MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Report of:	Professor R C Pearson, Medical Director
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Date of paper:	26th February 2018
Subject:	Never Events
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities	To improve Patient Safety, Clinical Quality and Outcomes
Recommendations	The committee are requested to note the information and the actions planned to mitigate risk of recurrence.

1.0 Background

1.1 Never Events are defined nationally as incidents which are wholly preventable - as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Serious harm does not need to have occurred for an event to be defined as a Never Event.

1.2 The Never Event Framework was updated in January 2018, there have been a number of changes to existing definitions and guidance with the addition of 2 completely new Never Events. The new guidance came in to force from February 2018.

1.3 Work is underway to communicate these changes across the organisation and to undertake an assessment of risk in relation to the changes.

1.4 In 2017-18 the legacy organisations of MFT reported 3 Never Events and post-merger there has been a further Never Event reported making 4 in total this financial year as of the end December.

2.0 Summary of Events

2.1 There were 3 incidents of wrong site surgery (Insertion of grommets in error, undertaking a cysto-vaginoscopy rather than a vaginoscopy and wrong side bronchoscopy and lung biopsy) and 1 wrong route medication (Oral sedation given via the intravenous route for renal biopsy), with 2 of the incidents occurring in an operating theatre setting.

2.2 Royal Manchester Children's Hospital experienced 3 of the events with the other event occurring at Wythenshawe Hospital.

2.3 None of the patients involved sustained serious harm and duty of candour was undertaken for each incident.

2.4 Full root cause analysis investigations have been undertaken for each incident.

2.5 In addition the Trust has been working with the Healthcare Safety Investigation Branch (HSIB) to support National learning relating to wrong route medication.

2.6 Medical staff in training were involved in 2 of the incidents and appropriate referrals to the Dean were made.

3.0 Key Findings

3.1 Local Safety Standards for Invasive procedures had not been developed for the renal biopsy procedure.

3.2 Whilst the safe surgery checklist processes were completed for the 3 wrong site surgery incidents there were deficiencies in how they were undertaken and a lack of clarity identified within the policy as to the exact requirements for each stage for example attendance at Team Brief and the need for view of consent by surgeon as part of Time Out.

3.3 There were issues relating to the Consent Policy and the level of understanding of this including taking consent on the day of elective procedures.

3.4 The Medicines Policy was not followed in relation to the preparation and administration of medicine.

4.0 Summary of Investigation Recommendations and Actions

4.1 A number of recommendations have been identified as part of each investigation with a range of actions to achieve these already undertaken or planned before the end of 2018.

4.2 The key recommendations are focussed on reviewing Safe Surgery, Sedation and Consent procedures, review of risk assessments, development of Local Safety Standards for Invasive procedures and education and awareness raising across the Trust.

4.3 The Trust will be working with HSIB to develop a simulation training video in relation to the wrong route medication error.

5.0 Recommendation

5.1 The Board of Directors is requested to note the information and the actions planned to mitigate risk of recurrence.

5.2 An update report will be provided on progress with actions in 6 months.