

Scenarios to support training in using a just culture guide

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We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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This resource supports organisations wishing to organise training exercises on how to use [A just culture guide](#). To help with the training, we have developed a series of case scenarios that facilitators can use to walk people through the tool.

Please note these exercises are for training purposes only. The examples are not references to real people or incidents. You should refer to the guide itself for information on how and when to use it.

The four case examples give you the material to explore how the guide works in practice. At the end of the document we provide a list of possible actions that can be tested for each scenario and highlight discussion opportunities to help trainers prepare for the session.

Remember to take **one action (or failure to act) by one staff member through the tool at a time**. For each action (or inaction) by each staff member, follow the arrows as directed by your yes or no answers, and stop when you get to any red, amber or green box.

Scenario 1: The 'faulty' oxygen cylinder

Yesterday, Mr A was admitted to an acute medical ward. He had been deteriorating over a few hours, raising concern his liver disease was progressing to multi-organ failure. An urgent transfer to the intensive therapy unit (ITU) was arranged. At the point this decision was made he was very ill, but conscious: with a pulse of 120; BP 92/56; respirations 28, and SATS 89% on 15 litres per minute of oxygen.

Porter Brian Baker brought a patient trolley to the ward and the ward team helped transfer Mr A from his bed to the trolley. Staff Nurse Jamie Jones and Doctor Sara Smith escorted Mr A to the ITU, which is at the opposite end of the hospital and down three floors in the lift.

Mr A's condition worsened considerably about halfway through this journey. He was cyanosed, had a rapid and faint pulse and agonal breathing. Nurse Jones and Dr Smith realised that although 15 litres per minute of oxygen should be flowing from the oxygen cylinder on the trolley to the oxygen mask Mr A was wearing, there was no flow. The cylinder was clearly at green so it had not run empty. Nurse Jones said it was definitely working when they left the ward as he could distinctly remember hearing a hiss when he turned the flowmeter dial to 15 litres. Nurse Jones and Dr Smith in turn tried to get the cylinder to work, but without success, and they concluded the cylinder must be faulty.

Nurse Jones suggested they stop at the nearest ward to use its wall oxygen and began to turn the trolley. However, Dr Smith overruled him and shouted at Brian Baker to push on to the ITU as fast as he could.

Mr A was close to having a cardiac arrest on arrival at the ITU about four minutes later, but was stabilised by the ITU team. He died three days later. His death was reported to the coroner, as although his condition was critical even before the oxygen supply was lost, this event would have reduced his chances of survival.

The investigation team collected the key facts, including:

- The technician who examined the cylinder found it was almost full and in good working order but had not been properly turned on. He explained that for oxygen to flow a plastic cap needed to be removed and an on/off valve turned, in addition to turning the flow dial to the correct flow rate (in this

case 15 litres per minute). If the valve is not opened a brief hiss of oxygen may still be heard but there is no further flow of oxygen. The plastic cap was still in place on this cylinder and the valve was closed.

- Brian Baker said he had been a porter for five years and had been taught to check and prepare oxygen cylinders each time he collects a trolley. About six months ago the porters were told by their supervisor not to turn oxygen cylinders on as this was a clinical task. Although he knew how to turn the cylinders on, he said that when problems arose on Mr A's journey he had assumed that if Nurse Jones and Dr Smith said the cylinder was faulty, then it must be faulty. He therefore just concentrated on pushing the trolley to ITU as fast as he could.
- Nurse Jones said he had 20 years of medical ward experience but was used to relying on the porters to bring trolleys complete with an oxygen cylinder ready for use. He had not had any training in using these cylinders and was not aware of any change in policy. He had turned cylinders on in emergencies in the past but those cylinders had a simpler design. He said he had genuinely believed oxygen was flowing when Mr A left the ward and could not understand why it was not mid route. He said that after the incident he looked up the instructions for these cylinders on the internet. While he considers himself to be technically adept, it took him a few minutes to understand how to turn them on properly using the numbered diagrams provided by the manufacturer.
- Nurse Jones said that when they were half way to the ITU and unable to get the oxygen cylinder working, he thought the priority was to get Mr A to a working oxygen supply as the patient's colour was so poor and his breathing so close to respiratory arrest. However, he knew that the worst of all responses was to play 'tug of war' over the trolley. So, when Dr Smith insisted on pressing on, Nurse Jones thought it was best not to waste more time by disagreeing.
- Nurse Jones' ward manager, Sister Paula Pinkerton, said she did recall receiving an email about the shift of responsibility for turning oxygen cylinders on. She assumed, however, that there would be some kind of central training programme and did not realise she was meant to submit the names of nursing staff who needed to be trained. The investigation team agreed this email, sent on behalf of the chair of the medical gases committee, was not as clear as it could have been.

- Dr Smith said she was at the start of her second foundation year (FY2) and had never been trained in how to turn on oxygen cylinders, nor did she realise she needed to be. She assumed porters or nurses should know what to do. When she checked the cylinder mid route she could not see anything wrong with it but there was clearly nothing coming out either. She agreed she shouted at the porter to keep going when Nurse Jones began to turn the trolley to a nearby ward. She said she decided it was best to press on to ITU because she thought Mr A was deteriorating fast and she would not be able to do much for him if they diverted to a ward. She added she knew how important it is to be decisive in emergencies and had talked her decision over with some close FY2 friends; they all agreed she did the right thing.
- Professor Philip Parker was the consultant leading the team Dr Smith works in. He said if it had been him with a cyanosed patient midway to ITU and an apparently faulty oxygen cylinder, he would probably have stopped off at the nearest ward to get the patient back on oxygen before they went into full arrest. However, he agreed it was not an easy decision to make.
- Dr David Douglas, the chair of the medical gases committee, said they switched to this cylinder design three years ago as it reduced the risk of cylinders being unintentionally left on. This reduced the risk of them being empty when needed or creating a fire hazard. Responsibility for turning cylinders on switched from porters to nurses about six months ago, to reinforce the message that oxygen needs to be prescribed rather than just given. The committee had not been monitoring take up of training but after this event it identified that only 22% of nurses had attended the local 'using oxygen cylinders safely' sessions.

Scenario 2: The stolen pethidine

Three new mothers complained about having had a very painful labour.

The investigation team suspected Midwife Greta Green had been injecting women in labour with 'water for injection' and keeping the pethidine they were prescribed for her own use.

Midwife Green admitted she has been doing this for some weeks as she had become addicted to opiates after her GP prescribed them for pain stemming from an earlier back injury sustained at work. She says that when her GP reduced her prescription she turned to the painkillers she could access at work. She said she was glad she has been found out. She was feeling very guilty knowing that the pain and distress these women went through each time she did this was her fault.

The investigation team found Midwife Green had been able to steal pethidine repeatedly because in the busy community midwifery unit it had become normal practice for midwives to bring prepared doses of pethidine into each other's labour rooms for checking and signing the controlled drugs register. In practice, midwives in the unit rarely observed each other injecting pethidine.

Three other midwives on the unit (Midwives Thomson, Scott and Wilson) had countersigned doses of pethidine prepared by Midwife Green but acknowledged they did not see her give the injections. The midwives said they were 'caught' between two policies. One of those policies states that they should not leave the side of the woman they were looking after if she was in active labour. They thought that policy was more important than the controlled drug policy that required them to accompany their colleague to observe the pethidine being given. With hindsight it appeared Midwife Green had picked times when she knew her colleague would not want to leave the woman they were caring for.

Scenario 3: The dispensing error

Gordon Grant is a pharmacist with 30 years of experience who owns and runs a pharmacy in a small market town. He provides a range of extra services including a free-of-charge home delivery service.

Mr Grant was considered as part of an investigation after Rachel, a teenager whose medication he dispensed, was admitted to hospital in status epilepticus (a life-threatening series of continuous epileptic seizures). The hospital discovered she had been taking clobazam rather than clonazepam for a week. While both medications can be used to treat epilepsy, they work in different ways and are prescribed in different doses. Confusing the two could lead to uncontrolled seizures in someone whose epilepsy is usually well controlled.

Mr Grant's delivery driver, Lucy Lee, remembered that, on being handed the medication, Rachel's mother said "This one doesn't look the same, have they changed the packaging?" Because Rachel's mother was worried, Lucy immediately rang Mr Grant to ask if it looked different because the packaging had indeed changed. Mr Grant replied "Yes, probably, tell her not worry".

Mr Grant accepted he must have picked up the wrong pack when he dispensed Rachel's medication. He said he didn't know how it happened as he was very aware of the risk of selecting the wrong pack for 'look alike, sound alike' drugs and always took extra care. He said he was sure Lucy's account of their phone conversation was truthful but said he really couldn't remember what was said. He explained that might be because shortly before Lucy rang him he'd taken a call from his wife. She said the hospital had just called to ask if she could attend outpatients that afternoon for the results of a blood test and to make sure she brought someone with her. Mrs Grant's GP had recently ordered blood tests and sent a sample to the hospital. Mr Grant said he reassured his wife the appointment would be routine but knew the news was likely to be bad (indeed, his wife was diagnosed with acute myeloid leukaemia).

Scenario 4: Nasogastric tube placement checks

Mrs T was recovering from a stroke on an acute stroke ward. She was unable to swallow safely.

Nurse Barbara Black inserted a nasogastric (NG) tube around midday but could not obtain pH within the safe range. In line with hospital policy she requested an X-ray to confirm the tube was correctly placed in the stomach before using it.

Mrs T had the X-ray taken and returned to the ward about 4 pm. Dr David Downton, who was on the ward to see another patient, checked the X-ray. He confirmed in Mrs T's notes that the tube was correctly placed and safe to use for feeding. Nurse Black started a feeding regime via the NG tube at about 4.30 pm. An hour or so later her condition generally deteriorated. The FY2 doctor covering the medical wards that evening reviewed Mrs T. She suspected pneumonia and checked the recent X-ray for signs of this. It was immediately obvious to her that the NG tube was placed in the right lung. The feed was stopped and Mrs T was transferred to ITU for treatment of the effects of the liquid feed introduced into her lung. Mrs T was still in intensive care and critically ill as the investigation started.

The investigation team collected the key facts, including:

- The nutritional nurse specialist explained the hospital policy. This states that only doctors who have been through eLearning and a competency check in interpreting NG tube X-rays can confirm placement. It takes a few weeks after junior doctors' rotation to get everyone through the training. The junior doctors' induction includes the very clear instruction that they must not check tube placement until they have been trained. She explained that in some ways this training is quite simple. It involves teaching doctors 'four criteria' for the specific points to check along the track of the NG tube. This is in contrast to the traditional but inaccurate methods of checking only the tube tip. Almost everyone passes their assessment first time as long as they've actually paid attention to the eLearning.
- The nutritional nurse specialist said she checked the records and Dr Downton attended the induction session two weeks' ago. He had been sent the link to the eLearning to complete in advance of a practical assessment scheduled for next Friday.

- The nutritional nurse specialist said nurses are expected to reinforce this training. They only let doctors check tube placement if they are on the intranet list of staff who have passed the assessment. The nurse specialist said that in her view almost everything Nurse Black did was in line with policy and good practice. The exception to this was in asking Dr Downton to check the tube without checking the list.
- Nurse Black said she has worked on the acute stroke ward for four years and knows how important it is to do these checks carefully. She said she usually checks the list. However, both ward computers were being used by colleagues at the time so she asked Dr Downtown if he had been through the trust's training and had been 'signed off' to do these checks. She said he assured her he had and she trusted him.
- Dr Downton said this is his first registrar post. He remembered being told in his induction not to do these checks until he had been through the trust's training. He thought it was "bureaucracy gone mad" to expect him to do more training and a test because he'd already learned this. He said that in his foundation year at another trust a more experienced junior doctor had shown him how to check if the tip of the tube was below the diaphragm. He said that he had checked X-rays "hundreds of times" since. He agreed with Nurse Black's general account of their conversation when she asked him to check Mrs T's NG tube. He said he had not been untruthful as he only told her he had been through "the training" and that he "could check NG tubes" rather than specifically stating that he had done this trust's training and passed the assessment.

Notes for trainers

These scenarios provide practice material for learning how the tool works. We recognise that they include some 'grey areas', as will real situations.

The guide looks to support **informed** discussion about grey areas and to challenge presumptions, excessive risk aversion and unconscious bias. The trainer may also note that this approach has similarities with the approach being taken by a number of NHS trusts to reduce disproportionate disciplinary action against black and minority ethnic staff.

For each scenario we have outlined below what actions can be assessed and the areas for discussion.

	Actions you may wish to take through the guide	Areas for discussion
Scenario 1: The ‘faulty’ oxygen cylinder	<p>Nurse Jones did not turn the oxygen cylinder on correctly.</p> <p>Nurse Jones did not notice the oxygen cylinder was not on.</p> <p>Porter Baker did not recognise the oxygen cylinder was not on.</p> <p>Dr Smith did not recognise the oxygen cylinder was not on.</p> <p>Dr Smith could not turn the oxygen cylinder on.</p> <p>Nurse Jones could not turn the oxygen cylinder on.</p> <p>Dr Smith pushed on to ITU rather than stopping at the nearest ward to use its wall oxygen.</p> <p>Nurse Jones did not argue against the decision to push on.</p> <p>Porter Baker did not speak up to say he knew how to turn the cylinder on.</p>	<p>This scenario gives an opportunity to:</p> <ul style="list-style-type: none"> consider actions taken not only by clinical staff close to the incident but also actions by others in the weeks or months before the incident cover what is meant by the foresight test, in circumstances where there are some clear problems with the trust’s processes for ensuring staff can manage oxygen cylinders safely cover what is meant by the substitution test. Differences between what a junior doctor and a senior doctor might do in an emergency are described, and there are questions about whether an experienced staff nurse and a junior porter should have been more assertive.

	Actions you may wish to take through the guide	Areas for discussion
	<p>Sister Pinkerton took no action in response to the poorly written email announcing a change in responsibilities.</p> <p>Dr Douglas approved a poorly written email communicating the change in responsibilities.</p> <p>Dr Douglas had no plan to monitor take-up of training to accompany the change in responsibilities.</p>	
Scenario 2: The stolen pethidine	<p>Midwife Green injected women with 'water for injection' when they had been prescribed pethidine.</p> <p>Midwives Thomson, Scott, and Wilson countersigned doses of controlled drugs without observing them being given.</p>	<p>This scenario gives an opportunity to:</p> <ul style="list-style-type: none"> reflect that deliberate harm can occur in circumstances less rare and dramatic than notorious cases like Harold Shipman draw out that Midwife Green was intentionally causing harm to the women, even if she was sorry after it occurred consider that theft has to be treated as a criminal act even if no patient was affected. The just culture guide can still be used when the patient safety incident involves theft explore the foresight and substitution tests in circumstances where a whole team or unit has adopted the same behaviours.

	Actions you may wish to take through the guide	Areas for discussion
Scenario 3: The dispensing error	<p>Pharmacist Grant dispensed the wrong medication.</p> <p>Pharmacist Grant dismissed delivery driver Lee's question without checking.</p>	<p>This scenario gives an opportunity to:</p> <ul style="list-style-type: none"> explore the foresight and substitution tests in a small healthcare provider where one person is both manager and frontline clinician consider the mitigating circumstances as Pharmacist Grant was clearly distracted by distressing news.
Scenario 4: Nasogastric tube placement checks	<p>Nurse Black took Dr Downton's word that he had completed the training when she was unable to check the list owing to no computers being available.</p> <p>Dr Downton told Nurse Black that he had "the training" and that he "could check NG tubes".</p> <p>Dr Downton checked the X-ray despite not having had the trust's training.</p> <p>Dr Downton misinterpreted the X-ray.</p>	<p>This scenario gives an opportunity to:</p> <ul style="list-style-type: none"> cover what is meant by the foresight test in a scenario where trust processes for ensuring staff know how to manage NG tubes seem to be well organised explore what is meant by the substitution test in a scenario where a doctor does not appear to behave as their peers would. Draw out that there will be some staff who, even if they have no intention of harming a patient, may still need some individually focused action to help them work safely in future.

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