Beyond Reason: midwives and anti D

Sinead Mc Nally
Clinical risk Coordinator Reproductive Health.
NHS Lothian
Edinburgh

SHOT annual update meeting
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Royal College of Physicians, London
Activity and areas of responsibility

- 6,500 births
- >2,500
- Gynaecology
- EFREC
- PSC
- Maternity; community/hospital
- Neonatology 44 cots
Background

OWAM(2000)
BSNHS(2001)

The Reason Model
and Accident Causal Chain

Organizational Influences
Latent Failures
Unsafe Supervision
Latent Failures
Preconditions for Unsafe Acts
Latent Failures
Unsafe Acts
Active Failures
Failed or Absent Defenses
Mishap

Source: Adapted from Reason, 1990
Google
SERIOUS HAZARDS OF TRANSFUSION

Patient
Develops ARDS

Improper ventilation technique

Inadequate patient monitoring

Lack of supervision

Inadequate training and staffing skills mix

Communication

Transfer guidelines
accidents and incidents

defences in depth

unsafe acts

psychological precursors of unsafe acts

line management deficiencies

fallible decisions
The “in approach”

- Systems rather than individuals
- No blame culture
- No blame statement

Therefore the completion of this form will not on its own, lead to disciplinary action except where acts or omissions are negligent or malicious or criminal, or constitute misconduct.
Errors in Healthcare: Systems or Individuals? Have we got the balance right?

Sinead McNally
Clinical Risk Coordinator for Reproductive Health

William Longworth
2007
The worm turns....
"Until the computer is back in service, everything that goes wrong should be blamed on the copier."

- Avoid responsibility
- Obtain a scapegoat
- Poor investigation
- Satisfy media
- No learning
- Cover up.
A Tale of Two Cultures

- Blame and fear.
- Asking “who went wrong” (If things are not working, look for what the people are doing wrong and then give them a rollicking)
- Whose fault? Whose head must roll?
- Little opportunity to learn in a blame culture

- A No-blame culture.
- Asking “what went wrong” “why did it go wrong” (If things are not working, find out which processes need to be changed.
- What happened? What can we learn?
- Staff share and learn from mistakes.
“The safety agenda requires us to switch from an individual focus to a systems focus but in making this switch, professional accountability has been cast as the “black sheep” of safety improvement”

Prof Walton 2004
“Just as it was wrong in the past to focus only on individuals, it is equally wrong today to think all adverse outcomes are caused by system problems with no attention to professional duties and responsibilities.”
The perceived contest between whether individuals or bad systems cause patient injuries has confused many health professionals and managers.
“A blame culture is neither feasible nor desirable” (GAIN 2004)
People who fail to act responsibly (e.g. premeditated or intentional unsafe acts or decisions involving a reckless disregard toward the safety of patients) remain exposed to consequences.
Medication errors

MgSO4
Fentanyl/IV Antibiotics
Clexane
IV Antibiotics
Abidec
Diamormphinne/Syntometrine
Error causation....

What did these have in common

- Overfamiliarity
- Complacency/endemic
- Retirement
- Complaining culture
- Looked ..didn’t check
- Assumptions “told me to do it”
- Distraction
FIVE RIGHTS

Right Drug
Right Patient
Right Dose
Right Route
Right Time

A BIRD IN THE HAND
Responsibility for the final check........
at the bedside.

“Some of the errors detected (such as those involving paracetamol or morphine sulphate) could have potentially led to an adverse event if they had been administered without insight. This highlights the essential role that each team member plays in preventing drug events: in particular, vigilant nursing (midwifery) staff who are placed within the system to be the last person who has the opportunity to check the medication is appropriately prescribed and dispensed before it is administered.”


Recent administration/checking events:

konakion
Clexane
Anti D
MgSo4
Think risk....think checking.
Responsibility for the final check at the bedside.

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Recent administration/choices:
- konakion
- Clexane
- Anti D
- MgSo4

Think risk....think checking.
Anti d errors and strategies to prevent reoccurrence
Supervisor of midwives
Investigation process
Action plans
Remedial action

- Change of practice area
- Provide evidence of supported practice on the administration of anti d
- Complete e learning module “better blood transfusion level 1Safe Transfusion Practice
- Complete the NHS Lothian Accountability Workbook
- Complete the NHS Lothian documentation workbook
Conclusion.

• FROM HUMAN FACTORS TO ORGANISATIONAL FACTORS AND BACK AGAIN........

• HAS THE PENDULUM SWUNG TOO FAR?

• FROM “BLIND EYE “ TO “NO BLAME”? 
The way forward......

Don’t abandon accountability!

**Accountable:** Answering for one’s own conduct and obligations, meeting commitments, doing what you say you are going to do

**No-blame:** People who make honest mistakes or misjudgements will not incur blame........
ANY PERSONS (EXCEPT PLAYERS) CAUGHT COLLECTING GOLF BALLS ON THIS COURSE WILL BE PROSECUTED AND HAVE THEIR BALLS REMOVED.