Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6516

Please reply to:
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Trust Management
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26 January 2021

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Never events.

You asked:
1. Number of 'never Event' (point 6 c) started by the organisation since the 23rd May, 2019.
2. If, there has been a 'never event' commissioned as per point 6 c), has this report been published in any forum and if so where?
3. If, there has been a 'never event' commissioned as per point 6 c), what learning was found?
Not restricted to the never events the following:
4. Number of staff suspensions in 2017, 2018, 2019 and 2020 by respective year.
5. In decisions to suspend staff, is there any formal written assessment the organisation conducts to assess the effect on health and welfare of suspension of the staff member the organisation is considering suspending, if so please disclose a copy?
6. Number of staff disciplinary investigations started in 2017, 2018, 2019 and 2020 by respective year.
7. Number of staff disciplinary investigations started in 2017, 2018, 2019 and 2020 by respective year split down by investigated by an internally employed investigator or an externally contracted investigator. If the numbers are too low to reveal, it can be given by all four years together the split.

Trust response:
1.
a) June 2019 – lumbar puncture on wrong patient
b) January 2020 – wrong route medication
c) February 2020 – injection in wrong eye
d) October 2020 – misplaced NG Tube (on-going / open investigations)

e) November 2020 – retained swab (on-going / open investigations)

2. Yes, these are published in the SI Update report and the Quality Committee reports and reviewed by the Senior Executive team including the Chief Executive, the learning is shared in the Governance Gazette and the Pulse Newsletter. Information regarding Never Events is also published in the Board papers.

3.
a) Should have had a lumbar puncture guideline ii) Reflective practice from Advanced Neonatal Nurse Practitioner
b) Purple syringes to be immediately and obviously available in all theatre Recovery areas, Reflective learning by individual concerned, Reflective learning for nurse witnessing medication being drawn up, Human factors training for all directorate staff, Trust wide awareness of never event
c) To ensure documentation in healthcare records is accurate, Team learning – staff to be aware of importance of looking back in the patients records to ensure the correct eye is being treated
d) Not applicable – on-going/open investigations
e) Not applicable – on-going/open investigations