Learning from incidents

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infant PATIENT SAFETY Working together

Revised in 2015, the *Serious Incident Framework* devised by NHS England,[1] describes serious incidents as those which: "Include acts or omissions in care that result in: unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm including those where the injury required treatment to prevent death or serious harm or abuse." This article will describe the process for investigation of a serious incident by way of a case study and consider how implementing a 'just culture' can enhance support for staff and the investigation process.

The incident

All infants born to hepatitis B positive mothers require a first dose of hepatitis B vaccination within 24 hours of birth. Depending on infection markers, viral load and/or the infant's birth weight, hepatitis B immunoglobulin may also be required with the first vaccination.

A term infant who required the hepatitis B vaccination and immunoglobulin following birth only received the vaccination. This case involved the maternity and neonatal units. The omission in care was identified when the baby was reviewed as part of a paediatric follow-up appointment. The incident was declared a serious incident.

This case fulfils the definition of a serious incident: the infant required vital treatment and the omission in receiving medication may have an impact on the future wellbeing of the infant. While it is recognised that the administration of the hepatitis B vaccine and immunoglobulin does not exclude the possibility of the infant acquiring hepatitis B, without it an opportunity to receive a key component of clinical care has been missed, which may have affected the newborn infant's long-term health.

The investigatory process

Following identification of the incident via the in-house reporting system, an internal meeting (known as a 72-hour meeting in the NHS England *Serious Incident Framework*) to discuss it was arranged. Joint meetings support a platform for cross specialty working (maternity and neonatal teams) with representatives from Public Health England. The internal meeting also provides an opportunity to ensure that staff and the patient/next of kin (in this case, the parents) are well supported and receive information regarding the omission in care. As part of a serious incident investigation it is mandatory to inform the parents of an incident when it occurs. This is known as statutory 'duty of candour' and clinicians need to be open and transparent with patients about their care and treatment, especially when it is not delivered in accordance with policies and procedures.[2]

An early meeting provides an opportunity to reduce and/or mitigate risks in relation to the incident, and before an investigation is completed. The mitigation of risks is vital as an investigation can take up to 60 working days, as defined within the *Serious Incident Framework*.

It is good practice to involve parents as early as possible to allow families the opportunity to contribute to the investigation. Not all families will accept this offer but when feedback is given, it does give a useful perspective to an investigation. Receiving information in this way, at such a difficult time, should be treated sensitively. In this case, the mother was invited to contribute but she did not. It is important to maintain contact and communications with the family during the investigation.

In this case study, the mitigation of risk process included a retrospective review of infants born to high risk mothers over the previous 12 months to ensure that their treatment pathway was appropriate and that they had received both the vaccination and the immunoglobulin. This audit was undertaken as it could not be assumed that the pathway of care had been appropriate for all other infants, however, it was found that care had been appropriate for all, with the exception of the trigger case. The process also included early implementation of enhanced documentation within the clinical notes and strengthening of the antenatal and newborn screening failsafe systems.

The next step in an investigation process is to gather information including healthcare records, staffing, acuity, guidelines/policies and accounts from the clinical teams involved in the case. This information can be gathered in the form of interviews and/or statements (which should be kept on file).

A very useful way of reviewing an incident and gathering the accounts of the staff involved is known as a 'facilitated root cause analysis meeting,' 'after action review'[3] or 'round table meeting'. This process provides an opportunity to gather all staff members involved in the incident together to discuss the reasons why the expected care did not occur or deviated from agreed practice. It also serves as a platform for

FIGURE 1 The Sign up to Safety campaign poster describing a just culture.

debriefing and enables staff to contribute to the investigation by suggesting areas for improvement. The environment needs to be open, welcoming and one that embodies a just culture.

What is a just culture?

Marx (2001)[4] first used the terminology of just culture in relation to patient safety. The model is widely used in the aviation industry and designed to encourage individuals to report incidents and provide a platform for understanding the underlying factors as to why an incident or near miss occurred.

A national campaign to help organisations implement safety improvement plans to reduce harm in the NHS – the Sign up to Safety campaign[5] – has launched a helpful poster describing a just culture (**FIGURE 1**). It is vital to have a just culture when mistakes occur, as it seeks to provide support to those who have made errors in clinical care and understand the underlying factors as to why the incident occurred, which assists with making robust recommendations to improve clinical practice.

During the investigation of the hepatitis B immunoglobulin incident, the staff were very open and honest about their clinical practice and the reasons why the expected standard was not reached (contributing components were identified as human and system factors that have since been addressed). Their openness enabled a thorough investigation, and thus the recommendations that were made addressed the root causes of the incident. Staff also provided suggestions and solutions to reduce the likelihood of recurrence and, for this investigation, many of the recommendations that were implemented were suggested and led by the staff involved.

This case raises a number of questions that all units and organisations should consider (**FIGURE 2**). The learning points to come out of this incident across both maternity and neonatal specialties were as follows:

1. Reiterate and reinforce that medication must not be prescribed without a review of the blood results. This has been subsequently included within clinical protocols and is reinforced at induction for junior doctors and training for midwives, thereby ensuring it is embedded into clinical practice.

- Do clinical teams have access to clear documentation or alerts to inform them of the maternal blood results and expected management of a newborn infant?
- Have you completed a recent audit for the hepatitis B pathway? What were the findings?
- How do you investigate incidents and near misses?
- Are you confident you have robust failsafe systems for the antenatal and newborn screening pathways?
- Do you have an opportunity to meet with clinical teams or be involved in an after action review?
- Have you embedded a just culture within your organisation?

FIGURE 2 Could a similar incident occur in your unit?

2. Standardise the documentation in the neonatal notes as part of the antenatal screening pathway to clearly state whether an infant requires hepatitis B vaccination and/or immunoglobulin. During the investigation mothers who were pregnant and booked with the service had their notes updated accordingly. It is now standard clinical practice for all new mothers booking with the maternity service.
3. Develop a checklist to assist with reviewing and strengthening the antenatal screening failsafe systems for the tracking of outcomes for the newborn in the postnatal period.
4. Strengthen training and share the incident widely across both specialties.
5. Audit the implementation of any recommendations.

References

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