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Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report to the Trust Board: 7th February 2019

Wider organisation learning from a Never Event:
Wrong eye injection in BMEC out patients on 25th October 2018

1. TRUST-WIDE ISSUES TO ADDRESS RISK OF SIMILAR EVENTS

1.1 Over the last 7 years there have been 7 never events reported from BMEC. In each case human error was a significant factor in each event, where correct procedure had not been followed, leading to the never event (wrong eye, wrong patient, wrong lens x 3, wrong laser surgery, retained object post op).

1.2 A more rigorous process for reviewing practice for undertaking these sorts of procedures for all operators and staff involved is needed. Particular groups to focus on will be new starters to the Trust as well as new team members.

1.3 Behaviours of established staff and individual team members need to be assessed on a regular basis to identify where challenges to attitude and behaviour may need to be made. This can be by way of reference to 360 degree appraisal as well as more frequent audit of performance in these at risk clinical settings. (The frequency of any form of audit will need to be reviewed by individual teams based on team working and procedure undertaken)

1.4 Learning from this never event should be disseminated through EQC asking for GDs to re-identify all clinical areas in their groups where wrong site procedure may occur. A report of these clinical areas and the safety checks already in place to make sure that error does not occur will be asked for. In addition, proposals for improving the checks that are already in place as well as any learning from the ophthalmology NE will be adopted where needed.

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