

Royal College of Psychiatrists Consultation Response



DATE: 17th November 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: Never events

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by: Dr George Ikkos- Honorary Treasurer of the Royal College of Psychiatrists and Clinical lead representative of the Academy of Medical Royal Colleges.

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Consultation response

The Royal College of Psychiatrists welcomes the opportunity to respond to the “never events” consultation.

In general, the Royal College of Psychiatrists fears that the extended list of proposed “never events” risks causing more harm than good to patient care, from the psychiatrist’s perspective at least. Furthermore it may severely and unfairly penalise mental health services providers for isolated incidents.

1. Do you agree that the list of events and the definitions that we have produced below should be used for the new “never event” list and that they are consistent with the “never event” criteria outlined earlier?

Reducing the number of serious adverse incidents within the Health Service is a priority for policy makers, managers, clinicians and users of services. It is important that any such attempt is evidence based, open and explicit. The document did not outline the evidence base for the list in the first place. The “never events” policy has been around for 2 years, there is no data on whether this has had any impact which would inform any debate on expanding the list.

There is clearly a difference between an event that simply must not happen e.g. amputating the wrong leg and something which could possibly happen that is highly undesirable. For example, prisoners have been known to escape from prison by means of a helicopter landing in the prison grounds. If such a thing happened within the medium secure unit, should the unit itself realistically be penalised for this?

It is interesting that in relation to the existing mental health “never events” that these are events that patients do, where as in the case of all other events it is clearly clinicians that carry out the actions.

2. Do you agree with the inclusion of the events listed below but have suggestions for amending the scope and/or definition of the events?

We have some concerns that the extended list has unacceptable ambiguity in several of the definitions and criteria, and are perhaps more slanted towards outcomes than events. This will in our view lead to difficulties in that the events will be more open to interpretation, and the original concept of never events may be diluted.

Examples of problems in definition include "failure to prescribe or administer insulin when clinically indicated in a healthcare setting" or "where the dose of opioid given was inappropriate to the patient's condition and needs". There is ambiguity in the lack of definition of "potential to cause severe harm" and similar issues with the term "serious injury".

1. Death or serious injury arising from the inadvertent administration of ABO/HLA-incompatible blood or blood products or transplant of ABO/HLA incompatible organs

There may be problems in definition of severe injury.

2. Death or serious disability associated with entrapment in bedrails whilst being cared for in a healthcare facility

While we agree with the principle of this never event, we are concerned at the potential unintended consequences of such criteria. In particular we are concerned that there may be a knock on effect on a healthcare setting's willingness to manage people with confusion who at times can be very challenging, and often have extended lengths of stay. If during a year-long admission, injury occurs on the one day cot sides are used to help manage risk (when there is a crisis in staffing levels, for example), and the organisation loses payment for that whole episode, it may have the result that the organisation will no longer be as willing to accept the risk of managing people with confusion. If a community placement has to then transfer that patient to a general

acute hospital, it will be less willing to accept the patient back again. There may be problems in definition of serious disability.

3. Death or serious injury as a result of a healthcare professional's prescribing, preparing or administration of insulin in overdose, or his or her failure to prescribe or administer insulin when clinically indicated in a healthcare setting.

This event appears to be two joined together. The second part "failure to prescribe or administer insulin when clinically indicated in a healthcare setting" raises issues of definition, interpretation and detection / measurability. We are uncertain whether there is sufficiently exact guidance on the clinical indication for insulin use to make this workable. It again may have unintended consequences that mental healthcare settings will not be as willing to look after people with diabetes.

4. Death or serious injury arising from failure to recognise and act on critical oxygen saturation levels in a patient undergoing general anaesthesia.

There may be difficulties with the definition of critical.

5. Death or serious injury associated with the use of wrongly prepared high risk injectable medication, including dose, when the error occurs in the healthcare facility preparing and administering the medication

There is no definition of what a high risk injectable is. The reference in the document simply states "A summary of all high and moderate-risk injectable products should be completed for each clinical area."

6. Death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare facility

There does not appear to be any existent guidance or alerts and therefore puts this out of the definition of never events using the Department of Health criteria.

7. Death or severe injury as a result of the administration of the wrong gas or failure to administer the correct gas at all through a line designated for oxygen in a healthcare facility

No comments.

8. Daily administration of oral methotrexate for non-cancer treatment or provision of oral methotrexate for non-cancer treatment with the instruction to take daily

No comments.

9. Death or serious injury arising from overdose with opioid medicines where the dose of opioid given was inappropriate to the patient's condition and needs

Who defines inappropriate? Does this refer only to prescription of opioids for pain?

For substance misuse, patients die on oral methadone usually because they combine them with other substances (e.g. alcohol, benzodiazepines). It is not clear how controllable this is in terms of prevention. We would therefore not support the idea of a never event for opioid death, at least not within mental health (including substance misuse) settings.

10. Death or serious injury arising from overdose of midazolam injection.

No comments.

11. Death or serious disability while being physically restrained in any mental healthcare setting including mental healthcare settings within prisons.

Definitions of severe disability and restraint are potentially a problem.

In relation to the new “never event” of death under restraint even if absolute best practice is followed it is possible that a death could still occur; for example because of an unsuspected pre-existing physical condition in the patient. It may be that staff would be deterred from restraining patients correctly and that other risks could arise, e.g. physical risk to the patient, risk to other patients or staff. It may also be that other forms of managing the situation such as pharmacotherapy could be encouraged inappropriately and cause other risks.

If this proposed “never event” was included it should be extended to all settings as there are many people with confusion requiring restraint in general hospital settings. This may have negative implications in that general hospitals will be less likely to want to manage people with disturbed behavior.

12. Death or serious injury resulting from falls from unrestricted windows.

This should be for all settings. For example it is directly relevant to the number of people with confusion in general hospital settings.

13. Death or serious injury caused by administration of oral/enteral medication, feed or flush intravenously or intrathecally; or caused by intravenous medication administered intrathecally or vice versa

No comments.

3. Do you have any additional suggestions for events and/or definitions to be included on the “never event” list?

We considered a number, but have concerns about the diluting of the original concept of never events, and the potential unintended negative effects of such events on the availability of care.

4. Do you agree with cost recovery for all providers, given that some incidents relate to short term, low cost interventions and others relate to long-term care where cost recovery could be many thousands of pounds? This could disproportionately affect small providers.

There is some unfairness in the system in relation to providers of services that are low volume and high cost. If a commissioner is reimbursed for the whole of an episode of care within a medium security mental health setting, then in 3 years this may be well over half a million pounds even though the overall majority of care could have been to an excellent level. The occurrence of a “never event” leading to prolonged Intensive Care Treatment may literally bankrupt a mental health provider and we can therefore not support this proposal.

As previously indicated we have concerns about the unintended consequences of Trusts declining to manage complex people with co-morbid physical and mental health difficulties (particularly elderly people with confusion in the context of physical illness). This could be very damaging to patient care. Services which are already in financial difficulties leading to suboptimal care may be further financially penalised.

The tendency to penalise providers will impact on reporting systems leading to further under reporting, especially of treatment related issues and encourages a fault/blame-based culture as opposed to a report and learn culture.

5. Do you have alternative suggestions for the contractual framework?

If the estimate of between 1 and 2 events per year is correct, this is likely to have little financial impact on a trust compared to the potential for clinical negligence claims of having had a “never” event. In that context we question whether there really is any additional benefit from having the financial penalty at all.

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