



Adverse Incidents, Complaints and Claims Lessons Learnt and Feedback Newsletter

Issue 1, January 2009

PATIENT SAFETY NEWS

PLEASE REPORT ANY SIMILAR INCIDENTS

An AIRI form was received relating to a CD oxygen cylinder that, although the contents gauge displayed full and the seals were still intact, the cylinder was found to be empty when an attempt was made to administer oxygen to a patient. Anecdotal evidence suggests that there have been similar incidents that have gone unreported. The matter has been reported to BOC. The Trust is currently awaiting a reply.

WRONG PATIENT / WRONG ADDRESS

It has been reported on more than one occasion that ambulance staff have either been presented with the wrong patient or given the wrong address when conveying a patient home from hospital.

Please be ever vigilant.

Your assistance is required to avoid harm to the patient by checking and double-checking your patient's name and destination. Remember when asking the patient for their name and address always to ask open-ended questions e.g. "can you please confirm your name and address". Always avoid asking closed questions e.g. "Are you Mrs T for the ????? Street?"

IS YOUR BM MACHINE ACCURATE?

An adverse incident report form has been received from another Trust raising concerns over the accuracy of one of our BM Machines. On investigation it was discovered that there was no documentary evidence to support that quality control checks had been undertaken.

As these machines are used daily and often to inform the diagnosis and treatment of a patient it is most important that they are regularly quality checked by a designated person(s).

METACLOPRAMIDE AND THE UNDER 20's

Paramedics beware! Several adverse incident reports have been received involving the administration of metaclopramide to patients under the age of 20.

"Best practice": Whenever/ wherever practicably possible refer to the JRCALC guidelines prior to administering any drug. This is especially relevant when administering medicines to young people.

CLAIMS AGAINST THE TRUST Who Pays?

We do! The first £25,000 of every successful claim is paid directly by the Trust. The balance (money in excess of £25,000) is paid by the Welsh Risk Pool (WRP). However, this is a risk pooling scheme, not an insurance policy. What's the difference? All monies held by the WRP comes from money paid into it from all the NHS organisations in Wales. So, whichever way you look at it, claims are funded from monies which could have been available for patient care. Over 90% of claims (staff and third party Road Traffic Collision personal injuries) received and settled by this Trust are small-value claims below £25,000. Therefore the majority of successful claims against the Trust are paid directly from its existing budget. Whilst this underlines the economic importance of learning lessons to prevent similar recurrences, the human cost for both patients and staff must not be forgotten.

SAFER PRACTICE

INFUSION FLUIDS

Several adverse incidents have been recorded which have involved the wrong type of infusion fluid being administered. The fluids involved have been:

- Sodium Chloride in 0.9%
- Sodium Chloride in 10% Glucose
- Sodium Lactate (Hartmans)

In the emergency situation one fluid can easily be mistaken for another, therefore raised awareness and

vigilance are required by all EMS staff in order to avoid any similar adverse incidents.

Remember It Only Takes Seconds!

Whenever/ wherever possible it is always advisable to double check with a colleague that the drug or infusion fluid you intend to administer to the patient is the correct one.

Patient Safety News For NHS Direct Staff

Right patient/wrong record

Remember, in order to select the correct record from the details provided by the patient you must have 3 confirmed matches from the following list:: Name, DoB, Post Code, Address, Phone Number. Any 3 matches from the list will ensure the correct record is attached to the correct patient.

Incorrect GPOOH Selection = Inappropriate Caldicott Breach

Recently there has been an increased number of patient details sent to the wrong GP Out of Hours service. Result = potential delay in patient care, and an inappropriate Caldicott Breach. Therefore take a second to ensure the GP selected is the right one.