



## **JAG ISREE: Improving Safety and Reducing Error in Endoscopy Learning from patient safety incidents: case of the month**

### **September 2019: going down the rabbit hole**

#### **About this case study**

Each month JAG publishes a case of the month highlighting a real life clinical scenario which has impacted patient safety. Case studies are contributed by JAG leads and endoscopy services across the UK and are designed to provide a opportunity for discussion and to share learning. This case is adapted from a real life clinical scenario and highlights the cumulative impact of patient safety incidents on patients and clinicians.

#### **Case synopsis**

Complex patients were booked onto a consultant's afternoon list. The list was overbooked. The morning list was over-running and despite the trainee being ready, the start of the list was delayed. The trainee endoscopist was not signed off for independent colonoscopy and the consultant was delayed in theatre. The nurses asked where the consultant was, the trainee was unsure but said he would start the list.

The trainee was frustrated with the delays and was anxious to start the list. After the first patient was brought into the room the nurses noted the consent form had not been completed. The trainee completed the consent in the room, verbally expressing frustration this had not already been completed. Sedation was administered prior to the oxygen saturations probe being placed or oxygen being administered.

The first patient was known to have polyps and the indication on the request form was for a 'therapeutic colonoscopy'. The procedure had been incorrectly listed as a diagnostic colonoscopy with no additional time allocated.

The insertion was challenging with sub-optimal bowel preparation, complex looping and discomfort to the patient. Sedation was supplemented without checking the oxygen saturations. The patient was following the endoscopic view and questioning the presence of polyps, which were dismissed by the trainee.



As the technical challenges of the procedure intensified (unclear views, unable to resolve the loops and progress) the trainee's communication with the nurses and the patient diminished.

The nurses recognised the trainee was in difficulty and indirectly proposed solutions ('shall we call a consultant?', 'shall we check if there's a paediatric scope available?') but these suggestions were met with silence, followed by hostility. The trainee was distracted during the procedure as his mobile phone rang on multiple occasions (the trainee was also on call). The trainee was uncertain about caecal landmarks as he was unable to visualise the appendiceal orifice but recorded adequate caecal views had been obtained. The withdrawal time was rapid and the trainee was unable to spend time washing the mucosa due to time pressures. A polypectomy was attempted and then abandoned. The trainee was unable to communicate the outcome of the procedure to the patient due to time pressures.



## JAG analysis

What are the learning points you took away from this case?

How could things have been improved?

The following patient safety incidents were identified by JAG. They have been categorised for severity (mild, moderate and severe) based on the actual or potential impact to the patient and adherence to clinical guidance, as well as by the following themes:

1. Oxygen monitoring
2. Distractors and time management
3. Non-technical skills and training
4. Documentation and reporting errors
5. Technical skills and equipment
6. Sedation intravenous access and monitoring
7. Drug errors
8. Consent
9. Histology and sampling errors
10. Administrative error

Patient safety incident	Theme	Severity
Overbooking of endoscopy list ('consultant to do' cases)	3	Minor
Delayed list start time resulting in time pressure	2	Minor
Unsupervised trainee performing procedure	3	Severe
Sub-optimal and incomplete consent process	8	Minor
Procedure performed by a trainee required a consultant due to case difficulty	5	Severe
Sedation with no check of oxygen saturations	6	Minor
Sedation with no oxygen	6	Severe
Abandoned polypectomy	5	Moderate
Communication with nurses and patient declines with increasing technical case difficulty	3	Minor
Hostility to nursing team	3	Minor
Mobile phone distractions	2	Minor

Did you identify any other patient safety incidents?



## Learning

This case demonstrates the multiple systems failures prior to the procedure culminating in the trainee inheriting multiple errors that contributed to a suboptimal procedure.



### Overbooked list

System errors are prevalent in the organisation of procedures and the clinician is often the inheritor of risk. An overbooked list and parallel on call commitment should be escalated with the endoscopy clinical lead.



### Lack of supervision

As a trainee, completing a procedure without adequate supervision puts the patient and the trainee at increased risk of an adverse event. Attempting a polypectomy unsatisfactorily without supervision exposes the patient to risks of incomplete polypectomy and perforation. Trainee endoscopists should not perform procedures unsupervised if they are not JAG certified.



### Self-awareness

Recognising when a task is beyond your skill set and acting upon it is key to patient safety.



### Communication

Having good situation awareness and effective communication with the nursing team may prevent 'tunnel vision' at stressful times and may avert a crisis. Nursing staff should be empowered to challenge endoscopists if they feel patient safety is compromised and should seek senior medical or nursing assistance if necessary.



### Using checklists

Utilising tools such as checklists enhances the likelihood of adhering to basic patient safety measures (i.e. checking oxygen saturations) particularly at times of stress when cognitive workload is increased.



### Implement team briefing

A team briefing would have identified the overbooked complex list and alternative measures put into place proactively.



Do you have a case study from your service which could be featured in JAG's case of the month?

Please contact [askjag@rcplondon.ac.uk](mailto:askjag@rcplondon.ac.uk) for more information.

### References

1. Matharoo et al 'A Prospective Study of Patient Safety Incidents in gastrointestinal endoscopy'. Endoscopy International Open 2016;04: E83-E89

*This case is based on several documented adverse events and the narrative has been adapted to enhance educational benefit. No identifiable information has been provided.*

Document control	
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