Appendix 3

Learning from Never events – A Wrong Site Extraction (WSE)

Including Reflective Learning Log for Appraisal

How does the team learn from a WSE?

Investigation and analysis of a WSE should collect information regarding not only the technical aspects of what went wrong but also the human factors that may have contributed to the WSE . Managing the response to Never Events is a critical component of corporate and clinical governance.

An open and supportive culture is essential to facilitate and enable open reporting and learning from Never Events.

Providers must establish effective governance mechanisms to ensure that:

- There is early, meaningful and sensitive engagement with the affected patients and/or their families/carers from the point that the WSE is identified, throughout the investigation and action planning, to closure of the incident. Details of the conversation must be documented in the patient records, and disclosure must not be delayed whilst the Never Event status is being determined. All staff should be familiar with related requirements of Being Open [15] and the Duty of Candour[2] and information should be shared in line with this Guidance;
- Investigations are undertaken by appropriately trained and resourced staff and/or teams that are sufficiently removed from the incident to be able to provide an objective view;
- Never Events are investigated via root cause analysis by specific dedicated and trained staff. Investigations should follow a systems-based methodology to ensure identification of all the possible contributory factors and root causes;
- The investigation will also identify focused actions, including those which relate directly to the patient and their family/carer, plus clear learning outcomes.

Effective governance mechanisms should be established to ensure:

- timely reporting and liaison with their commissioning bodies.
- the incident is reported to the CQC.
- compliance with reporting and liaison requirements with agencies such as: NHS Improvement ; the Care Quality Commission (CQC); Public Health England and the Health and Safety Executive.
- commissioners are encouraged to publish information relating to all serious incidents, including Never Events, within annual reports and other public facing documents such as governing body reports, including data on the numbers and types of incidents, ensuring patient confidentiality is respected. Incidence of Never Events must be identified in the commissioner's annual report and the provider's quality accounts, again ensuring patient confidentiality. This should include, where possible:
    - data on the type and number of Never Events, including historical context and related incidents;
    - a summary of each Never Event;

    - the learning derived from the incident(s), with a particular focus on the system changes that have been made to reduce the probability of recurrence;
    - how learning has been shared at all levels within the organisation, and also, externally.
- A strong and supportive culture, which supports the team involved in a Never Event, will enable the required learning from the incident and facilitate improvements in the quality of practice. The support provided is critical if we are to avoid 'second victims' amongst those members of staff involved in a Never Event such as wrong site extraction.
- At an individual level, the practitioner should be logging the incident and providing a reflection with learning outcomes for their Appraisal documents.
- **N.B. It is acknowledged that there is a need for a simplified reporting system and therefore, work will commence on developing a revised reporting system in early 2017.**

1. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013 - http://www.midstaffspublicinquiry.com/report 4 Patients First and Foremost: the Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry, Department of Health, March 2013 - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_

2. Building a Culture of Candour: a review of the threshold for the duty of candour and of the incentives for care organisations to be candid, March 2014 - http://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf 9 The Duty of Candour

3. *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation 2013* (https://www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=reporting+patient+safety+incident+to+CQC+from+primary+care+dental+practise

4. http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

5. Revised never events policy and framework 2015 *http://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/never-evnts-pol-framwrk-apr2.pdf*).

REFLECTIVE LEARNING LOG - for APPRAISAL

Patient Identifier:
Age & sex of patient:
Medical/Dental and relevant Social History:
Brief summary of Never Event, including: ● **Risk Factors**
Effect of never event on patient: ● **How will the outcome be managed?**
How did the clinical team manage the never event? • **What went well?** • **What did not go well?**
What has been learnt from the never event? • **Root causes** • **Mitigation of risk factors** • **What will be done differently next time?** • **How will it influence your future approach to similar cases?**
● How has the learning been shared amongst the team/service? **● Has the learning been reflected in updated operational procedures/training?** **● Have the members of the team who were involved in the never event, received adequate and appropriate support?**