How safe is your operating theatre?

In February 2014 NHS England published the Summary of the report of the NHS England Never Events Taskforce; Standardise, Educate and Harmonise; Commissioning the conditions for safer surgery. The purpose of this report was to put forward recommendations as to how the number of surgical never events in England can be reduced to an acceptable level as currently these are the most commonly reported types of never events in the NHS in England. In 2012/13 there were 255 surgical never events reported to Strategic Health Authorities: 83 wrong site surgery, 42 wrong implants/prosthesis and 130 foreign objects retained postoperatively.

C onsidering all of the processes which have been put in place since the introduction of the WHO checklist by the National Patient Safety Agency in 2009 never events are still occurring. So why is this happening? What the report found is that professionals, researchers, patient representatives and organisational leaders agree that:

• The Checklist is changing culture. There is now an increasingly widespread view that ‘this is the way things should be done’. By 2011, 91% of theatre staff surveyed would have wanted the Checklist used for their own surgery.

• Where the Checklist is treated as a tick-box exercise it is of limited use. The Checklist is not an end in itself, but a tool to promote systemic change and prompt safer behaviour. Like all tools, its effectiveness depends on the skill with which it is applied.

• The Checklist has promoted systemic change when professionals and organisations have embedded it into wider practices, protocols, and pathways. Similarly it has prompted safer behaviour when other means of changing behaviour – such as education and peer pressure – have been mobilised to support it. Beneficial outcomes are thus the result of professional leadership, organisational commitment, and time spent on local implementation.

• The Checklist alone is not sufficient. We must lower the prevalence of harm still further.

AFPP have had many reports from you as members about the struggle to get whole team buy-in to the correct use of the checklist, particularly your medical colleagues, through the Professional Advisory Service and networking at various regional events. Last month, Dawn Stott and I were invited to give a presentation about AFPP, the WHO checklist and never events to an NHS trust in England who had experienced never events in their own trust. Through the discussions with them at this event it was evident that they were using the checklist but not as it should be due to noncompliance from their medical colleagues and also apathy from some of their theatre colleagues to challenge this behavior. In addition when it was first introduced there was no real training on how to use it but just rolled out from one area where it was championed by an anesthetist.

The taskforce are therefore proposing a strategic approach that consists of three interlocking and equally vital elements:

1. Standardising generic operating room procedures (such as swab, needle and instrument counts) and will take a lead role in developing and continuously reviewing national standards. As you know AFPP already have national standards for theatre practice and we have been contributing to the taskforce discussions through representation on various committees via Mona Guckian Fisher and Tracy Coates.

2. Systematic education and training for undergraduate training for doctors, nurses and operating department practitioners and in postgraduate training for managers, and also continuing professional development for registered practitioners. It will be the responsibility of the HEE, GMC, Deaneries and medical colleges to ensure that there is appropriate safety training in all curricula.

It is the responsibility of the OQC to monitor and check for compliance of areas 1 and 2.

3. Harmonising activity to support patient safety in hospitals. The recommendation is that professional and organisational incentives must align to support safety and the development of a just culture. This will include applying financial penalties to trusts only if they fail to provide an effective response to a never event. The NHS Litigation Authority (NHSLA) will make explicit that national and local standards determine the legal standard of care and the register bodies (GMC, NMC and HCPC) will consider concordance with standards when assessing fitness to practice and issuing professional guidance.

Past President Tracy Coates is now working for the NHSLA which gives AFPP a good link to keep current with national implementation of the above processes.

I encourage you all to read the full report as this will definitely be impacting on your practice and you need to be fully aware of its impact.

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Reference
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