Incident date	Date Reported on STEIS	SI Category	CSU	Description	Contributory factors
21/06/2012	29/06/2012	Wrong site surgery	Women's & Children's - Women's Health	Patient Had a laparasopic procedure/laparotomy/right salpingectomy on the but had to return back to theatre the following day for a laparotomy secondary to a missed daignosis.(Ruptured left Ectopic pregnancy) then had to have a repair of the left tube.	The management of the consent process within the Trust. Details of handover of patient between doctors not known Written World Health Organisation (WHO) checklist not being completed before surgery.
20/07/2017	04/08/2017	Surgical error (retained foreign body)	Women's & Children's - Women's Health	Patient was admitted for TVT cystoscopy and posterior repair. On the morning patient stated that night staff had checked for a vaginal pack in situ and couldn't see anything, they took the patients catheter out and the patient had passed x1 urine. Amall amount of gauze protruding from her vagina. On removal found that it was a surgical gauze x1	Final swab count undertaken before the completion of the invasive procedure (cather insertion)

18/02/2018	21/02/2018	Drug Incident (administration of medication by the wrong route)	Medicine - Acute & Care of the Elderly	Patient given oral solution Methadone in a syringe driver	Lack of knowledge of Methadone administration other than oral. Process of the second check carried out by staff nurses Communication - dr letter that accompanied the patient but did not highlight sub-cutaneous Methadone administration or instructions for administration Oral Methadone is not on the MK Formulary Reduced staffing levels to establishment The on-call pharmacist did not validate the syringe driver prescription
15/04/2015	21/05/2015	Surgical error (wrong implant/prosthesis)	Surgery - Head & Neck	Implant power 22.50 inserted when correct implant power should have been 25.50. Not recognised at time of procedure but error was noted when the patients notes were reviewed by specialist grade for second implant.	Illegible handwriting on the whiteboard may have contributed to the error Operating staff within theatres did not follow the checking procedure within the theatres operational policy.

18/05/2018	08/06/2018	Surgical Error (wrong site surgery)	Surgery - Head & Neck	A patient was reviewed in the MDT cleft clinic. It was noticed that two the teeth which were due to be extracted were still present. Secondly a tooth which was not part of the extraction plan had been removed.	Complicated dentition The photo was taken 8 months before surgery & filed historically in notes The responsible surgeon was not available for advice due to annual leave Team did not have all of the relevant information relating to the full treatment plan on he day The dental alignment on examination under anaesthesia did not reflect the notes or x-ray The notation of the teeth in the clinical notes was confusing in that supernumery teeth were also being noted as lateral incisor teeth and vice versa.

14/06/2017	26/06/2017	Surgical error (wrong implant/prosthesis)	Surgery - Musculoskeletal	As I was submitting data to the National Joint Registry - I noted that there was a mismatch of implants used on a trauma patient who undergone a hybrid (uncemented cup with cemented stem) total hip replacement. The cemented femoral component made by Stryker was used with a femoral head component made by Biomet. These two components should not be matched for this procedure because of their taper difference.	Communication Once removed from the packaging staff are not able to identify that non compatible component parts are being inserted since they look very similar and the prosthetic head would still fit into the cup peri-operatively There was a junior Scrub Team in theatre that day who were less familiar with the equipment and prosthesis/implants The World Health Organisation (WHO) checklist 'Time out' requires confirmation that staff have everything they need to proceed but there is no specific checks on the correct equipment or prosthesis/implants, and there is not documented formalisation of prosthesis/implant insertion at the 'Sign Out' There is no documented checking of the prosthesis/implants or signature of compatibility by the surgeon The Surgeon when verbalising agreement on the prosthesis in theatres before the boxes are opened is undertaking this from within the laminar flow 'curtains' making visibility of the wording on boxes less clear More than one system of prosthesis is used in the Trust to be best meet

					patients' needs The Scrub Nurse and SN have both confirmed that they were not aware of the incompatibility of stem/head mismatches

29/03/2017	31/03/2017	Wrong site surgery	Surgery - General Surgery	Patient scheduled and consented for left ureteric stent insertion. During sign out noted that stent had been inserted to right ureter.	The procedure took place on a day when the locum staff grade was very busy and he felt under pressure Legibility of the consent form Communication - surgeon/radiographer Staff do feel able to challenge senior staff however there are occasions when challenging colleagues is especially difficult when interventions are out of their scope of practice.
16/10/2012	30/10/2012	Surgical error (retained foreign body)	Women's & Children's - Women's Health	Mothers partner phoned labour ward to say partner has passed a swab. Confirmed/retrieved vaginal pack.	WHO surgical safety checklist is not routinely used for this type of procedure Another urgent operation was being planned in a second theatre to which staff were required for FY2 was being supervised by the SrT 6 who was present during the suturing however did leave for a short period to ascertain whether the next patient had been anaesthetised All on call doctors, for Obstetrics and Gynaecology (O & G), cover both Obstetric and Gynaecology patients therefore it is possible to be unavailable for some patients.

05/12/2018	07/12/2018	Surgical error (retained foreign body)	Women's & Children's - Women's Health	Retained swab post Kiwi delivery & suturing of tear	Locum registrar Missing swab not escalated Whiteboard not used to count swabs Communication -handovers Perineal Trauma and repair guideline not followed Staff awareness of checking process
08/06/2018	12/06/2018	Drug Incident (overdose of insulin due to abbreviations or incorrect device)	Medicine - Internal Medicine	Patient was given 4 mls of Actrapid instead of 4 units, subcutaneously.	Lack of knowledge of insulin administration from a vial and the difference between volume and units Communication - seeking of advice Staff nurse did not use effectively use the manufacturer's information provided clearly on the packaging of Actrapid to calculate the volume needed
18/09/2017	21/09/2017	Wrong site surgery	Core Clinical & Support Services - Diagnostic & Screening	The patient was admitted electively for a CT guided biopsy for the right lung mass.Post biopsy he developed pneumothorax. He was then repositioned from a prone position he had been for the biopsy to a supine position. This led to incorrect assessment and had a chest drain inserted in the left lung.	Emergency chest drain insertion Chaotic emergency situation with multiple staff involvement in a small CT scanner is not designed for the peri-arrest patients, which could have contributed to an already pressured situation There was a change of clinician performing the chest drain insertion

23/06/2014	23/03/2016	Wrong site surgery	Surgery - Head & Neck	Complaint received from the parents of a child in 2015 advising their child had come in for a biopsy on a lymph node on her neck. The result of this was that part of the thyroid gland was removed and damage was caused to the voice box.	In small children with lymph nodes it can be quite difficult to identify and differentiate between the various tissues. This type of surgery does not utilise imaging or ultra sound control.
30/04/2014	02/05/2014	Surgical error (retained foreign body)	Women's & Children's - Women's Health	Woman said she had felt something coming out of her vagina, the midwife checked and found a tampon which had been insitu since repair	Tampon removal was not formally checked by a vaginal/perianal sweep on completion of suturing by the Registrar Trust's Perineal Trauma and Care policy is not explicit with regards to swab/tampon/needle counts and whose responsibility this is Documentation White board not used for swab/tampon count Communications between all staff The swab count was undertaken by the midwife and student midwife. The Registrar did not count the swabs since from her perspective a second perineal suturing pack had not been opened and the initial count was undertaken by the midwife and the student midwife The tampon was not correctly inserted in line with Royal College of Midwives/Royal College of Obstetrician and Gynaecologists guidelines

16/07/2015	17/07/2015	Surgical error (wrong site surgery)	Surgery - Musculoskeletal	Patient consented for medial release left elbow. Procedure caried out was lateral release left elbow.	Consultant Orthopaedic Surgeon did not complete the consent form or mark the patient pre-operatively (which is their usual practice) since they were helping a colleague with another complex operative case which over ran. These were both later checked and confirmed as correct The WHO “Time Out” (final check) was undertaken before the Consultant Surgeon went to scrub. The WHO Surgical Safety Checklist notes that “Time out” should be read out loud before the start of the surgical intervention e.g. before knife to skin. The Theatre Operational Policy appendix for the WHO notes that “Time out” to be undertaken before skin incision The Registrar was called away and hence was not in theatre during the procedure – they may have noticed the wrong site if present in Theatre at the time of the incision

08/12/2016	09/12/2016	Falls from poorly restricted windows	Medicine - Specialty Medicine	Patient allegedly removed safety stop from window in bay, opened window and climbed out and fell from first level to ground. Significant fracture to left lower leg and fractured right lower leg	Patient agitation & withdrawl from alcohol There is no evidence of an appropriate risk assessment being completed to include moving the patient to another bed space, the provision of 1:1 care, potential of slips, trips and falls, from height as required by Health & Safety legislation and Trust Falls policy There is no evidence of an assessment of the window (following the patient's initial attempt to get out) to include the restrictors being in place (as per Estates and Facilities/EFA alerts and Health and Safety Executive/SE guidance) and the feasibility of the patient being able to get out via that route. There was no robust maintenance programme in place in relation to the checking of window restrictors

TheMKWay

CARE. COMMUNICATE.
COLLABORATE. CONTRIBUTE.

NHS
Milton Keynes
University Hospital
NHS Foundation Trust