The curious incident…

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The complete collection of these and other articles is now available in a book 'The Oblique View'. Further details can be obtained from Nikki@tfmpublishing.com or www.amazon.co.uk

We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab…and beyond. In this column, he muses on curious incidents and their significance in our working practices.

This term has recently achieved particular recognition as part of the title of a bestselling book in 2003 by Mark Haddon and, even more recently, as a stage production. It derives from the following conversation between Sherlock Holmes and Police Inspector Gregory in one of Sir Arthur Conan Doyle's 1892 short stories from the Great Detective's memoirs, *Silver Blaze*. A racehorse by that name is stolen and the trainer – one John Straker – lies dead, with his head "shattered by a savage blow from some heavy weapon".

Gregory: "Is there any other point to which you would wish to draw my attention?"

Holmes: "To the curious incident of the dog in the night-time"

Gregory: "The dog did nothing in the night-time"

Holmes: "That was the curious incident"

I couldn't think of another way of introducing this topic, namely the use of incident reporting – seen as a fundamental component of a hospital's Governance structure and, indeed, of any organisation which seeks to improve the quality of its processes and their outcomes.

But what constitutes an event that should be highlighted in this way? Who should report it and what actually happens to such documentation? How are reports processed such that lessons are learned and thereby necessary improvements made?

I've no doubt that all these elements are perfectly defined using management parlance, and can all be found on hospital intranets or within the volumes of numerous lever-arch files sitting on shelves next to major incident plans and standard operating procedures. What follows is simply a personal view from someone who works within such a structure and is all too aware that these issues are not well understood by many of our colleagues.

Recognising incidents…

"That shouldn't happen". How often have we either heard that phrase or even uttered it ourselves? It might be about a patient-related letter that has been misfiled or a blood test result wrongly transcribed into the case notes; it might be about a nurse moved from one ward to another because of short-staffing or an elderly patient falling whist making their way to a toilet at 3 a.m.; or it might be about the administration of amoxicillin to a patient with an allergy to penicillin or an X-ray tube that has failed yet again in a catheter lab well overdue for replacement.

The first question, no matter how trivial an event appears, might be: "Is this something that should not occur?" The examples alluded to above would all fall into this category one way or another, some clearly being more important than others, but who is responsible for raising any concerns?

Any member of a healthcare team could produce a report that provides an account of events, ideally being guided by a more senior colleague if necessary. A specific template is used that allows the report to be uploaded onto a dedicated database (such as Datix – a commonly used commercial system; you should visit their website, as I just did) and of course this should be done as soon as is practicable after an untoward event to ensure that facts are accurate and not degraded by the vagaries of memory and the passing of time.

…and recording

In addition to the when (date and time), where (ward, operating theatre, outpatient department) and what (staff shortage, balloon pump malfunction, needle stick injury) the who aspect is anonymous so that any patient involved (if there was one) is not identified and nor are any professionals (other than making reference to their designation such as surgical registrar, Band 5 nurse or medical secretary).

You can see that the scope of such a process knows no bounds, and nor should it; the impact of a typo in an outpatient letter advising a prescription for a frail, elderly lady of digoxin at four times the intended dose, is just as significant as that upon a bereaved family having to wait hours to receive their loved one's death certificate.

As to seriousness, incidents are graded alphanumerically and by colour coding. Depending upon a number of criteria they may be classified from insignificant (green) to catastrophic (bright red). Essentially the key elements are the actual harm that resulted (rather than the potential for harm), and the likelihood of recurrence. There is also an indication

as to where the impact of any incident might be most felt, ranging from personnel and resources to the environment and the reputation of the organisation.

Hence a potential trip hazard might be graded green, producing no injury and accepted as a near miss, whilst a catheter lab X-ray tube constantly belting out fatal amounts of radiation on a Chernobylian scale would attract a red label, much national opprobrium and a potential criminal prosecution for the CEO. You get the idea?

Whilst green and perhaps yellow events are discussed at the relevant Governance forum and any learning points disseminated, more impressive colours are escalated to the heady levels of the organisation's executive and beyond to commissioners and patient safety groups.

Any pattern in the number or type of incidents can be picked up by trend analysis so that clear signals of system failure can be discriminated from background noise. Frequently occurring events such as staff shortages or catheter lab breakdowns, will feature on a Risk Register as testimony to the fact that the Trust is aware of the potential problems that might ensue and is 'managing' that risk by putting in place measures that should mitigate it.

My own involvement with this process has prompted a number of observations. Doctors rarely report incidents; the vast majority come from the nursing staff. I guess this is because they are in day-to-day contact with patients and the intensity of the ward environment is such as to expose any failures such as drug errors, falls, staff shortages, bed unavailability, delayed discharges, etc...

Encouraging curiousity

There is an increasing desire to embrace a 'questioning' culture (sometimes used synonymously with the term 'challenging' – although I think the latter implies opposition and is unnecessarily confrontational). All individuals involved in patient care, and regardless of profession, seniority or experience, should feel free to enquire if they don't understand or to raise concerns if they have them. We should positively encourage incident reporting, by all personnel, in order to promote an environment in which questions are aired and discussed, in a transparent and open way, without finger pointing or blame.

The more the merrier? One would be concerned if there were to be a trend towards fewer reports as this might suggest that staff were inattentive or letting minor issues go unreported. Similarly, one might be equally concerned if the number increased as this might be interpreted as indicative of a system approaching failure.

I suspect there will be a happy medium, no doubt calculated somewhere in Whitehall and being the optimal number of monthly reports as a function of patient volumes, staff numbers, departmental budget and other obscure parameters that some boffin has found to be mathematically influential. The important point is that incident reporting is the *language* of change and improvement. Unless untoward events are highlighted in this way, we cannot expect our managers to be aware of – let alone respond to – concerns.

I have only been the subject of one incident (thus far at any rate, and green I hasten to add) and which came about as follows:

I was in a clinic and as my next patient came in, so did an administrator anxious to explain why no referral letter or notes were available and only a fluorescent pink 'temporary folder' was on my desk enclosing a sheet of patient sticky labels, a blank page of A4 and today's electrocardiogram (ECG) recording. I was in the process of reassuring her that I could manage, not least by using the traditional, well-established, tried-and-trusted technique of actually talking to the patient, when she plonked herself down on a chair next to him, clearly intent apparently on providing an affidavit.

I simply said, "Please sit down, why don't you?" No sooner had these words left my mouth than I could see her face change. The previously earnest furrows of purposeful enthusiasm suddenly flattened giving way to a dawning realisation that her life's single mission (well, at least that morning's), namely to explain in detail where the notes were and why, was not only unnecessary, it was also unwanted. After a few seconds of fidgeting and awkward silence she left.

During a subsequent Governance meeting, and in the appropriate agenda item slotted between 'Complaints' and 'Root-cause analyses,' there it was; an incident raised against me for…sarcasm!

To tie up a loose end, the 'murderer' referred to above was, of course, the horse itself. The trainer had approached the stables at night with the criminal intention of nobbling it and, as he was a familiar visitor, the watchdog was not prompted to bark in alarm. Whilst he attempted to nick a leg tendon with a particularly delicate knife, the horse lashed out in self-defence and caught the poor chap on the bonce with a shoed hoof.

A tad worse than sarcasm then