The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	20 May 2013
Title:	Update on the last two 'never events' reported in March and April 2013.
Executive Summary:	Provide the Board with a review of the last two never events
Action Requested:	To review
Report of:	Ms Cheryl Etches, Chief Nursing Officer
Author: **Contact Details:**	Ms Charlotte Hall Deputy Chief Nurse Tel 01902 695962 Email charlotte.hall6@nhs.net
Resource Implications:	Each never event incurs penalties
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	CQC, NHSLA
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details

1	The Trust maintains a clear overview of reported 'never events' that details the summary of never events reported since May 2011 and this is referred to and reviewed regularly by the chief nurse, attached. It is clear there have been improvements in the incidence of never events; **2011/12: 10 never events reported** **2012/13: 3 never events reported** **2013/14 1 never event to date** This paper summarises the last two never events reported using the Department of Health Guidance 'List of never events' 2012/13 '.

2	**March 2013 - Retained foreign object**. The patient attended for a routine outpatient appointment on 1 March 2013 and a planned CT scan of the kidney was undertaken which was reviewed and formally reported on 19 March 2013. The report, in conjunction with the patient's medical records was reviewed on 28 March 2013; this is when the incident was detected. The 48 hour report indicates there may have been a failure of the management plan to remove the drain in 2010 and this is part of the full root cause analysis to be completed by 26 June and with the investigating officers within the surgical division. However the patient has been reviewed by a consultant urologist and consultant surgeon in the Trust and underwent further surgery 29 April. Where the drain was found to have slid out easily, there was no indication of fluid collection or infection. An incisional hernia was also repaired simultaneously and the patient will be reviewed again in four weeks' time. The full root cause analysis will be completed and submitted as per process through the division within the appropriate time scales.
3	**April 2013 - Retained foreign object:** On 16 April 2013 at 06.43, a patient delivered a baby in the delivery suite by Ventouse extraction. The lady required suturing post-delivery and this was undertaken by the SpR assisted by the midwife who had cared for the patient during her labour. When suturing, the SpR inserted a tampon which was apparently accounted for at the swab count. Later at 02.30 in the early hours of the following day (17 April) the patient passed the tampon when urinating and this was witnessed by the midwife on the ward. The full root cause analysis is currently underway however from the 48 hour investigation undertaken by the deputy chief nurse and consultant obstetrician it is apparent that there were a number of failures in adherence to policy including; inaccurate swab count following completion of the suturing procedure and no use of the white boards for recording what swabs, tampon and needles have been used.

Royal Wolverhampton NHS Trust Never Event Timeline May 2011 - May 2013

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		Description of Event/events	Date of event	Reported as incident/SUI	Date reported as NE	RCA commenced	RCA Completed	Incident formally closed
1	May-11	• **Retained Foreign Object** –A gauze swab was applied to a vaginal wall tear following normal delivery and not noted and therefore was not removed. The patient reported the swab coming away the next morning when she visited the toilet.	• 11 May 2011	11-May-11	19-May-11	25-May-11	28-Jun-11	14-Dec-11
2	Jun-11	•**Wrong site surgery/Misidentification of patients** – Two female patients with the same surname attended a dermatology department at the same time, the wrong patient was called in by the doctor who performed a skin biopsy leading to the wrong surgery being performed. Following the procedure the doctor noted the mistake.	• 13 June 2011	16-Jun-11	22-Jun-11	29-Jun-11	16-Jan-12	27-Mar-12
3	Jun-11	**Wrong Gas Administered**. A patient with pre-existing cardio respiratory disease was admitted with central cord syndrome following a fall, and required the administration of oxygen via nasal cannulae to maintain their saturations. It was thought that a bed with piped oxygen supply was not available on the admitting ward. The cylinder therefore being used to administer oxygen to the patient ran out overnight, and the patient was discovered unresponsive with oxygen saturations of 79%. The empty cylinder was discovered when a rebreathe bag was attached to it. The patient suffered a cardio respiratory arrest and consequently died.	26-Jun-11	26-Jun-11	01-Jul-11	04-Jul-11	31-Aug-11	25-Jan-12
4	Jul-11	**The maladministration of insulin -** A patient initially admitted for surgery suffered a stroke during the operation and was eventually transferred to West Park Hospital for rehabilitation. During this transfer communication re their diabetic management was successful. A subsequent readmission to New Cross, and eventual transfer back to WPRH saw a failure in the handing over of the diabetes due to the use of use a different medication chart. This resulted in the patient not receiving insulin for 13 days. The patient became unwell and required additional treatment to overcome the effects of insulin omission. The family complained that the patients deteriorating condition was not acted on without their prompting. At this point the omission of insulin was highlighted as a serious event and fulfilled the categorisation of a Never Event.	30-Jul-11	15-Aug-11	21-Oct-11	Initial RCA: 16.08.11 Second RCA commenced: 21.10.11	10-Feb-12	Aug-12
5	Aug-11	**Retained Foreign Object** – A Lahey swab was left in during a VATs procedure for the excision of a biopsy from a mediastinal mass. The scrub nurse noted the error in the swab count but the surgeon could not see the swab either via the internal camera equipment in use for the procedure or on a requested X-Ray. The patient was x-rayed on the table but the surgeon could not see the swab on the x ray. At a later date a radiologist examining the same x-ray identified the swab. The swab was removed in theatre to where the patient coincidentally had to return to have a further biopsy	12-Aug-11	12-Aug-11	25-Aug-11	24-Aug-11	04-Oct-11	27-Jan-12
6	Oct-11	**The inappropriate administration of daily oral methotrexate -** An elderly patient received 3 days of methotrexate instead of one tablet a week. The doctor had re prescribed medications onto a new chart and mistakenly written daily as opposed to weekly. The patient received no permanent harm as a result of the incident.	15-Oct-11	17-Oct-11	27-Oct-11	30-Nov-11	21-Dec-11	Jul-12
	Nov-11							
	Dec-11							
7	Jan-12	**Retained Foreign Object -** A Patient went to the operating theatre for a subtotal hysterectomy and peritoneal washings. Bleeding was excessive and a swab was retained in the abdomen, which was noted in the recovery area during a "peace of mind " count. An xray confirmed this and the patient was immediately returned to theatre and the swab removed. It is suspected that an abdominal Robinson drain became damaged during this second operation, and a length of it was retained in the abdomen following post-operative drain removal on the ward. The retained length was not noted a week post operatively on an abdominal x-ray, this was performed when the patient became unwell with abdominal distension, and as the patients clinical condition was improving they were discharged home, only to be readmitted 8 days later via A & E in a state of collapse. A CT scan identified the retained drain and the patient returned to theatre for its removal, the draining of a pelvic abscess and end colostomy fashioning.	03-Jan-12	03-Jan-12	04-Jan-12	unable to clarify date RCA commenced	30-Apr-12	Jul-12
8	Feb-12	**Retained Foreign Object -** A vaginal pack was left in situ following discharge. The patient returned to the ward and it was removed. No harm resulted	19-Feb-12	19-Feb-12	20-Feb-12	27-Feb-12	03-Jul-12	Aug-12
9	Feb-12	**Retained Foreign Object -** Retention of guide wire following Seldinger chest drain insertion• Patient was admitted on 03/04/2012 for removal of retained guide wire left insitu following Seldinger chest drain insertion on 10/02/2012 – the wire was noted insitu on CXR taken in out patients on 20/03/2012. The incident was not reported at that time. However the patient was informed of chest x-ray findings immediately during outpatient appointment on 20/03/2012 by Consultant Surgeon and advised of treatment plan. • Patient was listed for theatre and wire was safely removed on 04/04/2012, he was discharged home on 05/04/2012. • Ward manager escalated to matron on 05/04/2012 her concern as to the retention of a guide wire being possible never event. Matron immediately escalated incident and completed Datix report. • Retention of guide wire was not identified on chest x-rays taken immediately following chest drain insertion and post drain removal. • Failure to identify incident as a Never Event during the admission process, OPD, Pre-assessment • Failure to complete Datix incident report once retention of guide wire identified. • Standard procedures (chest x-ray) followed regarding chest drain insertion and removal – failure to identify retained wire.	10-Feb-12	05-Apr-12	05-Apr-12	06-Apr-12	01-Jun-12	Sep-12
10	Mar-12	**Wrong site surgery (tooth extraction) -** The patient was admitted for tooth extraction at the Phoenix Health Centre prior to orthodontic intervention. The Dentist extracted upper 3 instead of upper C. Reported in April	07-Mar-12	16-Mar-12	15-Mar-12	23-Apr-12	15-May-12	Aug-12
	Apr-12							
11	May-12	**Retained Foreign Object –** The patient had a Ventouse extraction in delivery suite. The lady required sutures post-delivery during both procedures a number of swabs may have been used from both the delivery pack and the suture pack and a swab was left in situ mistakenly.	28-Apr-12	03-May-12	04-May-12	04-May-12	08-Jun-12	Aug-12
	Jun-12							
	Jul-12							
	Aug-12							
	Sep-12							
	Oct-12							
12	Nov-12	**Retained Foreign Object**. A patient had a cytoscopy performed in July 2012. At the subsequent OPD on 12 Nov 2012 patient complained of a lump sensation 'down below' and on examination by consultant was found to have a vaginal swab in situ. Patient confirmed this had been inserted at cystoscopy.	12-Nov-12	12-Nov-12	12-Nov-12	13-Nov-12	Draft report 16.1.13	Feb-13
	Dec-12							
	Jan-13							
	Feb-13							
13	Mar-13	**Retained foreign object** drain left in from Sept 2010 procedure. Mr Cook/Mrs Elgadel to operate w/c 29.4.13	Sep-10	28-Mar-13	28-Mar-13	29-Mar-13	Due 17 May 2013	Due 26 June 2013
14	Apr-13	**Retained foreign object:** Ventouse delivery Tampon left in	16-Apr-13	17-Apr-13	19-Apr-13	19-Apr		Due 16 July 2013
	May-13							