IMPROVING SAFETY AND REDUCING ERROR IN ENDOSCOPY (ISREE): A JAG INITIATIVE

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Background

- JAG is committed to providing universal high quality and safe endoscopy as embedded in the Global Rating Scale (GRS).
- This requires acknowledgement that error is common, may not result in harm or complications, but that addressing latent risk can prevent patient safety incidents.
- Many errors relate to failures in human factors, ENTS and teamwork, which require training and assessment. Medical error is more prevalent in situations of complexity.
- Though generally safe, endoscopy is a complex task, performed in teams. As population demographics evolve, straight-to-test pathways become embedded and complex therapeutic options extended; endoscopists need to develop a proactive culture towards safety and learning from error.

Aims

- JAG aims to develop a work stream to Improve Safety and Reduce Error in Endoscopy (ISREE).
- A 1 day workshop was designed to develop an implementation plan to achieve this goal.

Methods

- 35 participants including multi-disciplinary clinicians and academics with safety expertise and a patient attended.
- Participants were asked to recall as many endoscopy adverse events or errors as possible.
- Key presentations highlighted the background to medical error, how to investigate it, development of non-technical skills frameworks (anaesthetics and endoscopy), safe sedation, human factors training and implementation science.
- A patient recounted her experiences of endoscopy.

Methods continued

Facilitated group sessions focused on 5 key areas:

1. Improving training in ENTS and human factors
2. Error prevention
3. Reporting error
4. Learning from error
5. Managing underperformance (endoscopists, teams or units).

Wider discussion synthesised a list of feasible actions that JAG could prioritise for staged implementation (Table 1).

Results

Multiple errors were reported by all delegates and recurrent themes were common. Examples included:

- Wrong patient for procedure (n=4)
- Decontamination breach (n=2)
- Histology mislabelling (n=5)
- No suitable bed for patient post-procedure (n=2)
- Drug errors (n=3)
- Poor interaction with other teams (n=1)
- Failure to follow MDT advice (n=1)
- Futile procedure (n=2)
- Suboptimal checklist (n=2)
- Erroneous decision-making – resecting diverticulum (n=1)
- Wrong patient information (n=5)
- Futile procedure (n=2)

Theme	Training in ENTS	Preventing error	Error reporting	Learning from error	Managing underperformance
Example priority	Named Safety Champion in every unit	Named Anaesthetic Lead for every endoscopy service	Optimise use of current IT systems to report error e.g. National Endoscopy Database (NED)	Optimise use of current ERS* to capture errors pre- and post-procedure	Use of endoscopy-specific 360 degree tool to identify underperformance

Table 1: Five error themes with example priorities

Conclusion

JAG plans to develop a 5 year ISREE Implementation Strategy reflecting the identified priorities to:

1) Improve endoscopists training in effective error reporting and learning.
2) Implement system level approaches to safety and performance improvement.

JAG also aims to improve its communication to disseminate learning and support endoscopy services in the UK.