

Risk Reporting in Gynaecological Surgery at North Middlesex University Hospital
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- The 2016 RCOG document 'Providing Quality Care For Women' (1) emphasises the importance of risk monitoring, including investigations and escalating in response to clinical incidents
- Sets standards for departments
- Each trust must have a documented strategy for recording and actioning risk incidents
- Clinical Governance Advice No. 2 (2) proposes a list of incidents which should be reported

Clinical incident	Organisational incidents
Damage to structures (e.g. ureter, bowel, vessel)	Delay following call for assistance
Delayed or missed diagnosis (e.g. ectopic pregnancy)	Faulty equipment
Anaesthetic complications	Conflict over case management
Venous thromboembolism	Potential service user complaint
Failed procedures (e.g. termination of pregnancy, sterilisation)	Medication error
Unplanned intensive care admission	Retained swab or instrument
Omission of planned procedures (failure to insert planned intrauterine contraceptive device after a hysteroscopy)	Violation of local protocol
Unexpected operative blood loss > 500 ml	
Moderate/severe ovarian hyperstimulation (assisted conception)	
Procedure performed without consent (e.g. removal of ovaries at hysterectomy)	
Unplanned return to theatre	
Unplanned return to hospital within 30 days	

- Colposcopy:
 - excessive blood loss at treatment necessitating admission during OP treatment or within 24 hours of surgery
 - syncope at treatment necessitating admission following OP treatment
- General Gynaecological Work:
 - blood loss > 1.5L at surgery
 - conversion of vaginal hysterectomy/oophorectomy into laparotomy
 - injury to the visceral organs at open surgery – bowel, ureters, bladder and major vessels
 - intraoperative blood transfusion
 - surgery lasting longer than 3 hours not previously anticipated
 - unplanned urgent assistance required from another consultant
- Minimal Access Cases:
 - urgent unplanned assistance required from another consultant
 - bowel or bladder injury
 - conversion of laparoscopy to laparotomy
 - fluid deficit at hysteroscopic surgery of 1.5L
 - uterine perforation necessitating laparotomy or laparoscopy
- Post surgery:
 - admission into HDU/ITU
 - need to return patient to theatre within 24 hours of surgery
 - readmission into hospital within 10 days for complications related to surgery requiring admission for longer than 24 hours
 - repeat laparotomy or CT-guided drainage of pus within 2 weeks of surgery

- Retrospective review July to December 2021
- 366 handover lists reviewed (morning and evening handover lists for 6 months)
- Each case compared against the NMUH Datix trigger list and compared to Datix submitted during the study period

- There were 62 Datix formally submitted over a six-month period
- Only 7 of the 62 Datix submitted were reportable incidents from the trigger list
- A breakdown of the incident reports received, and their relevant categories, are detailed



- 58 Datix identified from examining the handover lists
- We are currently reporting <12% of our risk incidents in gynaecology

- Handover lists alone cannot capture all departmental patient contacts or events which require incident reports
- Lack of understanding of which incidents require reports
- Gross underreporting by junior doctors – over 90% of Datix were filled by nursing or administrative staff

A word cloud of terms related to patient safety. The words are arranged in a circular pattern, with 'time' and 'negative' being the most prominent. Other significant words include 'errors', 'formal', 'incident', 'threat', 'blame', 'responsibility', 'trouble', 'long', 'reactive', 'forms', 'mistake', 'admin', 'root-cause', 'reporting', 'culture', 'issues', 'punishment', 'error', 'discouragement', 'systemic', 'paperwork', 'responsible', 'patient', 'safety', 'big', 'punitive', and 'form'. The words are in various shades of red, orange, and yellow.

- We did an informal exploration of issues around incident reporting with junior doctors within our department
- Though 90% of doctors have completed an incident report as some stage of their career, only 10% have filled one out in Gynaecology.
- Whilst most doctors understand the rationale for reporting, there are significant barriers including time and negative perceptions of risk reporting, as well as poor understanding of the specific issues for which incident reporting is mandatory.
- Other issues raised included a lack of feedback following submission of an incident report, which also disincentivises doctors from participating in the process.

- Despite deficiencies, there has been an absolute increase in the amount of incident reporting by all staff when compared to a previous audit in 2017.
- We have instituted new measures based on feedback from our colleagues, which should empower junior doctors to submit incident reports.
- We hope to re-audit this project to assess for effectiveness later this year.

1. Royal College of Obstetricians and Gynaecologists (RCOG). Providing Quality Care for Women: Standards for Gynaecology Care. 2016. Available at <https://www.rcog.org.uk/media/mgnejcft/gynaestandards.pdf>
2. Royal College of Obstetricians and Gynaecologists (RCOG). Improving Patient Safety: Risk Management for Maternity and Gynaecology (Clinical Governance Advice No. 2). 2009. Available at <https://www.rcog.org.uk/media/j5uimqj3/cga2improvingpatientsafety2009.pdf>