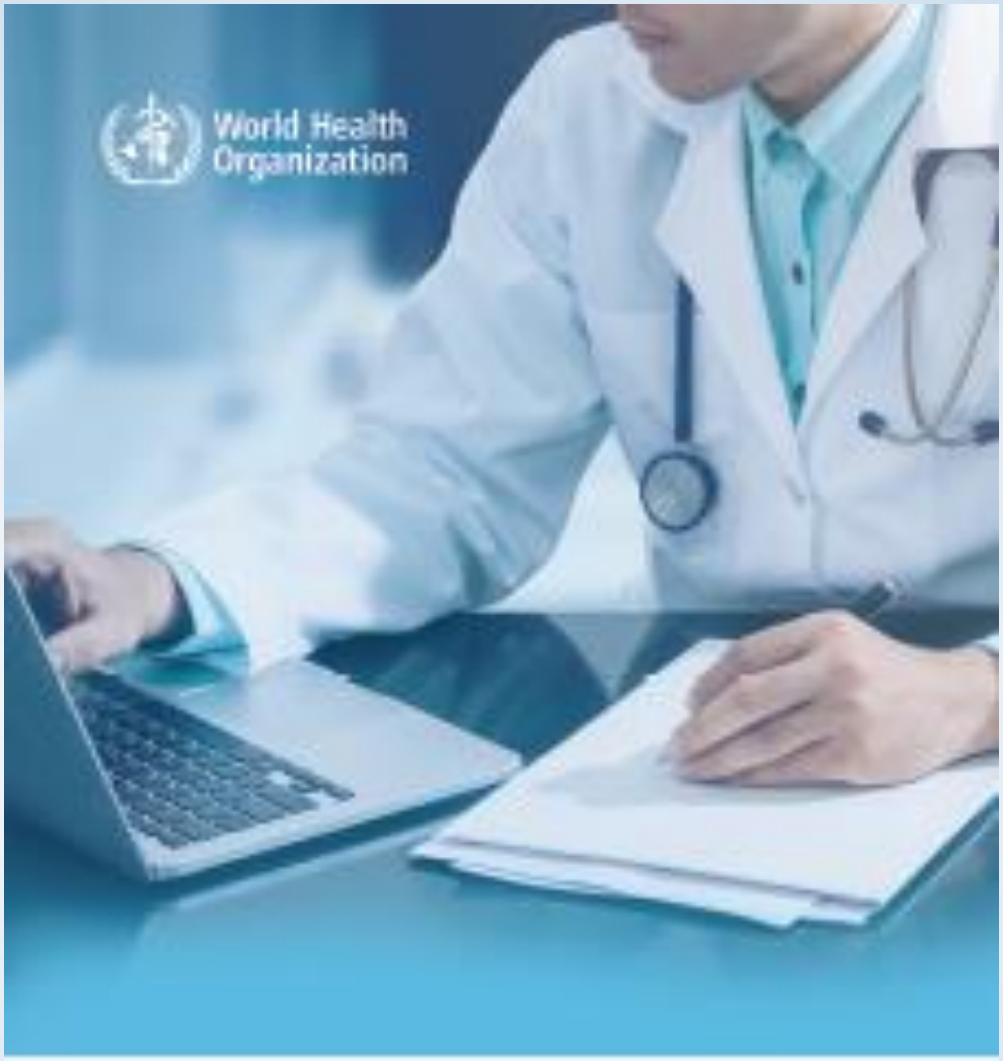
Global Patient Safety Network Webinar Series

5 March 2021

Sir Liam Donaldson

WHO Patient Safety Envoy



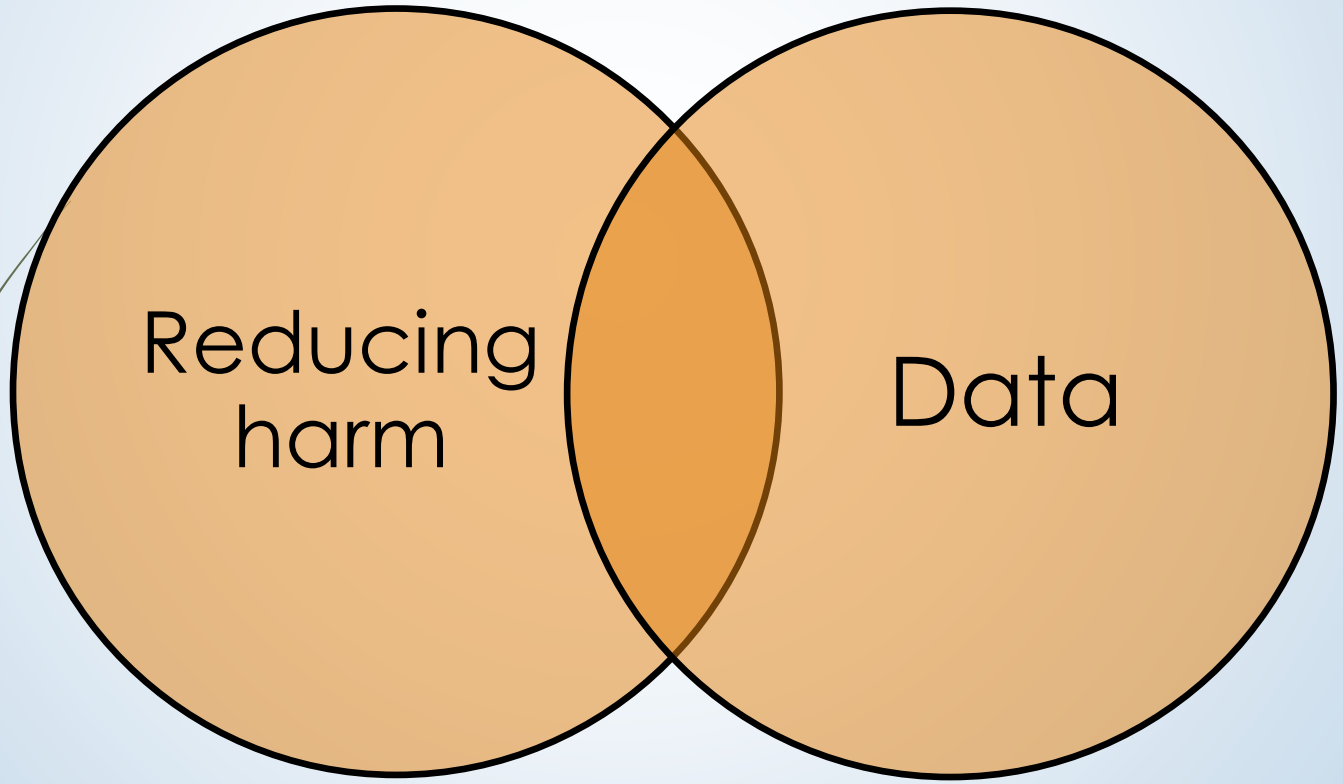
Patient Safety Incident Reporting and Learning Systems

Technical report and guidance

Responding to a patient safety incident report

Source: World Health Organization

Can we be data driven?



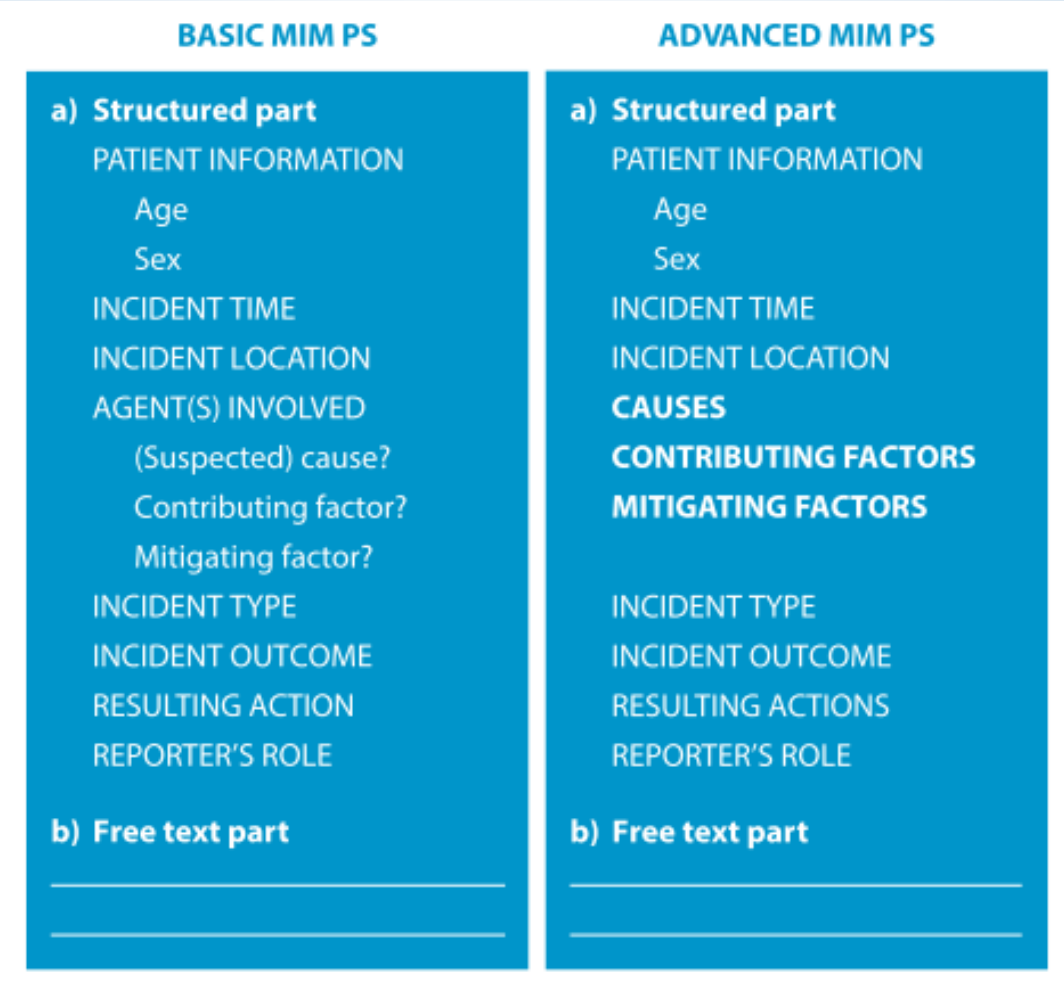
Barriers to full impact of incident report systems

Volume of data

Culture

Investigative capacity

Minimal information model for patient safety incident report and learning systems (MIM PS)



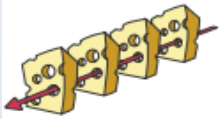
BASIC MIM PS	ADVANCED MIM PS
a) Structured part	**a) Structured part**
PATIENT INFORMATION	PATIENT INFORMATION
Age	Age
Sex	Sex
INCIDENT TIME	INCIDENT TIME
INCIDENT LOCATION	INCIDENT LOCATION
AGENT(S) INVOLVED	**CAUSES**
(Suspected) cause?	**CONTRIBUTING FACTORS**
Contributing factor?	**MITIGATING FACTORS**
Mitigating factor?	
INCIDENT TYPE	INCIDENT TYPE
INCIDENT OUTCOME	INCIDENT OUTCOME
RESULTING ACTION	RESULTING ACTIONS
REPORTER'S ROLE	REPORTER'S ROLE
b) Free text part	**b) Free text part**

Source: World Health Organization

Assessment of patient safety incident reports

Source: World Health Organization

Uses and limitations of aggregated patient safety incident data

	ACTIVITY	SOURCE OF ANALYSIS	STRENGTHS	WEAKNESSES
	**Surveillance**	All incident types	Highlights broad patterns and trends	Weak on systemic insights; little immediately actionable
	**Performance assessment**	Incidents covering particular fields of care	Creates opportunity for system redesign and improved safety within a field of care	Requires extensive further investigation to assess nature of performance weaknesses
	**Breakdown in resilience**	Incidents pointing to failures in standards or control measures	Enables correction of breaks in defences	Causation can be wide ranging and restorative action complex
	**New and uncommon sources of serious harm**	Incidents of novel type showing clustering in time and space	Immediate opportunity to block harm and protect future patients	Needs highly active mining of data

Source: World Health Organization

Extracts from patient safety incident reports mentioning 'communication causes'

- cardiac arrest team sent to wrong ward
- wrong records consulted prior to clinical decision
- doctor bleeped to attend deteriorating patient but did not get message
- patient transferred from another hospital without adequate documentation

Source: NRLS

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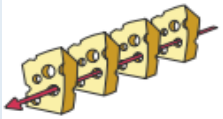	**Breakdown in resilience**	Incidents pointing to failures in standards or control measures	Enables correction of breaks in defences	Causation can be wide ranging and restorative action complex
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Source: World Health Organization

Incident report

At 22:00 hours, a nurse assisted by two others passed a nasogastric tube using the Cortrack system. The system identifies nasogastric placement using a visual screen. The nurses confirmed the tube placement as being in the lower quadrants of the screen and thus commenced feeding the patient. The feed was commenced at 23:00 hours and stopped at 24:00 hours as the nurses were not satisfied that the tube was correctly placed. The nurses contacted the doctor on call. An X-ray was performed and the tube was in the lungs. Patient died.

Source:NRLS

Misplaced nasogastric tubes with feeding

Source: NHS Improvement; 2018/19 data provisional

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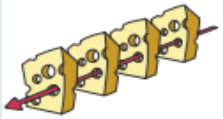	**Breakdown in resilience**	Incidents pointing to failures in standards or control measures	Enables correction of breaks in defences	Causation can be wide ranging and restorative action complex
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Source: World Health Organization

Incident report

An 11 year old girl presented to the emergency department with abdominal pain in the early hours of the morning. The duty paediatric surgical registrar made a provisional diagnosis of acute appendicitis. The child was reviewed by the consultant the next morning and although the clinical picture was not "classic for appendicitis", she was scheduled for appendectomy. The locum surgical registrar (first operation in the hospital) carried out the procedure and the specimen was sent to the lab labelled "inflamed retrocoecal 3cm appendix". Histopathology came back as "pre-pubertal ovarian tissue; no appendix tissue present".

Source: CORESS

Uses and limitations of aggregated patient safety incident data

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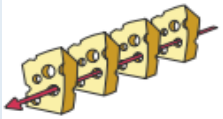	**Breakdown in resilience**	Incidents pointing to failures in standards or control measures	Enables correction of breaks in defences	Causation can be wide ranging and restorative action complex
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Source: World Health Organization

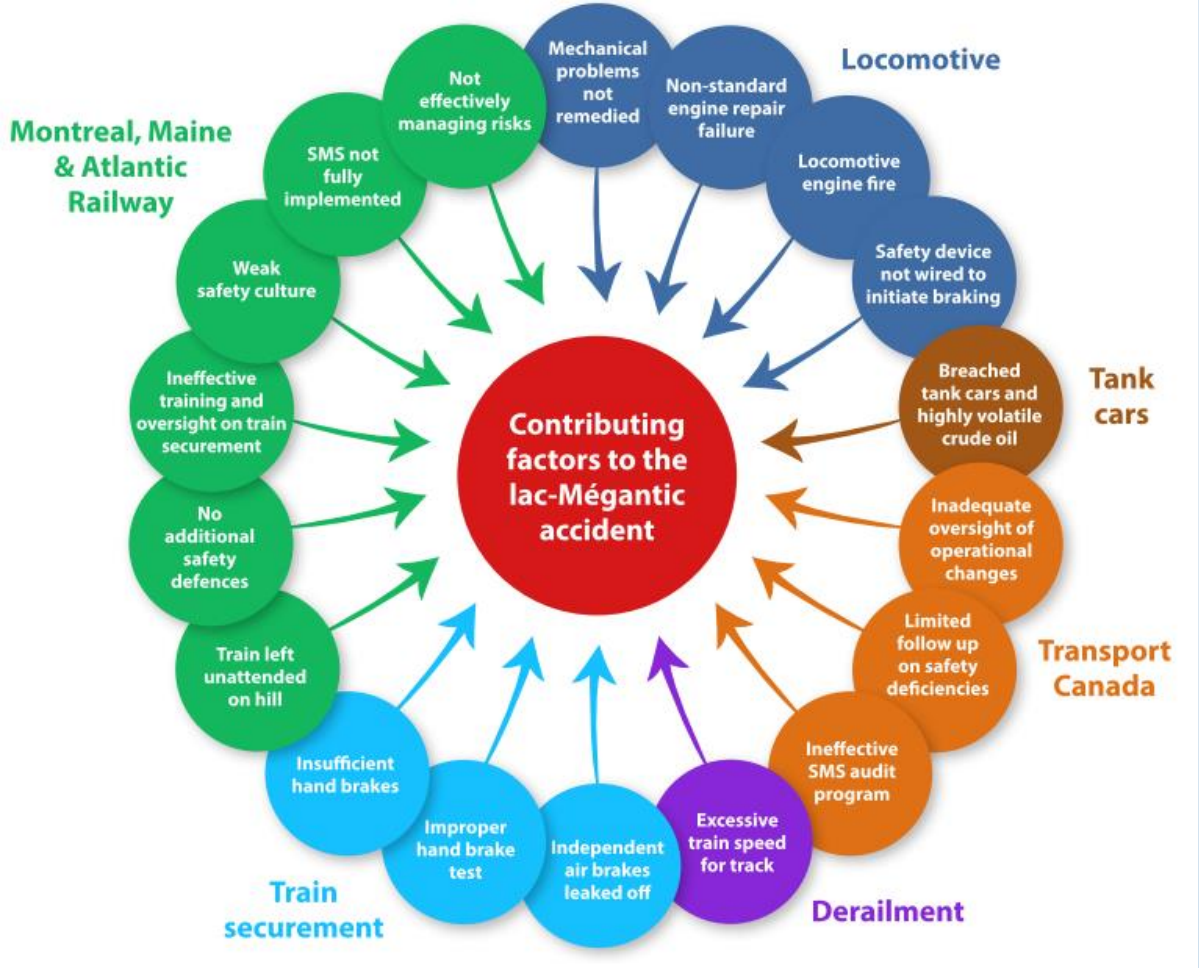
Incident report

- Second general anaesthetic case on afternoon orthopaedic list. Fit and well young ASA 1 patients for removal of ganglion. Patient given IV induction. Anaesthetic registrar unable to ventilate patient. Guedal airway placed. Still unable to ventilate. Consultant anaesthetist realised there was no terminal gas/oxygen flow. Patient desaturated. Emergency ambubag requested and used. Patient ventilated easily.
- On inspection of anaesthetic circuit a disposable cap was discovered blocking the angle piece. It transpired that the offending piece of equipment had been 'doctored' for purposes of a simulation teaching session some weeks previously. The doctored airway had been re-sealed and placed in the anaesthetic room.

Source:NRLS

Lac-Mégantic disaster

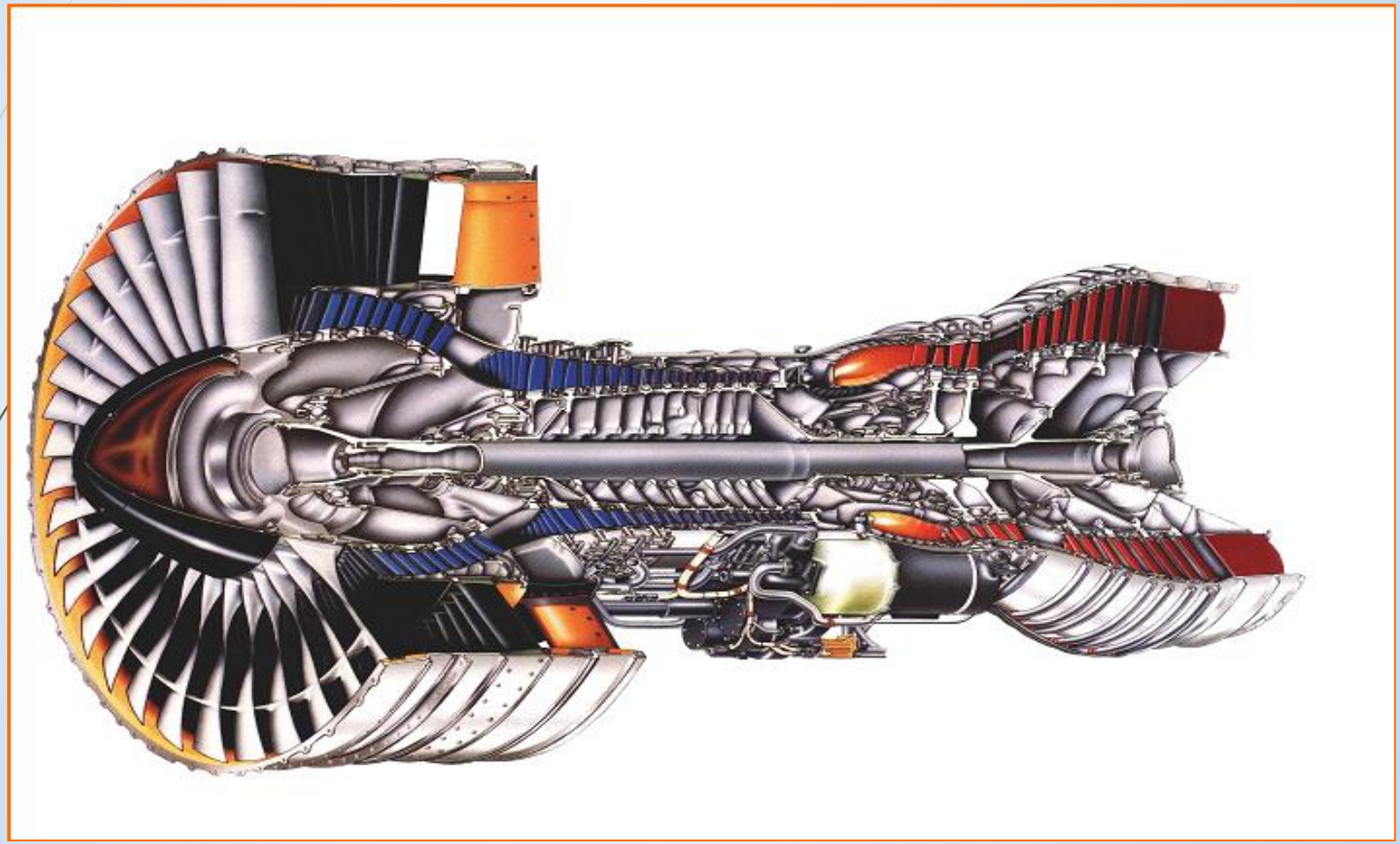
Complex combination of factors contributing to Lac-Mégantic runaway train accident



Source: Reproduced from Transport Safety Board of Canada *(24)*.

Learning from incidents: the sparrow and the eagle

Learning to save lives: the orange-wire test



Source: Donaldson L. When will healthcare pass the orange-wire test? The Lancet 2004; 364: 1567-1568