Plymouth Hospitals NHS
NHS Trust

Report for:	Plymouth Health and Adults Overview and Scrutiny Committee
Report Topic:	Never Event Update Report
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1. Background

The Plymouth Health and Adults Overview and Scrutiny Committee (POSC) last received a report on Never Events from Plymouth Hospitals NHS Trust (PHNT) in July 2011.

Since July 2011, PHNT has reported 3 Never Events as below:

Incident Category	Reported Date	Investigation Status
Retained foreign object post procedure	28.09.2012	Ongoing
Wrong site surgery	25.07.2012	Complete
Maladministration of insulin	26.09.2012	Ongoing

The above incidents were escalated as 'Never Events' to NHS Plymouth and the South of England Strategic Health Authority (SWSHA) at the earliest opportunity. All patients and families affected have received a full apology from the Trust.

Where a serious incident (including Never Events) has occurred, a full investigation is conducted to identify all immediate actions required to ensure ongoing safety and potential learning opportunities. Patients and families are asked to participate in this process and will often contribute to the investigation and design of solutions to prevent future incidents. Every never event has an associated safety improvement programme.

The prompt escalation and reporting of these incidents is a good indicator of a strong safety culture at PHNT - we actively encourage all of our staff and patients to report areas of concern because all of these incidents will provide learning so we can continue to improve the safety we provide to patients.

2. Never Event Summary:

Incident Summary:

Retained foreign object post procedure. The patient has received a full apology from the Consultant Surgeon.

Investigation Summary:

The investigation is ongoing at this time and is being led by a senior clinical investigator.

Immediate Actions Taken:

The following actions have already been implemented. Further actions will be added once the investigation is complete.

- Immediate changes to practice implemented within operating theatres to ensure all surgeons and theatre teams are aware of the incident and of the associated risks
- Gall bladder collection bags to be included in the swab count with immediate effect

3. Never Event Summary:

Incident Summary:

Wrong site surgery.

Investigation Summary

The investigation) is complete and has been approved by the South of England Strategic Health Authority.

Immediate Actions Taken:

The following actions have already been implemented.

- Immediate changes to practice implemented within operating theatres to ensure all surgeons and theatre teams are aware of the incident and of the associated risks.
- Immediate changes to practice to ensure that all procedures (excepting specified exclusions) are appropriately marked and that appropriate checks are in place to confirm this.

4. Never Event Summary:

Incident Summary:

Maladministration of insulin.

Investigation Summary

The investigation of this adverse event (Never Event) is being led by a senior clinician and is ongoing at this time.

Immediate Actions Taken:

The following actions have already been implemented. Further actions will be added once the investigation is complete.

- Immediate changes to practice implemented within Emergency Department (ED) to ensure verbal instructions for administration of medicines are not in use – NMC Guidelines reiterated
- Inpatient Diabetes Team have provided immediate support to ED and further education sessions have been booked
- All medical and nursing staff within ED to complete NHS Diabetes Safe Use of Insulin E-learning package
- Apology and explanation given to patient's family and followed up in writing on 28th September 2012
- Insulin e-learning package developed to educate all clinical staff on issues arising from this adverse event

5. Improvement Plans

The investigation and subsequent learning for each Never Event has been incorporated into Trust-wide Patient Safety Improvement Programmes. The Trust has established a Surgical Safety Improvement Programme (led by the Assistant Medical Director) and a Safe Use of Insulin Improvement Programme (led by the Clinical Director for Medicine) to ensure that the recommendations and actions identified through investigation are monitored until point of completion.

The Trust's Safe Care Group (chaired by the Medical Director) currently monitors these improvement programmes on a monthly basis. A monthly report is also provided to the Trust's Safety and Quality Committee and further updates are provided to the Trust Board on a regular basis (last update 9th November 2012).

6. Surgical Safety Checklist Update

PHNT recognises that two of the aforementioned Never Events occurred in a surgical setting and may appear to relate to previously reported incidents. Investigation has identified that the two recent surgical Never Events were not attributable to poor compliance with the Surgical Safety Checklist.

PHNT continues to perform the Surgical Safety Checklist to a very high standard and collects a combination of qualitative and quantitative data to support this and continue to drive improvement. Learning identified by PHNT in this domain has been shared regionally and nationally. The Trust was recently 'highly commended' in the National Patient Safety Awards 2012 for this work.