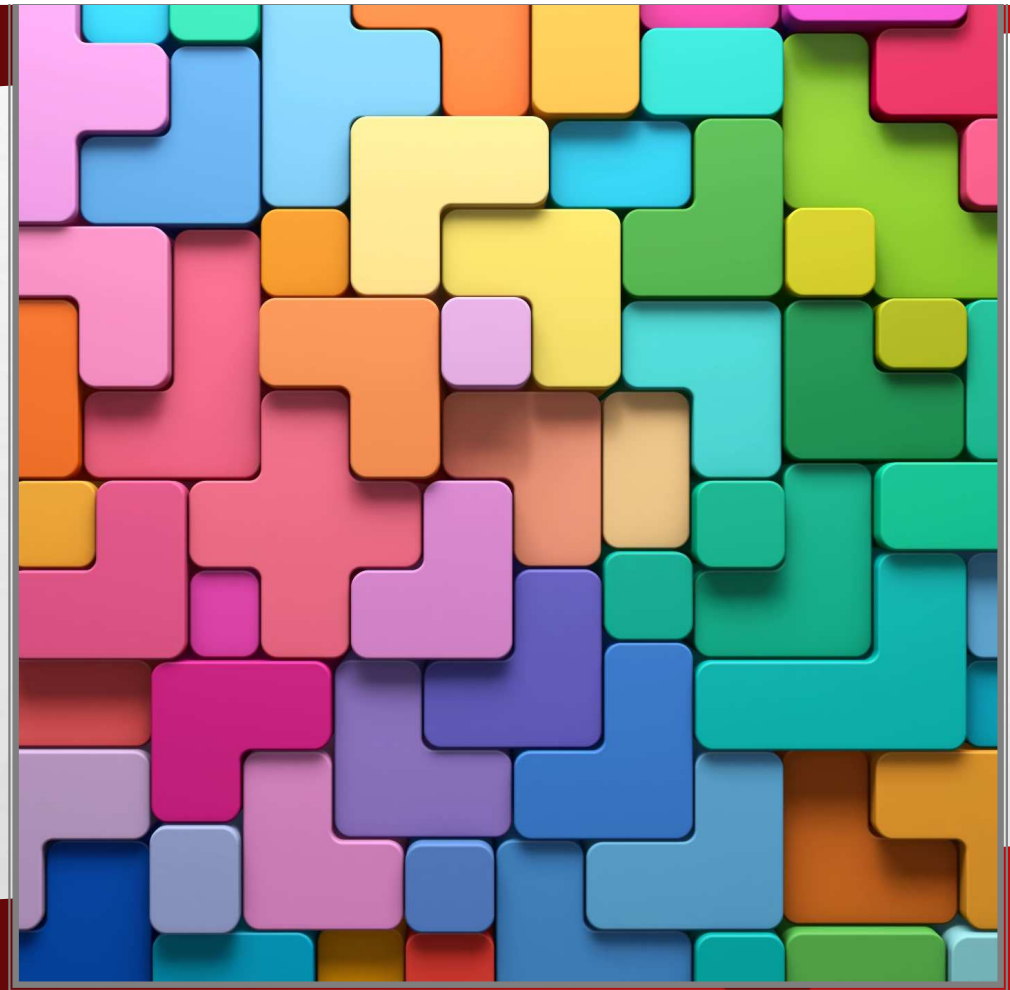
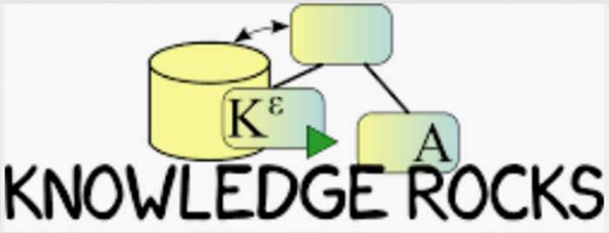


WELCOME
QUANTITATIVE RESEARCH RESULTS FROM ACROSS NHS ENGLAND

NIGEL ROBERTS – HEAD THEATRE PRACTITIONER - ODP
BIRMINGHAM CHILDREN'S HOSPITAL
PHD STUDENT
MSC, BA (HONS), NEBOSH, PRINCE 2

- SURGICAL SAFETY CHECKLIST (SSC)
- LOCSSIPS
- HUMAN FACTORS AROUND THE DELIVERY OF THE SSC

PURPOSE OF TODAYS KNOWLEDGE SHARING



- TO FURTHER IMPROVE OUR CURRENT KNOWLEDGE OF THE SURGICAL SAFETY CHECKLIST.
- TO THINK ABOUT THE CURRENT CHALLENGES FACING EVERYONE IN THE OPERATING THEATRES.
- TO CONSIDER THE IMPACT OF HUMAN FACTORS ON THE SURGICAL SAFETY CHECKLIST AND PATIENT SAFETY.
- CONSIDER THE TERM ‘NEVER EVENT’ DOES IT NEED TO BE UPDATED?
- KEN KIZER INTRODUCED THE TERM IN 2001

Organisation

During the presentation think about your own organisation.

How is the Surgical Safety Checklist (SSC) delivered?

LocSSIPs – How are the LocSSIPs integrated into daily clinical practice?

What daily challenges do we all face in the delivery of the SSC?

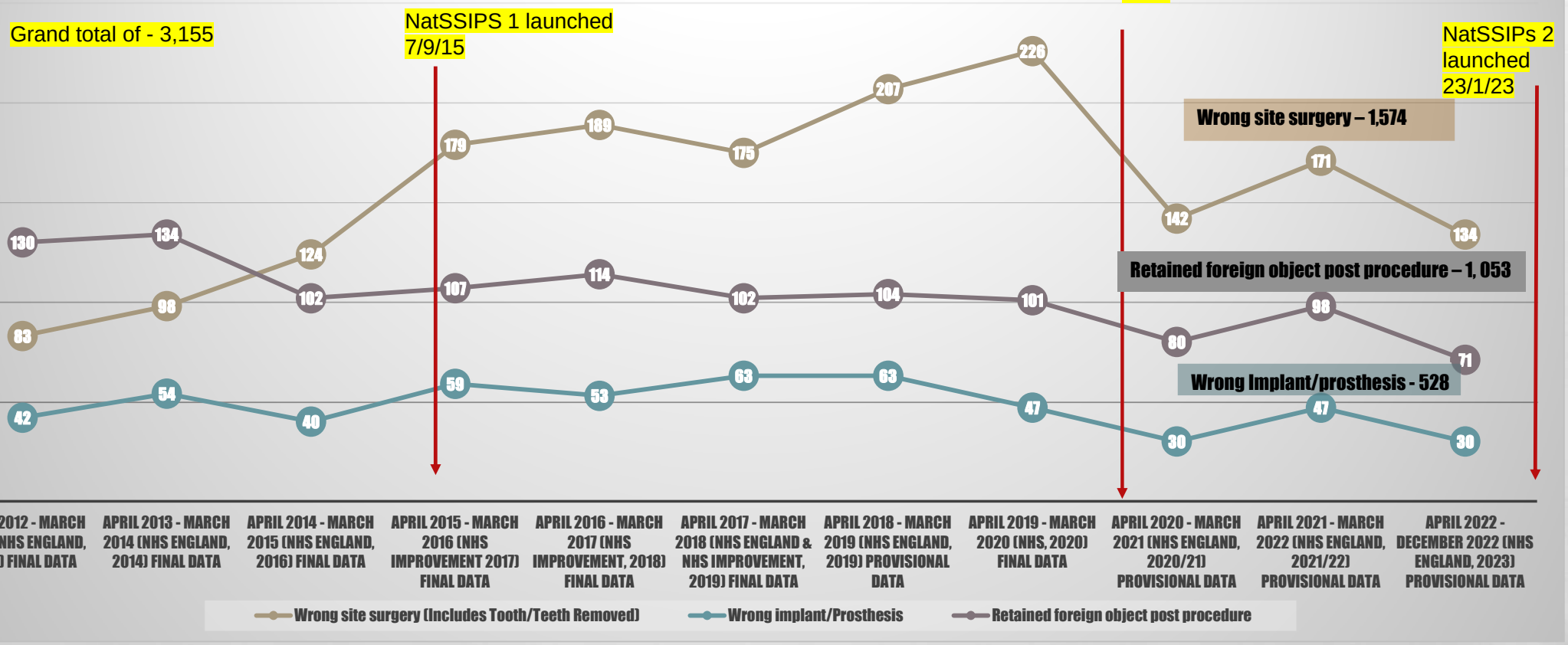
NHS

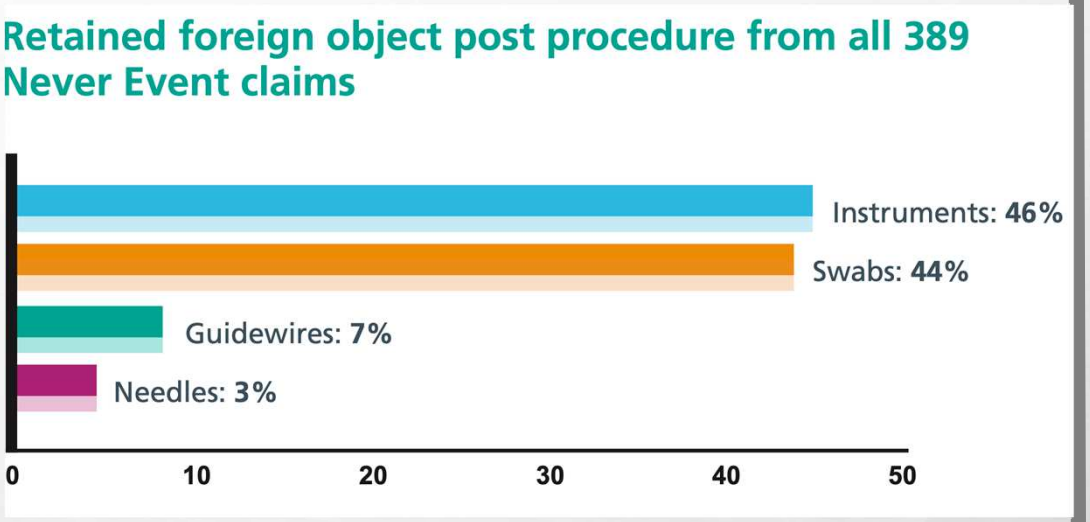
WHAT IS A NEVER EVENT?

- *SERIOUS INCIDENTS THAT ARE ENTIRELY PREVENTABLE BECAUSE GUIDANCE OF SAFETY RECOMMENDATIONS PROVIDING STRONG SYSTEMATIC BARRIERS ARE AVAILABLE AT A NATIONAL LEVEL AND SHOULD HAVE BEEN IMPLEMENTED BY ALL HEALTHCARE PROVIDERS.*

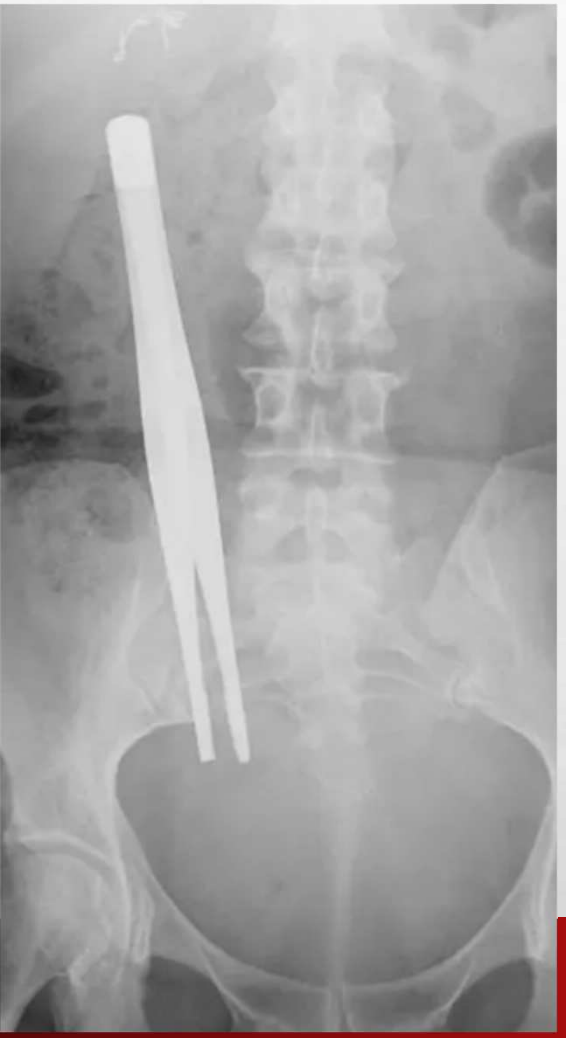
(NHS ENGLAND, 2021)

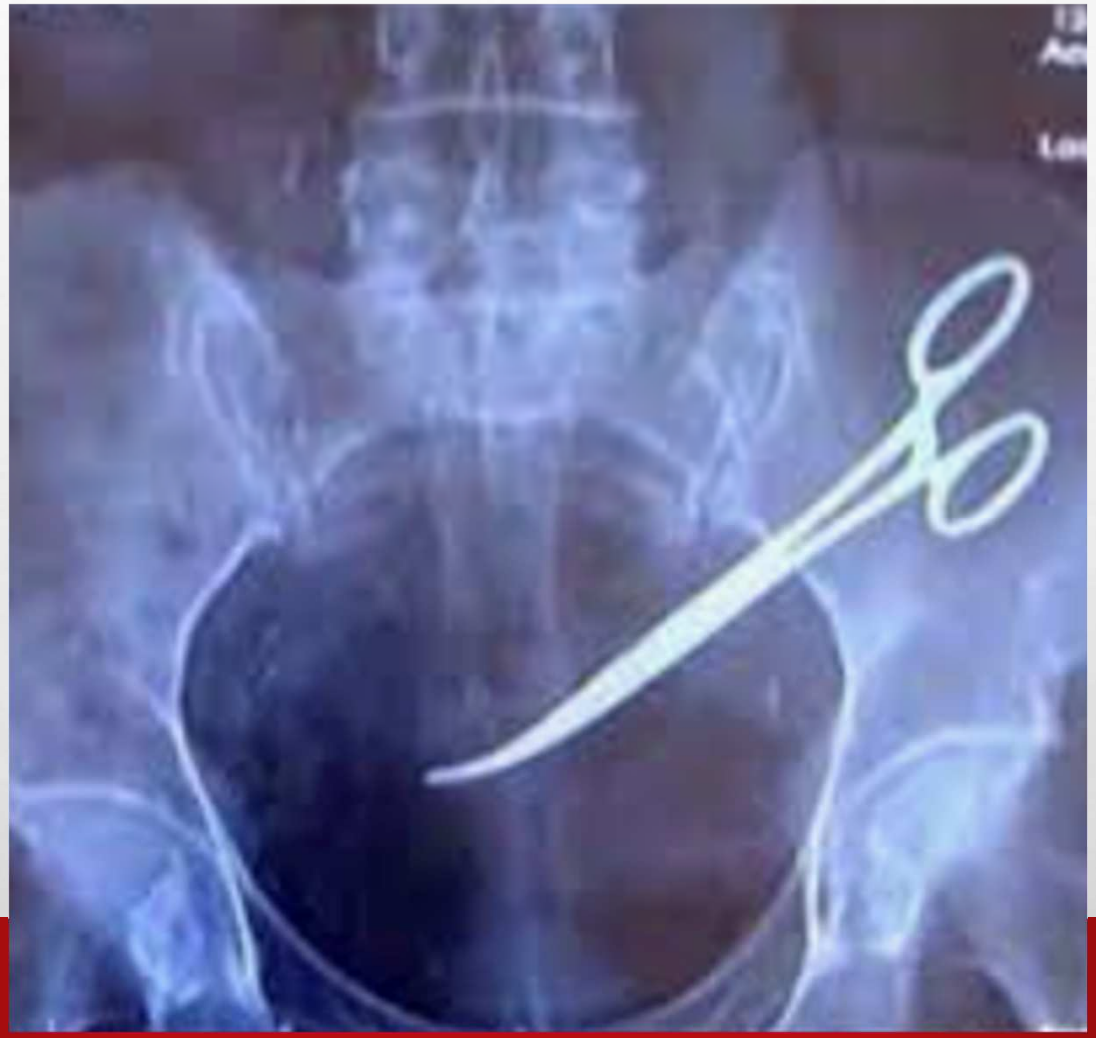
Number of Never Events (Final and Provisional Data) April 2012 - December 2022





DATA BETWEEN 1ST APRIL 2015 TO 31ST MARCH 2020 REVEALS THAT 389 CLAIMS WERE SETTLED, WITH DAMAGES PAID, FOR RETAINED FOREIGN OBJECTS POST-SURGERY. THESE WERE CLASSED AS NEVER EVENTS. THIS COST THE NHS £12,472,347 (NHS RESOLUTION, MARCH 2021).





THEMES OF WRONG IMPLANT/PROSTHESIS

1ST APRIL 2018 – 31ST MARCH 2022

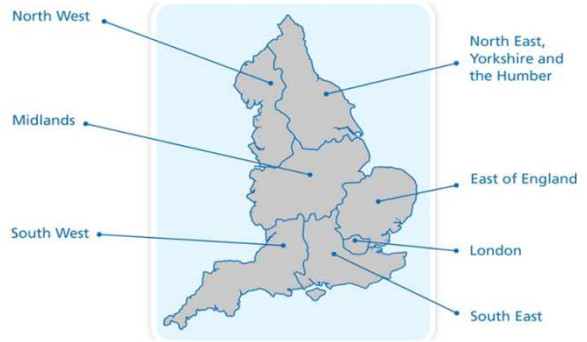
Theme of 'wrong implant/prosthesis'	Number reported (280 in total) 1st April 2018 and 31st March 2022
Labelling and Packaging	26
Human Error	28
Distraction	11
Checking processes/procedures	122
Time of day	2
Documentation	26
Communication	11
Storage	16
Time pressures	13
Computer systems	8
Training	9
Staffing	8

QUANTITATIVE RESEARCH RESULTS

- NINE TRUSTS WERE NOT YET IN EXISTENCE BETWEEN APRIL 2015 – MARCH 2020 AT THE POINT THAT LOCSSIPS WHERE FIRST INTRODUCED;
- SIX TRUSTS WERE EXCLUDED AS A RESULT OF ONLY APPEARING TO HAVE ONE OPERATING THEATRE THEREFORE MEANINGFUL DATA WAS DIFFICULT TO ASCERTAIN;
- TWO OF THE TRUSTS ARE NON-NHS;
- WE REMOVED THE DATA FROM A FURTHER TRUST BECAUSE OF A POSSIBLE CONFLICT OF INTEREST;
- THREE TRUSTS DID NOT PROVIDE ANY CONTACT DETAILS.

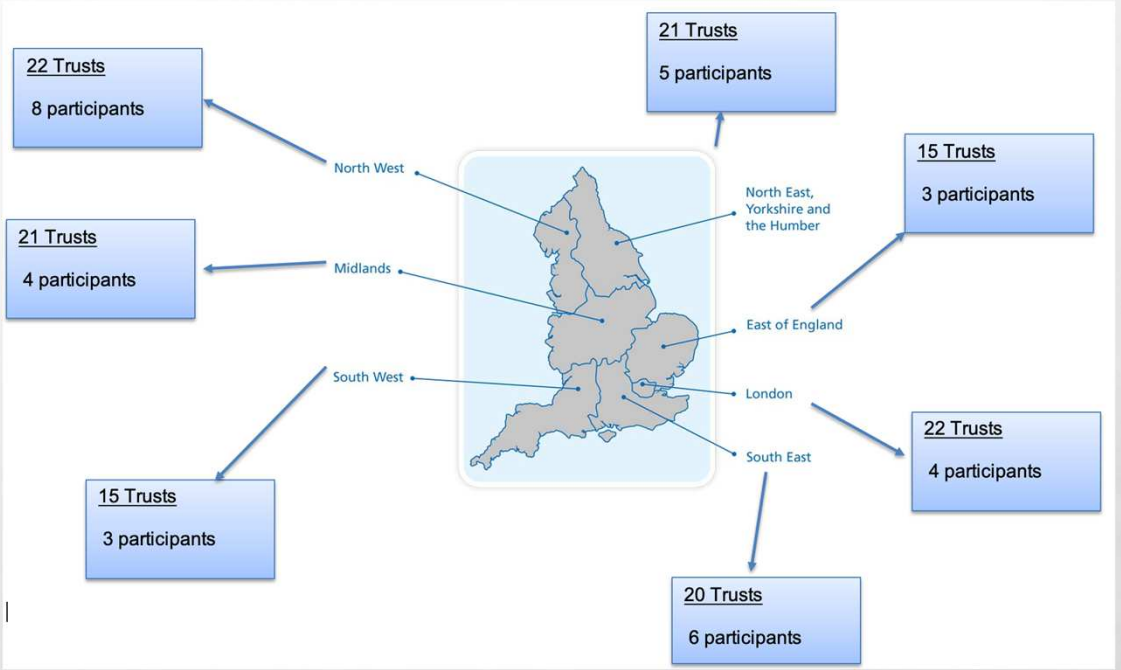
Region	Number of Trusts
London	23
Southwest	21
Southeast	22
Midlands	25
East	18
Northwest	26
Northeast & Yorkshire	22
Total	**157**

Area	Number of Trusts	Number of Operating Th
London	22	512
Southwest	15	275
Southeast	20	438
Midlands	21	524
East	15	272
Northwest	22	366
Northeast & Yorkshire	21	531
Total	136	2918



ACTUAL NHS ENGLAND TRUSTS THAT PARTICIPATED

33 (24%) OF NHS ENGLAND TRUSTS PARTICIPATED



RESULTS

Training – 56% of respondents stated that training on how to deliver the checklist was not offered by their trust

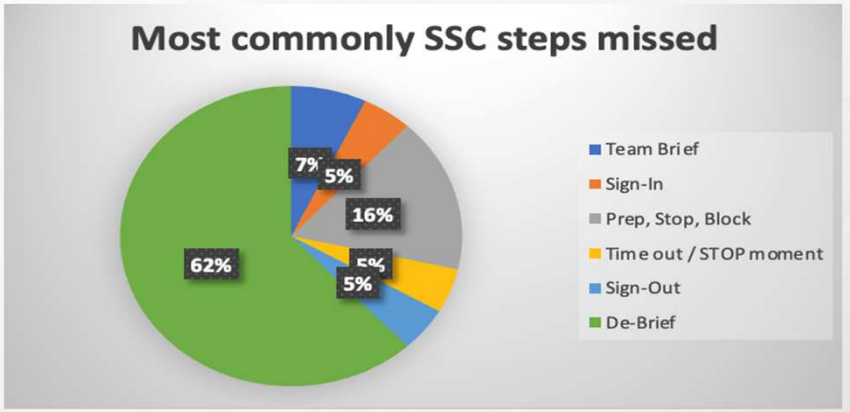
Guidance from the WHO – 78% of respondents stated that the guidance from the WHO is clear

Multidisciplinary teamworking - 91% of respondents asked for collective training on the checklist, human factors and simulation

Types of Checklists - 60% of respondents stated that their trust has both generic and specialty checklists.

Format of the WHO SSC - 93% of respondents felt that NHS England should provide the WHO SSC electronically.

Time - 83% of respondents felt that there was enough time to undertake the SSC



Checklist champions - 29% of respondents stated that they have checklist champions.

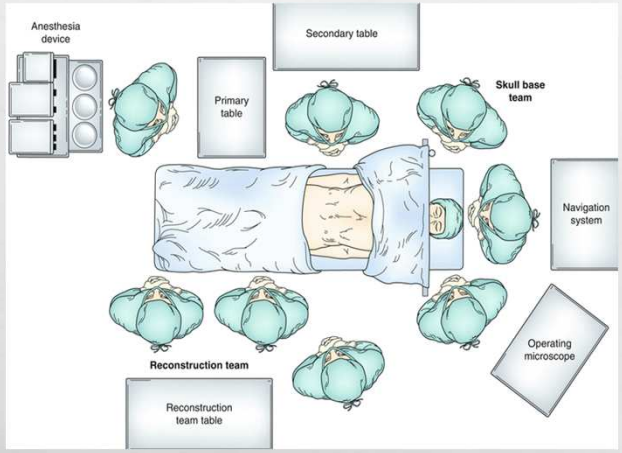
Auditing - 98% of respondents stated that the SSC is Audited.

Feedback following a Never Event - 71% of respondents stated that they always receive feedback following a Never Event

Speak up - Even though steps are missed, 89% of respondents stated that they would speak up if there was a patient safety concern.

Revise the current SSC - 98% of respondents felt that the nhs needed to revise how the delivery of the ssc was undertaken

Most common steps missed - 78% of respondents felt that all five/six steps was as important as each other.



BARRIERS TO THE DELIVERY OF THE CHECKLIST/LOCSSIPS

1. STAFF ATTITUDE – 27%
2. CULTURE – 21%
3. TIME 18%

95% OF RESPONDENTS STATED THAT NON-TECHNICAL SKILLS TRAINING SHOULD BE PROVIDED.

87% OF RESPONDENTS STATED THAT TRAINING SHOULD BE A COMBINATION OF ONLINE, PRACTICAL AND SIMULATION

NATSSIPS/LOCSSIPS

NatSSIPs 2 Summary
Organisational and Sequential Standards

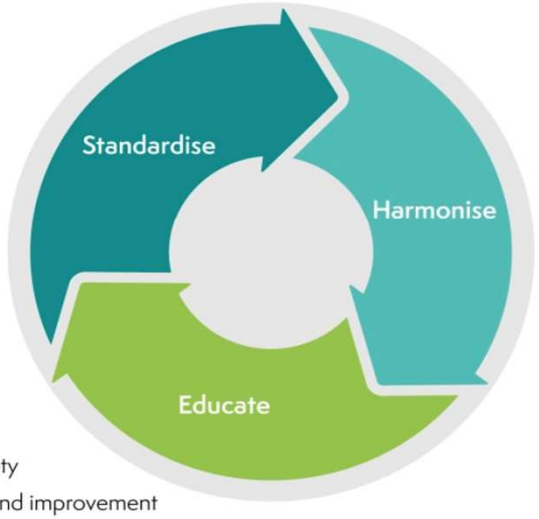
Centre for Perioperative Care

Organisational Standards

People for safety
- Patients as partners
- Staff to deliver
- Roles in safety
- Training in safety
- Human factors understanding

Processes for safety
- Documentation
- Scheduling
- Induction
- Governance

Performance for safety
- Data for assurance and improvement
- External body engagement



Sequential Standards ('The NatSSIPs 8')

1. Consent and Procedural verification
2. Team Brief
3. Sign In
4. Time Out
5. Implant use
6. Reconciliation of items
7. Sign Out
8. Debrief/Handover

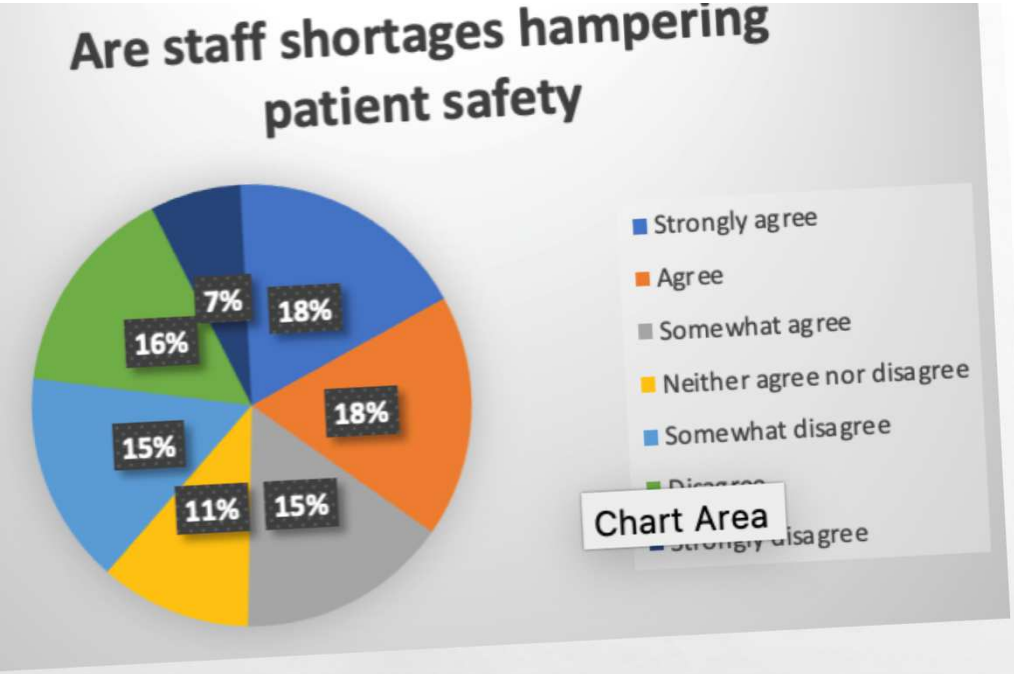
Organisational action is required by everyone if we are to succeed.

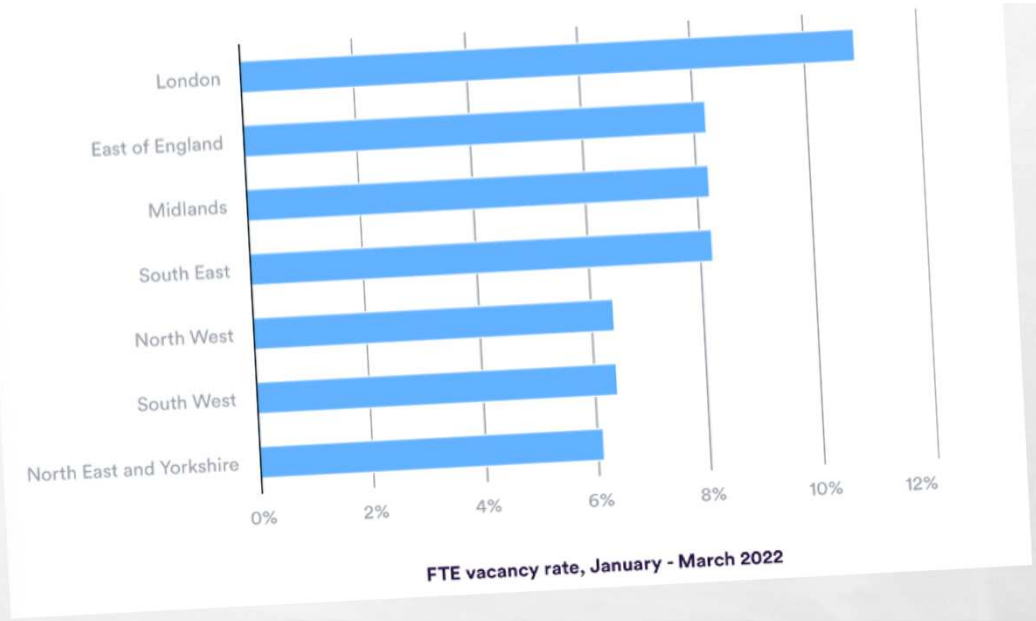
- **ORIGINALLY LAUNCHED 7TH SEPTEMBER 2015**
- **2ND LAUNCH 23RD JANUARY 2023**

NATSSIPS/LOCSSIPS RESULTS

SHOULD THE CQC AND/OR THE ICB'S HOLD NHS TRUSTS TO ACCOUNT?

- 44% OF RESPONDENTS EITHER STRONGLY AGREE OR AGREE THAT NATSSIPS HAVE HELPED.
- AUDIT 29TH NOVEMBER 2021. ASKED ONE QUESTION: DO YOU HAVE NATSSIPS/LOCSSIPS IN YOUR THEATRE DEPARTMENT? ACHIEVED A 58% RESPONSE RATE (79/136 NHS ENGLAND TRUSTS)
- SIX PARTICIPATING TRUSTS HAVE STILL YET TO IMPLEMENT LOCSSIPS. (AS OF NOV. 22)
- AT THOSE SIX TRUSTS BETWEEN APRIL 2015 AND MARCH 2022, 60 INTRAOPERATIVE NEVER EVENTS HAVE OCCURRED. (PROVISIONAL AND FINAL DATA USED)
- 84% OF RESPONDENTS FELT THAT NHS TRUSTS SHOULD BE HELD ACCOUNTABLE FOR NOT INTRODUCING NATSSIPS/LOCSSIPS
- NATSSIPS ARE NOT JUST FOR THEATRES. THEY ARE FOR OTHER AREAS IN THE TRUST





STAFFING AND LEADERSHIP

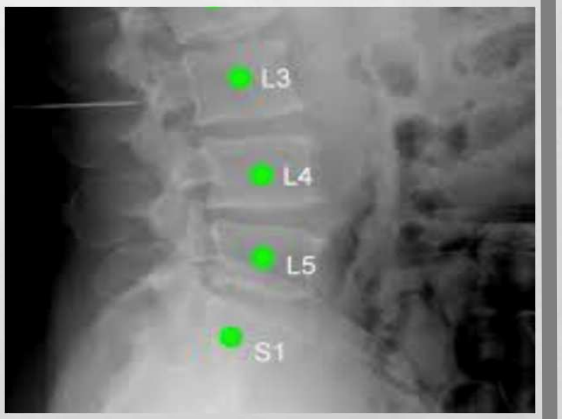
NHS FUNDING (2022) REPORT THAT THERE ARE CURRENTLY 132,139 VACANCIES

POSSIBLE NEW NEVER EVENTS

Falls from operating tables
Cumberland Infirmary
Hip surgery – Dropped – Bump to back of head – Died six weeks later, on the 21st May 2021

SURGICAL FIRES (NON-AIRWAY) 80% OF RESPONDENTS EITHER STRONGLY AGREE OR AGREE THAT NON AIRWAY FIRES SHOULD BE CLASSED AS A NEVER EVENT

The revised never events policy and framework for 2018 that was last updated in February 2021 (NHS improvement, 2021, pp. 5) excludes **wrong level spinal surgery**

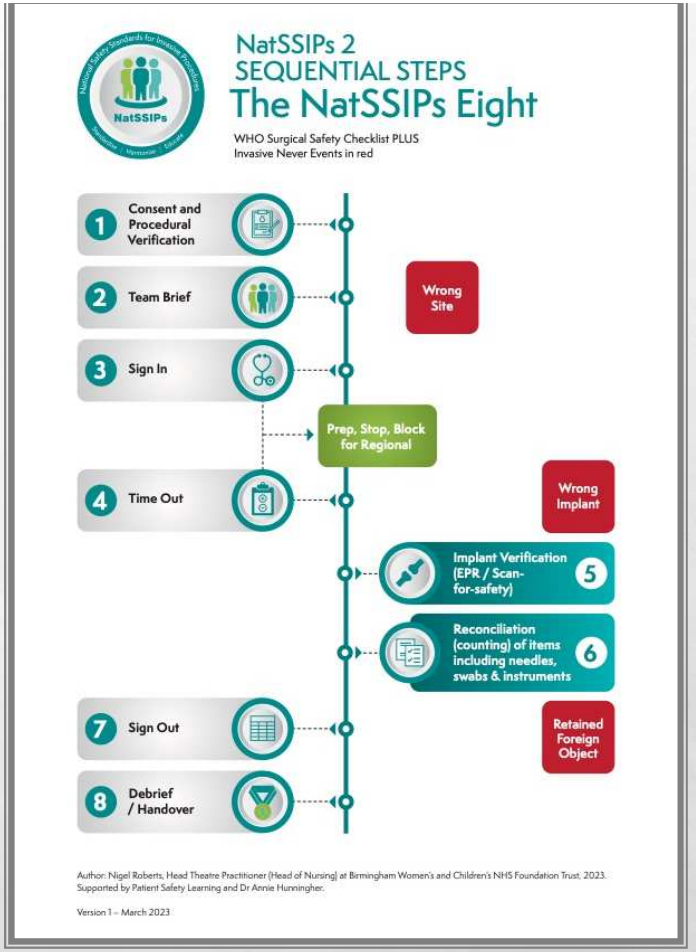


PHRASE – NEVER EVENT

- 1ST INTRODUCED IN 2001 – KEN KIZER
- 82% OF RESPONDENTS STATED THAT THIS PHRASE SHOULD REMAIN
- TINGLE (2022) ARGUES THAT THE TERM SHOULD NOT CHANGE OR BE DILUTED AND ARGUES THAT WHEN A NEVER EVENTS OCCUR, IT CANNOT BE EXCUSED.

THE NATSSIPS EIGHT IN A SIMPLE FLOW DIAGRAM

- **THINK PATIENT SAFETY!**



NEXT STAGES TO THE RESEARCH

- QUALITATIVE RESEARCH
- FOCUS GROUPS
- METHODOLOGICAL TRIANGULATION

A THOUGHT TO LEAVE YOU WITH……

- PROCESSES WE DEAL WITH DAILY ARE BEHAVIOURAL, PHYSICAL AND COGNITIVE.

- WHEN ASKED TO PERFORM A TASK THERE ARE MULTIPLE FACTORS INFLUENCING THE DECISION:
  - YOU AS THE STAFF MEMBER – OTHER STRESS, WELL-BEING
  - THE TASK ITSELF – HAVE YOU DONE IT BEFORE, COMPETENCE
  - TECHNOLOGY – DIGITAL, PAPER, BOARDS
  - THE INTERNAL WORKING ENVIRONMENT AND BACKGROUND NOISE – SUCTION, RADIO, CONVERSATIONS
  - TRUST POLICIES AND PROCEDURES – NATSSIPS (2), SOPS, CHECKLISTS
  - POSSIBLE EXTERNAL FACTORS – LABELLING, PRODUCT DESIGN, DELIVERIES

STAFF SHOULD NOT BE BLAMED OR MADE SCAPEGOATS.

WE ARE ALL HUMAN, MISTAKES HAPPEN.

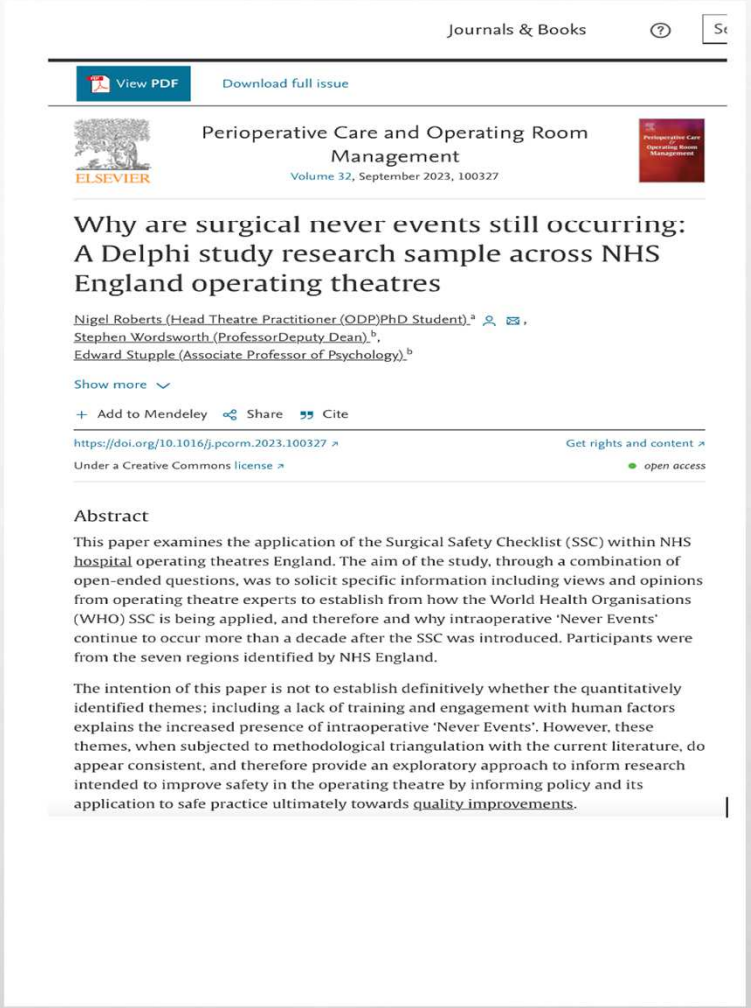
ITS HOW WE PREVENT THEM MOVING FORWARD.


THANK YOU AND QUESTIONS

PUBLICATIONS

WHY ARE SURGICAL NEVER EVENTS STILL OCCURRING: A DELPHI STUDY RESEARCH SAMPLE ACROSS NHS ENGLAND OPERATING THEATRES.

- PERIOPERATIVE CARE AND OPERATING ROOM MANAGEMENT, SEPTEMBER 23, VOLUME 32.



Journals & Books

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Perioperative Care and Operating Room Management
Volume 32, September 2023, 100327

Why are surgical never events still occurring: A Delphi study research sample across NHS England operating theatres

Nigel Roberts (Head Theatre Practitioner (ODP)PhD Student) [a],
Stephen Wordsworth (ProfessorDeputy Dean) [b],
Edward Stupple (Associate Professor of Psychology) [b]

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Abstract

This paper examines the application of the Surgical Safety Checklist (SSC) within NHS hospital operating theatres England. The aim of the study, through a combination of open-ended questions, was to solicit specific information including views and opinions from operating theatre experts to establish from how the World Health Organisations (WHO) SSC is being applied, and therefore and why intraoperative 'Never Events' continue to occur more than a decade after the SSC was introduced. Participants were from the seven regions identified by NHS England.

The intention of this paper is not to establish definitively whether the quantitatively identified themes; including a lack of training and engagement with human factors explains the increased presence of intraoperative 'Never Events'. However, these themes, when subjected to methodological triangulation with the current literature, do appear consistent, and therefore provide an exploratory approach to inform research intended to improve safety in the operating theatre by informing policy and its application to safe practice ultimately towards quality improvements.

Safer Surgical Checklist – Literature review.
The Operating Theatre Journal, November 2021, Issue 374
Further reading https://bit.ly/OTJNROBERTS

Never event audit at the University Hospitals of Derby and Burton following Covid-19.The operating theatre journal, January 2022, Issue 376
For further reading https://bit.ly/OTJJAN22

LocSSIPs – An audit of NHS England Hospital Trust operating theatres.
The operating theatre journal, March 2022, Issue 378
For further reading https://bit.ly/OTJMAR2022

Human Factors.
The operating theatre journal, May 2022, Issue 380
For further reading https://bit.ly.OTJMAY2022

Human Factors.
The operating theatre journal, June 2022, Issue 381
For further reading https://bit.ly.OTJJUNE2022

Human Factors.
The operating theatre journal, July 2022, Issue 382
For further reading https://bit.ly.OTJJULY2022

Surgical Fires.
The operating theatre journal, August 2022, Issue 383
For further reading https://bit.ly.OTJAUGUST2022

Service Evaluation of the current World Heath Organisations Surgical safety checklist in Spine surgery at the University Hospitals of Derby & Burton (UHDB). Could this lead to a change at NHS Improvement?
The operating theatre journal, September 2022, Issue 383
For further reading https://bit.ly/OTJSEPTEMBER2022

Delphi Study Round One – A study across NHS England Hospital Trust Operating Theatres.
The operating theatre journal, December 2022, Issue 387
For further reading https://bit.ly/OTJDECEMBER2022

Surgical Fires – Why aren't surgical fires classed as a Never Event?
Clinical Services Journal (2023), Volume 22 (1), pp. 49-51
For further reading: https://content.yudu.com/web/1u0jl/0A1up6l/CSJ-January2023/html/index.html?origin=reader

Delphi Study Round Two - A study across NHS England Hospital Trust Operating Theatres.
The Operating Theatre Journal, January 2023, Issue 388, pp. 12 -19
bit.ly/OTJJANUARY2023

Understanding checklist challenges.
Clinical Services Journal, February 2023, volume 22 (2), pp. 25 -30
https://content.yudu.com/web/1u0jl/0A1up6l/CSJ-February-2023/html/index.html?origin=reader

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The Operating Theatre Journal, February 2023, Issue 389, pp. 12- 15
https://www.paperturn-view.com/uk/otjonline/the-operating-theatre-journal-9?pid=MzA304399

A deeper dive into safe surgery barriers.
Clinical Services Journal, March 2023, Volume 22 (3), pp. 19 –24
https://content.yudu.com/web/1u0jl/0A1up6l/CSJ-March-2023/html/index.html?origin=reader

Safe Surgery Checklists: final conclusions
Clinical Services Journal, April 2023, Volume 22 (4), pp. 19 22-
https://content.yudu.com/web/1u0jl/0A1up6l/CSJ-April-2023/html/index.html

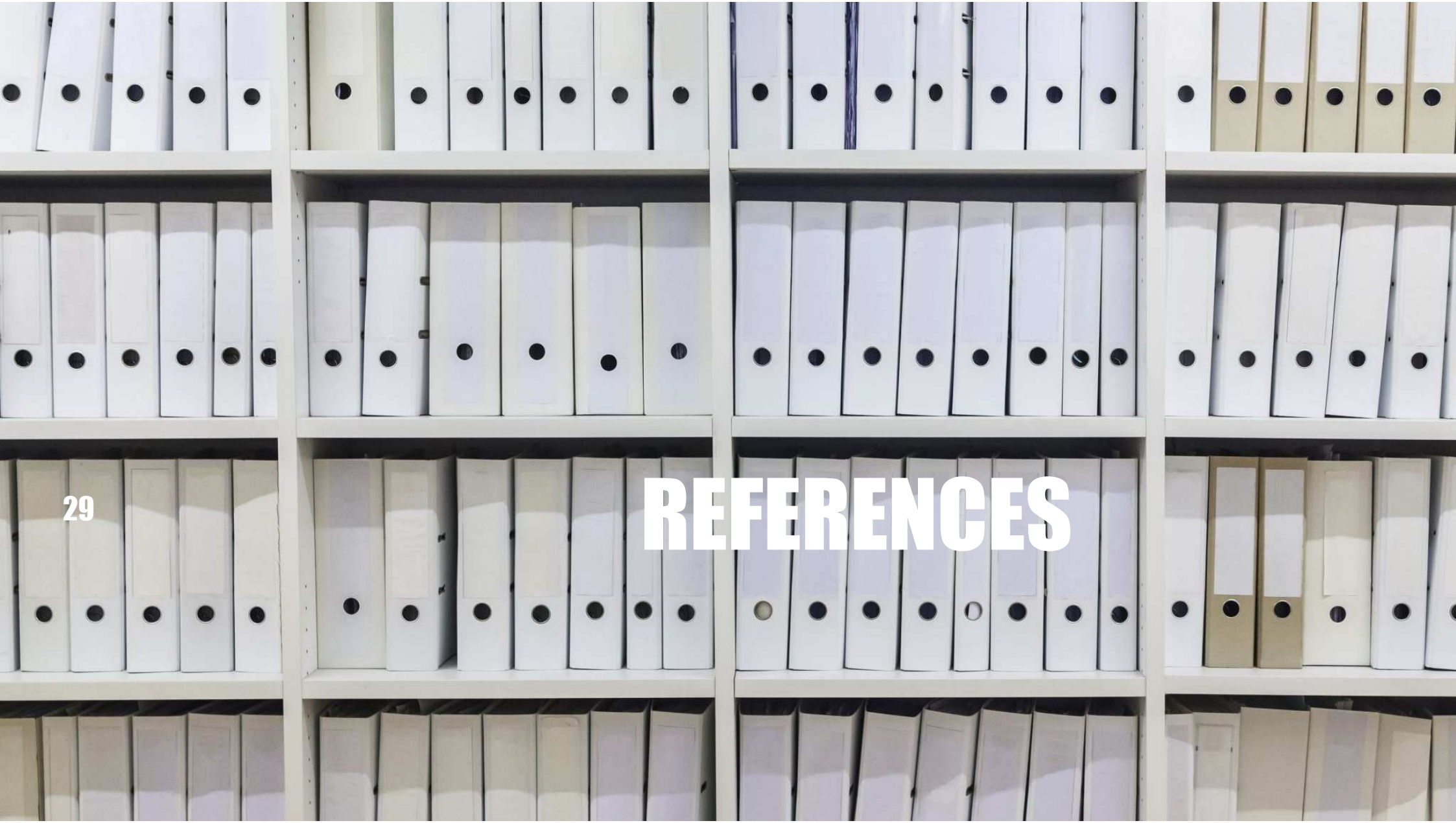
Surgical Fires: Why are they not classed as Never Events? (August 2022)
https://www.pslhub.org/learn/patient-safety-in-health-and-care/high-risk-areas/surgery/surgical-fires-why-are-they-not-classed-as-never-events-august-2022-r7448/

Why are intra-operative surgical Never Events still occurring in NHS operating theatres? (16th September 2022)
https://www.pslhub.org/learn/patient-safety-in-health-and-care/high-risk-areas/surgery/why-are-intra-operative-surgical-never-events-still-occurring-in-nhs-operating-theatres-r7452/Why are intra-operative surgical Never Events still occurring in NHS operating theatres? - Surgery - Patient Safety Learning - the hub (pslhub.org)\

Delphi Study round one – A study across NHS England Hospital Trust operating theatres (11th November 2022)
https://www.pslhub.org/learn/improving-patient-safety/human-factors-improving-human-performance-in-care-delivery/delphi-study-round-one-–-a-study-across-nhs-england-hospital-trust-operating-theatres-11-november-22-r8158/

Delphi study round two – A study across NHS England hospital trusts operating theatres (13th December 2022)
https://www.pslhub.org/learn/improving-patient-safety/delphi-study-round-two-a-study-across-nhs-england-hospital-trusts-operating-theatres-r8364/

The National Safety Standards for Invasive Procedures (NatSSIPs2) (5th April 2023) – NatSSIPs 2 combined with the WHO checklist infographic.
https://www.pslhub.org/learn/patient-safety-in-health-and-care/high-risk-areas/surgery/natsipps-2-sequential-steps-the-natsipps-eight-–-flow-chart-28-march-2023-r9095/



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