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AVOIDING MISTAKES

Alex Dabek looks at what the NHS could do to limit errors

According to figures published recently by the NHS Trusts, at least 40 patients suffered avoidable deaths in London hospitals during 2017, and a further 200 patients experienced problems which may have contributed to their untimely deaths.

These figures may still increase as a number of hospitals have not yet published their data for the whole year.

These publications are being conducted on the initiative of the Health Secretary, Jeremy Hunt, who wants to make the NHS the best in the world at learning from mistakes.

While Mr Hunt's ambition is a commendable one, the reality is still very different. The NHS has a long way to go to truly make amends.

I specialise in spinal injury claims, and a significant proportion of the claims I deal with arise from clinical negligence. It is astonishing how many of these feature some of the most cardinal and entirely avoidable errors.

Even more astonishing is the fact that they are repeated over and over, with NHS Trusts failing to learn any lessons from these mistakes; mistakes that can cost lives or result in life changing injuries.

Below, I have highlighted just some of these avoidable errors.

Neurological observations

Neurological observation is a collection of information on a patient's central nervous system (consisting of the brain and spinal cord).

In spinal surgery, the main purpose for undertaking and recording these observations is to assess the patient's baseline neurological status on admission.

The purpose is to identify any changes that require a prompt response to any neurological deterioration that might occur, so as to prevent any permanent damage to the spinal cord.

The observations should include assessment of movement, sensation and power in the upper and lower limbs, as well as comparing the left side with the right.

Neurological observations are routinely undertaken by nursing staff. Given their importance to the patient's wellbeing, nurses have to be adequately trained in using different assessment tools and when to appropriately escalate a patient's care.

Hospitals should have relevant policies in place setting out the necessary assessment tools or charts to be used, and the frequency of these observations.

It is imperative that these neurological observations are consistently undertaken and recorded accurately, at regular intervals. Any detected neurological deterioration should trigger a medical review.

This is not rocket science - and yet failure to undertake proper and / or timely neurological checks is one of the most frequent allegations of negligence I see in spinal injury claims.

These allegations range from: a hospital's failure to use correct assessment tools (charts) for assessing patients following spinal surgery; a surgeon's failure to instruct nursing staff as to the neurological observations required and their frequency; through to errors by nurses failing to undertake full checks or to request a medical review if changes are noted.

Until sufficient resources are allocated to provide adequate training and to ensure appropriate time is set aside for nurses to undertake the necessary checks as frequently as required, I think it is unlikely that we will see a reduction in the number of claims relating to these errors.

Consent process

Time and time again, I see issues with the way patients are consented for their spinal surgery or other procedures.

Spinal surgery is one of the most complex surgical areas, and yet doctors repeatedly fail to advise their patients of the material risks associated with spinal surgery and / or other related procedures.

Since *Montgomery*, it is imperative that doctors ensure a patient is given all the information they need to make an informed decision.

One would have thought that since *Montgomery*, doctors would have received the necessary training on how to consent but that, sadly, does not appear to be the case.

The recent case of *Hassell v Hillingdon Hospitals NHS Foundation Trust* [2018] EWHC 164 (QB) is one such example of inadequate consenting, and one I often come across in my practice. In this case it was found that the claimant was not warned against the risk of paralysis, and that the operating surgeon failed to employ reasonable care and skill to not only ensure that the claimant was aware of the material risks of the operation, but also of the alternative conservative treatment options that were available (see *PI Focus* March 2017, page 22).

In one of the cases I assisted on, the operating surgeon admitted, as part of the complaint process, to not being allocated sufficient time for appointments and effectively 'rushing' through the consent process.

There were a number of failures in terms of the consenting process in this case. The surgeon failed to explain to the patient that there were two surgical approaches to the proposed surgery, and just decided himself to take the approach that carried a much greater risk of spinal cord damage. This had dire consequences for the patient as that very risk eventuated.

It is clear to me that with appropriate training and better resources (including suitable time allocation for consenting) these cardinal mistakes could be avoided.

There also needs to be a uniform policy setting out guidance on how the consent process should be undertaken, and the extent of information that patients should be provided with.

Cauda Equina Syndrome (CES)

Cauda Equina Syndrome (CES) occurs when the nerve roots at the end of the spinal cord (often referenced as a horse's tail) are compressed and disrupt motor and sensory function in the lower half of one's body.

CES is a medical emergency and can lead to incontinence and permanent paralysis.

Despite being a well-recognised condition, with a number of red flags, there is a concerning lack of uniform approach across the NHS towards investigating CES.

We often find that there is a significant delay in diagnosis, and therefore treatment, for this life changing condition.

Mr Crocker, consultant spinal surgeon at St George's Hospital, refers to 'pathway failures' as one of the main reasons why there is so much litigation in the area of spinal surgery, and CES in particular (*Crocker M, 'Clinical Negligence in Spinal Surgery 2018' (St George's Hospital, 2018)*).

Having attended a 2017 seminar on CES presented by Dr Punt of No 5 Chambers, he aptly sums up these issues as 'the perennial sad tale of the horse's tail'.

In his research article published in the British Journal of Neurosurgery, Mr Todd, consultant neurosurgeon and one of the leading experts in the field of CES, concludes that as much as two-thirds of the so-called 'red flag' symptoms/signs of CES were those of late irreversible CES, and could be in fact seen as 'white flags', ie. flags of defeat and surrender (*Todd, N.V., Guidelines for cauda equine syndrome. Red flags and white flags. Systematic review and implications for triage [2017]. British Journal of Neurosurgery, 31(3): 336-339*).

He goes on to say that 'only 32% of the symptoms/signs were true "red flags" ie. they warn of further, avoidable damage ahead.

'Guidelines should be redrawn to emphasise referral of patients who are at risk of developing CES or who have early CES.

'It is illogical for these guidelines to emphasise the clinical features of severe, often untreatable, CES.

'Demand for emergency MRI will increase; MRI is part of triage and should be performed at the DGH [District General Hospital].'

According to Mr Todd, an example of a red flag would be bilateral radiculopathy. If this symptom is present, it warns that further damage might occur and should be acted on immediately. An example of a white flag would be perineal anaesthesia which if present, would usually mean that the die has been cast.

It is clear that the current management of patients with CES is not fit for purpose. It needs to change so that an urgent MRI scan is undertaken whenever early signs of CES are noted.

Medication errors

According to the recent figures published by the NHS, medication errors are suspected to be behind approximately 1,700 deaths each year, and potentially contributing to a further 20,300.

The cost to the NHS associated with these medication errors is estimated to be in the region of £1.6bn.

The most common medication errors I have come across are:

- prescribing/dispensing the wrong medication, often resulting in loss of consciousness and falls;

- failure to stop certain drugs prior to spinal surgery, resulting in internal bleeding and spinal haematomas;
- failure to administer thrombo-prophylaxis post-surgery, resulting in pulmonary embolisms.

While every claim has to be considered on its own facts, and not every medication error will meet the threshold for clinical negligence, I am astonished at how often these errors recur with evidently no lessons being learnt from previous claims and incident reports.

Even more astonishing is the fact that some clinicians and trusts may knowingly deviate from standard practices and published guidance, without providing logical reasoning.

For one such client I represented, thrombo-prophylaxis was not offered despite the fact that, in line with the relevant College of Emergency Medicine guidelines (CEM), there were sufficient risk factors mandating its administration.

In this case, the decision to discharge the patient (in her 30s) without thrombo-prophylaxis was made by an on-call orthopaedic registrar who only reviewed her by telephone and failed to appreciate that her Body Mass Index (BMI) put her into the 'at risk' category.

As a direct consequence of this failure, my client subsequently died from a blood clot which had developed.

This case highlights further the lack of sufficient training, inadequate resources and startling absence of a consistent approach across the NHS.

Change of culture

In December 2017, when discussing his initiative to publish data about avoidable deaths, Mr Hunt told BBC Radio 4's *Today* programme that it was: 'about hospitals creating a culture which makes it easy for staff on the frontline to say, "look, something went wrong; I think it could have had a different outcome and we need to learn from this so it doesn't happen again".'

While it is undeniable that more needs to be done to create a culture of transparency in terms of the

medical care afforded to patients, the proposed changes should not just be about the frontline staff.

It is equally important that NHS Resolution (NHSR) adopts a more conciliatory approach when dealing with clinical negligence claims. The common issues we see with the NHSR defending often indefensible claims are:

- Retracting admissions made in the NHS complaint correspondence;
- Failing to engage in Alternative Dispute Resolution (ADR) at an early stage;
- Tactics delaying progress of the litigation, including unnecessary delay in providing letters of response and defence;
- Deliberately withholding admissions to achieve a more favourable settlement (one that takes into account litigation risks).

My case where there was a failure to offer thrombo-prophylaxis showcases some of the above issues.

In this case, the NHSR took a very hard-line approach to the claim, effectively retracting concessions previously made in the NHS complaint correspondence.

This was despite concerns expressed by the coroner during the inquest over the failure for the deceased to be reviewed by a doctor in person prior to discharge.

During the inquest, the doctor in question admitted that if he had had a face to face review with the patient, he would have probably offered prophylaxis.

Consequently, this claim, which was entirely capable of early resolution, was fought fiercely for over three years before the defendant made their first offer to settle.

During that time, a number of logic defying arguments were put forward by the defendant; including that the CEM guidelines only applied to in-patients and as the deceased was not admitted, the guidance had no application.

It was also argued that the relevant Trust was not in breach of the CEM guidance as other trusts also did not adopt it.

We were also told as a reason for diverting from the recommended guidance, that routine thrombo-prophylaxis would cost the NHS nearly £4 million a year.

This last argument brings me to my final comment; if claims such as this one were settled early, (or received early admissions so that parties could focus on evaluating the losses), significant costs could be saved, freeing up some much needed resources to ensure that the avoidable mistakes can, in fact, be avoided.

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