Never in a month of Sundays

There is often a gap in understanding amongst healthcare professionals on what constitutes a patient safety incident.

But is it just the surgeon that is responsible for ensuring that never means never? We know better. This is a priority responsibility of our involvement in the process of delivering perioperative care. We have the standards which need to be applied in order to ensure this. Standards of practice that have been available and in place for many decades. Failure to apply the standards results in often catastrophic outcomes.

In September 2015 NHS England launched a set of 13 national standards compiled by an expert task force of which AfPP were involved in order to attempt to provide a solution to this very real and ongoing problem.

The National Safety Standards for Invasive Procedures (NatSSIPs) were published to support the provision of safer care and to reduce the number of patient safety incidents related to invasive procedures.

Four people die and more than 125 are badly hurt every day in the NHS as a result of errors in their care.

I have heard argument many times that in the scheme of things these statistics are a small proportion of the overall numbers of patients treated in our hospitals. Indeed, there is some justification for this argument in the world of statistical analysis.

However, my argument poses the question of how much does this analysis change if one of the 120 is someone you know or someone you love? Your parent, child, husband, mother, father, niece, nephew, grandparent, friend, partner, neighbour, other, that is affected by error on a daily basis in the NHS?

The statistics available for the month of January this year (January 1-31, 2016) show that there were 22 serious incidents that appear to meet the definition of a never event as outlined in the never events list 2015/16.

Of these incidents 11 are identified as wrong site surgery, 5 as wrong implant or prosthesis, 5 retained foreign objects post procedure, and 1 is a misplaced naso- or oral-gastric tube.

The previous month in December 2015 there were 31 serious incidents meeting the definition of a never event. Of these there were 12 wrong site surgeries, 6 retained foreign objects post procedure, 5 wrong implant procedures, 3 misplaced naso- or oral-gastric tubes, 3 wrong route administration of medication errors, 1 fail from poorly restricted windows, and 1 overdose of methotrexate for non cancer treatment.

It doesn’t take a rocket scientist to work out that the majority of these incidents described above sit firmly in the perioperative/interventional areas of healthcare. That’s us my friends and colleagues.

Never needs to improve greatly on a month of Sundays, and for that we are all responsible.

References

Association for Perioperative Practice 2016 Standards and Recommendations for Safe Perioperative Practice (awaiting publication 2016) Harrogate, AfPP

Darzi A 2016 These appalling errors bring shame on surgeons The Times, Tuesday, 13 February (Lord Darzi of Denham was a Labour Health Minister 2007-09)


Saying something will not happen in a month of Sundays, generally means that it is not likely to happen. It’s the use of exaggeration as a figure of speech and means a long unspecified period, but a month of Sundays doesn’t mean something will never happen. www.collinsdictionary.com
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