World Patient Safety Day – Safe Health Workers, Safe Patients

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The second ever World Patient Safety Day takes place today, 17 September 2020, with a focus on making health worker safety a priority for patient safety. Healthcare workers are currently working in what are arguably the most challenging conditions since the inception of the NHS. The Covid-19 pandemic has seen healthcare workers strive to continue to provide face to face care where necessary, with appropriate protection for themselves and their patients, and to adapt to provide remote healthcare services. Whilst patient safety remains the ultimate goal of any safety initiative, such initiatives cannot succeed without proper support and safe conditions for staff.

The WHO estimates that one in every ten patients in high-income countries is harmed while receiving hospital care, with nearly 50% of incidents being considered preventable. NHS Resolution reported the annual cost of harm arising from clinical activity covered by the Clinical Negligence Scheme for Trusts in 2019/20 was £8.3 billion. Improvements in patient safety can not only lead to better outcomes for patients by avoiding harm, but can also result in significant financial savings due to reducing claims and the need for further treatment. This in turn allows increased funding to be invested in patient care, innovation and preventing harm.

We routinely review the clinical negligence claims we advise on and provide feedback to our NHS Trust clients on risk management issues. We have reviewed our settled claims for hospital Trusts for 2019/20 to identify the most common causes of claims and risks to patient safety:

- **Lack of informed consent**

Consent continues to be one of the main themes since the decision in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

We continue to see numerous examples where the record of discussions regarding treatment options and risks was inadequate or incomplete, or where there is no record of the content of the discussion. All reasonable alternative treatment options should be discussed with patients, in a way they can understand, and the material risks of any recommended treatment should be discussed. Any conversation should be documented and ideally written information should be given to patients to allow them time to reflect on different options and to ensure they fully understand the risks and benefits of different options.

Our Trust clients have shown the ability to adapt to the changed working environment due to the current pandemic and have adapted the way consent is taken in some circumstances, including remote consent, and we discussed this in our recent podcast.

- **Inadequate examinations and investigations**

The WHO estimates that in the US, diagnostic errors contribute to approximately 10% of patient deaths and that diagnostic errors account for 6-17% of all harmful events in hospitals.

A review of our data saw multiple incidents of missed opportunities to make a diagnosis due to inadequate examinations being conducted and/or a failure to conduct further investigations. These incidents also highlight the need to ensure all relevant information, including any differential diagnoses being considered, is provided in any referral to inform the necessary investigations.

- **Failure to escalate**

In the cases we have handled we have seen multiple examples of failing to appropriately escalate matters in accordance with internal policies along with uncertainty about what should be done by senior staff/departments when referrals are received.
Clear referral pathways should be documented and awareness improved of internal policies/protocols. This is a vital part of junior doctor induction and the culture of working needs to encourage escalation upwards without fear. Wider system working is essential with clear routes to referrals in to specialist centres.

- **Pre-operative checks and surgical checklists**

We have seen a number of cases where pre-operative planning could be improved by seeking an opinion from another speciality, ensuring pre-operative checklists are fully completed or ensuring that all available imaging is reviewed prior to surgery. We have also identified areas where detailed procedure specific checklists could help to improve patient care, for example by outlining steps to be taken or additional checks to be made if the anatomy encountered is unusual and makes surgery challenging. Any surgical procedure carries risks and is associated with known complications. Ensuring that those complications are detected and addressed pre and intra-operatively is important to reduce ongoing harm to the patient.

GIRFT has highlighted this particularly in respect of Orthopaedics.

- **Record keeping**

An overarching theme throughout the majority of the cases we reviewed was the quality of documentation. Detailed record keeping helps to prevent incidents by ensuring all relevant information is available to anyone who reviews the patient's records. It is also vital that accurate information is captured – a mistake as simple as recording the wrong result in a patient's records could have serious consequences.

Detailed record keeping also helps to support internal investigations when things go wrong and to inform learning from any patient safety incidents.

Although any healthcare professional could be directly responsible for the types of errors outlined, improving patient safety requires action at an organisational level and requires the support of the leadership team. It is important to remember the human factors as well as system issues which can underlie many mistakes. These include fatigue, stress, familiarity, and working culture. Providing appropriate support to healthcare workers is crucial not only to enable the provision of safe care, but also to assist organisations in learning from mistakes when things go wrong. This issue has never been more important than at the current time with the challenges that all our healthcare workers face.

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