19 pandemic and provide feedback to the Health Board. This information is currently awaited.

RCA Review

A full RCA review has been undertaken for each of the Never Event incidents. A Control Group has also been established for each incident. The RCA report has been finalised in 4 of the 5 cases and closure forms submitted to Welsh Government (WG). An Improvement and Learning Action Plan has been developed for each incident.

The one incident (incident 5 - retained foreign object post procedure) that remains open is due for closure with the Delivery Unit (who have now taken the responsibility for Serious Incidents from WG) on 7th December 2020. The draft RCA report has been received by the Control Group who have provided comment. The Improvement and Learning Action Plan is being developed.

Retained foreign object post procedure (incident 1)

The review identified that there was non-adherence to best practice and Health Board guidelines to ensure that the swab count was correct prior to and following the procedure. Several contributory factors were identified, however none of these related to the pandemic.

The Directorate has developed and fully implemented an improvement and learning action plan to address the findings and recommendations of the RCA review.

Wrong site surgery (incident 2)

The review concluded that the Safety Standards for Patients undergoing Invasive Procedures within Radiology Departments – Local Safety Standard for Invasive Procedure (LOCSSIP) did not include computerised tomography (CT) guided biopsy or chest drain insertion and had not been through a formal consultation and approval process.

There was no documented evidence that the World Health Organisation (WHO) Surgical Safety checklist for Radiological Interventions was followed; this resulted in confusion over the

appropriate side of the pneumothorax, particularly as patients are placed prone (facing downwards) for the biopsy and are supine (facing upwards) during recovery.

The delivery of the service had changed in respect of guidance in relation to COVID-19, with new systems and processes implemented rapidly which staff were unfamiliar with, thus allowing room for error.

Wrong site surgery (incident 3)
The review concluded that there was non-adherence to Health Board policies and national guidelines (WHO safety check list and Stop Before You Block (SBYB) process) due to human error contributed to by a change in operating theatre processes. The newly introduced changes in theatre processes were due to the COVID-19 pandemic and infection control measures related to aerosol generating procedures (AGPs) in Orthopaedic surgery.

The Directorate developed an improvement and learning action plan to address the findings and recommendations of the RCA review. However, this had not been fully implemented before incident 4 occurred.

Wrong site surgery (incident 4)
The review concluded that the Anaesthetist and Operating Department Practitioner (ODP) did not follow the correct process in relation to the SBYB checklist. There is a collective responsibility for SBYB which is an additional step in the WHO checklist, to do further checks when blocks are required and provides a moment to stop, to review, and confirm the appropriate side and site of the intended block. Specifically, the team did not visualise the marking arrow or double check the consent form together in the formal Health Board (HB) process. The patient was asked to confirm the site of her hip pain by the Anaesthetist, however there were some conflicting accounts in relation to the patient's ability to understand at this stage.

The Anaesthetist involved was not aware of the recent previous incident and the ODP was vaguely aware that there had been a previous incident but could not recall any of the details. The Directorate developed an improvement and learning action plan to address the findings and recommendations of the RCA review (and also incident 3). The improvement and learning action plan has been fully implemented.

COVID-19 Pandemic Related Themes Identified
COVID-19 pandemic related contributory factors were identified in 3 of the 4 incidents that have been fully reviewed.

In relation to incidents 3 and 4, the NICE COVID-19 guidance related to the operating theatres recommends that when AGPs are required (such as induction and extubation) patients should be placed directly in the theatres and should be anaesthetised and recovered in the theatre with minimum staff present. The staff should wear personal protective equipment (PPE) such as FFP3 respirators, disposable fluid repellent coveralls or long sleeved gowns, gloves and eye protection.

In the Anaesthetic Rooms there is a visual reminder to SBYB. The usual prompts were not visual in the operating theatre which is now acting as the Anaesthetic Room during COVID-19 pandemic.

The use of full PPE in incident 3 also contributed to distraction, a lack of attention to detail and staff fatigue. The incident review concluded the Anesthetist and ODP were balancing the change in environment, the change of process and the need for full PPE which divided their attention and concentration. Between patients, there was a need to change PPE requiring concentration for the new "donning" and "doffing" process. The practitioners involved

recognised that there was a lack of concentration which contributed to the incident. There was also an associated fatigue when wearing the PPE and a lead coat (required for orthopaedic surgery) for prolonged periods. The Health Service Investigation Branch (HSIB) report *Covid-19 Transmissions in Hospital*, published on 29th October 2020, recognised that staff fatigue and building design impacted on activity during the pandemic.

In both incident 3 and 4, the impact that full PPE has on communication has been recognised as a contributory factor. The obstacle to communication that face masks create for people (including healthcare workers and patients) who are deaf or have hearing loss, and how frightening it can be to be cared for by people in PPE, has been recognised. The Anaesthetists in both incidents found it difficult at times to hear and communicate with the FFP3 mask on.

Similarly, in incident 2, the use of PPE and changes to the department in response to the COVID-19 pandemic were contributory factors. There was ineffective communication flow between staff, with handover delayed due to infection control measures. In addition, the use of PPE such as masks and visors inhibited communication.

Sharing of Learning

Incident 1, 2 and 3 have been presented to the Listening and Learning Sub-Committee; the reports included the improvement and learning action plans and, for incident 3, the seven minute briefing that was circulated within Theatres and Anaesthetic Services.

Following the previous QSEAC meeting on 4th October 2020, the Triumvirates were asked to include a report on the never event within their exception reports to the Operational Quality, Safety and Experience Sub Committee (OQSESC) in order that learning could be shared with other Directorates in the Health Board.

Improvement and Learning Action Plans – Assurance

The Quality Assurance and Safety team have recently implemented a new process to gain assurance that previously agreed improvement and learning plans have been fully implemented. An audit of improvement and learning plans is underway.

As previously reported, in relation to 4 of the 5 never events, the Directorates have fully implemented the improvement and learning actions plans. The Quality Assurance and Safety team will undertake additional checks to ensure that the actions are still in place 4 to 6 months after the completion date provided.

Argymhelliad / Recommendation

The Quality, Safety and Experience Assurance Committee (QSEAC) is asked to note the report and receive assurance that action has been taken to address the issues identified during the RCA reviews of the never events.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**		
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	4.1	Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks are identified at service level and monitored through service risk registers and escalated to corporate risk register through governance
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:** **Cyfreithiol / Legal:** **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	Contained within the report.