BAUS Response to HSIB document

BAUS and the BAUS Section of Endourology acknowledges the Healthcare Safety Investigation Branch (HSIB) investigation into the delayed removal of a JJ stent, the specific need to log and track ureteric stents and the benefit of improved GP and patient communication for patients in whom a JJ stent has been inserted. We agree that ensuring patients and their GP are aware of the potential symptoms from stents, including symptoms mimicking urinary tract infection (UTI), as well as confirmed symptomatic microbiologically confirmed UTI that could be caused by a stent. We also agree that a clear plan of when, where and how the stent should be removed should be explicitly communicated to both the patient and the GP.

We confirm that we have noted the following key findings of the report:

• There is currently no national stent register being used across the NHS.
• Hospitals deploy a range of systems to track and log stent insertion. Some trusts also have systems to reconcile stent removal (that is, to log the removal of each patient's stent against the record of its insertion). Paper-based stent logging/tracking appears to be effective in the absence of electronic systems.
• The combination of human oversight and effective stent logging/tracking systems may be beneficial in preventing delayed removal of stents. Systems should not rely solely on human oversight.
• Other medical specialties which use ureteric stents may not use the same stent logging/tracking systems as the urology team.
• Patients being discharged with stents in situ need clear and consistent communication, both verbally and in writing.
• Involving patients in their care has been shown to improve the quality and experience of care.
• The written advice available for patients with ureteric stents is inconsistent across the country.
• Poor communication may lead to loss of opportunity for patients to self-care and be aware of potential complications with their stents.
• Clear information given to patients with tethered stents (stents that can be removed by the patient) ensures compliance with their planned removal schedule.
• GPs and other clinical staff working in primary and urgent care services may not be aware of the side effects and complications associated with ureteric stents.
• Hospital discharge letters and other communications do not carry standardised information for healthcare professionals about ureteric stents.
• The Summary Care Record system (which makes an electronically collated version of patients' healthcare records accessible to a range of clinical services) does not currently have a 'flag' or other method of identifying patients with ureteric stents.

In response to the report, the issues raised have been discussed at length during BAUS Section of Endourology committee meetings, and further input has been sought from the Urology GIRFT Joint National Clinical Leads ([redacted]), [redacted] in his role as NHSE National

Clinical Lead for Innovation, and [redacted], NCIP National Clinical Lead for Urology.

The theme of these meetings has been to agree that the morbidity of an inappropriately prolonged JJ stent dwell time is considerable and that encrusted stents represent a complex endourological challenge for their removal and subsequent patient management, including the possibility of loss of renal function.

However, whist we fully appreciate the consequences of the individual cases where this occurs and share the HSIB goal to improve patient safety by mitigating the risk of overdue stent removal or change, there is no clear picture as to the scale of the problem of delayed stent removal.

We do not have access to data that gives either the numerator of the number of encrusted stents in the UK per year, nor the denominator for the total number of stents that are inserted or changed in the UK per year. We feel that this data is vital to our understanding the scale of the problem of delayed stent removals and the impact of this on patients, as well as the associated medico-legal costs to the NHS.

Furthermore, as has been clearly elucidated in the HSIB report, stent tracking is a complex process requiring considerable IT and human resources. It relies on accurate record keeping for both the initial stent insertion as well as subsequent removal or exchange of that stent. The solutions will therefore require investment both in IT and personnel, as well as time to achieve the goal of reduced stent-dwell morbidity.

On this background, we have answered the HSIB report's Safety recommendations and observations as follows.

Safety recommendation R/2020/091:

It is recommended that the British Association of Urological Surgeons, in collaboration with other relevant specialties (such as the Royal College of Radiologists and British Transplant Society), develops national standards which support electronic and paper-based systems for stent logging/tracking. These standards should include guidance on monitoring and human oversight.

We agree with the HSIB recommendation that the insertion of a JJ stent should be a clear part of the operation note and discharge summary. In addition, we agree that some form of localised stent tracking is mandatory, but in the absence of a centralised NHS digital solution for tracking temporary implantable devices (such as stents and catheters), it is difficult for BAUS and partner organisations to develop consistent national standards. We recognise that Trusts across the country employ a range of mechanisms to track ureteric stents currently, and that these vary in terms of the human oversight required as well as in their integration with existing electronic patient care records. As a minimum standard, we suggest that:

1. Reasons for, and details of the ureteric stent insertion are clearly recorded in the operative record, or on a specific proforma which is to be attached to the patient's notes (an example can be found in Appendix 1).

2. All urology departments have a system in place to track ureteric stent insertion, change and removal, although we recognise that at present, the format of such tracking systems will vary.

3. Human oversight of the stent database is essential at present as there is no standardised IT solution which will alert the clinician to an overdue stent exchange or removal. Clinicians and administrative staff working within urology should be allocated time in their job plan to allow oversight of such a database, which represents a considerable amount of work.

4. Urologists should liaise with other colleagues who insert/manage patients with ureteric stents (principally radiologists, oncologists, transplant surgeons and gynaecologists) to ensure all patients with stents are monitored appropriately regardless of the clinical setting.

Safety recommendation R/2020/092:

It is recommended that the British Association of Urological Surgeons works with the Patient Information Forum to review its stent patient information leaflet. This should include accessibility and clinical considerations, especially with regards to side effects and complications, and advice on the action to take should concerns arise.

This point has been addressed by the new BAUS patient information leaflet (PIL) ("Living with a stent") published in 2022. The PIL has been updated with all the relevant information regarding stent symptoms, and now includes a section at the back of the leaflet which is to be filled in and given to the patient upon their discharge. This will provide patients with individualised information regarding their intended stent dwell time as well as with contact information for the relevant clinical team members (Appendix 2).

We hope that this improved PIL containing bespoke information will empower patients to take a role in shared-care of their stent as highlighted in the HSIB report.

Safety recommendation R/2020/093:

It is recommended that the British Association of Urological Surgeons provides guidance for staff working within the stone care pathway to promote consistent advice to patients as part of discharge planning.

In addition to the standardised information about stents in the newly updated BAUS PILs as detailed above, we have incorporated stent information as part of the BAUS Endourology/NHS GIRFT acute stone pathway, which was published last year. This GIRFT pathway emphasises the importance of primary treatment of obstructing stones unlikely to pass spontaneously (ideally within 48 hours) by means of extracorporeal shockwave lithotripsy (SWL) or ureteroscopy (URS). The pathway contains exemplars of best practice to demonstrate how this aspirational target can be achieved, including utilisation of urology area networks (UANs) to ensure patients have rapid access to necessary treatment. By encouraging the primary treatment of ureteric calculi, it is hoped that fewer "temporising stents" will be inserted in such

patients over time. Information regarding the GIRFT acute stone pathway has been disseminated widely at both the Section of Endourology annual meeting in October 2021 as well as at the main BAUS congress in 2022. We would encourage all urology units to continue to develop their localised pathways using the GIRFT best practice examples to guide them.

Safety recommendation R/2020/094:

It is recommended that the British Association of Urological Surgeons encourages members to include information in discharge letters and other communication sent to GPs and patients regarding patients' stent status, potential complications and the possibility of a retained stent.

We agree with this recommendation, and we would encourage that information regarding stent insertion and follow up is detailed clearly in the operative record. We have concerns that discharge information may already be long and complex, and information regarding stents is only one aspect that may need to be communicated to the GP. Due to variance in hospital IT systems, it is impossible to implement a digital "flag" which will be applied uniformly across the NHS.

As a minimum standard, we feel that GPs should be made aware of the following information on discharge letters/summaries.

- The reason for the insertion of the J-J stent
- The intended stent dwell time and whether it is intended that it will be removed or changed

We would suggest that all discharge information should be copied to patients and/or their carers. An example of a standardised discharge pro-forma that could be sent to GPs can be found in Appendix 3.

Time will be needed for busy GPs to ensure that this information is read and understood, and education programmes will be needed to help GP practices appreciate the similarities in symptoms of UTI and those that might be more directly attributable to a JJ stent.

Urinalysis (ideally formal microbiological culture rather than dipstick analysis) should be encouraged before patients are started on empirical antibiotics, unless they are febrile or otherwise systemically unwell.

We have also noted the additional safety observations in the report.

Safety observation R/2020/073:

The NHS Summary Care Records (SCR) system is being developed to allow for specific patient groups to be flagged. It may be beneficial for the British Association of Urological Surgeons to liaise with NHSX should opportunities arise in the future to use SCR to flag patients with ureteric stents to aid communication with primary/urgent care services.

We agree that there is a need for a digital / technological solution for stent tracking. However, it is apparent that there is no immediate solution to the technical problem of building a system to track temporary implanted devices – extending beyond stents to vascular access catheters, urinary catheters etc.

There seems to be no immediate prospect of device tracing being developed within the NHS, by device companies or by entrepreneurs as the practical issues are considerable, and the potential commercial return from developing and running such a system are uncertain.

Safety observation R/2020/074:

The National Institute for Health and Care Excellence guidance for the management of urinary tract infections does not include ureteric stents as a cause of urinary symptoms which could mimic a urinary tract infection. It may be beneficial for this potential complication to be considered in the next review of this and other clinical practice guidance.

We agree and would be very pleased to collaborate with the authors of this guidance.

Conclusions

Having taken all the above into account, we feel that the encrusted stent issue does not lie fully within BAUS' remit, nor within the GIRFT Urology programme and therefore wish to "flag up" that the problem is complex, short of data, and remains unresolved, despite this timely and important HSIB report.

We are pleased to have published the updated BAUS stent PIL and we feel that it provides patients with some clarity regarding stent symptoms, expected stent dwell time and contact details of the team responsible for management of their stent. It is however contingent on members of the clinical team filling in the information accurately.

Ultimately, improved information delivery will allow patients to act as equal partners in their stent care and they will hopefully feel more confident to alert clinicians to potential stent issues including delays to removal/change.

Importantly, we feel that clarity is needed with regard to "ownership" of the delayed stent removal issue, in particular as to which parts of the NHS should be taking a lead going forward. As an example of this, we feel that a large part of the issue is fundamentally one that should sit within individual trust clinical governance systems and yet there are no recommendations for action by trust medical directors in the HSIB report.

Finally, we suggest the following as points of action for BAUS and GIRFT to undertake.

1. Basic clinical governance responsibilities mean that there is a need for GIRFT and BAUS to flag up that the HSIB report has highlighted that patients remain at risk. GIRFT and BAUS will need to write to the National Director for Patient Safety (Aiden Fowler). The advice would be, at the very least, to request all medical directors of acute trusts to ensure that they have effective stent tracking processes in place, as detailed above.

2. BAUS will consider carrying out an audit of contemporary stent management practices. This could identify current approaches to stent tracking and attempt to quantify the problem of delayed removal of stents.

3. GIRFT could enquire about medico-legal costs through the GIRFT links with NHS Resolution.

4. To discuss with the Medical Device Safety Programme team how temporary device safety will be incorporated into their work.

5. BAUS may liaise with the Royal College of General Practitioners to discuss how information regarding stent symptoms and the importance of timely stent removal can best be disseminated to GPs.

Ex-Chair BAUS Section of Endourology – [redacted]

Honorary Secretary of BAUS Section of Endourology – [redacted]

President of BAUS – [redacted]