Learning from near misses and adverse events in paediatric surgery – analysis of cases submitted to CORESS confidential reporting system

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INTRODUCTION

CORESS (Confidential Reporting for Surgical Safety) is an independent UK-based charity analysing near misses and adverse events contributed via a confidential reporting system. It publicises and promotes lessons learnt to enhance patient safety (Figure 1).

We set out to analyse the paediatric surgical cases submitted and identify the non-technical factors at play.

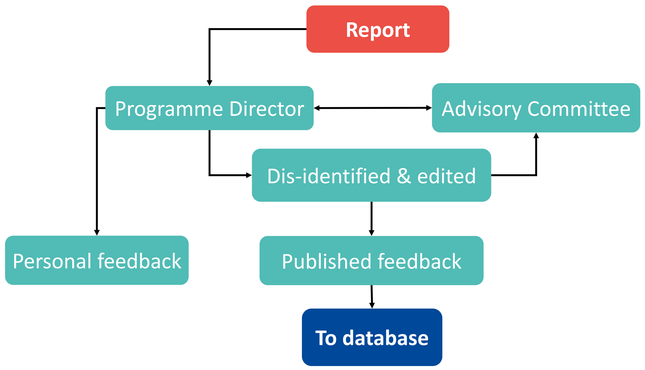


Figure 1. CORESS analysis process

METHODS

Cases submitted from 2005 onwards were selected if involving a child or a young adults with complex needs. We note exact demographics are sometimes altered for confidentiality reasons, thus these were not collected.

Cases were classified as near miss, recognised treatment complication, or avoidable harm. Where relevant, Clavien-Dindo complication grade was assigned.

Each case was analysed in accordance with the Non-Technical Skills for Surgeons framework, as well as the CORESS Patient Safety Analysis Framework (Figure 3).

RESULTS

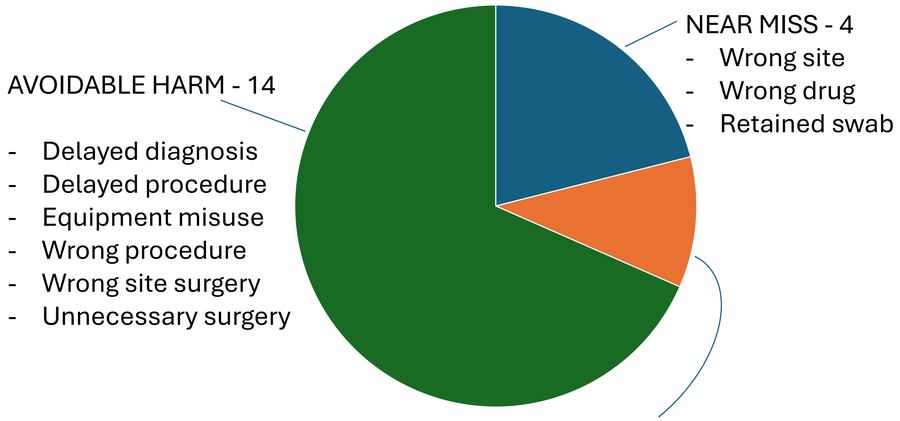


Figure 2. Cases submitted to CORESS

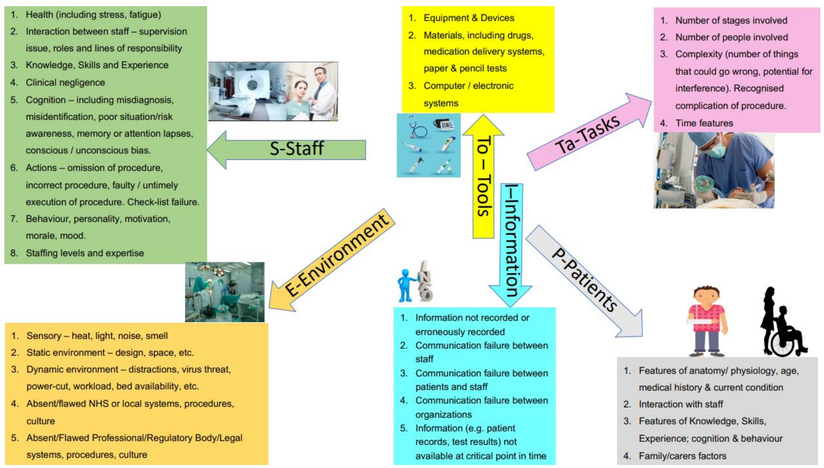


Figure 3. CORESS Patient Safety Analysis Framework

ANALYSIS

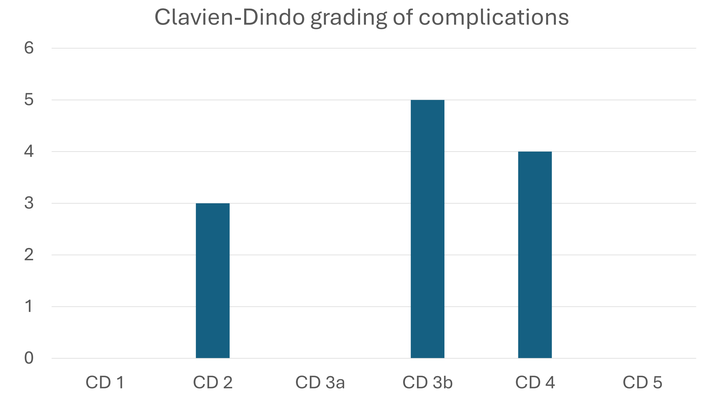


Figure 4. Clavien-Dindo cases classification

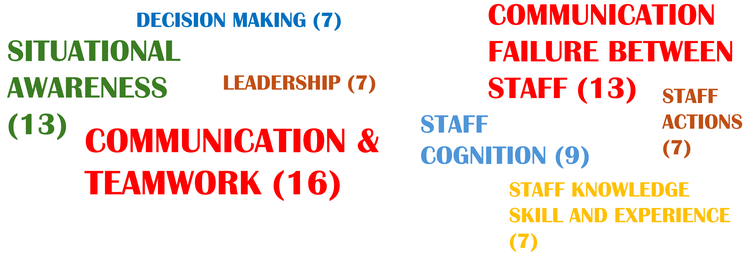


Figure 5. NOTSS and CORESS Patient Safety Analysis Framework

CONCLUSIONS

Analysis of reported events highlights multifactorial nature of cases reported. Communication and situational awareness are recurring themes, pointing towards importance of non-technical skills in paediatric surgery.