When the fault lies within the structure and with the leadership

An auxiliary nurse gave the wrong dose of insulin during a home visit. The Norwegian Board of Health Supervision made the following assessment. Delegating the tasks of measuring blood sugar level and administering insulin to an auxiliary nurse was not unsound practice, but in this case inadequate training had been given, and no system had been established to obtain help when required.

A middle-aged woman, pregnant for the first time, had discoloured amniotic fluid and was admitted to a very busy maternity unit. The junior registrar and the senior consultant were fully occupied. Foetal heart monitoring (CTG – cardiotocography) showed pathological findings, but the midwife was uncertain how to interpret these findings. The senior consultant lost track of the patient, and a necessary Caesarean section was delayed. The Norwegian Board of Health Supervision found that there were no guidelines for calling extra help in times of extra heavy workload, and that cooperation between the midwife and the doctor with regard to monitoring and reporting were unclear and inadequate.

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These two events are examples of how provision of health services today is characterized by teamwork between many different people, complicated patterns of cooperation, and use of advanced technology. Adverse events are often the result of unclear responsibility, inadequate communication, or lack of awareness of the vulnerability of the system.

In developing methodology for supervision, the Norwegian Board of Health Supervision has had a desire to assess the system to a greater extent after adverse events have occurred. People within the system cannot always avoid making wrong assessments or acting incorrectly. The leaders of health institutions must identify areas and situations where there is risk, and must establish structures to prevent human error leading to adverse events.

- The health service must be organized in such a way that health care personnel can provide adequate health care in accordance with the legislation.
- There must be a safety culture throughout the organization.
- Safety barriers must be established to prevent adverse events from occurring.
- There must be an open culture for analysing adverse events and learning from them.

Planned supervision using system audits is based on the organization's leadership and management system, and analyzes how the established structures and routines can influence the end product. Incident-related supervision is carried out after an adverse event has occurred. The analysis involves finding out what happened, how it happened, and why it happened. The answers to these questions provide the institution with the opportunity to learn from the event.

When we assess supervision cases, we direct our attention at the institution's management system. This involves several levels in the organization:

- We ask about routines that apply to the specific situation.
- We identify possible areas where deficiencies in the system may occur.
- We ask about organization and management related to the adverse event.
- We recommend the organization to carry out an internal investigation.
- We assess the actions of the health personnel who were involved in the event, in the light of the managerial conditions that have been identified.

In order to clarify the course of events and to gain information about the managerial conditions, it may be appropriate to have a meeting with the institution at an early stage. This also provides the opportunity to point out the duty that the institution has to carry out an internal investigation of the event, and in this way to learn from the event.