TABLE 2

Comparison of findings of preliminary internal and Human Factors-led external reviews of the first three incidents investigated. The “dimensions” of the workplace setting identified as relevant to the incident (as described in the text ) are noted in parentheses in the Independent Review column.

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|  | Internal Investigation | Independent Review |
| Incident 1 (Omission of anticoagulation) | Causal influences identified   * Lack of prompt on EPR\* to restart anticoagulation. * Inability to review all medications on one screen in EPR | Causal influences identified   * Failure to seek surgical advice over complex post-surgical effusion *due to* excessive workload and inadequate supervision of junior medical staff.   (Culture, Environment, Organisation/System, People)   * Major delays in decision making whilst anticoagulation was suspended *due to* weak systems for making, recording & and reviewing treatment plans. (Environment, Organisation/System, Task) * Inappropriate test (CTPA instead of CXR) ordered to evaluate chest drain, leading to 4 day delay in restarting anticoagulation *due to* lack of appropriate supervision of junior staff *and* absence of systems for regular review of patient status and plans (Tools, Organisation/System, People) * Failure to restart anticoagulation after procedure *due to* EPR issues as noted by internal team *and* unclear responsibility for post-procedure care. (Tools, Organisation/System, Culture) |
| Recommendations made   * Omit rather than suspend doses of anticoagulation for patients undergoing a procedure, if date of procedure is unknown. * Addition of an EPR function to allow prescribed medication to be viewed by category. | Recommendations made   * Review interdisciplinary working between resp. medicine and thoracic surgery; develop better referral protocols/guidelines * Overhaul ward round & handover procedures on resp. medicine to improve supervision, reduce delays and clarify plans * Revise EPR prescribing screens to allow view of all medication, permit a SUSPEND function with regular PROMPTS to restart medication |
| Incident 2 (Administrative error in reporting) | Causal influences identified  **Staff factors**: Inappropriate assumption of authority to change reporting process; no situational awareness of impact of decision.  **Organisation**: Lack of governance structure, policies, SOPs, audit, quality control or assurance to guide and monitor reporting. Unreliable general admin systems.  **Communication**: Inadequate communication from management to staff and vice-versa  **Equipment**: no ability to request histopathology tests electronically | Causal influences identified    Internal Investigation analysis endorsed, with one major addition: Appointment of clinical staff to administrative posts without training in required skills, or appropriate time allocation for management duties was an important Culture-related permissive factor allowing the Staff, Organisation and Communication problems to develop. |
| Recommendations made   * Development of policies and procedures to guide reporting process * Improved management/staff communication and development of quality assurance processes * Extension of electronic requesting and reporting to include histopathology * Modification of electronic system to ensure audit of report receipt and action * Endoscopists to ensure that referring doctor is sent report | Recommendations made   * Internal Investigation recommendations endorsed * Adequate training in administration, management, governance and quality assurance to be given to Drs with significant administrative responsibilities |
| Incident 3 (Perinatal death) | Causal influences identified   * Inappropriate allocation of high-risk labour to junior midwife * Failure of midwife to appreciate warning signs and call help * Delay in obtaining US scan * Failure by US staff to respond rapidly to bradycardia on US scan * Failure of Obstetric registrar to attend immediately when shown scan | Causal influences identified   * Missed opportunities in ante-natal clinics to highlight IUGR and re-categorise pregnancy early on   (Culture, Organisation, People)   * Lack of clear unit protocols or SOPs for IUGR, GpB Strep and PROM (Organisation, Task, Tools) * Patient not transferred to specialist unit although no neonatal bed was available locally, *due to* communication breakdown or unclear leadership. (Organisation, Culture, People) * Loss of situational awareness leading to decision to repeat USS scan when patient had signs of active labour *due to* lack of experience or supervision   in midwifery team (Organisation, People)   * Communication breakdown between midwifery and obstetric team led to delay in decision to go to section (Organisation, Culture, People) |
| Recommendations made   * Meeting with senior Midwives to stress importance of appropriate staff allocation * Training lecture for midwives on premature labour, bradycardia and urgent escalation * Training meetings with ultrasound staff around prioritisation of cases and response to warning signs * Reflection meeting with Registrar around response to emergencies | Recommendations made   * Review cultural and leadership issues in Midwifery unit * Address workforce and experience issues against clinical acuity in obstetric service * Conduct multidisciplinary review of local antenatal care pathways, policies and SOPs for IUGR & high risk pregnancies including policies for escalation of care, against national guidance on best practice * Review of training needs and support for midwives and trainee obstetric staff. * Review of processes for prioritisation of ultrasound examination of antenatal patients and for escalation of concerns from USS to labour ward. * Consider providing USS service at point of care. |