

Chapter 1

“Small things matter”

*“Experience is the toughest teacher
because she gives the test first,
and then the lesson.”*

Unknown

Introduction

In any people orientated organisation, mistakes and accidents will be an emotive business, none more so than in health care. The story in this chapter is one that many healthcare workers will recognise and the principles easily transfer to other sectors. It is about how one small incident led to a fairly complex set of circumstances that needed resolving.

Key themes

Small things can have a huge impact

When we think of calamities and disaster we tend to remember the big events, the earthquakes, the collapse of large companies, the explosions and the deaths. However, many smaller difficulties are experienced every day and some of these can have significant consequences on individuals and their families. It is easy to overlook the smaller mistakes without understanding their true operational, emotional and financial impact. In this chapter, Dr Roger Bodley, a consultant radiologist, shares his story about how a cleaner came to be pricked by a dirty needle, and the impact of this incident.

Inspections and protocols can reduce error rates, but not avoid them entirely

Like many large and complex organisations, hospitals have many protocols and procedures designed to make the process of care and the patient’s experience less variable and safer. Designing safety into organisation systems that depend significantly on human decision-making, then there will always be a higher potential for error than when working with mechanical systems. Humans are fallible – we all make mistakes, and there are many reasons why this happens. No matter how detailed the protocol and directions, there will always be room for error if a human is involved.

To tell or not to tell

In busy and pressurised organisations it is easy to overlook the small incidents. This can happen subconsciously – we might not even notice the little event – or consciously – we make the decision to ignore what happened and not to report it. If the incident is a big one, then taking

no notice is difficult. The problem with small events is that they are easier to ignore. The big problem is we know that many small events are precursors to the big one – ignore them at your peril.

Personal Experience

“I had always considered myself obsessive about the handling of used needles and sharp objects after surgical procedures and I take great care to dispose of them promptly and properly. So I felt awful when it appeared I was probably responsible for one of our cleaners being accidentally pricked by a needle when she was clearing away clinical waste. Needles should be disposed of into a special plastic sharps bin so this kind of accident can’t happen.

On a Monday afternoon I was carrying out a biopsy on the liver of someone who was jaundiced. This involves using a long needle for the biopsy and a small one to deliver a little bit of anaesthetic. It seems the small needle, which is transparent and nearly invisible, ended up in the clinical waste bag. Not surprisingly, the longer needle, which was more visible, and everything else was disposed of correctly.

The first I knew about a problem was when the head of our department told me the next day. Apparently the cleaner felt the prick of a needle on one of her fingers when she cleared away the waste bin during the evening. She reported it to her manager who then reported it to the duty nurse who filled out an accident report.

As it was possible that the needle could have come from a number of interventions carried out in the same treatment room on the Monday, I did think for a moment that it couldn’t be mine so why should I have to deal with it. I couldn’t believe it really was my fault as I was the one person who always nagged others about safety and took so much trouble over clearing up after myself.

However, I realised that the most important thing was to sort out the problem, and to learn from what happened. The sorting out took up a whole afternoon during which all routine work had to be postponed to the evening. I don’t begrudge this, but the impact of recovering from an accident is always far more effort than the preventative work. I think sometimes we don’t report near misses and small incidents because we worry we don’t have time to sort it out.”

“Why are needlestick injuries so important? Well, the obvious problem is that the needle will be contaminated in some way and it’s possible for some diseases such as hepatitis and the HIV virus to be unintentionally transmitted to the person who is stuck by the needle. The cleaner needed to be offered some tests and I also had to contact the patient

Dr Roger Bodley is a consultant radiologist at Stoke Mandeville Hospital in England. This is a rural district general hospital with a world-renowned spinal injuries centre.

Roger trained as a student and junior doctor at Oxford, England and then practised as a general practitioner for six years in Australia. He returned to the UK in the mid 1980’s and trained in radiology. He specialises in interventional “keyhole” procedures.

He does not hold formal management position and believes that leadership is a factor in all jobs, at all levels.

to ask him whether he would undergo similar tests. All of this was a needless worry for both the cleaner and the patient.

I rang the patient and asked him to come in for some blood tests but didn't explain fully why until I saw him. I felt it would be better to explain what happened face to face. He was not best pleased. At the time of this incident HIV was in the press a lot and there were many negative connotations with just having the test. He could have refused but in the end he agreed it was in the best interests of the cleaner and himself too. I did apologise to him and he accepted this was an unintentional error.

The cleaner was very anxious, as she knew the risks. She was keen to have the tests. I spent some time counselling her about what happened, as it was important we didn't lose her trust in us. She was an important member of our team and we relied on her to keep our treatment rooms to high standard of cleanliness and she had a right to expect we would ensure her safety at all times.

In the end the tests all proved negative, though this doesn't mean there was no impact on the cleaner or the patient. The emotional upset and decision-making that had to be done was significant. Similarly, I felt shaken by the fact that I had made a mistake, even when I prided myself on being so careful. It seems that no matter what the protocols are, no matter how much training, no matter how many times I check, there is always room for a mistake to slip in. The danger seems to be in the routine and small things which are easy to forget about."

"As a result of this and other similar incidents the hospital introduced a policy where anyone who experiences this sort of problem goes immediately to the emergency department where they receive certain immunisations as an immediate precaution, and also receive early counselling. I think there are a lot less incidents now."

"This accident happened quite a while ago and in telling the story for this book I spent some time reviewing my own practice with regards used needles. I was astonished to find that when I thought about it, I discovered some potential problems and near misses. It was a bit like taking your driving test when you've been driving for twenty years – somehow the bad habits creep in and become so intuitive that it is difficult to even notice them, let alone stop them!"

Reports indicate that around 1 million needle stick injuries happen per year in the USA. In the 1980's at least 50,000 to 60,000 health workers contracted serious infections from needle sticks, with around 200-300 deaths per year.

There are more than 20 different diseases that can be transmitted; for example, hepatitis, HIV, syphilis, malaria, tuberculosis, herpes and others.

The cost of testing, treatment, counselling, medical costs and lost wages is put at between \$200 and £2,000 if the person is not infected, and if they are infected with, for example HIV, the costs rise to \$500,000 through to £1,000,000.

(Source: Deadly Needles, San Francisco Chronicle: 13-15 April 1998)

In the UK there it is estimated there may be 500,000 needle sticks per year. The UK tends to focus on the responsibility of the individual and the use of special bins to place needles in, while the emphasis to improve safety in the USA is on the design of safer needle devices.

(Source: Nursing Times; 26 Feb 99)

Leadership Reflections

This story about a needle stick injury highlights a number of key issues for leaders:

- Taking ownership
- Making the apology
- Reporting near misses
- Understanding human fallibility
- Ensuring a supportive learning culture

Taking ownership

Things will go wrong and it is so easy to ignore the little events or try to blame someone else for the bigger ones. It is also easy to spend a lot of time working out who is to blame and therefore who should sort out the problem. However, sometimes, the most important task is to recover from the calamity – especially when other people, such as patients, customers, suppliers, contractors, staff etc. are involved and potentially badly affected.

One way of looking at calamities is to see the wider picture of what happened. In many cases there is not one person who is to blame, but rather a whole series of events that are all connected in one complicated web of interactions.

It is important to appreciate the complexities of how chains of events come about. An essential leadership role is to ensure those adversely affected by an incident, no matter how big or small, are taken care of in a timely and appropriate manner.

Do you think there is a culture of blame in your team or organisation?
What do you think you could do to help break this down?
In what ways can you lead by example by not blaming someone, but immediately getting on and resolving the issue?

Making the apology

When patients, customers and others who are on the receiving end of something going wrong, they usually report that when they make their complaint all they are really looking for is an apology. They would like the doctor, the company or the supplier, to acknowledge they have made a mistake, and then, and only then, can both parties move on in their relationship. Some of those impacted will take the issue further and may sue for compensation; others may feel the apology is sufficient. However, for many, the complaints journey is a complex and emotive one that often ends up in court or at a tribunal, just because someone couldn't say sorry.

**“Recommendation 34
When things go wrong, patients are entitled to receive an acknowledgement, an explanation and an apology.”**

*Learning from Bristol:
The NHS Department of Health Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*

<http://www.doh.gov.uk/bristolinquryresponse/bristolresponsech2.htm>

When last did you make an apology for something that went wrong, even if it was not directly your fault?

Can you think of occasions when an apology would have made the situation better?

Reporting near misses

For every accident that happens, research indicates that there were a possible 300 times when the incident nearly happened. This is known as the Heinrich Ratio: 300 – 29 – 1 ratio between near misses, minor injuries and major injuries. Heinrich also estimated that 88% of all near misses and workplace injuries resulted from unsafe acts.

Many organisations, including hospitals, have systems in place to record and analyse adverse incidents. Some of these also capture information on near misses. The reward for focusing on near misses is the knowledge that you can avoid an incident happening – take evasive action before something goes wrong. Many staff will prefer the more positive process of looking for patterns and taking preventative action, than going through the process of reviewing processes that have gone wrong.

One of the problems with near misses is we become so used to the routines we carry out that we no longer spot the risks. Think about driving your car down a narrow lane. You might be travelling at 50 mph and coming towards you is another car travelling at the same speed. You pass safely. However, there may have been only two inches between your wing mirrors; two inches apart from a devastating 100 mph impact. You may experience this every day as you travel to and from work. Maybe once a year you experience the snap of mirrors as they bush against once another – a near miss to remind you of the risks. Or maybe you don't get that warning...

*“The eye sees a great many things,
but the average brain records very
few of them.”*

Thomas Elva Edison

The theory suggests that for every reported needlestick incident, there were approximately 300 occasions when an incident nearly happened.

For Roger this means there were plenty of times when he nearly forgot to put the needle in the sharps bin, but remembered at the last moment. Obviously it is not possible to attend to all the potential problems all the time – we would never get any work done. To survive we filter out many of the cues and signals sent to our brain, and this is part of the problem – our inbuilt potential for error – our human fallibility.

Recall the last time you were involved in or responsible for an adverse event. Can you think of any occasions before it happened where there were the warning signs?

What were these?

Have you noticed any near misses since the event happened?

On what areas could you focus your attention and try to identify near misses so you can avoid a potential accident?

If you can't recall a near miss, are you satisfied with your ability to notice the small warnings that could signal a drift towards a larger calamity?

Understanding human fallibility

We are not perfect and we will always make mistakes. The amount of mistakes we make every working day is potentially large. If no major untoward incident happens we may not notice just how many mistakes we are making. We are limited by the way in which our senses and brain works. Some of us have in built biases that affect how we work. For example, have you ever put the cat in the fridge and the milk outside the back door? Or closed the front door behind you to find you've walked out without your keys? Or forgotten your home phone number? These are all instances of cognitive confusion.

"The only consistent people are the dead."

Aldous Huxley

We can make errors because we miss something inadvertently (an interruption diverts our attention), we select the wrong information (look at what is in the sharps bin but not look at the treatment table to see what is left behind), ignore information that is available, and over confidence in our abilities (don't see the needle because we don't usually forget to dispose of it appropriately).

What do you think are the most common types of errors that you make?

Do you miss out things because your attention is distracted or do you actually make the mistake because you are concentrating too much?

In what way can your personal errors affect your business?

What plans can you put in place to minimise the impact of these personal mishaps?

Ensuring a supportive learning culture

A key factor in being able to cope with large and small mistakes is to have a trusting work environment. This means feeling comfortable owning up to your own mistakes and helping others review theirs in a

constructive way. It helps when the people you work with have the same co-operative work ethic and are personable and friendly. Roger Bodley suggested the most important factor when dealing with calamities at work was to have good relationships in place – without them, it would not be possible to learn from mistakes.

In what way is your work environment conducive to the reporting and constructive discussion of errors?
What can you, as a leader, do to support the development of appropriate working relationships?

Conclusion

Small mistakes will happen. Whether these grow into large calamities that have a severe impact on the individuals involved and the organisation, is largely down to the ability of leaders; the ability to recognise mistakes as learning opportunities, the ability to appreciate the potential impact of near misses and small adverse events, and the ability to enable a supportive culture based on good working relationships.

Annotated bibliography and references

Interested in learning more about **patient safety**? There are numerous sites on the internet that cover this issue. Many hospitals will have their own site with guidelines and statistics. Check out the UK NHS National Patient Safety Agency www.npsa.nhs.uk. An excellent source of information and links to health care safety and improvement tools and techniques is the website co-owned by the British Medical Journal and the Institute of Healthcare Improvement in Boston – www.ihl.org

Near misses are well known in the safety world. Any search engine will generate useful papers and articles, specially if you search using keywords from your own industry e.g. “*near+miss hotel*”.

The Heinrich ratio: in Heinrich, H. W. 1941. Industrial Accident Prevention. 2nd edition, McGraw Hill, New York, NY.

Most of the work on **human fallibility**, as related to accidents, originated with the airline industry. Searches using the terms *human fallibility* and *human factors*, will elicit a wide variety of material.