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EORNA
EUROPEAN OPERATING ROOM NURSES ASSOCIATION

9th EORNA Congress
16-19 May 2019
The Hague, The Netherlands

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International Federation of Perioperative Nurses

Never Events & the XY Factor-UK Experience

Mona Guckian Fisher

President-IFPN

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Human Factors

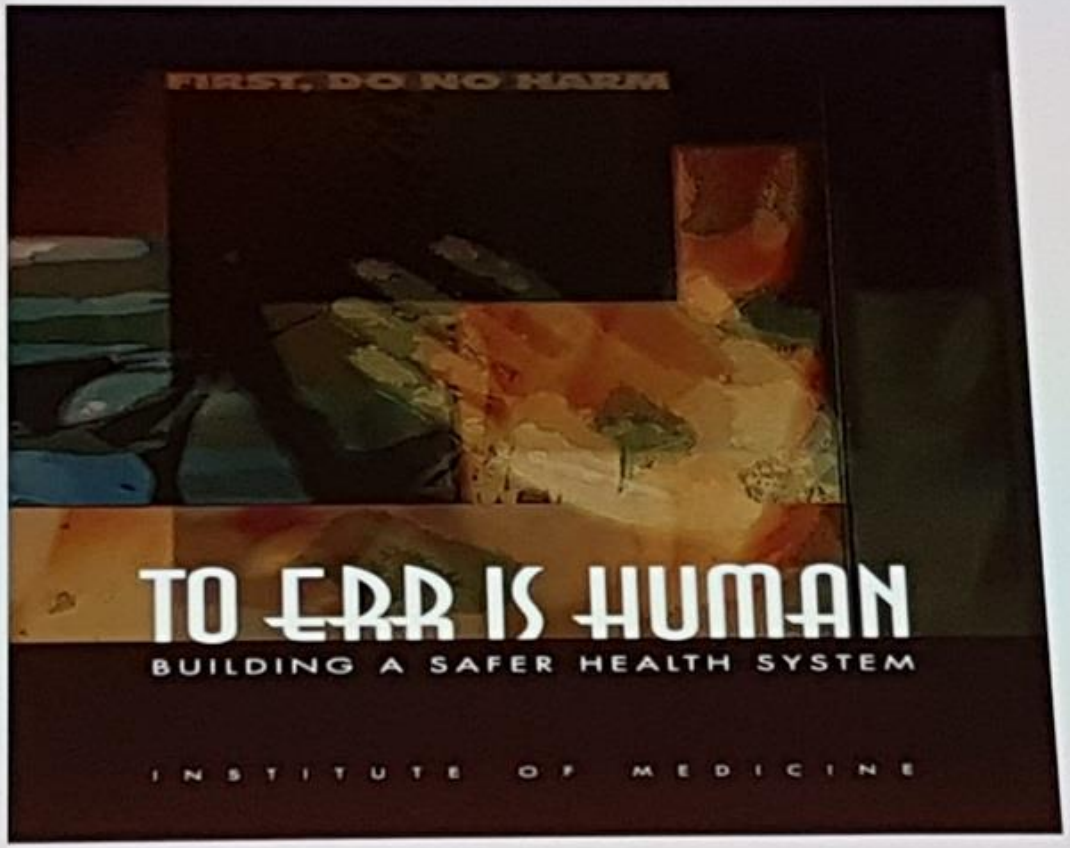
X X

female

X Y

male

Institute of Medicine Report – 1999



'Hospitals Can Be Dangerous Places'

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Perioperative Nurses- Safety Critical Responsibility

Surgical procedures- intended to save lives
can cause substantial harm with significant implications

Avoidable Harm-The Scale of the problem…

- **England** -the Hogan, Darzi and Black analysis say that 3.6% of hospital deaths have a 50% or more chance of being avoidable – that's potentially 150 avoidable deaths every single week.

- **Holland** and **New Zealand** make similar estimates. (UK Health Secretary Address March 2016)

- **US** estimate - up to 100,000 preventable deaths annually

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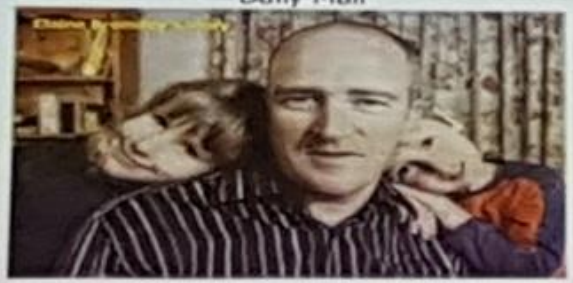
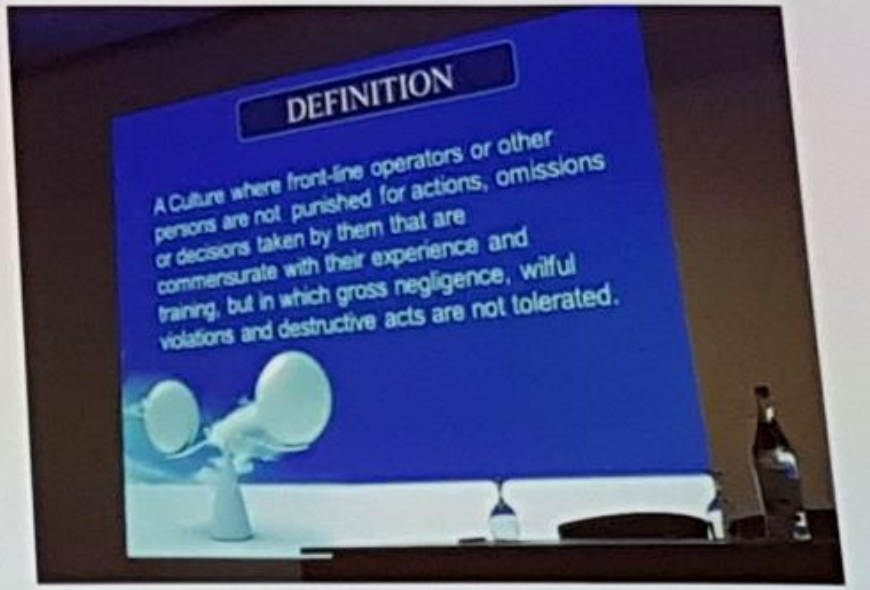
& WHO statistics tell us..

- reported crude mortality rate after major surgery is 0.5-5%
- 25% of patients have complications after operations
- Industrialised countries, nearly half of all adverse events in hospitalised patients are related to surgical care
- at least half of the cases in which surgery led to harm are considered preventable
- mortality from general anaesthesia alone is reported to be as high as 15% in some parts of sub-Saharan Africa (http://www.who.int)

Mum died after medics failed to act decisively

Daily Mail





Human Factors in Healthcare

Human Factors -ergonomics is a discipline that considers **both the physical and mental characteristics of people** as well as **the organisational** factors or wider socio-technical system.

The application of scientific methods to the design and evaluation of tasks, jobs, equipment, environments and systems **to make them more compatible with the needs, capabilities and limitations of people.**

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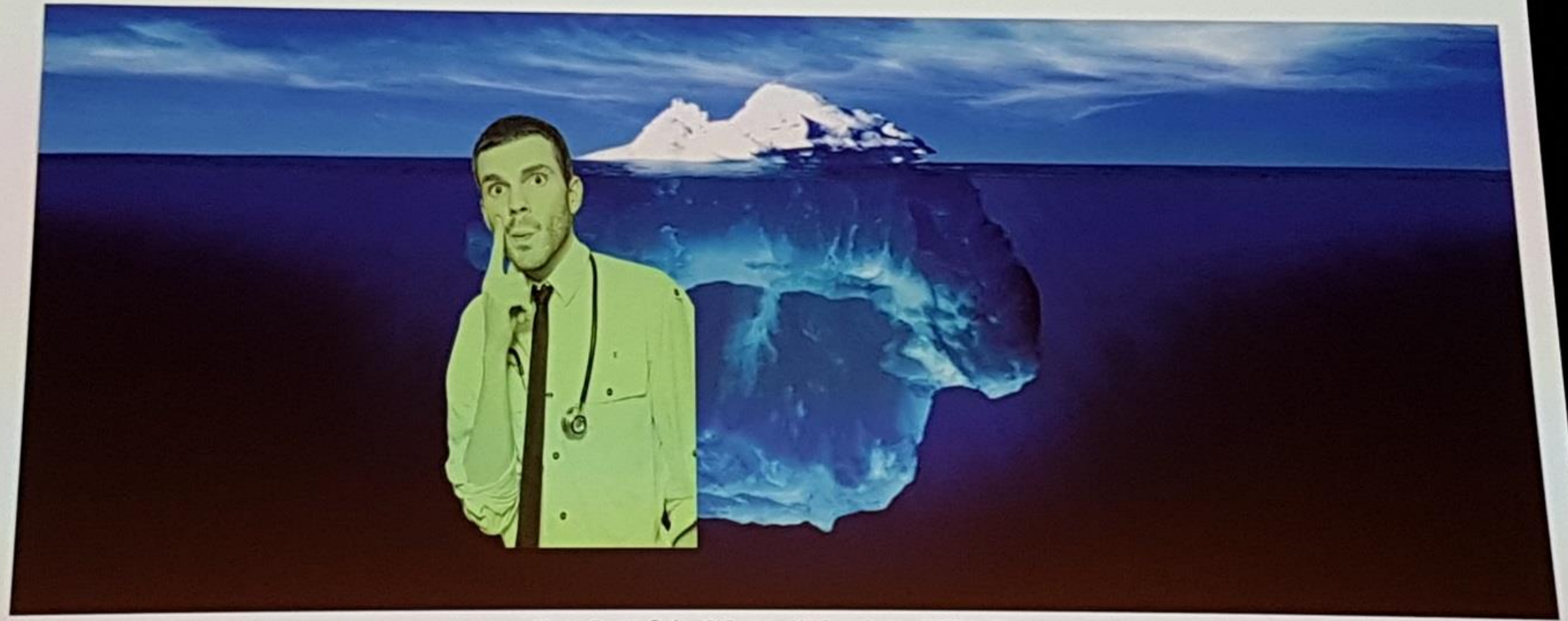

Never Events & the XY Factor - UK Experience -EORNA- The Hague-2019

Definition: Never Events

- Never Events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations.

Surgical Never Events are the most commonly reported types of Never Event in the English NHS

Serious Adverse Events-Incidents

- & **Serious Incidents** are defined differently…

- Serious Incidents -adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

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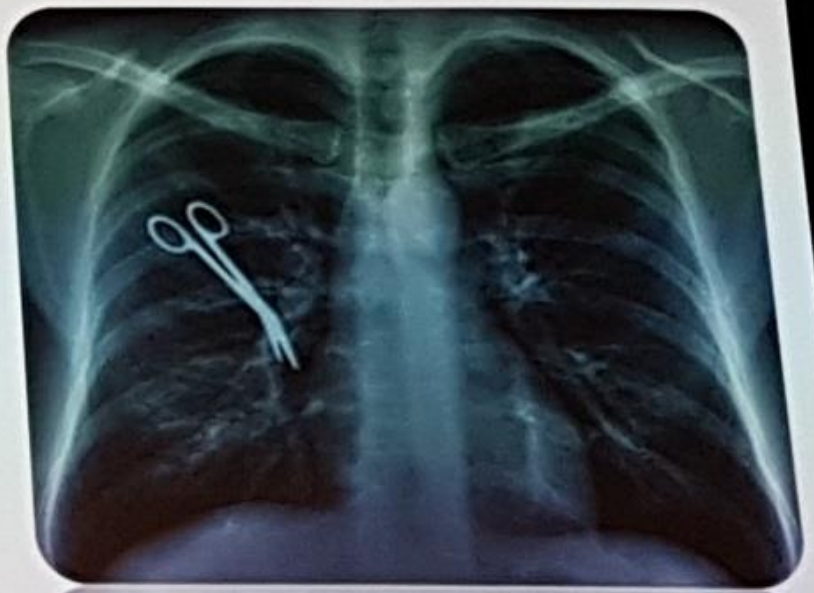
Total 496 incidence reported as Never Events (NE) in England NHS between 1 April 2018 and 31 March 2019

NHS

- Wrong site surgery - **207**
- Retained foreign objects post procedure - **104**
- Wrong implant prosthesis - **63**

75.4%



http://www.improvement.nhs.uk

What does the data tell us??

- **2017 – 2018: Total = 407**

- Wrong site surgery 175
- Retained foreign object post procedure 102
- Wrong implant- prosthesis 63

2018 – 2019: Total = 496

- Wrong site surgery 207
- Retained foreign object post procedure 104
- Wrong implant- prosthesis 63

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The underlying causes of Surgical Never Events

- Denial-Increase from 41% to 75% from 2017-2019
- Human fallibility
- Miscommunication
- Poor co-ordination of team activity
- Human-technology interaction
- Sub-optimal management of the environment

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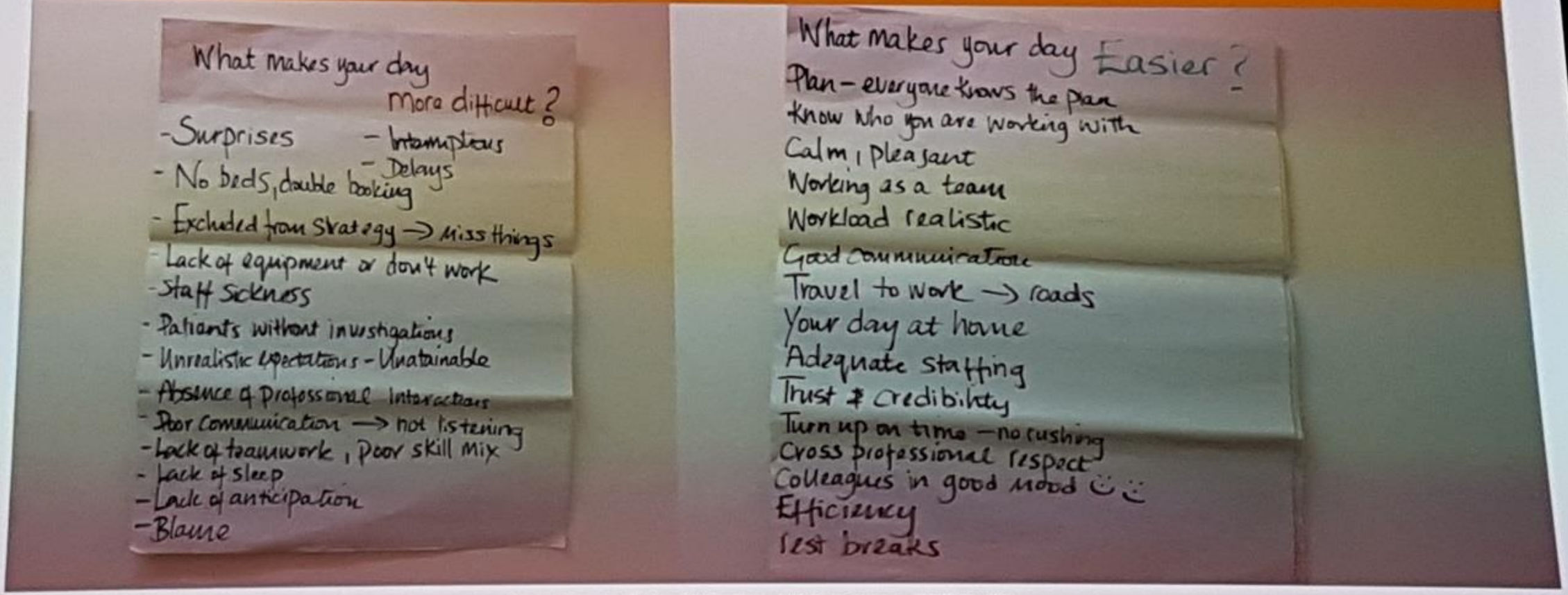
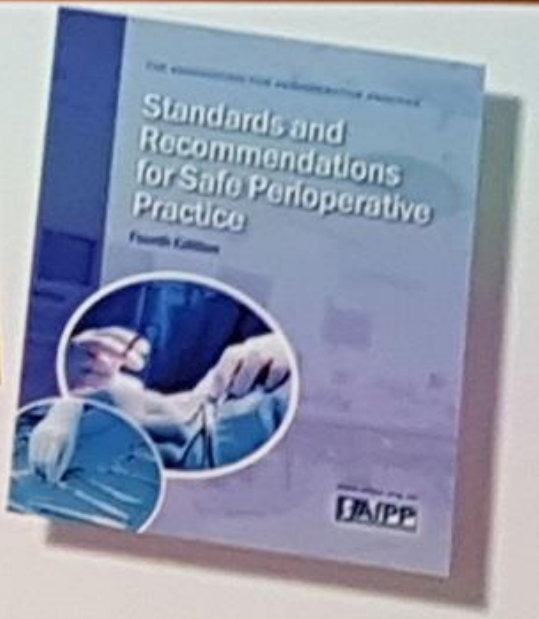
What makes your day? + & -



How do we attempt to reduce the Risk?

NHS England

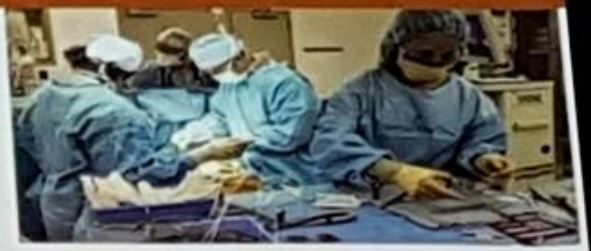


- Communication
- Situational awareness
- Consistent compliance with standardised processes
- Multidisciplinary team training-teams that work together should train together!
- Speaking up
- Stop the BLAME game – Just Culture

The heart of the healthcare professionals conflict

In the one

the organisation whispers



'never break regulations. Never take a chance. Never ignore written procedure. Never compromise safety.....

Yet .....

in the other ear they whisper *'don't cost us time. Don't waste our money. Get these patients through the system, do not breach the targets -don't find reasons why you can't'*

Adapted from Aviation reference in Dekker 2017.

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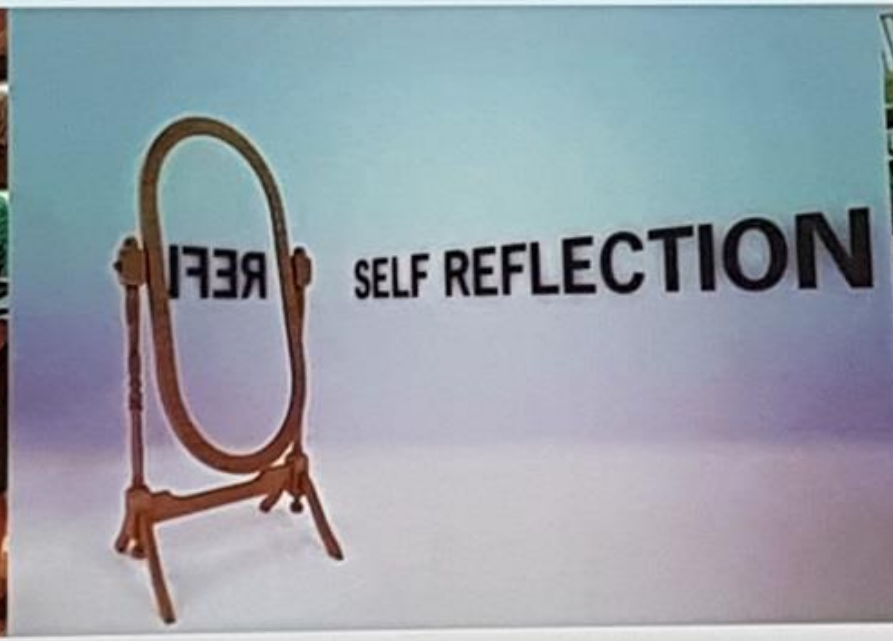
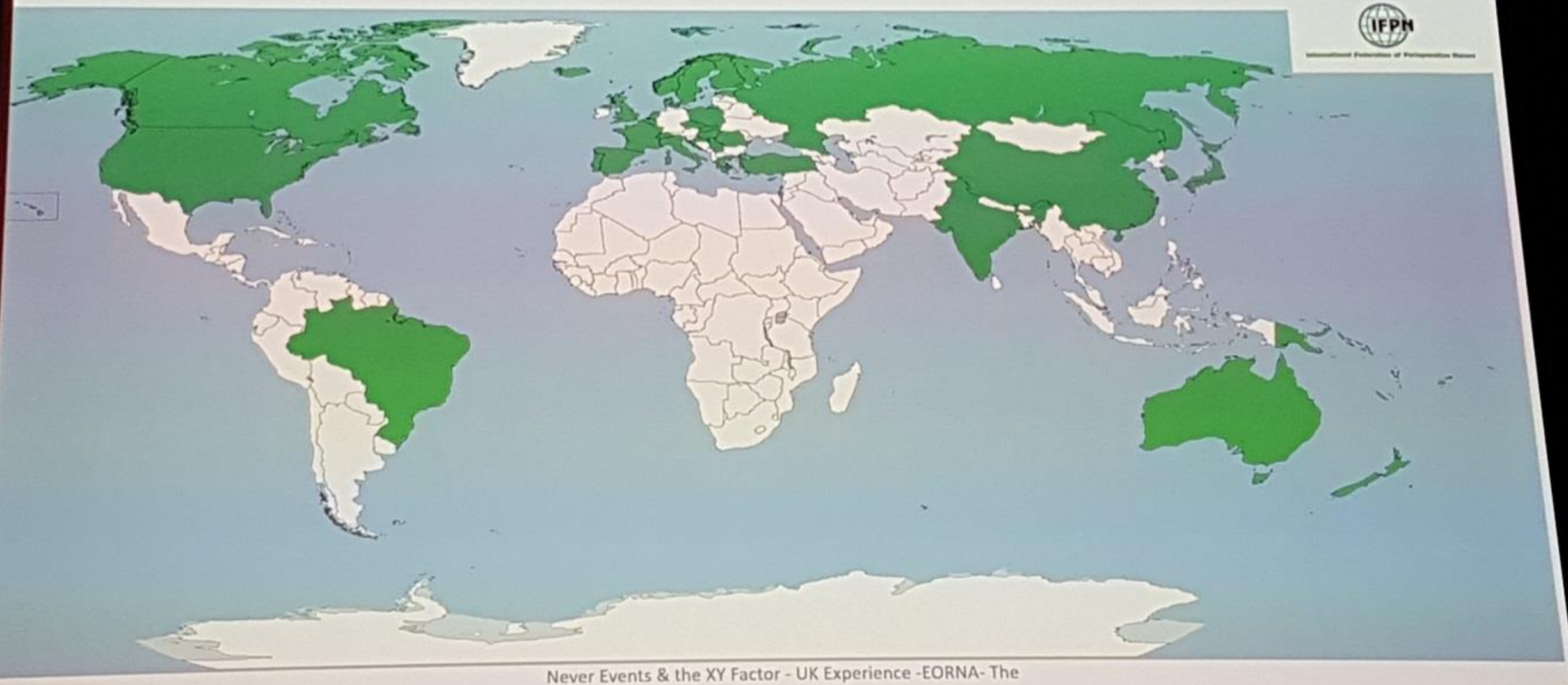
Responsibility-Ownership-Teamwork-Acceptance



Looking at the problem & the solution- It always begins with me…

International Federation of Perioperative Nurses (IFPN)



Can we make a positive contribution to the Reduction of harm to Patients & Colleagues in perioperative practice?

ACORN AUSTRALIAN COLLEGE OF PERIOPERATIVE NURSES

ΣΥ.Δ.ΝΟ.Χ.

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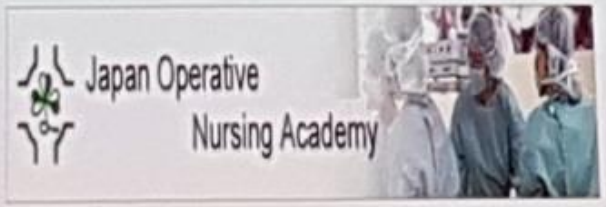
EORNA European Operating Room Nurses Association

PERIOPERATIVE NURSES COLLEGE N.Z.N.O

AORN Association of periOperative Registered Nurses

SOBECC NACIONAL ASSOCIAÇÃO BRASILEIRA DE ENFERMEIROS DE CENTRO CIRÚRGICO, RECUPERAÇÃO ANESTÉSICA E CENTRO DE MATERIAL E ESTERILIZAÇÃO



IAoRPN

Operating Room Nurses Association of Canada

Association des infirmières et infirmiers de salles d'opération du Canada

KAORN 수술간호사회

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