Incident 3 – WHO checklist incident

Doctor in training at ST5 in Clinical Radiology

Incident and resulting actions

A left-sided nephrostomy was requested on a patient with a single functioning left kidney. The procedure was planned for the next day's intervention list within the radiology department. The procedure was planned to be performed by the trainee under the supervision of a consultant interventional radiologist. A request form was completed for the left sided procedure.
The patient deteriorated between the request and the time of the planned nephrostomy and was showing signs of sepsis. The renal team felt that the sepsis was emanating from the non-functioning right kidney, and there was a discussion with the consultant interventional radiologist who agreed to drain the right kidney. The trainee was not aware of these discussions.

The patient came to the radiology department with documentation and pathway for a planned intervention on the left side. The list/white board in the department stated a left sided intervention. For the clinical reasons the trainee, however, performed a right-sided procedure under supervision, with no alteration of the paperwork or request form. No site-specific mark was used.
As the procedure did not tally with the documentation a clinical incident form was competed as this could represent a never event relating to wrong side intervention.

The trainee was supported through the investigation by his Educational Supervisor. It was noted that no skin marking was performed in this case but the guidance in radiology in this area is being developed by the Royal College of Radiologist as often the access point for an interventional procure may be on a different side to the target lesion. It was also noted that there was no documentation of the conversation between the renal team and the interventional radiologist and no new request as the intervention had changed.

The investigation concluded that this wasn't a never event as the patient had the correct procedure based on his clinical situation. It was recognised that the documentation did not support this and that there needed to be clarity on skin marking for invasive procedures in interventional radiology.

Reflective templates on this incident

These are examples of how the trainee may have undertaken and documented reflection on this event.

Personal reflection can help doctors consider the difference between what you were thinking at the time and your learning looking back after the event in order to help you think differently if something similar happens in the future.

A. Reflection based on Schon

Reflection-in-action – thinking ahead, analysing, experiencing, critically responding (in the moment)

What were you thinking at the time?

I was keen to understand why the clinical priority had changed in this patient and how we could best act to prevent further sepsis. I felt it was important to treat the patient and not the paperwork.

What was influencing that thinking?

I want to provide the best care for patients and treat situations as they arise. I felt that clinicians should adapt to changing clinical priorities, even if the paperwork does not support this.

I'm not sure the trainee did think about the paperwork at the time.

Reflection-on-action – thinking through subsequent to the situation, discussing, reflective journal

What is your thinking about the event now? Having time to think, discuss, review information etc

Safe site surgery has been around for a while and has gained considerable acceptance within the workplace in conventional surroundings such as theatres. Adapting these checklists for other areas such as interventional radiology is not so straightforward as the site and lateralities of access for intervention can frequently be different to the site and laterality of the target lesion. The process around this are described in the NATSSIPS (National Patient Safety for Invasive Procedures) guidance, but the specific guidance in radiology is currently being developed. It is very clear that never events should not happen, and that systems and checklists should be put in place to avoid this scenario. I have spoken to colleagues who are surgical trainees and they state that if the operation changes from the published list, then the list has to be altered along with new documentation. They also describe a briefing that occurs before any list of procedures as a final check on documentation. On reflection, I feel we should have adopted this approach and will wait for guidance on marking from the college. It was, however, the correct thing to do for the patient at the time.

Reflection can help manage the emotional impact of professional life. This can be personal or shared with a colleague/ trainer/ appraiser. The next 2 examples illustrate a professional approach to managing your emotional health and personal development

B. Reflection - The what, why, how approach

What do you want to reflect on?

An incident relating to safe site intervention

Why do you want to reflect on it?

When performing invasive procedures, it is vitally important to perform the correct intervention and avoid a never event. The checklists and documentation should prevent a never event.

Patients' clinical needs can change, and clinicians need to be able to change plans, however the processes need to facilitate this and not hinder. It is also important that colleagues collaborate to get the best outcomes.

How did you and how will you learn from this?

There is a different in the ethos in site marking in Interventional Radiology as the site of access can frequently be different from the site of the target lesion. The national guidance on this issue is being developed.

How have you been affected by this?

This episode really brought home how it could be possible to treat the wrong side of a patient, especially if the processes and checklists to support the prevention of a never event are still being developed. It also showed that translating processes from one part of an organisation to another department is not always straightforward, especially when the custom and practice is not as mature.

e.g. Being involved in the investigation made me anxious even though I was supported by my trainer and it is clear I did the right thing for the patient. I now better understand the importance of documenting changes to the treatment plan to ensure others are clear what is being done.

C. <u>Reflection based on Rolfe et al</u>

What? – (a description of the event)
What happened? What did I do? What did others do? **What did I think or feel?** What was I trying to achieve? What were the results? What was good or bad about the experience?
A patient had an invasive procedure on side different from what was requested and what was on checklists due to a change in the clinical situation.

So, what? – (An analysis of the event)
So, what is the importance of this? So, what more do I need to know about this? So, what have I learned about this? So, what does this imply for me? What do I feel about this?
Treating the opposite side to what was requested was the right thing to do to treat the patient's sepsis, but the documentation did not support this. Should we be treating the patient or the documentation? In the end the documentation should support what we do to patients and prevent errors. Wrong site surgery is a never event and the principles of surgery should translate to other invasive procedures performed outside the operating suite.

Now what? (Proposes a way forwards following the event)
Now what could I do? Now what should I do? Now what would be the best thing to do? Now what will I do differently next time?

I have reviewed the advice given by NHS England in invasive procedures. I have also discussed the custom and practice with colleagues who work in surgery in the operating department where safe side surgery and the WHO checklist are more established.

The guidance on invasive procedures in interventional radiology are being developed as frequently the site of access from the intervention can be different from the site of the target lesion.
I do feel the practice of a pre-list briefing would be beneficial as it allows the details of the case to be refreshed should there be new clinical information and allows planning of the procedure.

This final example provides a template for the practitioner to document planned changes to practice following reflection.

Template: Reflection based on Gibbs reflective cycle

Gibbs, G. (1988) *Learning by doing. A guide to teaching and learning methods*. Oxford Polytechnic: Oxford.

To fully learn from a situation, *what else could I have done* is a vital component. How this is recorded is a source of anxiety. It is likely that in a situation such as this, you will discuss alternative strategies for dealing with a similar situation again with your supervisor or other trusted senior. If you do not feel comfortable recording the details of your discussion here, it is acceptable to document that a discussion has taken place (see below).

Description – what happened?

A patient was planned to have an intervention to one organ. Due to a change in the clinical situation and following a discussion between the host team and the radiology department it was decided to treat the other organ to drain sepsis. The documentation on this patient all reflected the initial planned procure.

The patient made a good recovery from his sepsis.

Feelings – what were you thinking and feeling?

I was focussed on doing the right thing for a patient to adapt to a changing clinical situation. I felt that colleagues were communicating to change a plan for the benefit of the patient. The documentation and pathways seemed of secondary importance and in fact a barrier for clinicians to be flexible.

Evaluation – what was good and bad about the experience? What went well and what went badly?

The patient made a good recovery from his sepsis and changing the intervention was the right thing to do.

The documentation not supporting the change did lead to an investigation, which was time-consuming and caused me to consider how a wrong site intervention may occur.

Analysis – what sense can you make of the situation?

I have had to reflect on why safe site surgery pathways were introduced. There is national guidance in this area on the NHS England website. The challenge however is to see how custom and practice that has become the norm in operating theatres can be translated to other areas of the hospital where invasive procedures are performed. There is a particular challenge in radiology as the site of

access for intervention can be different from the site of the target organ, and the guidance on this is being developed.

Conclusion – what else could you have done?

I could have asked for a pre-list briefing to take into account the changing clinical information. This could have acted as a trigger to change documentation to reflect the change in side of the proposed procedure.

Or

I discussed alternative strategies for dealing with this situation with my supervisor and devised the action plan below.

Action plan – if it arose again, what would you do?

I will perform a pre-procedure briefing prior to any intervention and ensure that the documentation reflects the planned procedure. I will wait for the guidance in this area to be developed by the Royal College.