PACENET

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Clinical risk – Never Event

The problem

At a major hospital a patient attended for a pacemaker generator replacement. The pacing notes were unavailable. The operating consultant did not realise that one of the pacemaker leads was malfunctioning and required replacement. The generator was replaced without replacing the lead. This error was detected at the next pacing follow up. The event could be considered Wrong Implant surgery under the Never Event classification scheme. The patient sued.

The response

The absence of clinical records on the day of surgery was identified as the major contributory factor. The patient's main notes were available, but the pacing clinic notes were not. The lack of incorporation of these pacing notes into the main clinical record was also contributory. The Trust approached Clinical Network Systems to provide a solution which would ensure that all pacing records were always available at the time of surgery, and were also automatically incorporated into the Trust's main electronic medical record, available to all clinicians.

Highlight

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Your Contact

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