

- equipment in its operation (almost damaging a patient) and a member of medical staff being reminded to do something (which if omitted would have been an incident).
8. There were no “systems” in place to verify compliance with the policy, at least in the sense in which “systems” would be understood today. In practice, the policy was conscientiously followed nationally, particularly by nursing staff whose basic training emphasised the importance of such matters and whose supervision in practice was rigorously carried out where basic matters of patient safety were concerned. This professional duty has always been taken very seriously by nursing staff in particular, but amongst all healthcare professions. There is a strong ethos to learn from mistakes to ensure better and safer care of patients.
  9. In practice, it was usually nursing staff who recorded incidents which may also have involved medical staff. Where it was appropriate to do so, the medical staff took responsibility for writing in the patient’s medical records. As indicated above, in my experience throughout the NHS there was a uniform policy for each form to be scrutinised by a Senior Nurse or Head of Department/Physiotherapy/Occupational Therapy/Radiology/Pathology. My experience is of a common local procedure, that the person scrutinising the report form would initial and date the form, and take appropriate action upon individual incidents and any pattern that was emerging.
  10. A formal analysis was not usually maintained, although a specific incident or series of incidents might prompt a retrospective analysis. Thus, in practice, periodic analyses were carried out by Nursing Officers and acted upon as appropriate, including keeping Senior Nursing Officers and/or General Managers informed. Some of those with responsibility for these reviews and analyses would have kept their own records as an aide mémoire. Many others would have been well aware, on a daily basis, of where there were, for example, unusually high incidences of patients falling or falling out of their beds, and they would be looking for the contributory factors and how those might be put right. During the period of the Inquiry’s investigation there was much less emphasis on written procedures than there is today, but it would be wrong to interpret lack of a formal record as indicating lack of attention or lack of action where these were obviously necessary.