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)
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| 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
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| 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
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| 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)
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| 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.
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