Learning from Mistakes

Spring Educators Conference
May 2016
Fiona Crosfill
We’ve all been there.............
The more I practice, the luckier I get

- https://www.youtube.com/watch?v=t0GESlaVNdE 26
- https://www.youtube.com/watch?v=RGHoQfSjsXY 21

Practice Makes Perfect?
Recognising Mistakes
Mistake occurs

Mistake Recognised

Reporting process

Moderate or Serious?

Rapid review

Likely hospital induced harm?

Duty of Candour

Improved performance

Actions

Analysis

Improved performance
Reporting Incidents

Datix®

Please choose one of the following options

- Incident Reporting - IRM for...
- Coming Soon
  - April 2016
- Risk Register
- Inquests
- Information

Trigger List
<table>
<thead>
<tr>
<th>Low Harm</th>
<th>Moderate Harm</th>
<th>Severe Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential harm incident, inconvenience to patient</td>
<td>Unexpected additional treatment or longer hospital stay</td>
<td>Significant event requiring investigation in all cases</td>
</tr>
<tr>
<td>Blood sample mislabelled</td>
<td>Extended hospital stay due to operative complications</td>
<td>Unexpected death</td>
</tr>
<tr>
<td>Cancer operation</td>
<td>Hospital acquired infection</td>
<td>Unexpected admission to critical care</td>
</tr>
<tr>
<td>Medication error</td>
<td>Hospital acquired pressure sores</td>
<td>Never events</td>
</tr>
</tbody>
</table>

Rapid Review

Usually closed by area manager following brief investigation
# Rapid Review form

## Rapid Incident Review Report – Part 1

### Confidential

<table>
<thead>
<tr>
<th>Division</th>
<th>Specialty</th>
</tr>
</thead>
</table>

#### Date of review:

- **Review team (name/designation):**
  1. Senior Consultant
  2. Senior Anaesthetist/Health professional
  3. Clinical Governance team member
  4. Other (if required)

#### Patient Information

<table>
<thead>
<tr>
<th>Patient's last name:</th>
<th>D.O.B.</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First names:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nilt No:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Date of admission:**
- **Reason for admission:**

#### Incident Information

<table>
<thead>
<tr>
<th>Date of incident:</th>
<th>Time of incident:</th>
</tr>
</thead>
</table>

- **Exact location:**
- **Details of the incident:**

Provide detail of the consequence and outcome for the patient:

<table>
<thead>
<tr>
<th>6 Was there evidence of a lack of regular review by nursing staff?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes - what were the circumstances and what was the impact on the patient’s outcome?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7 Was there evidence that key policies/procedures or treatment protocols were not followed?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes - please give details and what was the impact on the patient’s outcome?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8 Is there evidence of harm caused by hospital acquired infection?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Is there evidence of harm caused by hospital acquired pressure ulcer?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>10 Is there evidence of harm caused by procedural error?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11 Is there evidence of harm caused by medication error?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12 Is there evidence of harm caused by staff fail?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Preventability of Incident (Check appropriate box)

- **Definitely not preventable**
- **Possibly preventable (but unlikely)**
- **Probably preventable**
- **Definitely preventable**

#### Patient Outcome & Summary

Please evaluate the care provided and whether the patient’s outcome has been affected by the incident? (e.g. additional treatment, return to theatre, long term disability, prolonged length of stay).

- **No substandard care, no effect on outcome**
- **Substandard care, but would not have affected outcome**
- **Substandard care, might have affected outcome**
- **Substandard care, would reasonably be expected to have affected outcome:**

*If the responses above are 3 or 4 and there is evidence that an error has or may have occurred by an act or omission CONSIDER THE APPLICATION OF THE DUTY OF CANDOUR.*
Serious incident investigation

Rapid review → Statements requested → MDT meeting → Draft report written → Investigation team meeting → Report completed → Feedback to Patient

Small MDT group to decide actions and recommendations, responsible parties and timelines

Levels of hospital caused harm
1: No substandard care
2: There are deficiencies in care unlikely to have affected the outcome
3: Deficiencies in care which may have affected the outcome
4: Deficiencies in care which are more likely than not to have affected outcome

Estimates likely hospital induced harm – level 1, 2, 3 or 4

All involved parties and investigation team, agree chronology, reconcile statements
Learning Lessons – Individuals

- All medical trainees involved in serious incidents should be recording this for revalidation
- Supervisors should escalate concerns not easily resolved locally
Fetal observations that should be carried out during induction prior to the establishment of labour
Observations should be documented in the maternal records

- Prior to Prostaglandin administration - Continuous electronic fetal heart monitoring should be performed no more than two hours prior to Prostaglandin administration, to confirm a normal fetal heart pattern.
- Following Prostaglandin administration - Continuous electronic fetal monitoring should be performed for a minimum of 20 minutes as soon as possible after administration
- Review minimum of six-hourly
- Following amniotomy - auscultate fetal heart; if normal, Intermittent auscultation minimum of hourly until regular contractions occur. If not normal, Continuous electronic fetal heart monitoring is indicated
- After commencement of Oxytocin - Continuous electronic fetal monitoring is indicated

<table>
<thead>
<tr>
<th>No pain</th>
<th>Any pain (including back ache, period type pain, tightenings) OR evidence of contractions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent Auscultation, minimum of 6 hourly unless there are clear indications for continuous electronic fetal monitoring, as described in the Fetal heart monitoring in labour guideline</td>
<td>Confirm fetal wellbeing with continuous electronic fetal monitoring for a minimum of 20 minutes, in accordance with the CEFM in labour guideline. If normal, can discontinue.</td>
</tr>
<tr>
<td>If pain becomes moderate or woman requires pain relief follow ‘Any pain’ pathway.</td>
<td>Intermittent auscultation minimum of hourly as long as pain/contractions continues unless there are clear indications for continuous electronic fetal monitoring, as described in the Fetal heart monitoring in labour guideline. Assess need for Vaginal examination and enquire about fetal movements.</td>
</tr>
</tbody>
</table>

If woman is distressed, pain is increasing or requires further oral analgesia, transfer to Delivery Suite.
# Mandatory Training – skills drills

<table>
<thead>
<tr>
<th>Time</th>
<th>Programme</th>
<th>Format</th>
<th>Trainer/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.30</td>
<td><strong>Venue: Seminar 7 Ed centre 1</strong></td>
<td><strong>Coffee and registration</strong></td>
<td></td>
</tr>
<tr>
<td>08.45</td>
<td>Perinatal Mental Health update</td>
<td>Lecture</td>
<td>Sue Rowlands</td>
</tr>
<tr>
<td>09.45</td>
<td>CTG update</td>
<td>Lecture</td>
<td>Angela McKee</td>
</tr>
<tr>
<td>10.15</td>
<td>Shoulder Dystocia</td>
<td>Lecture</td>
<td>Dr Grossmith</td>
</tr>
<tr>
<td>10.45</td>
<td><strong>Coffee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.00</td>
<td>Neonatal Resuscitation Update</td>
<td>Lecture and Drill</td>
<td>Lynne Walker</td>
</tr>
<tr>
<td>11.30</td>
<td>Vaginal Breech Birth</td>
<td>Lecture</td>
<td>Emma Ashton</td>
</tr>
<tr>
<td>12.00</td>
<td>Normal Birth update</td>
<td>Lecture</td>
<td>Emma Ashton</td>
</tr>
<tr>
<td>12.30</td>
<td><strong>Lunch</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.15</td>
<td>Eclampsia</td>
<td>Lecture</td>
<td>Dr Shuheibar</td>
</tr>
<tr>
<td>13.45</td>
<td>The Management of Neonatal IV antibiotics on the postnatal ward</td>
<td>Lecture</td>
<td>Sharon Roden</td>
</tr>
</tbody>
</table>

**Transfer to Delivery Suite**

Each Team moves around each of the workshops as per times on the programme.

<table>
<thead>
<tr>
<th>Team 1</th>
<th>Team 2</th>
<th>Team 3</th>
<th>Team 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.30-14.50</td>
<td>Shoulder Dystocia</td>
<td>Vaginal Breech</td>
<td>Massive Obstetric Haemorrhage-Neonatal Resuscitation-</td>
</tr>
<tr>
<td></td>
<td>Dr Grossmith</td>
<td>Emma Ashton</td>
<td>Dr Shuheibar</td>
</tr>
<tr>
<td>14.50-</td>
<td>Vaginal Breech</td>
<td>Shoulder Dystocia</td>
<td>Neonatal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Masssive Obstetric</td>
</tr>
</tbody>
</table>
Learning Lessons: Noticeboard
Our lessons of the week
for week commencing 25 April 2016

- **Fetal monitoring** - please ensure you obtain a quality trace that can be interpreted. In a recent HLI, the quality of the monitoring was poor and appropriate actions were not taken following an abnormal trace. If you have concerns about the fetal heart and are not able to monitor adequately, this should be escalated to a coordinator or medical staff without delay.

- When a woman is admitted, her hospital records must be obtained and reviewed and any relevant documentation completed.

- It is a requirement that a shoulder dystocia checklist is completed for babies being discharged home following shoulder dystocia.
Learning Lessons: Quarterly Newsletter

The most recent MBRRACE-UK confidential enquiry report into maternal deaths was launched on the 8th December 2015. The report presents the findings of maternal mortality surveillance 2011 to 2013 in the UK and the lessons learned from the confidential enquiries into maternal deaths of women with mental health related problems, substance misuse, cancer and blood clots and women who died by homicide.

Overall the maternal mortality rate in the UK continues to fall largely as a result of a reduction in deaths from 'direct' pregnancy causes. However, the rate of deaths from 'indirect' causes has not reduced significantly; these are deaths from conditions not directly due to pregnancy but existing conditions which are exacerbated by pregnancy, for example, women with heart problems. More of these deaths will need to be prevented in the future to reach the UK Government aspiration of a 50% reduction in maternal deaths by 2030.

The care of more than 100 women who died by suicide during pregnancy or in the year after giving birth between 2009 and 2013 was reviewed in detail. One in eleven of the women who died during or up to six weeks after pregnancy died from mental health-related causes. However, almost a quarter of all maternal deaths between six weeks and a year after birth are related to mental health problems, and one in seven of the women who died in this period died by suicide. Although severe maternal mental illness is uncommon, it can develop very quickly in women after birth and the woman, her family and mainstream mental health services may not recognise this or move fast enough to take action.

The care for women with substance misuse problems and those living socially complex lives was also reviewed with messages for future care echoing those for women with mental health problems and the need for joined-up multi-agency care to ensure that these women do not fall through the cracks between services. The report also contains messages for the future care of women with cancer and those at risk of blood clots, which is the primary cause of ‘direct’ maternal deaths.

Clear pointers for improving services and care by individual practitioners were identified and these are dis-
Teaching events

Following admission of patient with ketoacidosis in labour

Following long complaint about post-natal care and audit of debrief process

Why Does Diabetes Make Pregnancy Difficult?

Study day March 4th 2013

Case review, workshop on hand-over and induction process
Patient Experience Videos

- [https://www.youtube.com/watch?v=sCDR3LZbbyw](https://www.youtube.com/watch?v=sCDR3LZbbyw)
External Review

Cluster of Incidents, one serious incident

- Review own processes and actions
- Request external review of processes
- Perform internal review
- Improve process, follow recommendations
- Request external review of processes
Don’t Forget:

• Review action plans at each CG meeting
• Close actions when complete – may need to feed this back to patient
• Feedback to Trust Clinical Governance Group

Thank you