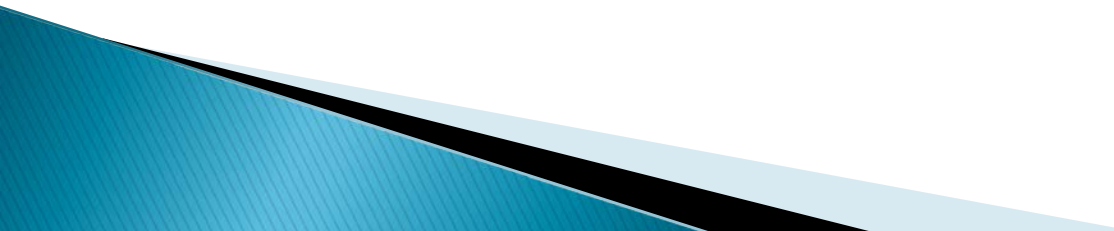


Threats and errors

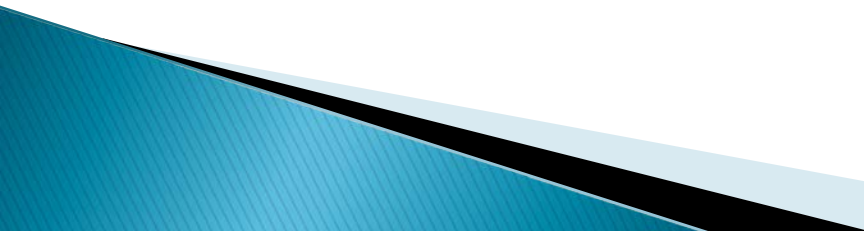
How a “never event” happened



Objectives

- ▶ Why do mistakes occur?
 - ▶ Review how failures can be identified by root cause analysis
 - ▶ Plan what could be done to prevent this happening again
 - ▶ Highlight the importance of a culture of safety in any organisation
- 

The scale of the problem....

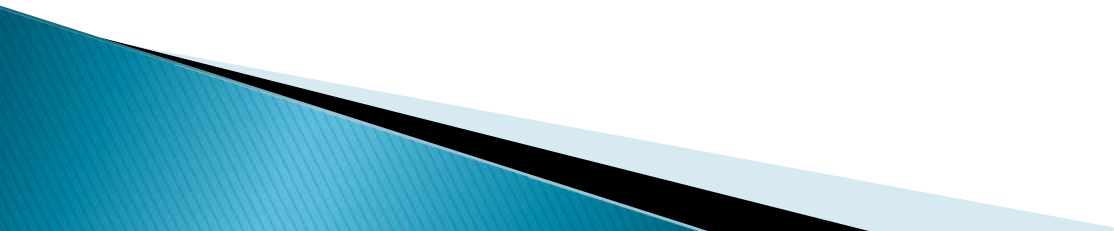
- ▶ Adverse events occur in around 10% of admissions or at a rate of an est. 850,000 adverse events a year
 - ▶ Adverse events cost approximately £2 billion a year in additional hospital stays alone
 - ▶ 400 people die or are seriously injured in adverse events involving medical devices every year
 - ▶ The NHS pays out every year around £400 million settlement of clinical negligence claims
 - ▶ Around 15% of hospital acquired infections may be avoidable and are estimated to cost the NHS nearly £1 billion every year
- 

Adverse events

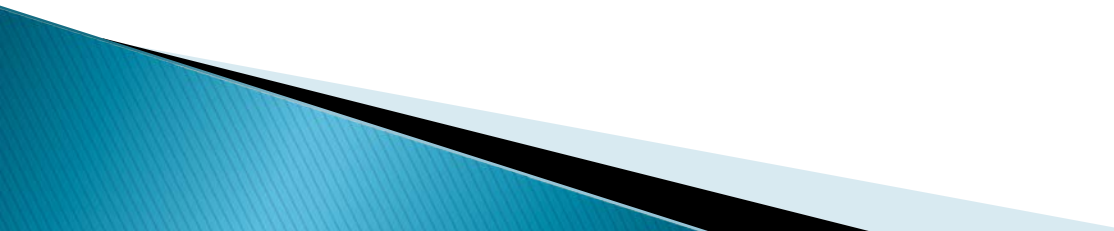
Retrospective review of 1014 records:

- ▶ 10.8% of patients experienced an adverse event
- ▶ 50% of the events were preventable
- ▶ 33% of adverse events led to moderate, or greater disability, or death
- ▶ "...it is estimated that for one patient in every 300 entering hospitals in the developed world, medical error results in, or hastens death"

The reality

- The elimination of accidents (and serious incidents) is unachievable.
 - Failures will occur, in spite of the most accomplished prevention efforts.
 - No human endeavour or human-made system can be free from risk and error.
 - Controlled risk and controlled error is acceptable in an inherently safe system
- 

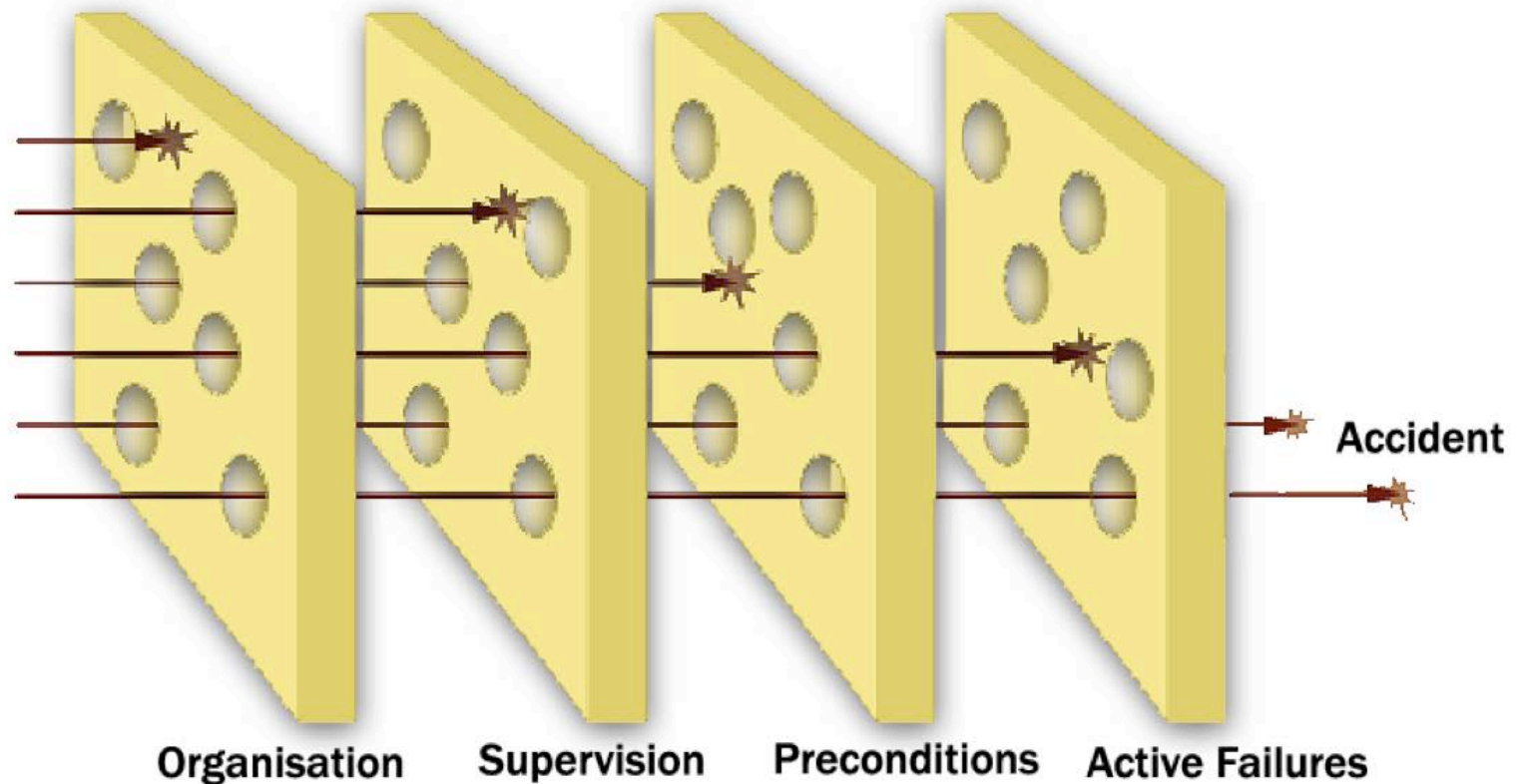
The philosophy

- ▶ To err is human
 - ▶ To cover up is inexcusable
 - ▶ To fail to learn is unforgivable
- 

Technology may not help....



Reason's model

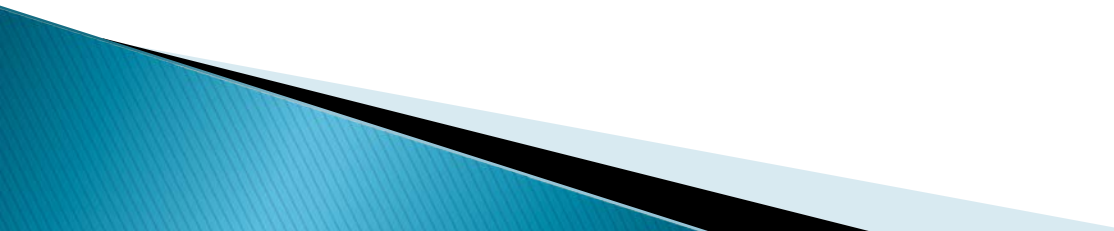


Threats and errors

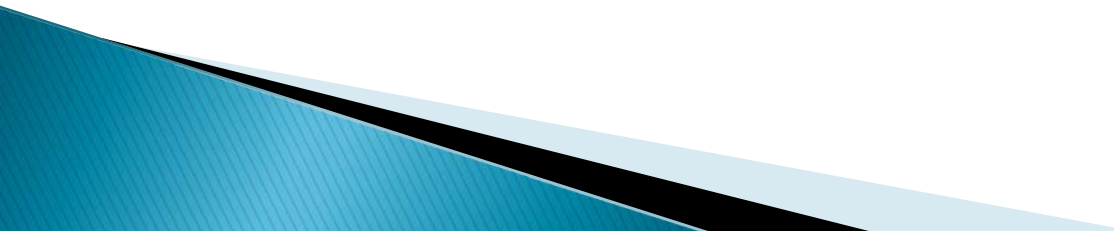


- ▶ LIBIYAN AIR CRASH
- ▶ VIDEO NOT AVAILABLE TO DOWNLOAD

Case study

- ▶ Where are the problems?
 - ▶ What types of threat are there?
 - ▶ What types of error are there?
- 

Threats and errors identified

- ▶ Why did they arise in the first place?
 - ▶ Contributory factors
 - ▶ What would you do?
 - ▶ The culture of the organisation
- 

Review

- ▶ Origin of mistakes in healthcare
 - ▶ Root cause analysis
 - ▶ Develop action plans
 - ▶ Culture of safety
- 