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Title: Never Events in Gastrointestinal Nursing

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Key points

Gastrointestinal diseases and disorders frequently require interventions that can lead to serious consequences for patients when the organisation has not put in place the correct systems and processes to prevent incidents from happening, procedures have not been followed (generally due to poor observation) or when an individual disregards protocol (generally due to lack of judgment).

Examples of various types of incidents that occur include: perforation of the oesophagus during endoscopic dilatation of oesophageal strictures, excessive restriction of the stomach during bariatric surgery and poorly siting a stoma.

It has been identified through research that over 400,000 patients suffer potentially preventable harmful events each year.

A 'Never Event' **(**incident) should be regarded as unacceptable in the health service.

It is the responsibility of every professional to develop their professional knowledge, skills and behaviours beyond that which they were assessed against with their initial qualification or entry to their professional register (CHRE, 2009).

In 2009/10 the National Health Service Litigation Authority made payments totalling £827 Million in respect to negligence claims on behalf of the National Health Service.

Healthcare professionals are accountable for their professional activities regardless of the level and context of their practice (CHRE, 2009).

Introduction:

Gastrointestinal diseases and disorders require a variety of interventions that can lead to serious consequences for patients when the organisation has not put in place the correct systems and processes to prevent incidents from happening, procedures have not been followed (generally due to poor observation) or when a practitioner disregards protocol (generally due to lack of judgment). "'Never events' are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place" (DoH, 2011a:1). Previously 'never events' were termed 'Serious Untoward Incidents' or 'SUIs'. For an incident to be identified as a 'never event' it must fulfil the following criteria:

- "The incident has clear potential for or has caused severe harm/death.
- There is evidence of occurrence in the past (i.e. it is a known source of risk).
- There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation.
- The event is largely preventable if the guidance is implemented.
- Occurrence can be easily defined, identified and continually measured" (DoH, 2011b:4).

Examples of various types of incidents that occur include: perforation of the oesophagus during endoscopic dilatation of oesophageal strictures, excessive restriction of the stomach during bariatric surgery, poorly siting a stoma, theft of prescription forms (FP10's), delays of biopsy results and lost referral of patients that have been diagnosed with gastrointestinal tumours. This article addresses the issues associated with 'never events' in the United Kingdom (UK). However it has relevance for readers working in gastrointestinal practice globally.

Background to Never Events:

It has been identified through research that over 400,000 patients suffer potentially preventable harmful events each year (Emslie, 2002). These events have been attributed to 'medical errors' that result in over 34,000 avoidable deaths and extended hospital stays costing the health service in excess of £2 billion per year (Emslie, 2002; Emslie et al, 2002). In addition, it has been found that claims for clinical negligence are rising in excess of £400 million with outstanding claims amounting to several billion pounds (Emslie et al, 2002). It can be surmised from these figures that events that may cause harm are a challenging issue for organisational cultures (Holt, 2011; Roberts, 2002).

In 2010 the UK Government put forward a proposal in its White Paper indicating that it wants to expand the current list of incidents considered to be 'never events'. A draft list of 'never events' was published in October 2010. A consultation followed seeking views on the proposals. Following the consultation, the list was revised and the policy clarified. This article addresses the final expanded list for use in the National Health Service (NHS) in 2011/12. It identifies risk, risk behaviours and also provides information on how risk management should be implemented. Although this article addresses 'never events' as they relate to the NHS in the UK, readers from other countries will find this article informative when considering critical incidents within their practice environment.

The 'never events list' includes the original eight events from previous years, of which some have been modified (National Patient Safety Agency, 2010). The list also builds on the draft list published in October 2010 to incorporate 25 'never events' on the expanded list. The Department of Health (DoH) indicates that the policy paper should be used in conjunction with the NHS Standard Contracts 2011/12. The target audience for the list in the UK is, Primary Care Trusts (PCTs), Chief Executives (CEs), NHS Trust CEs, Strategic Health Authority (SHA) CEs, Care Trust CEs, NHS Foundation Trust CEs, Medical Directors, Directors of Nursing, PCT Chairs, NHS Trust Board Chairs, Special Health Authority CEs, Directors of Finance, Doctors, Allied Health Professionals (this list includes nurses and technicians), General Practitioners (GPs) and Emergency Care Leads.

The 25 'never events' on the expanded list are:

1. Wrong site surgery (existing)
2. Wrong implant/prosthesis (new)
3. Retained foreign object post-operation (existing)
4. Wrongly prepared high-risk injectable medication (new)

5. Maladministration of potassium-containing solutions (modified)
6. Wrong route administration of chemotherapy (existing)
7. Wrong route administration of oral/enteral treatment (new)
8. Intravenous administration of epidural medication (new)
9. Maladministration of Insulin (new)
10. Overdose of midazolam during conscious sedation (new)
11. Opioid overdose of an opioid-naïve patient (new)
12. Inappropriate administration of daily oral methotrexate (new)
13. Suicide using non-collapsible rails (existing)
14. Escape of a transferred prisoner (existing)
15. Falls from unrestricted windows (new)
16. Entrapment in bedrails (new)
17. Transfusion of ABO-incompatible blood components (new)
18. Transplantation of ABO or HLA-incompatible Organs (new)
19. Misplaced naso- or oro-gastric tubes (modified)
20. Wrong gas administered (new)
21. Failure to monitor and respond to oxygen saturation (new)
22. Air embolism (new)
23. Misidentification of patients (new)
24. Severe scalding of patients (new)
25. Maternal death due to post partum haemorrhage after elective Caesarean section (modified) (DoH, 2011b:18-32).

Each of these incidents should be regarded as unacceptable in the health service. Furthermore, this list of incidents should not be regarded as the sum total of serious incidents; nor that incidents occurring outside of this list would not be considered as 'serious'.

Considering the Concept of 'Never'

'Never' is defined by the Chambers Dictionary (2011) as at no time and in no degree. This means essentially not ever. The concept of 'never' has drawn concern in the health service as to whether particular incidents are 'truly preventable' events (DoH, 2011b:6). 'Never' is an aspiration. The list defines incidents or 'errors' that deserve a particular scrutiny due to their devastating impact on the patient and their preventability. However particular scrutiny should be a watchword in which all healthcare practitioners engage. Fundamentally, critical incidents should not occur within the health service. Therefore efforts must be made by all healthcare practitioners to ensure the prevention of mistakes. When they do occur, the event should be reported so that lessons can be learned from the mistake.

Types of Risk

Emslie (2002) indicated that as healthcare becomes more complex and resources are stretched to the limit, the issue of managing risk is more important than ever before. Indeed with the continuing changes in healthcare and the complexities of managing with tighter budgets, fewer staff, shorter waiting times and an aging population it may be fair to surmise that the potential for risk is higher than it was in 2002. In order to manage risk the causes and types of errors that can lead to 'never events' must be identified. Identification should be within the healthcare organisation

itself and within the context of the individual practitioner's practice. The types of errors that can occur are:

- Type I – Omission
- Type II – Commission
- Type III – Unawareness (Roberts, 2002).

Omission typically involves a "failure to comply with current regulations or statute or to fail to comply with current professionally accepted practice" (Roberts, 2002:17). This may be due to lack of knowledge which could be associated with inadequate training or failure to engage in learning activities that keeps knowledge up to date. For example, Barber (2002) found in his research that 1 prescribing error occurred every 20 seconds in the health service where the practitioner was working a 50 hour week and that 59% of prescribing errors were associated with the wrong dose. Of these, 25% were serious errors.

Commission is any act committed that should not have been. Roberts (2002:17) indicates that commission is associated with a "lack of commitment or consideration for others involved in the healthcare process". For example, a practitioner may leave a needle on the bedside table resulting in injury to a patient or another healthcare practitioner. Holt (2011) indicates that there is a moral objective in accident prevention whereby there is a duty of reasonable care owed to others.

Unawareness arises from "a faulty specification of the nature of a problem which leads to real solutions being adopted to deal with wrongly identified problems, rather than incorrect solutions to real problems" (Roberts, 2002:18). In this instance errors occur through a lack of understanding about what the 'real' problem is or assumptions are made about what the problem might be. This type of error is most frequently associated with management decisions. Managers are out of touch with practice; not fully aware of what is occurring in the clinical setting and make decisions that impact on service delivery resulting in potential harm to patients and practitioners alike (Hoffman and Perry, 2005).

Part of managing risk is having an awareness of these errors. However, engaging in risk management behaviour is not generally taught as part of the medical, nursing, or allied health professional curriculum (Roberts, 2002). This may be why healthcare practitioners, regardless of their position in the health service do not remain alert to the identification of potential hazards or the consequences of their actions. Subsequently accidents occur. The basic common causes of accidents in the healthcare environment are associated with:

- Poor Housekeeping
- Substandard Practice
- Physical Environment
- People within the Environment
- Unsafe Practice
- Unsafe Conditions (Adapted from Roberts, 2002).

Undoubtedly we can recall instances where the aforementioned have led to an accident occurring. For example inattention to aseptic technique during a dressing change leads to a wound infection post laparotomy. Ultimately it is the responsibility of every person engaged in healthcare to maintain vigilance so that accidents are prevented (Holt, 2011).

Factors that Increase the Potential for Error

The common causes of accidents listed in the previous section are frequently affected by what can be termed 'job factors' (Holt 2011, Roberts, 2002). Job factors include the following:

- "Inadequate work standards
- Inadequate equipment
- Inadequate maintenance of equipment
- Abuse, misuse or failing to check equipment
- Inadequate leadership or supervision" (Roberts, 2002:26).

Inadequate work standards relate to risks that arise from lack of training and/or supervision. These can be associated with a dysfunctional organisational culture. 'We have always done it this way' is an example of a dysfunctional organisational culture.

Inadequate equipment or a lack of resources to do the job increases the risk of errors occurring. Within this context regular testing of equipment and preventative maintenance should occur. Where there is inadequate or the absence of testing, equipment can fail unexpectedly during use. In addition, when equipment (endoscopes for example) is not cleaned between patients, cross-infection can occur.

Abuse, misuse or failing to check equipment can lead to incorrect configuration and subsequently misdiagnosis or other significant harm occurring to the patient. Errors that can occur for example are when an endoscopist does not check that endoscopic equipment is ready for use and that the controls are all functional, when endoscopes are not carried properly leading to damage of the optics in the control head and tip or when endoscopes are not stored vertically in cabinets in which air can circulate.

Inadequate leadership or supervision is a calamity that is seen in many healthcare settings. Holt (2011) is adamant that poor leadership and supervision impact on all of the job factors listed in this article. It is the responsibility of management to ensure job factors are effectively managed. Furthermore, as stated previously in this article, it is the responsibility of every individual working within the healthcare setting to prevent and control risks.

Managing Risks

Throughout this article suggestions have been provided on how risks and specifically 'never events' should be managed. The government has indicated that "In the real world we accept that there is the possibility that unforeseen scenarios could mean that a 'never event' may not have been preventable … and that in individual cases,

(where) it can be shown that completely unanticipated or unpreventable circumstances led to an event occurring, we would suggest the commissioner and provider should agree not to classify it as a 'never event'" (DoH, 2011b:7). What is crucial is that issues are considered and discussed before events occur in each healthcare setting to ensure that prevention strategies are implemented. This is an essential principle in managing risk.

It is the responsibility of every professional to develop their professional knowledge, skills and behaviours beyond that which they were assessed against with their initial qualification or entry to their professional register (CHRE, 2009). This equates to ongoing professional development through continuing education initiatives; more commonly known as continuous professional development (CPD). Robust and well managed risk management processes are the foundation upon which patients are protected against 'never events' and the NHS is protected from incurring unnecessary costs associated with negligence (Box 1).

In 2009/10 the National Health Service Litigation Authority (NHSLA) made payments totalling £827 million in respect to negligence claims on behalf of the National Health Service (NHS).

The NHSLA is a Special Health Authority responsible for handling clinical and non-clinical negligence cases for the NHS in England.

Reference: The NHS Litigation Authority (2010) Factsheet 2: financial information, www.nhsla.com

Box 1: Costs associated with negligence

Conclusion

It is evident that to avoid failures that can result in 'never events', the sharing of good practice is essential. Healthcare professionals are accountable for their professional activities regardless of the level and context of their practice (CHRE, 2009). Nurses, and allied health professionals involved in the delivery of gastrointestinal care should be aware of factors that can increase the potential for error and conversant with clinical governance and risk management processes within their organisation. They should actively participate in the assessment of risk in their clinical areas. Nurses and allied health professionals engaged in gastrointestinal practice should be involved in the investigation of 'never events' so that learning is maximised and patient care improved.

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