NSW HEALTH

Safety Notice 008/09

31 March 2009

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Directors of Clinical Operations

Action required by:

- Directors of Clinical Governance

We recommend you also inform:

- Area Directors of Nursing and Midwifery
- Directors of Surgery
- Ophthalmologists
- Theatre Nurses

Expert Reference Group

Content reviewed by:

- Statewide Ophthalmology Service
- GMCT

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Insertion of intraocular lens

Reducing incorrect insertion of intraocular lens

Background

NSW Health has been notified of eleven incidents where the wrong size or type of intraocular lens has been inserted during surgery.

Contributing Factors

Contributing Factors resulting in the incorrect lens being inserted included:

1. not performing "Time Out" prior to surgery or not checking size and type of lens during "Time Out"
2. distraction or interruption during the checking process
3. the operating list order was changed, but the list change was not communicated to the surgeon and there was no check of the patient's ID in theatre
4. not checking the notes that arrived with the patient
5. confusing one patient for another patient due to similar names.

Suggested strategies for reducing incorrect insertion of the wrong lens

Processes for ensuring the correct patient is given the correct procedure on the correct site are detailed in the Correct Patient, Correct Procedure Correct Site policy (PD2007_079). The main steps confirm the patient's ID; Correct marking of the procedure site; and performing "Time Out" prior to the procedure to check the patient, procedure, site, implant and equipment. This policy should be followed for all surgical procedures.

A recommended lens insertion process reinforcing the the Correct Patient, Correct Procedure Correct Site policy (PD2007_079) specific to lens insertion surgery is attached and highlights the need to:

- verify the patient's ID by asking the patient their name and date of birth
- cross-check this information against the patient's notes and their ID band
- confirm the correct lens for the patient just prior to surgery, using the notes with the patient
- not select the lens until the patient arrives
- not lay out lenses in list order, as order may change
- take only one lens into the theatre at any one time
- involve the whole team in "Time Out" prior to the procedure to check the patient, procedure, site, implant and equipment

Suggested Actions by Area Health Services:

1. Ensure that this Safety Notice is distributed to all relevant clinical staff.

2. Review intraocular lens insertion practices to ensure staff comply with the Correct Patient, Correct Procedure Correct Site policy (PD2007_079), using the recommended intraocular lens insertion process as a guide. (Attached)

3. Please ensure staff are aware that further information is available via the CIAP website at:http://www.ciap.health.nsw.gov.au/ or http://internal.health.nsw.gov.au:2001/