Dr Richard Nicholl – Neonatal Unit experience

This slide I think it's from something called "Creating a healthier future". Some of you may remember it must be from at least 10 years ago. Whole thing about preventing errors in the NHS, and how can we limit the incidence in this case of GBS and how can we create systems that will tolerate errors, and so how can we effect, if you like, human behaviour to prevent this. Now any talk you go to on risk management will have this famous slice of cheese on it which you've all seen and **I was struck by the honesty of some of the previous speakers in some of the inefficiencies, errors and omissions**. So we've all got guidelines, we all think they're being adhered to, when something goes wrong we are sort of surprised that the guideline wasn't followed, some change in the guideline and I must say that in.. I got to the stage in my career that every time there's an adverse event and we have to review it, there's no question about the communication either within the teams or between teams is a very common theme when it comes to adverse events and certainly having a baby with group B strep is for sure an adverse event. One of the things I wanted to raise and I, this probably will echo with the neonatologists in the room is, every day we have a handover and as part of that handover the trainees talk about the income as well babies on the postnatal ward, Maybe they're not feeding well been a bit jittery, some jaundice, now without a shadow of a doubt they will preface - the first thing they will say is, there are no risk factors for sepsis. I hear this every day, seven days a week and sometimes I'm sitting there I'm thinking **"How do you know that? How do you know there's no risk factors for sepsis?"** If you remember the Donald Rumsfeld thing - the things we know and we don't know. All these babies in the postnatal ward there's lots of stuff that we don't know we don't know, but every day I hear this: "There's no risk factors for sepsis." Ok, so that's one of the problems, I mentioned handover; We are all very busy, we know there are lots of staffing shortages, you're all working in shifts with multiple shifts, multiple handovers, multiple opportunities for information to get lost. **I just think we need to step back from the data into the day job.** What actually happens?

Guidelines have been mentioned. My other hat is as a Foundation Training Program Director. Now the Foundation Doctors, That's Housemen nil money, they have to deal in our hospitals with about 80 admissions a night. Patients in their late eighties with multiple comorbidities. To survive the shifts, they need to have- I think it's either 70, that's seven zero, or 90, nine zero, guidelines. To survive one shift. We've talked about one guideline, every single one of you and your units has got dozens of guidelines, probably three figures. **I suspect if you went to work, if you just suspend your disbelief for a moment, and there was only one guideline you had to follow, and it was Group B Strep you'd probably be quite good at it. But it isn't. We haven't mentioned the guidelines for postpartum haemorrhage, for induction of labour and so on and so on and so on and**

these are things you are all expected to remember, to have access to, to adhere to when you have bank staff, agency staff, Doctors rotating every six months etc.

So I do worry about the guidelines as the solution and I do respect the honesty of the audits from the obstetricians showing that implementation is a problem, the variation between units and within units. Professor Steer mentioned the word "inefficient", he said that - I hope I'm quoting you right Professor Steer- , he said that "the risk-based approach is inefficient" and this is a slide that I took and to be honest this is our hospital many years ago and this is an example of why it's inefficient. So this, I took a photograph of a woman's notes, I'm not sure if I dare touch the pointer, but somebody was very concerned because this woman had group B Strep in the urine, so they wanted that to be known, they wanted something to be done about it, so they thought they'll write in the notes that there's group B Strep in the urine but I'm going to write it in big capital letters, and just to be on the safe side I am going to put an asterisk either side, then to make really sure I am going to get a yellow highlighter pen and I'm going to underline it and that way everyone's going to know this woman has group B Strep, and just as an absolute extra safety I'm going to get a different coloured highlighter and put that under.

You will not be surprised to hear that this woman did not get her IAP and the baby presented with seizures was on our neonatal units, had an abnormal MRI scan, which I'm not going to show. And at the age of two was deemed to be normal, now we heard speakers this morning, I will put my hand up we did not concede to follow this little girl up to school age, I have no clue how she is doing at school, so I use the word "Normal" with inverted commas and this is the reality of the current system, so I'm just trying to throw that into the mix that there's all sorts of human factors, we think we got these guidelines we've already seen from earlier presentations the introduction didn't reduce the rate, that there's problems with adherence, and I would much prefer to have a system, I mean I was thinking this morning on the tube on the way in I don't actually remember the last time a baby didn't get a Guthrie screen done. It just happens - magic fairy does it - it just seems to happen. Ditto ROP screening. I should imagine it's quite difficult to be pregnant and not get your serology done, it just happens. **And I'm sort of thinking wouldn't that be a good idea for GBS, just becomes part of the routine? Anyway that's just my personal view, as I said no data, no pictures but I just wanted to flag up the human factors of why we're not quite as good at doing this stuff as we think we might be.**