The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	27 January 2014
Title:	Never Events Update
Executive Summary:	The last Never Event occurred in September 2013. This paper provides an overview of the Never Events reported at RWT since April 2009 and also work that has been undertaken in the last two months to mitigate further recurrence in obstetrics and gynaecology
Action Requested:	For the Board to receive assurance
Report of:	Cheryl Etches, Chief Nursing Officer
Author: **Contact Details:**	Charlotte Hall, Deputy Chief Nursing Officer
Resource Implications:	None
Public or Private: **(with reasons if private)**	Public
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	CQC Registration Monitor Governance Framework Never Events DoH 2011/12
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

1. Background Details

Never events were first introduced to the NHS in 2009 and are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There have been three national iterations of the never event list which was last updated in January 2012 and contains 25 categories.

The implications of a never event are potential harm and sometimes death to the patient, financial in terms of the costs of the procedure are not paid to the Trust and possible financial recompense required to the patient and finally reputational; never events are largely preventative and are indicative of unsafe practice. They are a marker used by the CQC in their inspection process and also with the Trust Development Authority in assessing preparation for Foundation Trust status.

Attachment A provides details of all never events reported at RWT since April 2009. For the financial 2013/14, there have been three incidents, the last being reported in September 2013.

Considerable work has been undertaken across the Trust in reducing the risk of never events. Much of this is predominantly in the operating theatres where cultural and behavioural training has been provided by external agencies. This has continued into obstetric and midwifery led care where additional training in human factors has been provided by the Association of Perioperative Practice specifically designed to address the recurring themes of retained vaginal swabs and tampons (25% of the never events reported since 2009).

Both divisions maintain a procedural list of clinical practices that require the use of a safety checklist. The completion and use of these are monitored and reported monthly through the Patient Safety Improvement Group. Exceptions are noted and involve the clinical director taking appropriate action.

All incidents have been thoroughly investigated using the Trust's agreed root cause analysis tool and all have been closed by the CCG.

Attachment A **Royal Wolverhampton NHS Trust Never Events July 2009 - December 2013**

The Royal Wolverhampton NHS Trust

			Description of Event	Date of event	Closed by CCG
2009 - 2010	1	Jul-09	**Wrong site surgery** Opthalmology OPD. Wrong eye lid operated on.	08-Jul-09	
	2	Oct-09	**Retained Foreign Object** Small swab left in during cardiac operation. Removed under anaesthetic in Jan 2010.	09-Oct-09	
	3	Oct-09	**Retained Foreign Object** Theatre pack left in vaginal following laparoscopy and endometrial ablation. Identified at GP practice 5 days later	13-Oct-09	
2010 -2011	1	Mar-11	**Retained Foreign Object** A throat pack was inserted as part of the anaesthetic injduction. The pack was not removed post induction and remained in situ. Prior to recovery the removal was overlooked by the anaesthatist Partial upper airway obstruction resulted	02-Mar-11	
2011 - 2012	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-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-Jun-11	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	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	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	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	Jul-12
	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	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	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	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	Aug-12
2012 - 2013	1	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	Aug-12
	2	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	Feb-13
	3	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	Jun-13
2013 - 2014	1	Apr-13	**Retained foreign object:** Ventouse delivery Tampon left in	16-Apr-13	Jul-13
	2	May-13	**Retained foreign object :** Cariothoracic Theatres; A cancer patient had thoracic surgery on 01/05/13 and a swab count was completed, no discrepancy noted. Patient became unwell and was transferred to Critical Care. He subsequently underwent further surgery 05/05/13, during the swab count an extra swab was identified, however it was not clear if this was a retained swab from the previous surgery. Reported on datix 23 May 2013. Datix 104404. SUI no. 2013/15412	05-May-13	Closed
	3	Sep-13	**Retained Foreign Object:** Gynaecology Theatres, a lady had a laproscopic hysterectomy and a corrugated drain was inserted. Patient went home and later returned to ward because she felt something protruding, it was a drain that should have been removed prior to discharge.	13-Sep-13	Closed