BRITISH ASSOCIATION OF PERINATAL MEDICINE

Learning from serious clinical events

Situation

The ability to learn from serious clinical events is a key part of delivering improvements to care

Background

BAPM EC has previously supported the sharing of serious clinical events via our neonatal (perinatal) networks. It was agreed that we would develop agreed statements with the referring network and then a BAPM sub-group would develop the lessons and send out to Network leads as well as post on the members section of the website with notification through the email bulletins.

Assessment

The enclosed statements are the lessons from serious incidents reported to BAPM sub-group over the past 12 months.

Recommendations

BAPM EC is asked to

- Agree the lessons are appropriate
- Agree to send these out to Network leads and post on members section of the website

Bryan Gill

President Elect

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BAPM:2011/0001

EVENT: Potential strangulation hazard from Medicina NG lines

Several of the units within a network have identified a hazard involving a long Medicina nasogastric tube. The tube can potentially cause a loop to be created whilst inserted in a baby's nostril by the green wire from the cap working free from the purple hub. This can be placed over the babies head. Review of incident reports by Medicina Ltd noted that increased lengths (80-120cm) of extension sets increased the risk of such an incident.

MHRA have been informed of the hazard and investigated. Medicina have now changed the specification for future production. Medicina Ltd are to publish a booklet on nasogastric tube placement including length of tube.

Key practice points

1. Review current NG tube policies and ensure they are compatible with national guidance (the Medicina booklet may help inform this)

2. Review the need for longer length NG tubes in view of observed risk, regardless of manufacturer type

3. Consider other potential sources of this complication, e.g. i.v. lines, monitoring leads

BAPM: 2011/002

Event: Incorrect dose of inotropes given following transfer

Baby was transferred between 2 units in the network by the neonatal transport team. The referral unit had commenced dopamine and dobutamine infusions, which were continued by the transport team. On arrival at the receiving unit the infusions were changed to the standard at this unit, resulting in a two fold overdose in inotropes for 1 hour.

Key Practice Points

1. Networks should aim for unified network guidelines for common infusions

2. On handover , and at the beginning and end of transfers, 2 staff to check dose and infusion rate of all drugs(recommended good practice)

BAPM: 2011/003

EVENT: Fracture or deformation of ETT introducers

Several units in a network have reported problems with ET tube stylets / introducers becoming lodged in the tube and becoming stretched or fractured on removal. This seems to occur almost entirely with narrow calibre (2.5 mm ET tubes) and despite lubrication.

Key practice points

- Try to avoid the use of introducers during intubation as they give the inexperienced operator the feeling that they can use greater force to pass the ETT than is appropriate/required

- Consider developing a stepwise practice by reserving the use of introducers in those cases deemed difficult.

- Consider switching from using saline for lubrication to using aquagel for those cases deemed to need an introducer. The index unit has found this to be straightforward and allows easier extraction of the introducer especially with the small ET tubes. There does not appear to have been problems with tube blockage from the use of the gel as they are using a light coating around the introducer.

- Difficult extraction of the introducer should alert the operator that there may be a problem with the introducer. Remove with extreme care. Examine introducer after extraction and before IPPV is instituted.

- If serious resistance is felt on removal of the stylet then remove ET tube and stylet together and reintubate.